



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**CERTIFICATE OF COMPLIANCE**

This certificate is hereby granted to **EAGLEVIEW LANDING LP**

LEGAL ENTITY

To operate **EAGLEVIEW LANDING**

NAME OF FACILITY OR AGENCY

Located at **650 STOCKTON DRIVE, EXTON, PA 19341**

(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 **121**  
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 46**

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 **August 2, 2023** until **February 2, 2024**,  
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **146981**

  
ISSUING OFFICER

  
ACTING 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 - 04/23



**CERTIFIED MAIL – RETURN RECEIPT REQUESTED**  
**MAILING DATE: AUGUST 2, 2023**

[REDACTED]  
[REDACTED]  
Eagleview Landing, LP  
[REDACTED]  
[REDACTED]

RE: Eagleview Landing  
650 Stockton Drive  
Exton, Pennsylvania 19341  
License #: 146981

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections January 18, 2023, and February 16, March 1, and 3, 2023 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 146980 dated October 2, 2022 to October 2, 2023 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated October 2, 2022 to October 2, 2023 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from August 2, 2023 to February 2, 2023.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

[REDACTED]

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (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<br>Chapter 2600<br>Section: | Class of<br>Violation | Census at<br>Inspection | Fine Per<br>Resident<br>X Per day | Calculated<br>Fine<br>= Per Day | Mandated<br>Correction Date<br>(to avoid Fine)      |
|-----------------------------------------|-----------------------|-------------------------|-----------------------------------|---------------------------------|-----------------------------------------------------|
| 187d                                    | II                    | 93                      | \$5                               | \$465                           | 5 calendar days from<br>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 FIRST 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 FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[REDACTED]  
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

[REDACTED]

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.

Sincerely,

Juliet Marsala  
Deputy Secretary  
Office of Long-term Living

Enclosure  
Licensing Inspection Summary

cc:

[REDACTED]

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

**Facility Information**

**Name:** EAGLEVIEW LANDING **License #:** 14698 **License Expiration:** 10/02/2023  
**Address:** 650 STOCKTON DRIVE, EXTON, PA 19341  
**County:** CHESTER **Region:** SOUTHEAST

**Administrator**

**Name:** [REDACTED] **Phone:** [REDACTED] [REDACTED] [REDACTED]

**Legal Entity**

**Name:** EAGLEVIEW LANDING LP  
**Address:** [REDACTED]  
**Phone:** [REDACTED] **Email:** [REDACTED]

**Certificate(s) of Occupancy**

**Type:** I-2 **Date:** 03/27/2019 **Issued By:** Uwchlan Township

**Staffing Hours**

**Resident Support Staff:** 0 **Total Daily Staff:** 125 **Waking Staff:** 94

**Inspection Information**

**Type:** Partial **Notice:** Unannounced **BHA Docket #:**  
**Reason:** Complaint, Incident **Exit Conference Date:** 01/18/2023

**Inspection Dates and Department Representative**

01/18/2023 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

**License Capacity:** 121 **Residents Served:** 90

**Secured Dementia Care Unit**

**In Home:** Yes **Area:** SDCU **Capacity:** 46 **Residents Served:** 28

**Hospice**

**Current Residents:** 2

**Number of Residents Who:**

**Receive Supplemental Security Income:** 0 **Are 60 Years of Age or Older:** 90  
**Diagnosed with Mental Illness:** 1 **Diagnosed with Intellectual Disability:** 0  
**Have Mobility Need:** 35 **Have Physical Disability:** 0

**Inspections / Reviews**

**01/18/2023 - Partial**

**Lead Inspector:** [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 02/16/2023

Inspections / Reviews (*continued*)

## 02/22/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/16/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 03/16/2023

## 07/12/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/06/2023

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

## 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

*On December 24th, 2022, Resident 1 had a fall in their bedroom and suffered a broken orbital bone and a ruptured eye. Resident 1 was heavily bleeding from their injury. Resident 1 pressed their call bell at that time which was 7:24 am. The staff of the home did not respond to the call bell until 9:03 am.*

## Plan of Correction

Accept ( ) - 02/22/2023)

*The community admits that the call bell was not responded to in a time frame that we deem appropriate due to other mitigating circumstances. The community denies that the call bell was answered at 9:03 as the GM noted the call bell alert in her emails and contacted the community at 8:15 am and they responded immediately. The inspector at the time of this inspection was told that due to sending the resident out to the hospital, the call bell was not reset until after the resident left the community.*

*The community pulls call bells daily for review. All call bells that go beyond a no response 2 are sent to the email of the Resident Care Director, Garden House Director and General Manager and this practice has been in place.*

*Reception Staff have been trained to monitor the front desk computer and call out the bells once they are beyond a no response 2. They will receive further instruction if they receive no response from the care staff, they are to find a manager or take the master key and cell phone and check on the resident no later than 3/6/23. The phone will provide them with the ability to contact a manager or call 911.*

*The med tech that failed to carry a beeper received disciplinary action.*

*We have contacted our vendor that put the call bell system in place to find out if the no response alerts can go to a text rather than an email.*

Licensee's Proposed Overall Completion Date: 03/06/2023

Not Implemented ( ) - 05/05/2023)

## 141a - Medical Evaluation

## 2. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

## Description of Violation

*The medical evaluation for Resident 1 was not complete within 60 days prior to admission or within 30 days after admission of the resident. The medical evaluation was completed on 6/21/2022 and Resident 1 was admitted to the home on ( ).*

## Plan of Correction

Accept ( ) - 02/22/2023)

*The General Manager or designee will review all DME's prior to them being given to the nursing department to ensure that the dates documented by the MD are within 60 days prior.*

*A review of all current resident will be completed by the GM to ensure that no other DME's are out of the regulated time frame by 3/15/23*

**141a - Medical Evaluation (continued)**

Licensee's Proposed Overall Completion Date: 03/15/2023

Implemented [REDACTED] - 05/01/2023)

**187d - Follow Prescriber's Orders****4. Requirements**

2600.

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

**Description of Violation**

Resident 2 is prescribed Quetiapine 25 mg twice a day. However, resident 2 was administered both doses at once in the morning by Staff Person A. The resident refused the extra medication. Repeat Violation: 10/18/21

**Plan of Correction**

Accept [REDACTED] - 02/22/2023)

The staff person who prepared the medications has been retrained and received additional medication observations to ensure that he is following all the medications administration procedures and protocols.

All Med staff will receive additional medication administration training on the proper medications administration procedures and protocols by 3/6/23

The Community will continue to administer semi-annual medication observations on all medication technicians.

Licensee's Proposed Overall Completion Date: 03/06/2023

Not Implemented [REDACTED] - 05/01/2023)

**252 - Record Content****5. Requirements**

2600.

252. Content of Resident Records - Each resident's record must include the following information:

**Description of Violation**

Resident 1's record does not include an incident report from a 12/24/22 fall.

**Plan of Correction**

Accept [REDACTED] - 02/22/2023)

The IR was in a file marked "to be filed", as the General Manager had not had the opportunity to complete the filing. This was explained to the surveyor at the time." The IR was placed in the resident chart.

The General Manager will identify a designee to file documents timely if unable to so to ensure that all IR's get put in to the resident's file within 48 hours.

A review of all charts for past IR's for a time period of six months will be completed and any missing IR's will be placed in the resident record by 3/6/23

Licensee's Proposed Overall Completion Date: 03/06/2023

Not Implemented [REDACTED] - 05/01/2023)

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

**Facility Information**

**Name:** EAGLEVIEW LANDING **License #:** 14698 **License Expiration:** 10/02/2023  
**Address:** 650 STOCKTON DRIVE, EXTON, PA 19341  
**County:** CHESTER **Region:** SOUTHEAST

**Administrator**

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

**Legal Entity**

**Name:** EAGLEVIEW LANDING LP  
**Address:** [REDACTED]  
**Phone:** [REDACTED] **Email:** [REDACTED]

**Certificate(s) of Occupancy**

**Type:** I-2 **Date:** 08/03/2020 **Issued By:** Uwchlan Township

**Staffing Hours**

**Resident Support Staff:** 0 **Total Daily Staff:** 130 **Waking Staff:** 98

**Inspection Information**

**Type:** Partial **Notice:** Unannounced **BHA Docket #:**  
**Reason:** Complaint, Incident **Exit Conference Date:** 03/03/2023

**Inspection Dates and Department Representative**

02/16/2023 - On-Site: [REDACTED]  
03/01/2023 - Off-Site: [REDACTED]  
03/03/2023 - Off-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

**License Capacity:** 121 **Residents Served:** 94

**Secured Dementia Care Unit**

**In Home:** Yes **Area:** MC1 - MC2 **Capacity:** 46 **Residents Served:** 31

**Hospice**

**Current Residents:** na

**Number of Residents Who:**

**Receive Supplemental Security Income:** 0 **Are 60 Years of Age or Older:** 94  
**Diagnosed with Mental Illness:** 1 **Diagnosed with Intellectual Disability:** 0  
**Have Mobility Need:** 36 **Have Physical Disability:** 0

## Inspections / Reviews

02/16/2023 - Partial

Lead Inspector: [REDACTED]

Follow Up Type: *POC Submission*Follow Up Date: *03/13/2023*

03/21/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: *03/13/2023*

Reviewer: [REDACTED]

Follow Up Type: *Document Submission* Follow Up Date: *04/04/2023*

07/12/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: *04/03/2023*

Reviewer: [REDACTED]

Follow Up Type: *Enforcement*

## 17 - Record Confidentiality

### 1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

### Description of Violation

*On 02/16/23, at 11:06 A.M., MC 2 Residents Care task binder was left unlocked, unattended, and accessible on the kitchen counter of MC 2.*

### Plan of Correction

**Accept** [REDACTED] - 03/21/2023)

*Staff will receive additional training on privacy and confidentiality by 4/3/23.*

*The GM, Resident Care Director, Garden House Director, MOD or Designee will monitor that the binder is always kept in the team room or a locked cabinet during community rounds daily for a period of sixty days. Times of the rounds shall vary to ensure compliance.*

**Licensee's Proposed Overall Completion Date:** 04/03/2023

**Implemented** [REDACTED] - 05/05/2023)

## 42b - Abuse

### 4. 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

*- On 02/16/23, Department representatives were onsite investigating an incident and two complaints. The complaints are in regard to resident care including a lack of sufficient staff to provide adequate care. The home provided timecards for direct care and a shift report from Shift Key, who the home uses to cover open shifts. Based on these reports, only one direct care person worked the overnight shift (10:00 PM to 6:00 AM) on 01/28/23 which included a half hour break. Having only one staff person is not sufficient considering this is a four-story building with memory care units on two separate floors.*

*- The half hour break taken by the only direct care staff available on 01/28/23 means there were no direct care staff present to assist the residents. This is considered abandonment.*

*- Other dates reviewed include 02/03/23, 02/05/23 and 02/11/23. On all three of these dates, only two direct care persons worked the 10:00 PM to 6:00 AM shift. There was insufficient staff when considering the size and design of the facility.*

*- On 02/12/23, Staff member A left at 5:00 AM, leaving staff member B alone in the building until staff member C arrives at 5:46 AM.*

*- The demographics provided by the home on 02/16/23 state there are 91 residents in the home with an additional 3 on a leave of absence. A total of 36 resident have mobility needs including all 31 in the two separate secured*

**42b - Abuse (continued)**

dementia care units (a/k/a Garden House). In the event of an emergency or fire, 2 staff members would not be sufficient to safely evacuate and account for all of the 91 residents in the home.

**Plan of Correction****Accepted** [REDACTED] - 03/21/2023)

The community had two staff on 1/28 and we have statements from both of those staff. A contracted staff member that was on from 2 pm to 10 pm did not leave the community and remained to work the 10 pm to 6 am shift. Due to the fact [REDACTED] never requested the shift, and the community did not assign the shift so she did not appear on the community's portal as worked. At no time was any management made aware that staffing was below our approved staffing model as we schedule four staff and do not drop below three on the overnight shift.

All med techs from the 2 to 10 shift were immediately instructed that they are not permitted to leave the community until three overnight staff are in place and to call the Resident Care Director, Garden House Director, and Administrator if we do not have minimum staff and must wait for one of us to arrive.

The staffing sheets now have a notice that outlines the overnights staffing with directions to notify the management team.

The Resident Care Director and the Garden House Director for a period of two were required to contact the community at 10 pm to check on the staffing and ensure staff are following the procedure for notification.

The lead Med Tech assisting with staffing is no longer involved in any parts of the staffing tasks and the Resident Care Director and the Garden House Director have full responsibility to ensure that staffing is adequate. This employee was also given disciplinary action due to [REDACTED] failure to notify a manager of the situation.

The Administrator is reviewing the staffing with the nursing management team daily.

This issue was rectified immediately.

Licensee's Proposed Overall Completion Date: 03/13/2023

**Not Implemented** [REDACTED] - 05/05/2023)**42s - Privacy****5. Requirements**

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

**Description of Violation**

On 02/16/23 at approximately 9:40 AM, resident #5's leg and foot bandages were being changed by staff member D in the hallway outside room [REDACTED]. Privacy was not provided during this procedure.

**Plan of Correction****Accepted** [REDACTED] - 03/21/2023)

The staff person that did not provide privacy was spoken to immediately by the Garden House Director and the right to privacy was reviewed with the staff.

All care staff will receive training on privacy by 4/3/23 by the Garden House Director.

**In addition to the above plan of correction:** Administrator or designee shall interview three residents a week for six months to ensure staff are providing privacy to residents.

Licensee's Proposed Overall Completion Date: 04/03/2023

**Implemented** [REDACTED] - 05/05/2023)

## 42s - Privacy (continued)

## 57c - 2 Hours/Day

**6. Requirements**

2600.

57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

**Description of Violation**

*Based on demographics provided while onsite on 02/16/23 the home serves 91 residents in the home, including 36 residents with mobility needs, requiring a total minimum of 127 hours of direct care service. On 01/28/23, only 98.77 hours of direct care staffing was provided.*

**Plan of Correction****Accept** [REDACTED] - 03/21/2023)

*The community had two staff on 1/28 and we have statements from both of those staff. A contracted staff member that was on from 2 pm to 10 pm did not leave the community and remained to work the 10 pm to 6 am shift. Due to the fact [REDACTED] never requested the shift, and the community did not assign the shift so [REDACTED] did not appear on the community's portal as worked. At no time was any management made aware that staffing was below our approved staffing model as we schedule four staff and do not drop below three on the overnight shift.*

*All med techs from the 2 to 10 shift were immediately instructed that they are not permitted to leave the community until three overnight staff are in place and to call the Resident Care Director, Garden House Director, and Administrator if we do not have minimum staff and must wait for one of us to arrive.*

*The staffing sheets now have a notice that outlines the overnights staffing with directions to notify the management team.*

*The Resident Care Director and the Garden House Director for a period of two weeks were required to contact the community at 10 pm to check on the staffing and ensure staff are following the procedure for notification.*

*The lead Med Tech assisting with staffing is no longer involved in any parts of the staffing tasks and the Resident Care Director and the Garden House Director have full responsibility to ensure that staffing is adequate. This employee was also given disciplinary action due to her failure to notify a manager of the situation.*

*The Administrator is reviewing the staffing with the nursing management team daily.*

*This issue was rectified immediately.*

*Nursing managers will receive training on how to calculate hours per regulations by 3/13/23*

**Licensee's Proposed Overall Completion Date: 03/13/2023**

**Implemented** [REDACTED] - 05/05/2023)

## 57d - Waking Hours

**7. 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 01/28/23, a total of 127 hours of direct care was required. However, only 91.27 of the required hours, or 72 percent, were provided during waking hours.*

**Plan of Correction****Accept** [REDACTED] - 03/21/2023)

*Training with the Resident Care Director and Garden House Director will be completed by 3/13/23 on calculating staffing hours. Staffing hours will be calculated by the Resident Care Director and the Garden House Director for*

**57d - Waking Hours (continued)**

future shifts to ensure we are meeting the requirements of 75% during waking hours. These staffing hour calculations will be reviewed by the Administrator.

Licensee's Proposed Overall Completion Date: 03/13/2023

Implemented [REDACTED] - 05/05/2023)

**60a - Staff/Support Plan****8. 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 Violation**

- On 01/28/23, 02/03/23, 02/05/23 and 02/11/23, two or less staff were present in the home during the overnight shift. This staffing is not sufficient to meet the needs of the residents in the case of an emergency. This staffing information is based on staff interviews, timecards and the "Shifts Report" from Shift Key.

- On 01/28/23 and 02/11/23 during the overnight shift, there were no staff in the building trained to administer medications.

**Plan of Correction**

Accept [REDACTED] - 03/21/2023)

All med techs from the 2 to 10 shift were immediately instructed that they are not permitted to leave the community until three overnight staff are in place and to call the Resident Care Director, Garden House Director, and Administrator if we do not have minimum staff and must wait for one of us to arrive. The staffing sheets now have a notice that outlines the overnight staffing with directions to notify the management team.

The Resident Care Director and the Garden House Director were required to contact the community at 10 pm to check on the staffing and ensure staff are following the procedure for notification since the BHSL visit.

The administrator is monitoring the daily staffing sheets in conjunction with the nursing management team.

The Resident Care Director and Garden House Director have been informed that they will need to utilize our staff, agency RN/LPN or cover the shift regardless of whether there are any routinely scheduled medications effective 3/13/23.

We continue to interview, hire and train to have all Eagleview Landing overnights staff med tech certified.

Licensee's Proposed Overall Completion Date: 03/13/2023

Implemented [REDACTED] 05/05/2023)

**61 - Substitute Coverage****9. Requirements**

2600.

61. Substitute Personnel - When regularly scheduled direct care staff persons are absent, the administrator shall arrange for coverage by substitute personnel who meet the direct care staff qualifications and training requirements as specified in § 2600.54 and § 2600.65 (relating to qualifications for direct care staff persons; and direct care staff person training and orientation).

**Description of Violation**

On 01/28/23, substitute staff person A, who worked providing direct care services from 2:00 PM to 10:00 PM, was

**61 - Substitute Coverage (continued)**

scheduled to work the overnight shift (10:00 PM to 6:00 AM). However, according to the Shift Key report which determines hours paid, their shift ended at 10:00 PM. On 01/28/23, two other staff persons called out and another was a "no call/no show". This left one person working the overnight shift alone. Additional staffing was not provided on this date.

**Plan of Correction****Accept ( ) - 03/21/2023)**

The community had two staff on 1/28 and we have statements from both of those staff. A contracted staff member that was on from 2 pm to 10 pm did not leave the community and remained to work the 10 pm to 6 am shift. Due to the fact ( ) never requested the shift, and the community did not assign the shift, so ( ) did not appear on the community's portal as worked. At no time was any management made aware that staffing was below our approved staffing model as we schedule four staff and do not drop below three on the overnight shift.

All med techs from the 2 to 10 shift were immediately instructed that they are not permitted to leave the community until three overnight staff are in place and to call the Resident Care Director, Garden House Director, and Administrator if we do not have minimum staff and must wait for one of us to arrive.

The staffing sheets now have a notice that outlines the overnights staffing with directions to notify the management team.

The Resident Care Director and the Garden House Director for a period of two weeks were required to contact the community at 10 pm to check on the staffing and ensure staff are following the procedure for notification.

The lead Med Tech assisting with staffing is no longer involved in any parts of the staffing tasks and the Resident Care Director and the Garden House Director have full responsibility to ensure that staffing is adequate. This employee was also given disciplinary action due to her failure to notify a manager of the situation.

The Administrator is reviewing the staffing with the nursing management team daily.

This issue was rectified immediately.

**Licensee's Proposed Overall Completion Date: 03/13/2023**

**Implemented ( ) - 05/05/2023)****63a - First Aid/CPR Training****10. Requirements**

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

**Description of Violation**

- On 01/28/23, from 10:00 PM to 6:00 AM, 91 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

- On 02/12/23, from 5:00 AM to 5:46 AM, 91 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

**Plan of Correction****Accept ( ) - 03/21/2023)**

The community had two staff on 1/28 and we have statements from both of those staff. A contracted staff member that was on from 2 pm to 10 pm did not leave the community and remained to work the 10 pm to 6 am shift. Due to the fact ( ) never requested the shift, and the community did not assign the shift, so ( ) did not appear on the

**63a - First Aid/CPR Training (continued)**

community's portal as worked. Both staff were CPR certified.

The staff failed to notify management that the staff on 2/12/23 had left the community prior to the end of [REDACTED] shift and we did not have two staff for a 46-minute period.

Working on a change in staffing to med tech working 12-hour shift and care staff 8 hours and ending the shifts at different times for better crossover.

Notice posted on the daily staffing sheet to clearly delineate the staffing requirements for the 10 pm to 6 am shift.

The Resident Care Director and Garden House Director have full responsibility for the schedule and to ensure that there are two staff on all shifts that are CPR certified and three staff at minimum on the night shift. The Administrator is reviewing the staff with the nursing management team daily.

This was rectified immediately.

Licensee's Proposed Overall Completion Date: 03/13/2023

Implemented [REDACTED] - 05/05/2023)

**82c - Locking Poisonous Materials****11. 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**

On 02/16/23 at 10:36 AM, ZeP Neutral pH Floor Cleaner, with a manufacture's label indicating "KEEP OUT OF REACH OF CHILDREN AND PETS" and "FOR EMERGENCY MEDICAL ASSISTANCE, CALL YOUR LOCAL POISON CONTROL CENTER OR 1-877-541-2016", was unlocked, unattended, and accessible to residents in a kitchen cabinet in memory care 2. Not all the residents of the home, including the residents in memory care 2, have been assessed capable of recognizing and using poisons safely.

**Plan of Correction**

Accept [REDACTED] - 03/21/2023)

The floor cleaner was in a kitchen cabinet that had a broken lock. The floor cleaner was removed at the time of inspection and stored securely.

A cabinet will be placed in the back kitchen pantry that has no resident access. The cabinet will be locked and contain any kitchen or cleaning chemicals. Cabinet is ordered and will be in place on the first and second floor Garden House back of kitchen on or before 3/17/23.

Staff will receive training on poisonous materials and that only this cabinet is to be utilized for any cleaning, kitchen or laundry chemicals.

Licensee's Proposed Overall Completion Date: 03/17/2023

Implemented [REDACTED] - 05/05/2023)

**123c - Evacuation Diagrams****12. Requirements**

2600.

123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

**123c - Evacuation Diagrams (continued)****Description of Violation**

*The home currently serves 91 residents. However, there are no emergency evacuation diagram posted in either of the two memory care units. The evacuation diagrams are posted outside the secured entrance to both units by the elevator.*

**Plan of Correction****Accepted** [REDACTED] - 03/21/2023)

*Emergency evacuation signs have been ordered and will be posted on both floors of the memory care unit by 4/3/23. A temporary sign will be posted.*

**Licensee's Proposed Overall Completion Date:** 03/17/2023

**Implemented** [REDACTED] - 05/05/2023)**141a 1-10 Medical Evaluation Information****13. Requirements**

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

**Description of Violation**

*- Resident #6's medical evaluation did not include mobility assessment, updated annually or at the Department's request.*

*- Resident #7's medical evaluation did not include medical information pertinent to diagnosis and treatment in case of an emergency.*

**Plan of Correction****Accepted** [REDACTED] - 03/21/2023)

*The community was unaware of the diagnosis for Resident #7 and the physician failed to place the diagnosis on the Doctor's Medical Evaluation.*

*For new admissions, the DME will be reviewed with the resident and family so they can identify any missing diagnosis that the doctor may have not included, and the community would have no knowledge of.*

*All DME's will be reviewed by the Administrator or designee at least 24 hours prior to admission to confirm that they are completed.*

*This will begin immediately on 3/13/23.*

**Licensee's Proposed Overall Completion Date:** 03/13/2023

**Implemented** [REDACTED] - 05/05/2023)**162c - Menus Posted**

**14. 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**

*On 02/16/23 the posted "Week at a Glance" menu in the main dining room was dated for Sun 01/22/23 through Sat 01/28/23.*

*Menus were not posted in either of the two memory care units.*

**Plan of Correction****Accepted** [REDACTED] 03/21/2023)

*The Dining Service Director will post the weekly menu on Saturday that the next day on Sunday.*

*The Administrator or designee will check that the posting is up on rounds for the next 30 days to ensure that all menus are posted with the correct week.*

*This was rectified immediately with posted menus.*

**Licensee's Proposed Overall Completion Date:** 03/13/2023

**Implemented** [REDACTED] 05/05/2023)**162e - Menu Changes****15. Requirements**

2600.

162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

**Description of Violation**

*On 02/16/23, Cream of Broccoli soup was listed as the soup of the day on the Senior Executive's "Daily Specials" menu. However, this soup was not available. No notice was provided to the residents in advance of the meal.*

**Plan of Correction****Accepted** [REDACTED] - 03/21/2023)

*The Dining Services Director and all cooks will be trained on the necessity of posting any menu changes prior to the start of the meal. Changes will be posted on the dining room tables or a conspicuous place in either personal care and/or memory care.*

*This will be completed by 3/17/23*

**Licensee's Proposed Overall Completion Date:** 03/17/2023

**Implemented** [REDACTED] 05/05/2023)**183d - Prescription Current****16. 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**

*On 02/16/23, prescription strength Iodine prescribed for resident #7, was in room [REDACTED] however, resident #7 passed away on [REDACTED]*

**183d - Prescription Current (continued)****Plan of Correction**

Accept ( ) - 03/21/2023)

The Garden House Director or designee will inspect every room after the resident has been discharged to ensure no items that are prescriptions, OTC, samples or CAM's are present in the room.  
This will begin 3/13/23.

Licensee's Proposed Overall Completion Date: 03/13/2023

Implemented ( ) - 05/05/2023)

**187d - Follow Prescriber's Orders****17. Requirements**

2600.

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

**Description of Violation**

Resident #8 is prescribed prednisone tablet 1 MG - Take one tablet by mouth once daily. However, this medication was not administered to resident #8 on 02/16/23 because the medication was not available in the home.

Repeat violation: 10/18/21

**Plan of Correction**

Accept ( ) - 03/21/2023)

The staff requested the item but there were no refills and the pharmacy was waiting for the physician's order.

The pharmacy has released a new portal and training was completed on 3/9/23 for staff to log in and see if refills are available to be able to be proactive in asking for new prescriptions for medications that have 0 refills.

As of 3/13/23, staff will monitor medications that have no refills via the pharmacy portal and send a list over to the physician weekly as medications without refills are noted.

Licensee's Proposed Overall Completion Date: 03/13/2023

Not Implemented ( ) - 05/01/2023)

**221c - Post Activity Calendar****18. Requirements**

2600.

221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

**Description of Violation**

The home does not have a current weekly activity calendar posted in a public and conspicuous place in the home's memory care units.

**Plan of Correction**

Accept ( ) 03/21/2023)

The calendar was posted immediately at the time this was identified.

The calendar will be posted no later than the last day of the previous month so it is there on the morning of the new month by the Activities Director in Garden House in a conspicuous place and the resident's rooms. In personal care the calendar will be posted in a conspicuous place and delivered to each resident's apartment. The Administrator or designee will check during rounds to ensure that all neighborhoods' calendars are posted by the first of the month

Licensee's Proposed Overall Completion Date: 04/01/2023

Implemented ( ) - 05/05/2023)

## 227d - Support Plan Medical/Dental

## 19. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

## Description of Violation

The assessment and support plan for resident #7, dated [REDACTED], does not indicate the resident's DNR preferences in the event of an emergency. As a result, the home performed CPR and other extraordinary measures to resuscitate the resident after the resident was found unresponsive on 01/15/23.

## Plan of Correction

Accept [REDACTED] 03/21/2023)

A review of all charts will be completed by 4/3/23 to determine DNR status and a DNR sticker will be placed on the RASP on the first page at the top conspicuous for staff to note when reviewing the RASP.

Training will be given to the Resident Care Director, Garden House Director, Wellness nurse and all care staff where the DNR information will be posted and the ongoing responsibility of the nursing management staff to ensure all new admissions RASP show the DNR status.

Licensee's Proposed Overall Completion Date: 04/03/2023

Implemented [REDACTED] - 05/05/2023)

## 233c - Key-Locking Devices

## 20. 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 Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the door between rooms 125 and 127 on Memory Care 1.

## Plan of Correction

Accept [REDACTED] - 03/21/2023)

The code was posted immediately.

Beginning 4/4, environmental rounds with the directors will include the monitoring of postings on the memory care doors.

Licensee's Proposed Overall Completion Date: 04/04/2023

Implemented [REDACTED] - 05/05/2023)

## 237a - Activities

## 21. Requirements

2600.

237.a. The following types of activities shall be offered at least weekly:

## Description of Violation

On 02/16/23, Department representatives requested a copy of the Memory Care activity schedule because an activity

**237a - Activities (continued)**

*schedule was not posted. Initially the home provided a copy of the personal care schedule but then found a correct Memory Care Activity Schedule. Three activities were scheduled in the morning. Part of the investigation was to verify if activities were being completed, results below:*

- *9:30 AM - Bike Peddle Exercise (MC2) - Completed in MC1 Activity area with help of a video.*
- *10:00 AM - Famous Faces - Not completed.*
- *11:00 AM - Indoor Lawn Game - Not Completed.*

*At 2:00 PM a Frank Sinatra DVD Concert was listed but this was being presented on the PC side in the movie theater. The location of this activity was not listed on the Memory Care Activity Sheet.*

*At 4:00 PM ISpy TV Edition was to be completed. Whether or not this was completed was not verified.*

**Plan of Correction****Accept** [REDACTED] - 03/21/2023)

*We have hired an activities director for our Garden House via a transfer of staff and that person will be in place full-time as of 3/30/23. In the meantime, the personal care activities director is providing oversight to both neighborhoods.*

*The activities assistant that did not follow the calendar will be removed from the Garden House neighborhood and transferred to another department and a new activities assistant was hired today.*

*Effective immediately, the Personal Care Activities Director has been monitoring the activities and the calendar and providing additional coverage to provide activities in Garden House. The Activities Director weekly for 30 day will review the scheduled activities to ensure that they meet the needs of the residents.*

**Licensee's Proposed Overall Completion Date: 03/30/2023**

**Implemented** [REDACTED] - 05/05/2023)