



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**CERTIFICATE OF COMPLIANCE**

This certificate is hereby granted to **WATERMARK BELLINGHAM LLC**

LEGAL ENTITY

To operate **THE WATERMARK AT BELLINGHAM**

NAME OF FACILITY OR AGENCY

Located at **1615 EAST BOOT ROAD, WEST CHESTER, PA 19380**

(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 **80**

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 24**

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 **February 11, 2022** until **February 11, 2023**,  
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **146880**

  
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 628 – 01/21



Emailing date: February 11, 2022

[REDACTED]  
Watermark Bellingham, LLC  
[REDACTED]

RE: The Watermark at Bellingham  
1615 East Boot Road  
West Chester, PA 19380  
License #: 146880

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on May 3, 2021 and July 8, 2021, we have found the above facility to be in compliance with 55 Pa. Code Ch.2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

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

Enclosures  
License  
Licensing Inspection Summary

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

**Facility Information**

Name: *THE WATERMARK AT BELLINGHAM* License #: *14688* License Expiration Date: *06/08/2021*  
Address: *1615 EAST BOOT ROAD, WEST CHESTER, PA 19380*  
County: *CHESTER* Region: *SOUTHEAST*

**Administrator**

Name: [REDACTED] Phone: *4846531271* Email: [REDACTED]

**Legal Entity**

Name: *WATERMARK BELLINGHAM LLC*

Address: [REDACTED]

Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *I-2* Date: *01/06/2021* Issued By: *Chester County*  
Type: *C-2 LP* Date: *02/09/2001* Issued By: *Dept. L&I*

**Staffing Hours**

Resident Support Staff: Total Daily Staff: *41* Waking Staff: *31*

**Inspection**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
Reason: *Provisional* Exit Conference Date: *05/03/2021*

**Inspection Dates and Department Representative**

05/03/2021 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *80* Residents Served: *36*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Memory Care* Capacity: *24* Residents Served: *6*

**Hospice**

Current Residents: *5*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *36*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *11* Have Physical Disability: *5*

## Inspections / Reviews

## 05/03/2021 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *06/19/2021*

## 6/21/2021 - POC Submission

Lead Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *06/23/2021*

## 6/28/2021 - POC Submission

Lead Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *07/09/2021*

## 8/12/2021 - Document Submission

Lead Reviewer: [REDACTED] Follow-Up Type: *Exception*

## 54a - Direct Care Staff

## 1. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

## Description of Violation

*Direct care staff person A does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.*

## Plan of Correction

Accept

*Direct Care Staff A [REDACTED] This staff member meets all other employment requirements and has had no violations or complaints brought against [REDACTED] throughout the course of [REDACTED] employment. Per regulatory requirements, a letter of notification was distributed on June 16th to all residents/designated person with whom this staff member may provide care. Residents and families have been provided an opportunity to comment or question. All questions are to be provided along with waiver request to Department of Human Services and Licensing to determine continuance of employment as direct caregiver. Direct Care Staff A has been removed from the schedule as a direct caregiver until clearance of the waiver has been received.*

**Completion Date:** 07/23/2021 *Licensee's Proposed Date of POC Implementation*

## Document Submission

8/12/21 *CM* Implemented

*Staff A was removed from providing direct resident care and a notice was sent to families allowing thirty-days for questions or concerns. Efforts to obtain transcripts were in effect when employee left the company effective [REDACTED] 2021.*

## 60b - Additional Staffing

## 1. Requirements

2600.

- 60.b. The Department may require additional staffing as necessary to protect the health, safety and well-being of the residents. Requirements for additional staffing will be based on the resident's assessment and support plan, the design and construction of the home and the operation and management of the home.

## Description of Violation

*On May 2, 2021, from 3pm to 11pm, there were 36 residents in the home. The home had only two aide workers providing ADL's and IADL's. The home did not have anyone certified to administer PRN medications.*

## 60b - Additional Staffing (continued)

## Plan of Correction

Accept

*\*\*The violation indicates 3pm-11pm shift, however, in conversations with Surveyor and Field Office Supervisor, they reference 11pm to 7am. We are addressing both.*

*On May 2, during 3pm to 11pm there were 36 residents in the home. One of the scheduled caregivers called out sick. Although it was not written on the "Assignment sheet" one of the caregivers from morning shift stayed and worked 3pm to 11pm in order to provide care. This allowed for three caregivers. One certified medication administration aide and an agency LPN staff who were both available to administer PRN medications throughout the shift. During the 11pm to 7am shift, the "assignment sheet" failed to indicate that a per diem staff, who is a certified medication administration aide signed on to work this date. Time sheets verify this associate's attendance. Staff during the 11pm to 7am shift consisted of two caregivers and one certified medication administration aide who was available to administer PRN medications. All assignment sheets will be reviewed the next business day by Resident Service Director or designee to confirm any changes to scheduled staff and reflect the accurate staff attendance for the previous day. Administrator or designee will audit assignment sheets on a monthly basis and present to Community Quality Assurance Committee for six (6) months or until compliance has been achieved.*

**Completion Date:** 05/03/2021 Licensee's Proposed Date of POC Implementation

## Document Submission

8/12/21 *CM* Implemented

*Staff Audit Form completed by PCHA or designee weekly, to be reviewed monthly with Quality Assurance Team. Audits began May 30, 2021 and continue to ensure compliance.*

## 65a - FS Orientation 1st Day

## 1. Requirements

2600.

- 65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
  2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
  3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
  4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
  5. The location and use of fire extinguishers.
  6. Smoke detectors and fire alarms.
  7. Telephone use and notification of emergency services.

## 65a - FS Orientation 1st Day (continued)

**Description of Violation**

Staff person A, B and C, whose first day of work was [REDACTED] 20, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Staff person D, whose first day of work was [REDACTED] 20, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Staff person E, whose first day of work was [REDACTED] 21, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

## 65a - FS Orientation 1st Day (continued)

## Plan of Correction

Accept

The Community underwent a change in management on October 1, 2020. All staff who transitioned from previous company hold a hire date of [REDACTED] 2020. Staff persons A, B, and C who were part of the transition were not re-enrolled in orientation courses after having already completed such trainings with previous management company. It has been identified that all records of such training are no longer accessible as they are the property of prior company.

Staff persons D and E, who were hired after the change in management, completed an orientation course which included such topics listed under the term MANGO (mandatory general orientation). This orientation program did not provide an itemized list of topics covered and therefore, credit was not given to those employees.

Topics covered in Mandatory General Orientation include:

- HIPAA
- Resident Rights
- Prevention of Abuse
- Prevention of Harassment
- Reportable incidents
- Emergency preparedness
- Understanding and using fire safety equipment in your Community
- Community's Fire-safe area and/or designated evacuation meeting area
- Understanding Pennsylvania's Older Adult Protective Services Act
- Understanding Smoking Safety procedures
- Understanding the Emergency Medical Plan
- Safety in workplace
- Bloodborne pathogens and infection control
- Hazard Communication
- Control of Hazardous energy
- Hand hygiene and respiratory safety
- Compliance
- Telephone use and notification of Emergency Services

All transition staff and newly hired staff are scheduled to complete the required courses through MANGO and moving forward will attest to an itemized list of topics reviewed in the education for their personnel file. Completed itemized topics will be reviewed monthly with the Quality Assurance Committee until compliance is achieved.

Completion Date: 07/16/2021 Licensee's Proposed Date of POC Implementation

Not Implemented 8/12/21 *CM*

## 65b - Rights/Abuse 40 Hours

## 1. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

## 65b - Rights/Abuse 40 Hours (continued)

**Description of Violation**

Staff person A, B and C completed [REDACTED] 40th scheduled work hour on [REDACTED]/21. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

**Plan of Correction****Accept**

Staff persons A, B, and C were staff who transitioned from previous management company. All records verifying initial training hours and education topics were removed by previous employer as their property. Retraining for all topics required within 40 hours of scheduled work has been assigned for transitioned associates to complete. Current new hire practices emphasize the completion of regulatory required trainings prior to the end of scheduled 40-hours. An audit of employee trainings will be completed monthly and reviewed by Community's Quality Improvement Team for 3 months or until compliance is achieved.

**Completion Date:** 07/16/2021 Licensee's Proposed Date of POC Implementation

**Document Submission**8/12/21 *CM* Implemented

Checklist audit including description of Rights/Abuse training for new and existing employees initiated July 12, 2021. Efforts continue to capture all existing staff members in completing identified regulatory education items.

## 65d - Initial Direct Care Training

**1. Requirements**

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

**Description of Violation**

Direct care staff person A, hired on [REDACTED]/21, began providing unsupervised ADL services on [REDACTED]/21 and [REDACTED]/21. The staff person did not complete and pass the Department-approved direct care training course and pass the competency test until [REDACTED]/21.

**Plan of Correction****Accept**

Direct care staff person A was an associate who transitioned from previous management company. It is unclear if a Department-approved direct care training course had been completed prior to employment. Upon learning that this certificate was able to be validated, staff person A was rescheduled to take the exam and passed the competency test on [REDACTED] 2021. An audit of direct care training for all new and transition caregiver staff was performed to ensure valid competency tests are on file. Audit to be reviewed monthly with Quality Assurance Committee until compliance is achieved.

**Completion Date:** 06/22/2021 Licensee's Proposed Date of POC Implementation

Not Implemented 8/12/21 *CM*

## 66a - Staff Training Plan

**1. Requirements**

2600.

66.a. A staff training plan shall be developed annually.

## 66a - Staff Training Plan (continued)

**Description of Violation**

*The home does not have a staff training plan for 2021.*

**Plan of Correction****Accept**

*Training plan for 2021 has been completed and attached. Training plan will be written by Administrator and created with the input from monthly Quality Assurance Committee meetings, annual regulatory required trainings, and company-assigned trainings. Training calendars for upcoming year will be completed and distributed to department managers for department oversight no later than October 31st annually. Department managers will maintain staff attendance/completion logs for their respective departments and present to Community Quality Assurance Committee monthly.*

**Completion Date:** 06/18/2021 *Licensee's Proposed Date of POC Implementation*

**Document Submission**8/12/21 *CM* Implemented

*Annual staff training calendar has been uploaded and education continues with manager oversight for completion.*

## 82c - Locking Poisonous Materials

**1. Requirements**

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

**Description of Violation**

*Colgate toothpaste, with a manufacture's label indicating "seek immediate help if swallowed", was unlocked, unattended, and accessible to resident #1. Not all the residents of the home, including resident#1, have been assessed capable of recognizing and using poisons safely.*

**Plan of Correction****Accept**

*Staff members are educated regarding the importance of storing and locking of poisonous materials. Particularly as it related to those residents who are not capable of determining a poisonous substance. Staff assigned to work in the Secure Dementia Care Unit will complete rounds in all resident rooms once after morning care and once after evening care is provided to ensure removal of any poisonous materials. Rounds will be documented and reviewed by Resident Service Director or designee and brought to Quality Assurance Committee Monthly for three months or until compliance is achieved.*

**Completion Date:** 06/25/2021 *Licensee's Proposed Date of POC Implementation*

Not Implemented 8/12/21 *CM*

## 85d - Trash Receptacles

**1. Requirements**

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

**Description of Violation**

*The trash can in the kitchen does not have a lid.*

85d - Trash Receptacles (*continued*)**Plan of Correction****Accept**

*Dining staff have been educated to the importance of lids on trash receptacles to prevent the penetration of insects and rodents. Each receptacle has a matching lid that has been attached to the can to avoid loss/misplacement. Administrator or designee will perform inspection of kitchen receptacles weekly and report outcomes in monthly Quality Assurance Committee for three months or until compliance is achieved.*

**Completion Date:** 06/25/2021 Licensee's Proposed Date of POC Implementation

**Document Submission**8/12/21 *CM* Implemented

*Dining staff trained to the importance of maintaining lids on trash receptacles in the kitchen. Weekly audits completed by PCHA or designee continue.*

## 162c - Menus Posted

**1. Requirements**

2600.

- 162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

**Description of Violation**

*The home's menu for the week of May 10, 2021 was not posted in a conspicuous and public place in the home.*

**Plan of Correction****Accept**

*Weekly menus have been posted in dining area of Secure Dementia Care Unit and at the entry to dining area of personal care. Menus are changed weekly by dining director or designee and reflect menu for current and upcoming week. Administrator or designee will perform inspection of postings weekly and report outcomes in monthly Quality Assurance Committee meeting for three months or until compliance is achieved.*

**Completion Date:** 05/10/2021 Licensee's Proposed Date of POC Implementation

**Document Submission**8/12/21 *CM* Implemented

*Weekly audits of posted menus conducted by PCHA or designee initiated May 10 and continue to ensure compliance is achieved.*

## 187a - Medication Record

**1. Requirements**

2600.

- 187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

**Description of Violation**

*Resident #2 is prescribed Lisinopril 2.5mg . However, the resident's April 2021 Medication Administration Record (MAR) does not indicate diagnosis or purpose for the medication.*

**Plan of Correction****Accept**

*Education provided to all Med Technicians and LPNs regarding importance of identifying a diagnosis/purpose associated with the medication. Audit of MARs completed and request for diagnosis / purpose of medications from physicians or pharmacy where omitted on orders.*

**Completion Date:** 06/30/2021 Licensee's Proposed Date of POC Implementation

## 187a - Medication Record (continued)

## Document Submission

8/12/21 *CM* Implemented

Education provided to primary ordering physician. Nursing and med tech staff educated to look for and request purpose or diagnoses for any newly ordered medications.

## 187d - Follow Prescriber's Orders

## 1. Requirements

2600.

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

## Description of Violation

Resident #2 is prescribed Accu-check twice daily every Monday. Resident #2's blood glucose reading was not taken on Monday, April 12, 2021 at 4pm.

## Plan of Correction

Accept

Education was provide to all Med Technicians & LPNs regarding documentation as prescribed by physician when reading / administering blood glucose levels. A weekly audit will be conducted by Resident Service Director or designee and further education with staff as needed.

Completion Date: 06/30/2021 Licensee's Proposed Date of POC Implementation

Not Implemented 8/12/21 *CM*

## 227h - Support Plan Refuse Sign

## 1. 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 #3 participated in the development of [REDACTED] support plan on 03/31/21. The resident refused to sign the support plan. The home did not make a notation regarding the resident's refusal to sign.

## Plan of Correction

Accept

Education provided to staff responsible for creating/ reviewing support plans with residents and families. In particular, education regarding the involvement, or lack of involvement from those resident of the secure dementia care unit. An audit was completed to ensure that all residents were provided the opportunity to review and sign or refuse to sign their support plan with supporting documentation from community staff. Audits will be reviewed with Quality Assurance Committee every month for three months or until compliance is achieved.

Completion Date: 06/30/2021 Licensee's Proposed Date of POC Implementation

## Document Submission

8/12/21 *CM* Implemented

Resident support plans continue to be reviewed for resident signatures or refusal to sign. Audits are reviewed with community Quality Assurance Team

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

**Facility Information**

Name: *THE WATERMARK AT BELLINGHAM* License #: *14688* License Expiration Date: *06/08/2021*  
Address: *1615 EAST BOOT ROAD, WEST CHESTER, PA 19380*  
County: *CHESTER* Region: *SOUTHEAST*

**Administrator**

Name: [REDACTED] Phone: *6104366663 ext. 1018* Email: [REDACTED]

**Legal Entity**

Name: *WATERMARK BELLINGHAM LLC*

Address: [REDACTED]

Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *I-2* Date: *01/06/2021* Issued By: *East Goshen Township*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *45* Waking Staff: *34*

**Inspection**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
Reason: *Monitoring* Exit Conference Date: *07/08/2021*

**Inspection Dates and Department Representative**

07/08/2021 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *80* Residents Served: *35*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *sdcu* Capacity: *24* Residents Served: *5*

**Hospice**

Current Residents: *0*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *35*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *10* Have Physical Disability: *2*

## Inspections / Reviews

## 07/08/2021 - Partial

|                            |                                       |                                   |
|----------------------------|---------------------------------------|-----------------------------------|
| Lead Inspector: [REDACTED] | Follow-Up Type: <i>POC Submission</i> | Follow-Up Date: <i>08/06/2021</i> |
|----------------------------|---------------------------------------|-----------------------------------|

## 8/11/2021 - POC Submission

|                           |                                            |                                   |
|---------------------------|--------------------------------------------|-----------------------------------|
| Lead Reviewer: [REDACTED] | Follow-Up Type: <i>Document Submission</i> | Follow-Up Date: <i>08/16/2021</i> |
|---------------------------|--------------------------------------------|-----------------------------------|

## 8/12/2021 - Document Submission

|                           |                                     |
|---------------------------|-------------------------------------|
| Lead Reviewer: [REDACTED] | Follow-Up Type: <i>Not Required</i> |
|---------------------------|-------------------------------------|

## 65a - FS Orientation 1st Day

## 1. Requirements

2600.

- 65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
  2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
  3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
  4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
  5. The location and use of fire extinguishers.
  6. Smoke detectors and fire alarms.
  7. Telephone use and notification of emergency services.

## Description of Repeat Violation

Staff person B, whose first day of work was [REDACTED] 20, did not receive orientation on the following topics:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Staff person C, whose first day of work was [REDACTED] 21, did not receive orientation until 6/17/21.

## Plan of Correction

Accept

Required orientation checklist utilized and implemented into New Hire Orientation day. Watermark Bellingham continues to recapture the staff who transitioned from previous management company and complete the required trainings by way of signing off on the checklist.

Completion Date: 09/20/2021

## Document Submission

SP-8/12/21 Implemented

Staff person B resigned his position and left the company effective 7/16/2021

## 65d - Initial Direct Care Training

## 1. Requirements

2600.

- 65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.
  2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
  3. Initial direct care staff person training to include the following:
    - i. Safe management techniques.
    - ii. ADLs and IADLs
    - iii. Personal hygiene.

65d - Initial Direct Care Training (*continued*)

- iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
- v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.

**Description of Repeat Violation**

Direct care staff person A, hired on [REDACTED] 21. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test until 7/8/21.

**Plan of Correction****Accept**

Direct care certification by all non-licensed direct caregivers has been added to new hire checklist of required documentation. If associates cannot produce a current Nurse Aid Registry, or Direct Caregiver Certification upon hire, this training and test is administered within the first scheduled 48 hours of hire and prior to any unsupervised ADL services are completed. Audit of all current unlicensed direct caregiver personnel has been completed and will continue to update with all newly hired personnel.

**Completion Date:** 07/09/2021

**Document Submission****SP-8/12/21 Implemented**

Documents attached

## 82c - Locking Poisonous Materials

**1. Requirements**

2600.

- 82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

**Description of Repeat Violation**

On 7/8/21 at 10:30am, in Secure Dementia Care Unit room [REDACTED] for resident #1, there was a tube of Tom's of Maine Toothpaste labelled if accidentally swallowed, get medical help or dial poison control right away in an unlocked cabinet.

**Plan of Correction****Accept**

Staff educated to stow poisonous materials in locked cabinet. Nursing staff assigned to complete room sweeps after care performed to ensure items are properly stored. Resident designated persons sent notification regarding the importance of securing poisonous items or notifying staff when they provide new items that need to be stored on July 13, 2021

**Completion Date:** 07/13/2021

**Document Submission****SP-8/12/21 Implemented**

Documents attached.

## 187d - Follow Prescriber's Orders

**1. Requirements**

2600.

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

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

**Description of Repeat Violation**

*Resident #2 is prescribed Calmoseptine .44-20.6% ointment apply to red areas on buttocks 4 times daily however it was only applied 3 times on 7/6/21.*

*Resident #2 is prescribed check and empty foley bag every 4 hours, however it was not checked from 7AM to 11PM on 7/2/21.*

*Resident #2 is prescribed Mirtazapine F/C 30mg tablet 1 tablet (30mg) by mouth at bedtime however it was not administered on 6/20/21.*

*Resident #2 is prescribed Quetiapine Fumarate F/C 50mg tablet give 1 tab by mouth at bedtime however, it was not administered on 6/20/21*

**Plan of Correction****Accept**

*The Nurse responsible for the documentation omission was provided counseling regarding the importance of signing off medications and treatments once administered. Medication audit completed and counts were correct as if medication had been provided. Resident, designated person, and physician notified of medication documentation omission. On-going Medication Administration Record audits performed by nursing administration team with results reviewed by Quality Assurance Team monthly to ensure compliance in achieved.*

**Completion Date:** 07/09/2021

**Document Submission****SP-8/12/21 Implemented**

*Documents attached.*