Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY PUBLIC

November 6, 2023

[redacted], EXECUTIVE DIRECTOR
EC OPCO BERWICK LLC
[redacted]

RE: CELEBRATION VILLA OF BERWICK
2050 WEST FRONT STREET
BERWICK, PA, 18603
LICENSE/COC#: 22717

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/12/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *CELEBRATION VILLA OF BERWICK* **License #**: *22717* **License Expiration**: *07/09/2024*

Address: *2050 WEST FRONT STREET, BERWICK, PA 18603*

County: *COLUMBIA* **Region**: *NORTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *EC OPCO BERWICK LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/06/1998* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *61* **Waking Staff**: *46*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal* **Exit Conference Date**: *09/12/2023*

Inspection Dates and Department Representative

09/12/2023 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *76* **Residents Served**: *48*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *48*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *13* **Have Physical Disability**: *1*

Inspections / Reviews

09/12/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/21/2023*

10/30/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/06/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/06/2023*

Inspections / Reviews *(continued)*

11/06/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/06/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/09/2023*

11/06/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/06/2023*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

3c Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The home did not have the License Inspection Summary (LIS) report dated 6/1/22 posted conspicuously in the home as required.

Plan of Correction ***Accept (- 10/30/2023)***

Action: The Executive Director obtained a copy of the 6/1/2022 violation report and placed it in the violation summary report book located in the lobby entrance the same day as the survey, 9/12/2023.

Training: The Executive Director and members of the leadership team will be educated on regulation 2600.3c by 11/3/2023.

Ongoing: License Inspection Summary will be placed in the violation summary report book located in the lobby entrance after each inspection by the Executive Director or Administrative Assistant.

Licensee's Proposed Overall Completion Date: *11/03/2023*

Implemented (- 11/06/2023)

18 Compliance With Laws

2. Requirements

2600.
18. Applicable Health and Safety Laws A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The home's gas fired hot water heater did not have a carbon monoxide monitor installed 15 feet from it as required by the Care Facility Carbon Monoxide Monitoring Act.

Plan of Correction ***Accept - 10/30/2023)***

Action: The Maintenance Director immediately, on 9/12/2023, installed a carbon monoxide detector 15 feet from the gas fired hot water heaters. The Maintenance Director will audit the entire facility for proper carbon monoxide detector placement by 11/3/2023 and place/replace any carbon monoxide detectors found to not be in compliance with 2600.18.

Training: The Executive Director will provide the Maintenance Director with education regarding regulation 2600.18 by 11/3/2023.

Ongoing: The Executive Director will monitor for and ensure compliance with regulation 2600.18 during monthly quality assurance meetings beginning October 2023, and in monthly maintenance TELS logs which prompt the Maintenance Director to check and record carbon monoxide detector placement and function monthly.

18 Compliance With Laws *(continued)*

Licensee's Proposed Overall Completion Date: *11/03/2023*

Implemented ([redacted] - 11/06/2023)

65g - Annual Training Content

3. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff persons A and B did not have annual training on emergency preparedness and resident rights for the 2022 training year. Staff person C did not have fire safety training by a fire safety expert or training on emergency preparedness for the 2022 training year.

Plan of Correction ***Accept [redacted] - 10/30/2023)***

Action: Staff members A and B were educated on emergency preparedness on 10/18/2023 and residents rights on 9/21/2023. The Maintenance Director will train staff member C with annual fire safety training by 11/30/2023.

Training: The Executive Director will provide the Maintenance Director with education regarding regulation 2600.65.g by 11/3/2023. The Maintenance Director is enrolled in a 3 hour Train the Trainer fire safety training course scheduled for 11/8/2023 and will provide all staff with an in person fire safety training to be in compliance with regulation 2600.65.g by 11/30/2023.

Ongoing: The Executive Director and Administrative Assistant will audit all employee files monthly for compliance with regulation 2600. 65.g.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Implemented ([redacted] - 11/06/2023)

101j7 - Lighting/Operable Lamp

4. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Room 149 did not have a light source that could be reached at bedside.

101j7 - Lighting/Operable Lamp *(continued)*

Plan of Correction ***Accept (- 10/30/2023)***

Action: Room 149 was provided with an operable lamp placed within arm's reach of the resident's bed. All rooms were audited for a light source that is within arm's reach on 9/12/2023.

Training: The Executive Director or Maintenance Director will provide staff with education regarding regulation 2600. 101.j by 11/3/2023. Staff will be educated to monitor for and report to the leadership team any rooms that do not have an operable light source within arm's reach, and to provide the resident with a light source that is within arm's reach immediately, by 11/3/2023.

Ongoing: Direct Care Staff and/or the leadership team will monitor resident's rooms daily during care and report any room(s) found to be without a light source within arm's reach at bedside. The leadership team will review any reports at the monthly quality assurance meetings beginning October 2023.

Licensee's Proposed Overall Completion Date: *11/03/2023*

Implemented - 11/06/2023)

103i - Outdated Food

5. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

In the kitchen there was freeze dried dill with a date of 5/4 on it, there was no year.There were 3 containers of sour cream in the refrigerator. All had an expiration date of 9/1/2023.There was a container of Hershey's Strawberry Syrup with an expiration date of 8/2023.

Plan of Correction ***Accept - 10/30/2023)***

Action: The Dining Services Director immediately discarded all outdated/expired food items.
Training: The Executive Director or Dining Services Director will provide the Dining Services staff with education on regulation 2600. 103.i by 11/3/2023.

Ongoing: The Dining Services Director and/or dining staff will monitor food item expiration dates during daily refrigerator/freezer temperature checks. This will be reviewed during monthly quality assurance meetings beginning October 2023.

Licensee's Proposed Overall Completion Date: *11/03/2023*

Implemented (- 11/06/2023)

121a - Unobstructed Egress

6. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

121a Unobstructed Egress *(continued)*

Description of Violation

During the initial walk through, exit #4 was blocked from egress due to a resident sitting outdoors directly in front of the exit.
Also, a row of chairs in the activity room were placed directly in the path of the exit door of the activity room.

Plan of Correction ***Accept (- 10/30/2023)***

Action: The Executive Director asked the resident blocking exit door #4 with his motor scooter to vacate the area of the exit door and provided the resident with verbal education regarding the dangers of obstructing fire exits. The chairs in the activity room were immediately moved out of the path of the exit no longer obstructing the exit. Do not block exit signs were placed on the inside and outside of all exit doors. The Maintenance Director will check sign placement during assigned weekly checks.

Training: The Executive Director will provide staff members with education regarding regulation 2600. 121.a by 11/3/2023.

Ongoing: The Executive Director, Maintenance Director and members of the leadership team and staff will monitor fire exits for proper unobstructed egress daily when walking through the community. The Maintenance Director will document weekly via TELS maintenance logs. The leadership team will review findings at the monthly quality assurance meetings beginning October 2023.

Licensee's Proposed Overall Completion Date: *11/03/2023*

Implemented - 11/06/2023)

125a - Combustible Storage

7. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

The outdoor smoking area of the home revealed that the cigarette butt receptacle placed in the area is not being utilized by residents and staff. Numerous cigarette butts were observed covering the ground areas surrounding the smoking area.
In the Mechanical room within close proximity to the natural gas hot water heater, were cardboard, two cans of paint, and two cans of spray paint, all combustible items.

Plan of Correction ***Accept (- 10/30/2023)***

Action: All flammable substances and materials removed from the proximity of the gas fired hot water heaters by the Maintenance Director on 9/12/2023. "Do not store flammable materials within 3 feet of hot water heaters" conspicuously placed near hot water heaters by the Maintenance Director on 9/12/2023. On 9/12/2023 the Maintenance Director cleaned the smoking area of all cigarette butts that were discarded on the ground and placed signs stating to "Keep the area clean and use cigarette butt receptacle."

Training: The Executive Director will educate all staff regarding regulation 2600.125.a by 11/3/2023. Residents who smoke were provided with verbal education regulation 2600.125.a.

125a - Combustible Storage (continued)

Ongoing: The Executive Director, staff members and members of the leadership team will monitor and clean the designated smoking area daily to remain in compliance with regulation 2600.125.a. This will be reviewed at the monthly Quality Assurance meeting beginning October 2023.

Licensee's Proposed Overall Completion Date: *11/03/2023*

Implemented (- 11/06/2023)

132c - Fire Drill Records

8. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The following fire drills documented on the home's fire drill logs are recorded in minutes only and not in minutes and seconds: 8/11/22, 9/29/22, 10/26/22, 12/30/22, 1/24/23, 2/22/23, 4/24/23, 5/10/23, 7/18/23.

Plan of Correction ***Accept (- 10/30/2023)***

Action: The Executive Director immediately, on 9/12/2023, provided the Maintenance Director with education regarding regulation 2600. 132.c to prevent further non-compliance with this regulation.

Training: The Executive Director immediately provided the Maintenance Director with education regarding regulation 2600. 132.c. The Maintenance Director is enrolled in a 3-hour Train-the-Trainer fire safety course scheduled for 11/8/2023.

Ongoing: The Executive Director and/or Maintenance Director will monitor monthly fire drill log sheets for compliance with regulation 2600. 132.c. The leadership team will review the fire drill logs at the monthly Quality Assurance meeting beginning October 2023.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented - 11/06/2023)

132h - Designated Meeting Place

9. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

132h

The home's fire drill logs indicate that not all residents were evacuated during the following fire drills:

6/10/22—45 residents were in the home; 24 residents were evacuated.

7/22/22—48 residents were in the home; 25 residents were evacuated.

132h - Designated Meeting Place (continued)

This is a repeat violation from 6/1/22.
The fire drill logs also indicate during the 9/29/22 fire drill, staff were observed evacuating residents past the simulated fire area and during the 11/22/22 fire drill 1 resident was evacuated to the simulated fire area instead of a fire safe area.

Plan of Correction ***Accept (- 10/30/2023)***

Action: The Executive Director immediately, on 9/12/2023, provided the Maintenance Director with education regarding regulation 2600.132.h to prevent further non-compliance with this regulation.

Training: The Executive Director will educate all staff members regarding regulation 2600.132.h by 11/3/2023. The Maintenance Director is enrolled in a 3-hour Train-the-Trainer fire safety course scheduled for 11/8/2023. The Executive Director will be present during the next three fire drills to evaluate the process starting the month of November. This will be reviewed at Quality Assurance meeting starting October 2023. Fire Safety will be reviewed with residents immediately following the November 2023 fire drill.

Ongoing: The Executive Director and Administrative Assistant will monitor and ensure compliance with regulation 2600. 132.h by reviewing the fire drill log upon completion of the fire drill, and if necessary, conduct a follow-up fire drill for education for safety and compliance. The leadership team will review fire drill logs at the monthly quality assurance meetings beginning October 2023.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented - 11/06/2023)

183d - Prescription Current

10. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

The medication cart contained a blister pack of tablets for resident #1.
The resident did not have a current order for this medication.

Plan of Correction ***Accept 10/30/2023)***

Action: The Director of Nursing immediately removed the omeprazole 20mg tablets from the medication cart. This order was an active Veteran Affairs medication that was changed by the Primary Care Physician to pantoprazole 40mg but was not changed with the Veteran Affairs office, the Veteran Affairs pharmacy continued to send the omeprazole 20mg. Full medication cart audits using the medication cart audit tool were conducted by the Director of Nursing on 9/14/2023.

Training: The Executive Director will educate all clinical staff members regarding regulation 2600.183.d by 11/3/2023, and complete random medication cart audits starting 10/23/2023 for three months.

Ongoing: The Executive Director and Director of Nursing will ensure compliance with regulation 2600.183.d by completing weekly medication cart audits using the Medication cart audit tool starting on 10/23/2023. The

183d - Prescription Current (continued)

leadership team will review the medication cart audits at the monthly quality assurance meetings beginning November 2023.

Licensee's Proposed Overall Completion Date: *11/03/2023*

Implemented [redacted] - 11/06/2023)

185a - Implement Storage Procedures

11. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #2 has PRN orders for [redacted]. These medications were not on hand to administer if needed.
Resident #1 has a PRN order for [redacted], which was not on hand for administration.
Resident #3 has a PRN order for [redacted] which was not on hand for administration.

Plan of Correction ***Accept[redacted] - 10/30/2023)***

Action: Primary Care Physician made aware of resident's nonuse of as needed[redacted] with [redacted] and discontinued the medications, [redacted] was reordered and delivered by the pharmacy. Resident #1's medication was on hand and was stored in the medication storage room. Resident #3's medication was found in the medication cart in another residents "as needed" slot behind resident #3's slot.

Training: The Executive Director and/or Director of Nursing will educate clinical staff on regulation 2600.185.a and educate clinical staff on procedure to reorder as needed medications by 11/3/2023. Full medication cart audits using the medication cart audit tool were conducted by the Director of Nursing on 9/14/2023.

Ongoing: The Executive Director and /or the Director of nursing, and/or the Assistant Director of Nursing will complete weekly medication cart audits to ensure all active orders are available as and when needed. The leadership team will review the medication cart audits at monthly quality assurance meetings starting November 2023.

Licensee's Proposed Overall Completion Date: *11/03/2023*

Implemented [redacted] - 11/06/2023)

187a - Medication Record

12. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.

187a - Medication Record *(continued)*

5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #1 has an order for [redacted]; the medication is not listed on the Medication Administration Record (MAR).
Resident #1's MAR lists the medication [redacted]; this is not a currently prescribed medication for the resident.

Plan of Correction ***Accept (JH - 10/30/2023)***

Action: On 9/12/2023 Primary Care Physician was made aware of medication error and that [redacted] is a current Veteran Affairs medication and that [redacted] is not a current Veteran Affairs medication. Primary Care Physician discontinued [redacted] and ordered [redacted] in its place. Pharmacy updated Medication Administration Record to [redacted]. Medication error reported to the Department of Human Services on 9/12/2023. Resident, who is his own responsible party was made aware of medication error on 9/12/2023 as well.

Training: The Executive Director and Director of Nursing will educate the Medication Technicians on regulation 2600.187.a by 11/3/2023. The Executive Director and/or Director of Nursing will educate the Medication Technicians on the resident's 5 rights of medication administration by 11/3/2023. Medication Technicians will be observed administering medications by a Certified Medication Administration Trainer weekly for 2 weeks and 4 weeks later starting the week of 10/23/2023.

Ongoing: The Executive Director and/or the Director of Nursing will ensure compliance with regulation 2600.187.a by completing weekly medication cart audits starting on 10/23/2023. The leadership team will review the medication cart audits at the monthly quality assurance meetings beginning November 2023.

Licensee's Proposed Overall Completion Date: *11/03/2023*

Implemented [redacted] - 11/06/2023)

187b - Date/Time of Medication Admin.

13. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

The medication [redacted] is listed on the MAR for resident #1. The medication was initialed as administered. There is no current order for this medication and the medication was not in the med cart. The medication that was actually administered in place of [redacted] is [redacted]. Staff initialed the medication [redacted] as administered when it was not administered. Staff did not initial the medication Jardiance 25mg when it was administered because it was not

187b - Date/Time of Medication Admin. (continued)

listed on the MAR.
Also for resident #1, The medication [redacted] is listed on the resident's MAR, but was not found in the medication cart and is initialed as administered. The medication [redacted] which is not currently ordered for the resident, was administered in error.
This occurred from 9/1/23 through 9/12/23 daily.

Plan of Correction ***Accept [redacted] - 10/30/2023)***

Action: On 9/12/2023 Primary Care Physician was made aware of medication error and that [redacted] is a current Veteran Affairs medication and that [redacted] is not a current Veteran Affairs medication. Primary Care Physician discontinued [redacted] and ordered [redacted] in its place. Pharmacy updated Medication Administration Record to [redacted]. Medication error reported to the Department of Human Services on 9/12/2023. Resident, who is his own responsible party was made aware of medication error on 9/12/2023 as well.

Training: The Executive Director, Director of Nursing, and/or Assistant Director of Nursing will educate clinical staff on regulation 2600.187.b by 11/3/2023. The Executive Director, Director of Nursing, and/or Assistant Director of Nursing will educate clinical staff on the resident's 5 rights of medication administration by 11/3/2023. Medication Technicians will be observed administering medications by a Certified Medication Administration Trainer weekly for 2 weeks, then 4 weeks later starting the week of 10/23/2023.

Ongoing: The Executive Director and/or the Director of Nursing will ensure compliance with regulation 2600.187.b by completing weekly medication cart audits starting on 10/23/2023. The leadership team will review the medication cart audits and Medication Technician medication administration observations at the monthly quality assurance meetings beginning November 2023.

Licensee's Proposed Overall Completion Date: *11/03/2023*

Implemented ([redacted] - 11/06/2023)

187d - Follow Prescriber's Orders

14. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #1 has a current order for [redacted] The home did not administer this medication from 9/1/23 to 9/12/23 because it was not available in the medication cart. The home administered the medication [redacted] from 9/1/23 to 9/12/23; this medication is not currently ordered for the resident.
Resident #1 also has an order for [redacted], 1 capsule daily which was not administered on 9/9/23 and 9/12/23 because it was not available in the medication cart.
Resident #4 has an order for sliding scale insulin to be administered with meals and at bedtime. On 9/11/23 at 8pm there is a blood glucose reading of [redacted] documented on the MAR with 9 units of insulin administered. There was no blood glucose reading of [redacted] found in the resident's glucometer to confirm this reading and the requirement to administer 9 units of insulin.

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction ***Accept (- 10/30/2023)***

Action: On 9/12/2023 Primary Care Physician was made aware of medication error and that [redacted] is a current Veteran Affairs medication and that pantoprazole 40mg is not a current Veteran Affairs medication. Primary Care Physician discontinued [redacted] and ordered omeprazole 20mg in its place. The pharmacy updated the Medication Administration Record to [redacted]. Medication error reported to the Department of Human Services on 9/12/2023. Resident, who is his own responsible party made aware of medication error on 9/12/2023 as well. On 9/12/2023 Primary Care Physician and resident were made aware of missed probiotic medication doses; this was reported to the Department of Human Services. The probiotic medication was reordered and delivered by the pharmacy. Education provided to medication technician on accuracy of Medication Administration Record reporting.

Training: The Executive Director, Director of Nursing, and/or Assistant Director of Nursing will educate clinical staff on regulation 2600.187.d by 11/3/2023. The Executive Director, Director of Nursing, and/or Assistant Director of Nursing will educate clinical staff on the resident's 5 rights of medication administration by 11/3/2023. Medication Technicians will be observed administering medications by a Certified Medication Administration Trainer weekly for 2 weeks, then 4 weeks later starting the week of 10/23/2023.

Ongoing: The Executive Director, Director of Nursing, and/or Assistant Director of Nursing will monitor compliance with regulation 2600.187.d by completing weekly medication cart and glucometer audits using starting on 10/23/2023. Director of Nursing and/or the Assistant Director of Nursing will observe the Medication Technicians obtaining blood sugars once weekly for 4 weeks starting 10/23/2023. The leadership team will review the medication cart and glucometer audits at the monthly quality assurance meetings beginning October 2023.

Licensee's Proposed Overall Completion Date: *11/03/2023*

Implemented (- 11/06/2023)

190b - Insulin Injections

15. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff person A is a med tech and administers insulin to residents. Staff person A did not have training in insulin administration by a certified diabetes educator within the last 12 months.

Plan of Correction ***Accept - 10/30/2023)***

Action: Staff member A was scheduled to take the diabetic training the same day as the survey, 9/12/2023 at 4pm and successfully completed the training.

Training: The Executive Director, Director of Nursing, and/or Assistant Director of Nursing will provide education to clinical staff regarding regulation 2600. 190.b by 11/3/2023.

190b - Insulin Injections (continued)

Ongoing The Executive Director, Director of Nursing, and/or Assistant Director of Nursing will monitor and schedule yearly staff diabetic training to remain in compliance with regulation 2600. 190.b. The next diabetic training is tentatively scheduled for July 2024. The leadership team will review audits at the monthly quality assurance meetings starting October 2023.

Licensee's Proposed Overall Completion Date: *11/03/2023*

Implemented [redacted] - 11/06/2023)

227h - Support Plan Refuse Sign

16. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident Assessment and Support Plan for Resident #5 was not signed by the resident. There was no indication why the resident did not sign it.

Plan of Correction ***Accept [redacted] - 10/30/2023)***

Action: The Executive Director completed full Resident Assessment and Support Plan audits of all residents to ensure completeness which was completed by 9/18/2023.

Training: The Executive Director will educate the clinical leadership team on regulation 2600.227.h by 11/3/2023.

Ongoing: The Executive Director, Director of Nursing, and/or Assistant Director of Nursing will review all new Resident Assessment and Support Plan's to remain in compliance with 2600.227.h. The leadership team will review audits at the quality assurance monthly meetings starting November 2023.

Licensee's Proposed Overall Completion Date: *11/03/2023*

Implemented [redacted] 11/06/2023)