



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to EC OPCO CHIPPEWA LLC

LEGAL ENTITY

To operate CELEBRATION VILLA OF CHIPPEWA

NAME OF FACILITY OR AGENCY

Located at 104 PAPPAN BUSINESS DRIVE, BEAVER FALLS, PA 15010

(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide Personal Care Homes

TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed

85

or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions: Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 20

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes

(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from November 5, 2021 until May 5, 2022,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **449011**


ISSUING OFFICER


DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable
and should be posted in a conspicuous place in the facility.

HS 628P – 01/21



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: November 29, 2021

[REDACTED]
EC OPCO Chippewa LLC
Eclipse Sr Liv
Attn: Licensing
5885 Meadows Road, Suite 500 Lake
Oswego, Oregon 97035

RE: Celebration Villa of Chippewa
104 Pappan Business Drive
Beaver Falls, Pennsylvania 15010
License/COC#: 449011

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on February 24, 2021, February 25, 2021, May 6, 2021, May 7, 2021, May 24, 2021 and July 19, 2021, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (449010) dated January 18, 2021 to January 18, 2022. Additionally your certificate of compliance dated January 18, 2022 to January 18, 2023 is REVOKED. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). This FIRST PROVISIONAL license replaces all previously issued licenses. The certificate of compliance dated January 18, 2022 to January 18, 2023 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. Your FIRST PROVISIONAL license is enclosed and is valid from November 5, 2021 to May 5, 2022.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with Choose an item., must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 or § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 or 2800	Class of Violation	Census at Inspection X	Fine Per resident Per day	Calculated Fine = Per day_____	Mandated Correction Date (to avoid Fine)
<hr/>					
Section:					
<hr/>					
60a	II	47	\$5	\$235	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Shivani Patel, Enforcement Manager
 Pennsylvania Department of Human
 Services Bureau of Human Services
 Licensing Room 631, Health and Welfare
 Building 625 Forster Street
 Harrisburg, Pennsylvania 17120
 PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

The license indicates the facility's recent change in the name from Elmcroft of Chippewa to Celebration Villa of Chippewa.

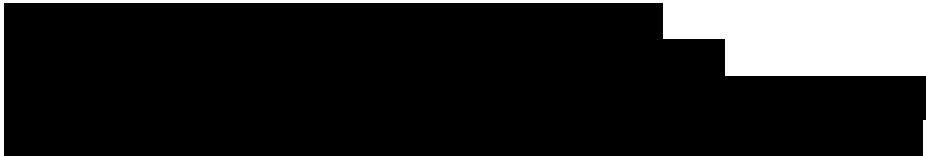
Sincerely,

A handwritten signature in black ink that reads "Jamie F. Buchenauer". The signature is written in a cursive, flowing style.

Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
License
Licensing Inspection Summary

cc:

A large rectangular area of the document has been completely redacted with black ink, obscuring several lines of text.

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

Facility Information

Name: *ELMCROFT OF CHIPPEWA* License #: *44901* License Expiration Date: *01/18/2022*
Address: *104 PAPPAN BUSINESS DRIVE, BEAVER FALLS, PA 15010*
County: *BEAVER* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: *7248913333* Email: [REDACTED]

Legal Entity

Name: *EC OPCO CHIPPEWA LLC*
Address: *5885 MEADOWS ROAD, SUITE 500, ECLIPSE SR LIV ATTN LICENSING, LAKE OSWEGO, OR, 97035*
Phone: *7248913333* Email: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *59* Waking Staff: *44*

Inspection

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *02/24/2021*

Inspection Dates and Department Representative

02/24/2021 - On-Site: [REDACTED]

02/25/2021 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* Residents Served: *44*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *20* Residents Served: *15*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *44*
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *15* Have Physical Disability: *0*

Inspections / Reviews

02/24/2021 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/25/2021*

Inspections / Reviews (*continued*)

4/27/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *05/04/2021*

5/4/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *06/01/2021*

8/31/2021 - Document Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Exception*

42b - Abuse

1. Requirements

2600.

- 42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #1's assessment and support plan, dated 12/20/20, indicates [REDACTED] is able to propel [REDACTED] in [REDACTED] wheelchair and staff will assist as needed. The home has an alarm system on the front door which is activated from 11:00 PM - 7:00 AM to alert staff if a resident exits the building. On [REDACTED]/21 at approximately [REDACTED] AM, the home failed to reactivate the alarm on the front door, which was disengaged to permit entry for an ambulance crew. Sometime thereafter, resident #1 eloped through the front door in [REDACTED] wheelchair to the outside.

On [REDACTED]/21 at [REDACTED] AM, resident #1 was found crawling on the ground near the front door of a neighboring dialysis clinic, approximately 500 feet downhill from the home, by a clinic employee. [REDACTED] was dressed only in a nightgown, had blood on [REDACTED] hands and feet and there was blood on the ground. [REDACTED] wheelchair was laying approximately 100 feet away from [REDACTED] in the snow. [REDACTED] was transported by ambulance to the emergency room where [REDACTED] presented with altered mental status and a body temperature of 87 degrees Fahrenheit. [REDACTED] was diagnosed with hypothermia, pericardial effusion, atrial fibrillation with rapid ventricular response and had abrasions on [REDACTED] upper and lower extremities.

42b - Abuse (continued)

Plan of Correction

Directed

Immediate Action

2/24/2021 Staff on duty night of [REDACTED]-21 were retrained on door alarms/re-setting door alarms and rounding to confirm that residents are in their rooms. Attachment A

[REDACTED]/2021 Proper functioning of door alarm was verified by Maintenance Director.

March 3 and March 4, 2021 -Executive Director completed a walk thru and in-serviced random staff during the walk-thru. In-service included review of the incident and re-training on door alarms. Attachment B

March 2021 Staff meeting -Incident was reviewed at staff meeting and all available staff on all shifts re-trained on doors alarms and rounding to check on residents. Attachment C

Training:

All employees will be re-trained on Regulation 42.b, the use of door alarm activation and proper re-setting by Executive Director or designee. Part of the training material is Older Adult Protective Services power point. Attachment D

To be completed by 5/31/2021

Executive Director contacted Adult Protective Services to request training. APS will send a ZOOM invite to all staff for 6/2/2021 at 2:00 pm for additional training to focus on signs and symptoms of confusion, disorientation, and elopement. For those that cannot attend the 6/2/2021 training a power point will be available for training by Executive Director or designee. Training will be completed by 6/15/2021.

All new associates will be trained upon hire on abuse and neglect (42.b) and all new hires and current staff will be trained annually on abuse and neglect (42b.)

Ongoing Monitoring:

Administrator or Designee will interview three residents each week for two months to assess for any concerns regarding care, safety and treatment, and, verify door alarms are activated and rounds are completed. Maintenance Director and/or Designee will conduct weekly check of all door alarms for proper functioning and keep documentation. All items will be reviewed on monthly basis at Quality Assurance meeting.

Directed:

Immediately upon receipt and daily thereafter at the beginning and end of each shift, a designated staff person shall inspect all alarmed doors to ensure the alarm is engaged and functioning properly. Documentation shall be kept.

SQ 5/4/21

During the next quality management plan review and evaluation, the home shall place an increased emphasis on these plans of correction and take action to improve the quality of its resident rights training for all newly hired staff within 40 scheduled working hours in accordance with §2600.65(b)(1) and annually in accordance with §2600.65(g)(3).

SQ 5/4/21

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

Facility Information

Name: *ELMCROFT OF CHIPPEWA* License #: *44901* License Expiration Date: *01/18/2022*
Address: *104 PAPPAN BUSINESS DRIVE, BEAVER FALLS, PA 15010*
County: *BEAVER* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: *7248913333* Email: [REDACTED]

Legal Entity

Name: *EC OPCO CHIPPEWA LLC*
Address: *5885 MEADOWS ROAD, SUITE 500, ECLIPSE SR LIV ATTN LICENSING, LAKE OSWEGO, OR, 97035*
Phone: *7248913333* Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *05/22/1999* Issued By: *Labor & Industry*
Type: *I-1* Date: *03/18/2011* Issued By: *Chippewa Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *58* Waking Staff: *44*

Inspection

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *05/24/2021*

Inspection Dates and Department Representative

05/06/2021 - On-Site: [REDACTED]
05/07/2021 - Off-Site: [REDACTED]
05/24/2021 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* Residents Served: *44*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *20* Residents Served: *9*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *44*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *14* Have Physical Disability: *0*

Inspections / Reviews

05/06/2021 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *07/05/2021*

7/2/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *07/12/2021*

7/9/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *08/01/2021*

8/31/2021 - Document Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Exception*

16c - Written Incident Report

1. Requirements

2600.

- 16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident #1's initial assessment and support plan, dated [REDACTED]/21, indicates [REDACTED] is not independent in bathing and direct care staff will provide assistance. On [REDACTED]/21 at approximately [REDACTED] AM, resident #1 awoke, got dressed and ready for breakfast. Staff person B entered [REDACTED] room and informed [REDACTED] needed to take a shower. Resident #1 told staff person B [REDACTED] was already dressed and ready for breakfast and [REDACTED] could get [REDACTED] shower after breakfast. Staff person B insisted [REDACTED] take [REDACTED] shower, proceeded to turn on the shower water and provided the resident with a washcloth and towel. Resident #1 undressed and got into the shower. Staff person B left the room, stating [REDACTED] would be right back. Resident #1 finished showering, turned off the water, and when exiting the shower, slipped and fell on the bathroom floor. Resident #1 was unable to stand and dragged [REDACTED] across [REDACTED] bathroom floor to a chair in [REDACTED] bedroom, where staff person B found the resident when [REDACTED] returned to the room. Resident #1 was transported via ambulance to the emergency room (ER), where [REDACTED] reported to ER staff [REDACTED] got out of the shower without any help and fell directly onto [REDACTED] left knee and was able to drag [REDACTED] to the chair and push [REDACTED] up. Resident #1 was diagnosed with a left displaced and depressed tibial plateau fracture and large lipohemarthrosis, [REDACTED] was admitted to the hospital, had surgery, and was discharged to a skilled nursing facility [REDACTED] 21.

On 4/14/21, resident #1's POA reported to staff person A, the home's administrator, that resident #1 stated no staff were present in [REDACTED] room on [REDACTED] 21, when [REDACTED] fell while exiting the shower, sustaining a serious injury. However, the home did not report this allegation to the Department until 5/8/21.

Plan of Correction

Accept

A state reportable was submitted by Administrator on [REDACTED].2021 for allegations of abuse/neglect that occurred on [REDACTED].2021.

The Administrator reported allegation of abuse/neglect to OAPS on 5.8.2021 that occurred on [REDACTED].2021.

Administrator will conduct a training with all current managers on 16c Written incident reports and Act 13 OAPS reporting by July the 9th 2021.

A new Administrator will be starting July the 12th 2021 [REDACTED] will receive training on 16c Written incident reports as well as Act 13 reporting within [REDACTED] first 40 hours of work and annually as well.

Administrator or designee will continue to monitor for compliance of 16c reportable incidents and conditions along with Act 13 OAPS reporting as well.

Completion Date: 07/31/2021 Licensee's Proposed Date for POC Implementation

Document Submission

see attachment



8/31/21 Implemented

42b - Abuse

1. Requirements

2600.

- 42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

42b - Abuse (continued)

Description of Violation

Resident #1's initial assessment and support plan, dated [REDACTED]/21, indicates [REDACTED] is not independent in bathing and direct care staff will provide assistance. On [REDACTED]/21 at approximately [REDACTED] AM, resident #1 awoke, got dressed and ready for breakfast. Staff person B entered [REDACTED] room and informed [REDACTED] needed to take a shower. Resident #1 told staff person B [REDACTED] was already dressed and ready for breakfast and [REDACTED] could get [REDACTED] shower after breakfast. Staff person B insisted [REDACTED] take [REDACTED] shower, proceeded to turn on the shower water and provided the resident with a washcloth and towel. Resident #1 undressed and got into the shower. Staff person B left the room, stating [REDACTED] would be right back. Resident #1 finished showering, turned off the water, and when exiting the shower, slipped and fell on the bathroom floor. Resident #1 was unable to stand and dragged [REDACTED] across [REDACTED] bathroom floor to a chair in [REDACTED] bedroom, where staff person B found the resident when [REDACTED] returned to the room. Resident #1 was transported via ambulance to the emergency room (ER), where [REDACTED] reported to ER staff [REDACTED] got out of the shower without any help and fell directly onto [REDACTED] left knee and was able to drag [REDACTED] to the chair and push [REDACTED] up. Resident #1 was diagnosed with a left displaced and depressed tibial plateau fracture and large lipohemarthrosis, [REDACTED] was admitted to the hospital, had surgery, and was discharged to a skilled nursing facility [REDACTED]/21.

Plan of Correction**Accept**

Administrator suspended employee pending investigation on [REDACTED] 2021 for incident that occurred on [REDACTED] 2021.

Administrator will terminate employee [REDACTED] 2021.

Administrator set up training for all current staff with APS, [REDACTED] via Zoom on Abuse/Neglect 6.2.2021.

Administrator or designee will retrain all staff during staff meetings by the end of July on 42b Abuse/Neglect.

Administrator or designee will re-educate staff regarding providing direct care services as indicated on the RASP (Support plan) including bathing/showering.

Administrator will continue to interview five residents each week for two more months until 8.15.2021 to assess for any concerns regarding care, treatment, or neglect.

Administrator or designee will review interviews during quality meeting for July and August.

A binder with education material on abuse/neglect will be placed in a conspicuous place for staff to reference by the end of July.

Completion Date: 07/31/2021 Licensee's Proposed Date for POC Implementation



8/31/21 Not Implemented

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

Facility Information

Name: *ELMCROFT OF CHIPPEWA* License #: *44901* License Expiration Date: *01/18/2022*
Address: *104 PAPPAN BUSINESS DRIVE, BEAVER FALLS, PA 15010*
County: *BEAVER* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: *7248913333* Email: [REDACTED]

Legal Entity

Name: *EC OPCO CHIPPEWA LLC*
Address: *5885 MEADOWS ROAD, SUITE 500, ECLIPSE SR LIV ATTN LICENSING, LAKE OSWEGO, OR, 97035*
Phone: *7248913333* Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *05/22/1999* Issued By: *L&I*
Type: *I-2* Date: *03/18/2011* Issued By: *Chippewa Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *73* Waking Staff: *55*

Inspection

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *07/19/2021*

Inspection Dates and Department Representative

07/19/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* Residents Served: *47*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *20* Residents Served: *17*

Hospice

Current Residents: *NA*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *47*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *26* Have Physical Disability: *0*

Inspections / Reviews

07/19/2021 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *08/09/2021*

8/9/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *09/01/2021*

8/31/2021 - Document Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Exception*

57d - Waking Hours

1. Requirements

2600.

- 57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 7/4/2021, the home served 45 residents, including 26 residents with mobility needs. Accordingly, the home was required to provide a minimum of 53.25 hours of direct care services during waking hours; however, only 49.32 hours of direct care services were provided during waking hours.

Plan of Correction

Accept

Action: the schedule was reviewed on 7-19-2021 and open shifts were filled for that week to confirm that 75% of personal care service hours are available during waking hours.

Training: The Operations Specialist re-educated community leadership team on 8-5-2021 regarding regulation 57d which included direct care staffing to encompass at least 75% of personal care hours during waking hours; direct care staff persons to be available at least 1 hour per day of personal care services to each mobile resident; and direct care staff to be available at least 2 hours per day of personal care services to each resident that has mobility issues.

Ongoing- Executive Director and/or designee will review staffing schedule daily to verify community is staffed to provide 75% of personal care hours during waking hours. Monitoring will be reviewed during weekly Quality Care Review (QCR) meeting with nurse(s), Executive Director, and other Leadership managers as available.

Completion Date: 08/31/2021 Licensee's Proposed Date for POC Implementation

Document Submission

see attachments



8/31/21 Implemented

60a - Staff/Support Plan

1. Requirements

2600.

- 60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Repeat Violation

On 7/10/21, the home served 44 residents, 25 of which had mobility needs, including at least 5 requiring the assistance of 2 staff persons to evacuate in an emergency. The home's staffing schedule indicates between 11:00p.m. and 7:00a.m. there were only 2 staff members present in the home which was not enough to provide personal care services, supervision and safe evacuation of residents in the event of an emergency as specified on the resident's assessments and support plans.

On 7/16/21, the home served 46 residents, 25 of which had mobility needs, including at least 5 requiring the assistance of 2 staff persons to evacuate in an emergency. The home's staffing schedule indicates between 11:00p.m. and 7:00a.m. there were only 2 staff members present in the home which was not enough to provide personal care services, supervision and safe evacuation of residents in the event of an emergency as specified on the resident's assessments and support plans.

Repeat Violation: 08/06/2020 et al

60a - Staff/Support Plan (continued)

Plan of Correction

Accept

Action- The schedule was reviewed on 7-19-2021 by Executive Director and Nurse, and open 11-7am shifts were filled for the week. When the new weeks' schedules were created, 3 staff were scheduled on 11-7am shift based on review of the residents' assessments regarding mobility issues.

Training- During the QCR on 8-4-2021, the Executive Director and the Operations Specialist re-educated and reviewed with the Nurse regulation 60a with regards to modifying the staffing as appropriate to meet the needs of residents as noted in residents' assessments and support plan, with an emphasis on mobility needs. The Leadership team was re-educated on regulation 60a as well on 8-5-2021 with regards to mobility/immobility definitions; the use of assessments to obtain the information in regard to care needs as well as staffing appropriately to those needs by the Operations Specialist.

Ongoing- Executive Director and/or designee will review staffing schedule daily to validate that direct care staffing for residents meets the needs of the residents as specified in the residents' assessments and support plan, including mobility needs. Monitoring will be reviewed during weekly QCR meeting with nurse(s), Executive Director, and other Leadership managers as available. Any discrepancies identified will be addressed as appropriate

Completion Date: 08/31/2021 Licensee's Proposed Date for POC Implementation



8/31/21 Not Implemented

226a - Mobility Assessment

1. Requirements

2600.

226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

The assessment for resident #1, dated 5/12/2021, indicates that the resident has only minimal mobility needs; however, staff and resident interviews, as well as observation by an agent of the Department, indicate that resident #1 requires the assistance of 2 staff persons for transferring.

Plan of Correction

Accept

Action: Resident #1's assessment was updated on 8-5-2021 to indicate that [REDACTED] is a 2-person transfer. Per direct observation, resident can transfer on [REDACTED] own without staff assistance, but there are days [REDACTED] may require more assistance. PT/OT services through Hospice were ordered on 8-5-2021 for resident #1. By 8-31-2021 all current residents' assessments and support plans will be reviewed to verify all information is accurate.

Training: During the QCR on 8-4-2021, the Executive Director and the Operations Specialist re-educated and reviewed with the Nurse regulation 226a; importance of review of assessment of residents with emphasis on mobility needs; and that assessments and support plans need to be reviewed to confirm appropriate staffing.

On 8-18-2021, The Executive Director and the Nurse will re-educate direct care staff and nurses on proper documentation of care within the community's electronic health record tool used by nurse(s)/designees when completing a residents assessment.

Ongoing: By 8-30-2021, during QCR weekly meeting the assessments and support plans of all current residents will be reviewed by Executive Director and Nurse to verify mobility needs of residents and confirm staffing per residents needs. Thereafter; mobility needs will be evaluated weekly at QCR by nurse, Executive Director, and the group will update Support plans as needed. At time of assessments, we will discuss with direct care staff to verify information is correct.

Completion Date: 08/31/2021 Licensee's Proposed Date for POC Implementation



8/31/21 Implemented

226a - Mobility Assessment (*continued*)**Document Submission***see attachments***8/31/21 Implemented**

233c - Key-Locking Devices

1. Requirements

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Repeat Violation

The directions for operating the magnetic lock releases on the SDCU exits near bedrooms #204 and #210 were incomplete. Both codes require entry of a numerical sequence followed by the "star" key; however, the directions posted at these exits did not include any indication of the inclusion of the "star" key in the sequence.

Repeat Violation: 10/23/2019 et al

Plan of Correction**Accept**

Action: on 7-20-2021 Directions for the door code were changed to include a star at the end of the access sequence. All doors in Memory Care were audited by the Executive Director to ensure proper code displayed.

Training: on 8-5-2021, the Operations Specialist re-educated the Maintenance Director on the requirements that the entire code (including symbols, if applicable) needs to be on the directions to get in and out of the SDU exits. All community Leadership will be trained on 8-5-2021 by the Operations Specialist regarding the abovementioned requirements.

Ongoing: The Maintenance Director and/or designee will perform daily checks to verify the posted codes are correct at all SDU entrances and exits.

Completion Date: 08/31/2021 Licensee's Proposed Date for POC Implementation

Document Submission*see attachments***8/31/21 Implemented**