



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **DRESHER CARE GROUP LLC**

LEGAL ENTITY

To operate **WOODLAND CREEK ALZHEIMER'S SPECIAL CARE CENTER**

NAME OF FACILITY OR AGENCY

Located at **1424 DRESHER TOWN ROAD, DRESHER, PA 19025**

(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

66

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 66**

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 **October 24, 2023** until **April 24, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **146051**

Janette Biderup
ISSUING OFFICER

Juliet Marsala
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: OCTOBER 24, 2023

[REDACTED]
[REDACTED]
Dresher Care Group, LLC
[REDACTED]
[REDACTED]

RE: Woodland Creek Alzheimer's Special Care Center
1424 Dreshertown Road
Dresher, Pennsylvania 19025
License #: 146051

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection April 12, 2023, May 16, 24, 25, 26, and June 12, 13, and 14, 2023, and July 12 and 13, 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 146050 dated April 27, 2023 to April 27, 2024 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 April 27, 2023 to April 27, 2024 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) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 24, 2023 to April 24, 2024.

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.

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 Chapter 2600:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
42b	2	32	\$5	\$160	5 calendar days from mailing date of this letter
185a	2	32	\$5	\$160	5 calendar days from mailing date of this letter
187b	2	32	\$5	\$160	5 calendar days from mailing date of this letter
187d	2	32	\$5	\$160	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 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.

[REDACTED]

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: 717-265-8942

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]
[REDACTED]
[REDACTED]
[REDACTED]

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

Facility Information

Name: *WOODLAND CREEK ALZHEIMER'S SPECIAL CARE CENTER* License #: *14605* License Expiration: *04/27/2024*
Address: *1424 DRESHERTOWN ROAD, DRESHER, PA 19025*
County: *MONTGOMERY* Region: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *DRESHER CARE GROUP LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *90* Waking Staff: *68*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Incident* Exit Conference Date: *04/12/2023*

Inspection Dates and Department Representative

04/12/2023 - On-Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* Residents Served: *45*

Secured Dementia Care Unit

In Home: *Yes* Area: *Entire home* Capacity: *66* Residents Served: *45*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *45*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *45* Have Physical Disability: *0*

Inspections / Reviews

04/12/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/30/2023*

Inspections / Reviews (*continued*)

05/03/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/07/2023

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 05/08/2023

05/09/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/07/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 06/08/2023

09/18/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/07/2023

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 4/1/23 around 4PM, staff member A witnessed resident 1 splash a cup of water onto staff member B while standing outside the dining area. Staff member B proceeded to backhand resident 1 on the chin and face area. Staff member B then grabbed resident 1 by the arms and pulled them back into the dining area. Staff person A did not report what they had witnessed until 4/6/23. The Act 13 report was not completed until 4/6/23 at 5:18PM.

Plan of Correction

Accept [REDACTED] - 05/09/2023)

employee placed on suspension pending termination 4/6/23

ED assigned mandatory training in Relias(online) for community due 4/30/23

ED re-educated staff on abuse and reporting 4/13/23

ongoing ED or designee to ensure mandated reporting and abuse covered during onboarding

10% employee interviews conducted quarterly by DON or designee of staff regarding regulation 15a. will be completed by June 30, 2023 for current quarter. Interviews to be completed annually following first year

Licensee's Proposed Overall Completion Date: 06/30/2023

Implemented [REDACTED] - 09/18/2023)

16c - Written Incident Report

2. 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

On 4/1/23 around 4PM, staff member A witnessed resident 1 splash a cup of water onto staff member B while standing outside the dining area. Staff member B proceeded to backhand resident 1 on the chin and face area. Staff member B then grabbed resident 1 by the arms and pulled them back into the dining area. Staff person A did not report what they witnessed until 4/6/23 and the home did not report this incident to the department until 4/7/23 at 8:55AM.

Plan of Correction

Accept [REDACTED] - 05/09/2023)

Once known, April 1 incident reported following regulation 16c

4/13/23 ED re-educated staff on abuse and reporting

10% employee interviews conducted quarterly by DON or designee of staff regarding regulation 15a. will be completed by June 30, 2023 for current quarter. Interviews to be completed annually following first year

Licensee's Proposed Overall Completion Date: 06/30/2023

Implemented [REDACTED] - 09/18/2023)

42b - Abuse

3. 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 4/1/23 around 4PM, staff member A witnessed resident 1 splash a cup of water onto staff member B while standing outside the dining area. Staff member B proceeded to backhand resident 1 on the chin and face area. Staff member B then grabbed resident 1 by the arms and pulled them back into the dining area. Resident 1 screamed for help while being pulled. Staff member A did not report what they witnessed at that time. On 4/3/23 Resident 1 was observed by a family member to have unknown markings on their face and was evaluated by a physician. On 4/6/23, Staff person A remembered the incident that they witnessed on 4/1/23 and reported it to the home at that time.

Repeated Violation-11/15/22, et al

Plan of Correction

Accept [REDACTED] - 05/09/2023)

employee placed on suspension pending termination 4/6/23

ED held staff meeting on abuse and reporting 4/13/23

ED assigned mandatory training in Relias(online) for community due 4/30/23

ED re-educated staff on abuse and reporting 4/13/23

10% employee interviews conducted quarterly by DON or designee of staff regarding regulation 15a. will be completed by June 30, 2023 for current quarter. Interviews to be completed annually following first year

Licensee's Proposed Overall Completion Date: 06/30/2023

Not Implemented [REDACTED] - 09/18/2023)

54a - Direct Care Staff**4. 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 B, does not have a US high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction

Accept [REDACTED] - 05/09/2023)

Audit completed of direct care staff files for compliance by BOM on 4/26/23

ED educated BOM on regulation 54a on 4/13/23

10% audit of employee files to be audited quarterly. First quarter completed by June 30, 2023, then September 30, 2023, and then December 31, 2023. Audits completed annually after he first year

Licensee's Proposed Overall Completion Date: 06/30/2023

Implemented [REDACTED] - 09/18/2023)

57c - 2 Hours/Day**5. Requirements**

57c - 2 Hours/Day (continued)

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

On 4/9/23, there were 42 residents in the home, including 42 residents with mobility needs, requiring a total minimum of 84 hours of direct care service. On this date, only 81 hours of direct care staffing was provided.

Plan of Correction**Accept** [REDACTED] - 05/09/2023)

Review of schedule completed immediately 4/12/23

ED re-educated staff on regulation 57c on 4/12/23

DON or designee will continue to monitor schedule daily

Licensee's Proposed Overall Completion Date: 05/08/2023

Implemented [REDACTED] - 09/18/2023)**57d - Waking Hours****6. 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 4/9/23, a total of 84 hours of direct care was required. However, only 58 of the required hours, or 70 percent, were provided during waking hours.

Plan of Correction**Accept** [REDACTED] 05/09/2023)

Review of schedule completed immediately on 4/12/23

ED re-educated staff on regulation 57d on 4/12/23

DON or designee will continue to monitor schedule daily

Licensee's Proposed Overall Completion Date: 05/08/2023

Implemented [REDACTED] - 09/18/2023)**162c - Menus Posted****7. 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 4/12/23, the home's posted menu was for 4/5 and 4/6 along with an anytime menu. The weekly menu for 4/9-4/15 was in the kitchen and not posted in a conspicuous and public place in the home.

162c - Menus Posted (*continued*)**Plan of Correction****Accept** [REDACTED] - 05/09/2023)*weekly menu posted immediately on 4/12/23**ED educated Chef on regulation 162c on 4/12/23**4/12/23 and ongoing Chef or designee will check weekly to ensure menu is posted***Licensee's Proposed Overall Completion Date:** 05/08/2023**Implemented** [REDACTED] - 09/18/2023)

227g -Support Plan Signatures

8. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation*Resident 1's support plan dated 3/2/23 is not signed or dated by the resident and assessor.**Resident 2's support plan dated 12/16/22 is not signed by the resident and is not documented that the resident was unable/refused to sign/participate.***Plan of Correction****Accept** [REDACTED] - 05/09/2023)*Resident #1 assessment unable to be signed by assessor as they are no longer employed with company. New assessment completed 4/20/23 and was signed by assessor (DON) is unable to be signed by resident and will be signed by POA.**Resident #2 assessment unable to be signed as resident is no longer a resident of the community**ED re-educated nursing on regulation 227d 4/13/23**HSD or designee will pull charts at random monthly, starting this month May to ensure compliance with regulation 227d. This will be evaluated on a quarterly basis for needed continuation.***Licensee's Proposed Overall Completion Date:** 05/31/2023**Implemented** [REDACTED] - 09/18/2023)

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

Facility Information

Name: *WOODLAND CREEK ALZHEIMER'S SPECIAL CARE CENTER* License #: *14605* License Expiration: *04/27/2024*
Address: *1424 DRESHERTOWN ROAD, DRESHER, PA 19025*
County: *MONTGOMERY* Region: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *DRESHER CARE GROUP LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *05/19/2019* Issued By: *Township of Upper Dublin*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *82* Waking Staff: *62*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *05/16/2023*

Inspection Dates and Department Representative

05/16/2023 - On-Site: [REDACTED]
05/24/2023 - Off-Site: [REDACTED]
05/25/2023 - Off-Site: [REDACTED]
05/26/2023 - Off-Site: [REDACTED]
06/12/2023 - Off-Site: [REDACTED]
06/13/2023 - Off-Site: [REDACTED]
06/14/2023 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 66

Residents Served: 41

Secured Dementia Care Unit

In Home: Yes

Area: Entire Home

Capacity: 66

Residents Served: 41

Hospice

Current Residents: 4

Number of Residents Who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 41

Diagnosed with Mental Illness: 41

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 41

Have Physical Disability: 7

Inspections / Reviews

05/16/2023 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 06/26/2023

06/27/2023 - POC Submission

Submitted [REDACTED]

Date Submitted: 07/20/2023

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 07/03/2023

07/10/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/20/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission

Follow-Up Date: 07/20/2023

09/18/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/20/2023

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 3/13/23, resident #1's dermatologist ordered treatment for [REDACTED] to include Permethrin cream from neck down to feet, including interdigital webspace's and under nails. In addition, household contacts be treated at the same time regardless of their exposure and all carpets and upholstered furniture should be vacuumed, with the bag/cannister emptied outside. The staff of the home applied the cream to the resident #1's legs, arms, chest, and back, on 3/20/23, but not as prescribed. The staff did not reapply in seven days, as ordered, nor on 5/31/23 after being reordered on 5/10/23. The home did not treat all the resident as prescribed nor did they implement the [REDACTED] protocols, contact precautions, isolation and the recommended environmental treatment of the home. The neglect to follow physicians' orders for resident #1 resulted in an outbreak of presumptive [REDACTED] for twenty-two residents.

On 5/10/23, resident #1's primary care physician and dermatologist conferenced with the home's administrator, staff A, advising of the increase of multiple residents with a presumptive [REDACTED] rash and to once again implement the previously ordered Scabies protocols. No additional treatment regime or the [REDACTED] protocols were implemented until 5/31/23.

Plan of Correction

Directed [REDACTED] - 07/10/2023)

5.10.23 Nursing or designee to round with providers to ensure enhanced communication and understanding of resident need

5.26.23 Community contact precautions were placed **by administrator**. All individuals except the residents were provided and wearing gowns/gloves at all times in the community **by the administrator**.

5.31.23 into 6.1.23 first community application of permethrin cream applied to whole house per prescribers orders **by clinical staff and med techs**.

6.1.23 whole house deep clean and laundry completed **by maintenance and housekeeping**.

6.7.23 Resident 1 seen by outside dermatology and cleared of any infection.

6.8.23 7 residents seen by onsite dermatology and cleared of skin condition. Dermatology made recommendation that whole house treatment and contact precautions were not needed. Precautions remained in place and treatment was completed

6.14.23 into 6.15.23 second community wide application of permethrin cream applied to whole house per prescribers orders **by clinical staff and med techs**.

6.15.23 whole house deep clean and laundry completed **maintenance and housekeeping**.

6.15.23 this completed the recommended and required treatment

6.19.23 ED re educated nursing team, **direct care staff and housekeeping** on regulation 42b **as it relates to neglect and not following physicia orders**. This included an overview of the regulation and importance of communicating with each other and following up with the provider

6.19.23 weekly MAR audit for 4 weeks and monthly after to ensure orders are correct and being followed by nurse or designee

6.26.23 weekly meeting with ED and nursing to review audit for 4 weeks and monthly after that.

42b - Abuse (continued)

Biweekly skin checks, of all residents, for next 60 days to ensure the residents are free of [REDACTED], starting immediately.

Starting, July 10, 2023, the ED will conduct random observations of at least five residents to ensure the residents are free of [REDACTED] or any other skin rashes for the next six months.

Starting, July 10, 2023, the ED will discuss neglect, for failure to follow physicians orders, at staff meetings for the next six months and maintain agenda plus staff sign in sheets for the Departments review.

Starting July 20, 2023, the ED will review the implementation of the violation report at the quarterly QA meetings. Documentation of the QA meetings will be maintained for the Departments review.

Directed POC initiated in bold type by [REDACTED] 7/10/23

Respectfully, please note, that administrator did not have a conversation with primary care provider and dermatology. That was our DON who is no longer in the community. The conversation that ED had with primary care provider on 5.10.23 was to reiterate house rules, which PCP did not like, ask questions and review concern for skin. During that conversation PCP recommended a whole house treatment for the residents but also expressed resident choice. Following that conversation the DON called all the families and offered the recommended treatment. Quite a few families declined due to the fact that their loved one did not have a rash and were concerned about the treatment. ED then sent out a written notice following the discussed and approved plan at the time.

Directed Completion Date: 07/03/2023

Not Implemented [REDACTED] - 09/18/2023)

42y - Health Care Choice

2. Requirements

2600.

42.y. A resident has the right to choose his own health care providers without limitation by the home. This includes the right to select the resident's own pharmacist provided that the pharmacy agrees to supply medications in a way that is compatible with the home's system for handling and assisting with the self-administration of resident medications.

Description of Violation

Residents of the home were denied access to their primary care physician on 5/26/23 and again on 6/2/23.

Plan of Correction

Directed [REDACTED] - 07/10/2023)

5.26.23 community experiencing an outside visit which required whole community attention. PCP had been in on 5.24.23 to see residents

6.2.23 nursing team was out of building due to schedule and callout. ED received a call from NP that she would not be in and ED communicated directly with PCP that there were no new concerns. PCP had been in to see residents 5.31.23

6.19.23 ED educated nursing team on regulation 42y to ensure that residents have access to their provider and to discuss community expectations with providers being a guest in the community. As of 5.10.23 providers are given a private conference room to chart and are rounded with in the community. Providers are continuously reminded of house expectations regarding privacy and are evaluating/treating residents in a private space.

6.19.23 and ongoing residents are free to choose their own healthcare provider

42y - Health Care Choice (continued)

7.30.23 community working on implementing consistency amongst providers. Only 1 visit per week is needed in house across all disciplines

We respectfully request the violation be removed. Under 55 Pa. Code Chapter 2600, under "2600.42(y) The home may specify that health care providers provide services in a manner that is consistent with the home's operations. The provider had already been in the community on a different day of each week in question. The residents were not denied access to the provider as it was requested that the provider come to the home on a different day.

DPOC, [REDACTED] 7/10/23:

The administrator or other administrative staff will no longer prevent resident physicians, nurse practitioners, physician assistance, home care staff and or hospice staff from visiting residents to provide care, starting immediately.

The administrator and or Wellness Director will provide a training to all staff on the importance of permitting health care oversight to all residents by 7/20/23 and discuss the importance of health care practitioner visits at monthly staff meetings for the next six months, starting within 10 days of receipt of this plan of correction (POC). Documentation will be maintained for the Departments review.

The administrator and or Wellness Director will communicate all resident needs to the primary care physicians to ensure care is available at all times for resident health, by 7/20/23 by sending an email to the health care providers on the unlimited access to care. Documentation of the email will be maintained for the Departments review.

The administrator and or Wellness Director will provide unlimited treatment opportunities for the residents primary care physicians and all other health care providers by providing privacy during medical treatments, starting 7/10/23.

The administrator and or Wellness Director will meet quarterly with random residents and primary care physicians to ensure the home is providing privacy during medical treatments and unlimited visits with health care providers, starting immediately.

Documentation of the quarterly meetings will be maintained for the Departments review.

Directed Completion Date: 07/03/2023

Not Implemented [REDACTED] - 09/18/2023)

82c - Locking Poisonous Materials**3. 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

The following medications were unlocked and unattended in the room:

- Inzo Barrier Cream, with a manufacture's label indicating "If swallowed get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to resident # 2 . Not all the residents of the home, including resident #2, have not been assessed capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials (continued)

- *Balmex Cream, with a manufacture's label indicating "If swallowed get medical help or contact a Poison Control Center immediately," was unlocked, unattended, and accessible to resident # 6. Not all the residents of the home, including resident #6 , have not been assessed capable of recognizing and using poisons safely.*

Plan of Correction**Accept** [REDACTED] **07/10/2023)**

5.16.23 Inzo Cream and Balmex were immediately secured by med tech

5.16.23 audit of the locked drawers in all rooms completed and ensured all chemicals away and secured by med tech and ED

5.16.23 ED re-educated staff on regulation 82c and stressed concern for safety in ensuring chemicals are secured

5.16.23 and ongoing HSC or designee will conduct random daily walkthroughs to ensure compliance. This will be a sampling of several resident rooms. If there is an unlocked drawer or chemical out, HSC or designee will pull caregiver for 1:1 additional education. That caregiver will then be spot checked over the next week.

This will be evaluated on a quarterly basis at the quality meeting, starting immediately.

Licensee's Proposed Overall Completion Date: 07/03/2023

Not Implemented [REDACTED] **- 09/18/2023)****185a - Implement Storage Procedures****4. Requirements**

2600.

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

Description of Violation

On 5/31/23 at 8am, resident #3 is prescribed Permethrin Cream was not available for administration, according to the Medication administration record (MAR's).

On 5/16/23 at 11:30 am, resident #3's prescribed Albuterol Inhaler was not present or available in the home.

Repeated Violation - 4/29/22, et al

Plan of Correction**Accept** [REDACTED] **- 07/10/2023)**

5.16.23 nurse called pharmacy to confirm albuterol order and location. Medication was present in the home since resident admission, pharmacy confirmed delivery. Nurse and other med tech were able to locate albuterol which had been misplaced on the med cart

5.16.23 ED re-educated nursing team to regulation 185a to ensure understanding of procedures for safe storage access, security, distribution, and use of medications and medical equipment by trained staff persons

6.19.23 weekly cart audit completed by med tech or designee for 4 weeks and monthly after to ensure compliance. ED or designee to work with nursing team on outcome of cart audit. This will be reviewed quarterly at quality and will be evaluated at the end of the year for continued need

185a - Implement Storage Procedures (continued)

Licensee's Proposed Overall Completion Date: 07/03/2023

Not Implemented [REDACTED] - 09/18/2023)

187b - Date/Time of Medication Admin.

6. Requirements

2600.

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

Description of Violation

Resident #1 is prescribed Zolpidem Tartrate 5mg, Lorazepam 0.5pm and Nyamyc Powder. Resident #1's May medication administration record does not include the initials of the staff person who administered these medications on 5/22/23 at 8pm.

Resident #3 is prescribed Donepezil HCL 10mg, Melatonin 5mg, and Tamsulosin HCL 0.4mg. Resident #3's April medication administration record does not include the initials of the staff person who administered these medications on 4/6/23 and 4/7/23 at 8pm.

Resident #3 is prescribed Atorvastatin 40mg, Calmoseptine Ointment, Gabapentin 100mg, and Memantine HCL 10mg. Resident #3's May medication administration record does not include the initials of the staff person who administered these medications on 5/22/23 at 8pm. The May medication administration record also did not include the initials of the staff person who administered prescribed medication Hydrocortisone 2.5% cream on 5/21/23 at 8am, 2pm and 8pm.

Resident #4 is prescribed Trazadone 50mg, Quetiapine Fumarate 50mg, Gabapentine 300mg. Resident #4's April medication administration record did not include the staff persons initials who administered these medications on 4/6/23 and 4/7/23. The April medication administration record also did not include the initials of the staff person who administered medication Quetiapine Fumerate 25mg at 1pm on 4/9/23.

Resident #4 is prescribed Quetiapine Fumarate 25mg, Quetiapine Fumarate 50mg, Trazadone 50mg and MAPAP EX 500 mg. The May medication administration record did not include the staff persons initials who administered these medications on 5/22/23 at 5pm and 8pm.

Repeated Violation - 4/29/22, et al

Plan of Correction

Accept [REDACTED] - 07/10/2023)

6.19.23 ED re-educated nursing team on regulation 187b

6.19.23 and ongoing peer to peer review during cart changeover to check for documentation. HSC and nurse spoke with staff on expected communication during med count and ensuring the documentation is completed. Med techs and staff passing medications including nurse, HSC and DON would participate in communication.

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

6.26.23 10% of MARS will be audited weekly by HSC or designee for the next 4 weeks. The audit will move to monthly following the 4 weeks. This will be evaluated on a quarterly basis at the quality meeting

Licensee's Proposed Overall Completion Date: 07/03/2023

Not Implemented () - 09/18/2023)

187c - Refusal of Medication**7. Requirements**

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 5/10, 5/11, 5/12, 5/13, 5/14, 5/16, 5/17, 5/18, 5/25/23 at 8am, resident #5 refused to take a scheduled application of Permethrin Cream. The home did not notify the residents primary care physician.

Plan of Correction

Accept () - 07/10/2023)

6.19.23 ED re-educated nursing team on regulation 187c focusing on ensuring the PCP is made aware that the resident refused the medication

6.19.23 nurse reviewed med refusal form and process with med techs. Staff will call the PCP and a progress note will capture the refusal and communication to the PCP. If needed, the provider will see the resident on their next visit to the community

6.26.23 10% of MARS will be audited weekly by the HSC or designee for the next 4 weeks. The audit will move to monthly following the 4 weeks. This will be evaluated on a quarterly basis at the quality meeting

7.31.23 med tech refresher training to be completed by certified med trainer/observer

Licensee's Proposed Overall Completion Date: 07/03/2023

Implemented () - 09/18/2023)

187d - Follow Prescriber's Orders**8. Requirements**

2600.

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

Description of Violation

Resident # 1 is prescribed Pantoprazole Sodium tablet 40mg. However, resident # 1 did not receive the medication, from 5/6/23 through 5/24/23 due to medication not being available for administration. Resident #1 did not receive prescribed Melatonin 3mg on 5/6/23 at 8pm as it was not available for administration.

Resident #1 is prescribed Triamcinolone 0.1% Cream apply topically to neck, chest, abdomen, back, arms and legs twice a day. However, the staff did not apply the cream to the resident on 5/3/23 at 8pm, 5/4/23 at 8am and 8pm, 5/5/23 at 8am and on 5/22/23 at 8pm. At no time during April and May did the staff apply the cream as directed to the neck or abdomen on any day during this months.

187d - Follow Prescriber's Orders (continued)

Resident #1 is prescribed Permethrin cream on 5/10/23. On 5/31/23, the cream was to be applied but was not available for application.

Resident #3 is prescribed Permethrin 5% cream to be massaged into skin from head to soles of feet, leave on for 8-14 hours, then shower one time. The Permethrin cream was applied to resident #3's arms, legs, chest and upper back on 4/27, 4/28, 4/29 and 4/30/23 but failed to apply to the entire skin as prescribed.

Resident #4 is prescribed Permethrin 5% cream apply and thoroughly massage into skin from head to soles of feet, topically, leave on for 8 to 14 hours, then rinse off. This was applied to resident #4 to the arms and legs only on 4/27, 4/28, 4/29, and 4/30/23 at 8am.

This was applied daily to resident #4 from 5/1 to 5/31/23 but not from the head to soles of feet only to arms and legs from 5/1 to 5/6, then from 5/7 to 5/31/23 applied to arms, legs, chest and upper back.

Resident #5 is prescribed Permethrin Cream starting 5/6/23 for 7 days head to soles of feet; administered for 4 days on 5/6, 7, 8, 9 – then again on 5/15, 5/19 – all, and on 5/20, 21, 22, 23, 24 only to both arms; 5/26, 5/27, 5/28, 5/29, 5/30, 31/23 for a total of 17 days.

Resident #7 is prescribed Permethrin Cream starting 4/26/23. The home did not start the treatment until 5/6/23, 10 days after the order. On 5/6/23, the staff began the application of Permethrin Cream to apply topically from head to soles of feet times 7 days. On 5/6 through 5/31/23, the staff applied the cream to Resident #7's legs, arms, chest for 26 days VS 7 and never to neck until 5/31/23.

Resident #8 is prescribed Permethrin Cream was ordered on 5/10/23. On 5/27/23, the MAR is blank and no documentation to indicate the cream was applied to the resident as ordered.

Plan of Correction**Directed (██████) - 07/10/2023)**

6.13.23 and 6.14.23 nurse re-educated med techs on applying topical creams as they med techs had not properly documented the administration of the medication. They were re-educated by the nurse who expressed proper administration along with proper documentation

6.19.23 ED re-educated nursing team on regulation 187d to ensure understanding of following prescribers directions

6.26.23 10% of MARs will be audited weekly for the next 4 weeks by the HSC or designee. The audit will move to monthly following the 4 weeks. This will be evaluated on a quarterly basis at the quality meeting.

DPOC SLW 7/10/23

The nurse re-educated the med techs on applying topical creams and the required documentation of the administration of the medication on 6/13 and 6/14/23. The nurse will contact the residents physicians that the medication was not applied as directed to all physicians of residents affected by the staffs failure to follow physicians directions by 6/15/23.

The nurse re-educated the nursing team on regulations 187d to ensure understanding of following prescribers directions. Documentation of the training will be maintained for the Departments review. Starting 6/26/23 10% of the MARs will be audited weekly for the next 4 weeks by the HSC or med techs. Physicians will be notified of any failures to follow physicians directions, starting immediately. The audit will then be done monthly following the 4 weeks. This auditing process will be evaluated on a quarterly basis at the QA meeting, starting every quarter for the next six months, starting immediately.

The administrator will be discussing following physician orders at monthly staff meetings for the next six months, starting within 10 days of receipt of this plan of correction. Documentation of the agenda and

187d - Follow Prescriber's Orders (continued)

staff sign in sheet will be maintained for the Departments review.

Directed Completion Date: 07/03/2023

Not Implemented [REDACTED] - 09/18/2023)

188b - Medication Error Reporting**9. Requirements**

2600.

188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #1 is prescribed Pantoprazole Sodium tablet 40mg. However, resident # 1 did not receive the medication, from 5/6/23 through 5/24/23 due to medication not being available for administration. The medication error was not reported to the designated person or prescriber.

Resident #3 is prescribed Permethrin 5% Cream started on 5/1/23 to be applied topically and thoroughly massaged into skin from head to soles of feet once a day for 7 days. The staff applied the cream to resident #3 on 5/1 through 5/18 (18 days) to both arms/legs, chest and upper back. The medication error was not reported to the designated person or prescriber.

Resident #4 is prescribed Permethrin 5% Cream started on 5/1/23 at 8am: massaged into skin from head to soles of feet topically, leave on for 8 to 14 hours rinse off DX Presumptive Scabies just once. The staff applied the cream daily from 5/1 to 5/31 but not from the head to soles of feet only to arms and legs from 5/1 to 5/6, then from 5/7 to 5/31 applied to arms, legs, chest and upper back. The medication error was not reported to the designated person or prescriber.

Plan of Correction

Directed [REDACTED] - 07/10/2023)

6.19.23 ED re-educated nursing team on regulation 188d and the system in place for identifying and documenting medication errors. Notebook was placed on med cart to support with discrepancies noted during medication administration. **Med Techs will be trained on the reporting process of any identified medication errors, by 7/25/23.**

6.19.23 ED reviewed proper documentation in MAR as the creams were applied correctly to resident #3 and #4; however, were not documented appropriately causing a documentation error. Ed, HSC, and nurse spoke with med techs to ensure proper understanding of documentation and how to appropriately document on the MAR when there is not a clear cut option

6.26.23 10% of medication administrators will be interviewed at random monthly to check in on proper medication error reporting. This will be evaluated on a quarterly basis at the quality meeting **by the administrator starting 6/26/23.**

DPOC, additional steps [REDACTED] 7/10/23

Effective 7/15/23, a Certified observer will conduct the required bi-annual MAR review with certified Med Techs, to ensure documentation of the application of creams/medications/treatments is completed correction. Documentation will be maintained.

188b - Medication Error Reporting (continued)

Directed Completion Date: 07/25/2023

Not Implemented () - 09/18/2023)

190a - Completion Medication Course**10. Requirements**

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person A, annual practicum was not signed by the trainer to indicate the staff completed the practicum successfully.

On 5-16-23 at 8:00am, provided all the medications for the 41 residents in the home.

Repeated Violation - 4/29/22, et al

Plan of Correction

Accept () - 06/27/2023)

5.16.23 Staff member B () was pulled from the med cart

5.19.23 staff member B was recertified by DON/med trainer

5.16.23 DON completed an audit of the med tech certifications

6.30.23 med tech audit tool completed and reviewed monthly by nurse or designee

7.31.23 med tech class to be completed

Licensee's Proposed Overall Completion Date: 06/30/2023

Implemented () - 09/18/2023)

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

Facility Information

Name: *WOODLAND CREEK ALZHEIMER'S SPECIAL CARE CENTER* License #: *14605* License Expiration: *04/27/2024*
Address: *1424 DRESHERTOWN ROAD, DRESHER, PA 19025*
County: *MONTGOMERY* Region: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *DRESHER CARE GROUP LLC*

Address: [REDACTED]

Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-1* Date: *08/05/2015* Issued By: *Tredyffrin Township*

Staffing Hours

Resident Support Staff: *34* Total Daily Staff: *98* Waking Staff: *74*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Incident, Monitoring* Exit Conference Date: *07/13/2023*

Inspection Dates and Department Representative

07/12/2023 - On-Site: [REDACTED]
07/13/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* Residents Served: *32*

Secured Dementia Care Unit

In Home: *Yes* Area: *Entire home* Capacity: *66* Residents Served: *32*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *32*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *32* Have Physical Disability: *0*

Inspections / Reviews

07/12/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *07/26/2023*

09/06/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: *09/11/2023*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *09/11/2023*

09/18/2023 - Document Submission

Submitted By: [REDACTED] Date Submitted: *09/11/2023*
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 7/12/23, at 9:15 AM, residents' medication records, including narcotics logs, were unlocked, unattended, and accessible in a cart left outside the main dining room.

Plan of Correction**Accept** [REDACTED] - 08/03/2023)

7.12.23 med tech secured the cart immediately including the medication records and narcotics log

7.20.23 DON re-educated med tech who left the cart items unsecured to the regulation and importance of HIPPA and safety

7.20.23 DON or designee will conduct weekly random observations of the med techs during med pass for 4 weeks. This will move to monthly after 4 weeks

9.30.23 Plan will be reviewed at quality meeting

Licensee's Proposed Overall Completion Date: 08/30/2023

Implemented [REDACTED] - 09/18/2023)**82c - Locking Poisonous Materials****4. 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

A bottle of MediChoice Shampoo and Body Wash, with a manufacture's label indicating "If swallowed get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to resident #2.

A bottle of Odoban Disinfectant Fabric & Air Freshener, with a manufacture's label indicating "Avoid contact with skin or eyes...Call Poison Control Center or doctor for medical advice," was unlocked, unattended, and accessible to resident #3.

Residents of the home, including resident #2 and #3, have been assessed not capable of recognizing and using poisons safely.

Plan of Correction**Accept** [REDACTED] 08/03/2023)

7.12.23 Maintenance Director immediately secured items

7.12.23 Maintenance Director completed an audit of all rooms and ensured all chemicals away and secured

7.27.23 DON re-educated care staff on regulation 82c

7.27.23 and ongoing DON or designee will conduct random daily walkthroughs to ensure compliance

82c - Locking Poisonous Materials (*continued*)

Licensee's Proposed Overall Completion Date: 07/27/2023

Not Implemented [REDACTED] - 09/18/2023)

85a - Sanitary Conditions

5. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 7/12/2023 at 9:40 AM, a strong odor of urine was observed in resident #4's room.

Plan of Correction

Accept [REDACTED] - 08/03/2023)

*7.12.23 Maintenance Director shampooed the carpet**7.12.23 Maintenance Director educated his housekeeping team on regulation 85a**7.12.23 and ongoing housekeeper or designee will check resident rooms daily. This room will be shampooed bi-weekly ongoing to support individual resident needs.*

Licensee's Proposed Overall Completion Date: 07/26/2023

Not Implemented [REDACTED] - 09/18/2023)

141b1 - Annual Medical Evaluation

6. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

*Resident 4's most recent medical evaluation was completed on 4/12/2022. The annual evaluation is overdue.**REPEAT VIOLATION: 1/12/23*

Plan of Correction

Accept [REDACTED] /03/2023)

*7.26.23 DON educated nursing staff on reg 141.b.1**7.31.23 all charts audited**8.2.23 DON will have audit system in place to ensure DME is being completed according to regulation**8.2.23 DON or designee will audit 10% of resident charts monthly to ensure compliance to regulation***Directed Plan of Correction (SLW 7/287/23) additional step:**

- **The DON will schedule a medical examination for resident #4 to ensure the medical evaluation is current, by 7/30/23.**

Licensee's Proposed Overall Completion Date: 07/31/2023

Implemented [REDACTED] - 09/18/2023)

183b - Meds and Syringes Locked

7. Requirements

183b - Meds and Syringes Locked (continued)

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 7/12/23 at 9:15, a cart containing narcotics and other medications and syringes was unlocked, unattended, and accessible in front of the main dining room.

Plan of Correction**Accept () - 08/03/2023)**

7.12.23 med tech secured the cart immediately containing the narcotics. Please note, syringes are not kept on the cart rather in the locked fridge in a locked room

7.20.23 DON re-educated med tech who left the cart items unsecured to the regulation and importance of safety

7.20.23 DON or designee will conduct weekly random observations of the med techs during med pass for 4 weeks.

This will move to monthly after 4 weeks

9.30.23 Plan will be reviewed at quality meeting

Licensee's Proposed Overall Completion Date: 08/30/2023

Implemented () - 09/18/2023)**183d - Prescription Current****8. 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 7/12/2023, albuterol prescribed for resident #5, was in one of the home's medication carts; however, the medication was discontinued on 4/5/23.

On 7/12/2023, triamcinolone 0.1% cream, prescribed for resident #6, was in one of the home's medication carts; however, the medication was discontinued on 7/6/23.

Plan of Correction**Accept () - 08/03/2023)**

7.12.23 med tech removed discontinued medications from the med cart

7.12.23 med tech audited med cart for any additional medication discrepancies due to discontinuation

7.20.23 DON educated med techs on 187.d and importance of following prescriber order by verifying MAR to paper order

7.20.23 and ongoing DON or designee will review new orders weekly for any discrepancy

7.28.23 and ongoing DON or designee will perform weekly cart audit for 4 weeks and monthly cart audits following the 4 weeks for any discrepancies

Directed Plan of Correction () 7/27/23) additional steps:

- **Starting 7/31/23, and monthly thereafter for six months, the administrator will conduct medication cart audits to ensure all medications are available for administration.**
- **Starting 7/31/23, the administrator will discuss following prescribers orders at monthly staff meetings for the next six months.**
- **Copies of the agenda and sign in sheet will be maintained for the Departments review.**

183d - Prescription Current (*continued*)

Licensee's Proposed Overall Completion Date: 08/03/2023

Implemented [REDACTED] - 09/18/2023)

187d - Follow Prescriber's Orders

9. Requirements

2600.

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

Description of Violation

Resident #4 is prescribed tramadol twice a day. However, this medication was not administered as scheduled to resident #4 on 7/11/2023 at 8:00 PM because the medication was not available in the home.

Repeated Violation - 1/12/23, et al

Plan of Correction

Accept [REDACTED] - 08/03/2023)

7.12.23 med tech confirmed the medication had arrived to the community and resident received regular dose.

Resident experienced no adverse effects to missing evening dose the night prior.

7.20.23 DON educated med techs on 187.d and importance of following prescriber order by verifying MAR to paper order

7.20.23 and ongoing DON or designee will review new orders weekly for any discrepancy

7.28.23 and ongoing DON or designee will perform weekly cart audit for 4 weeks and monthly cart audits following the 4 weeks for any discrepancies

Directed Plan of Correction [REDACTED] 7/27/23) additional steps:

- **Starting 7/31/23, and monthly thereafter for six months, the administrator will conduct medication cart audits to ensure all medications are available for administration.**
- **Starting 7/31/23, the administrator will discuss following prescribers orders at monthly staff meetings for the next six months.**
- **Copies of the agenda and sign in sheet will be maintained for the Departments review.**

Licensee's Proposed Overall Completion Date: 08/03/2023

Not Implemented [REDACTED] - 09/18/2023)

188b - Medication Error Reporting

10. Requirements

2600.

188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #4 is prescribed tramadol twice a day. However, this medication was not administered as scheduled to resident #4 on 7/11/2023 at 8:00 PM because the medication was not available in the home. The medication error

188b - Medication Error Reporting (continued)

was not reported to the resident's family or primary care physician.

Plan of Correction

Accept [REDACTED] - 08/03/2023)

7.12.23 med tech confirmed the medication had arrived to the community and resident received regular dose.

Resident experienced no adverse effects to missing evening dose the night prior.

7.28.23 DON educated nursing team and med techs regulation 188b

7.28.23 and ongoing DON informed the nursing team and med techs to the process of appropriate reporting and developed process to support reporting

Licensee's Proposed Overall Completion Date: 07/28/2023

Not Implemented [REDACTED] - 09/18/2023)

224a - Preadmission Screen Form**11. Requirements**

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #3's cognitive preadmission screening, dated 12/8/2022, does not include a determination that the needs of the resident require secured care due to Alzheimer's disease or other dementia.

Plan of Correction

Accept [REDACTED] - 08/03/2023)

7.13.23 during exit ED updated and dated resident 3's prescreen with the direction of the inspector

7.28.23 DON educated Health Services Coordinator and wellness nurse to regulation

8.4.23 Health Services Coordinator will audit resident charts for prescreens filled out with compliance

8.4.23 and ongoing DON or designee will review all documentation prior to admission to ensure the prescreen is filled out in entirety and within the past 30 days prior to admission

Licensee's Proposed Overall Completion Date: 08/04/2023

Not Implemented [REDACTED] - 09/18/2023)

227i - Support Plan Accessible**12. Requirements**

2600.

227.i. The support plan shall be accessible by direct care staff persons at all times.

Description of Violation

On 7/12/2023, resident #3's support plan was inaccessible to direct care staff.

Plan of Correction

Accept [REDACTED] - 08/03/2023)

7.13.23 Health Services Coordinator completed support plan and placed in community support plan binders for the direct care staff to access

8.4.23 Health Services Coordinator will audit care plan books to ensure all support plans are accessible to the staff

8.4.23 and ongoing Health Services Coordinator or designee will audit the support plan books monthly to ensure all current support plans are present

227i - Support Plan Accessible (continued)

Directed Plan of Correction [REDACTED] 7/27/23) additional steps:

- **Starting 7/31/23 the administrator or DON will conduct a monthly random audit of at least 10% of resident support plans to ensure they are complete and available for the staff's review for the next six months.**
- **Starting 7/31/23 the administrator will interview at least 10% of the direct care staff to ensure the support plan and tools to provide care are available as needed for the next six months.**
- **Copies of the audit and interviews will be maintained for the Departments review.**

Licensee's Proposed Overall Completion Date: 08/04/2023

Not Implemented [REDACTED] - 09/18/2023)

231c - Preadmission Screening

13. Requirements

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]/2022. However, the resident's written cognitive preadmission screening was not completed.

Plan of Correction

Accept [REDACTED] 08/03/2023)

7.13.23 pre-screen completed for resident #3 with the direction of inspector

7.13.23 ED re-educated on regulation

7.20.23 and ongoing DON or designee will audit 10% of pre screens quarterly for completion

Licensee's Proposed Overall Completion Date: 07/26/2023

Not Implemented [REDACTED] 09/18/2023)

234d - Support Plan Revision

14. Requirements

2600.

234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

The home has no support plan on file for resident #3. An entry was last made on the resident's Assessment and Support Plan Updates and Changes form on 2/3/2023; however, no support plan or update was done when the resident began hospice care on 6/19/23.

A support plan for resident #4 was last completed on 7/15/2022; however, an incident on 7/2/2023, in which resident

234d - Support Plan Revision (continued)

#4 became violent with another resident, should have prompted an update to [REDACTED] support plan, as it indicated a change in the resident's behavior.

Plan of Correction**Accept [REDACTED] - 08/03/2023)**

7.13.23 Health Services Coordinator completed support plan for resident #3 and updated support plan for resident #4

7.20.23 DON educated Health Services Coordinator on regulation 234d

8.4.23 Health Services Coordinator to audit support plans to ensure completion and compliance with the regulation

8.4.23 and ongoing DON or designee will ensure completion of the support plan in compliance with the regulation at admission, annually, and at the time of any change to include additional interventions as needed

Directed Plan of Correction [REDACTED] 7/27/23) additional steps:

- **Starting 7/31/23 the administrator or DON will conduct a monthly random audit of at least 10% of resident support plans to ensure they are complete and available for the staff's review for the next six months.**
- **Starting 7/31/23 the administrator will interview at least 10% of the direct care staff to ensure the support plan and tools to provide care are available as needed for the next six months.**
- **Copies of the audit and interviews will be maintained for the Departments review.**

Licensee's Proposed Overall Completion Date: 08/04/2023

Not Implemented [REDACTED] - 09/18/2023)