pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **COLUMBIA HANOVER OPCO, LLC**
LEGAL ENTITY

To operate **THE VERO AT BETHLEHEM**
NAME OF FACILITY OR AGENCY

Located at **4700 BATH PIKE, BETHLEHEM, PA 18017**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

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 **140** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 36**

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 **January 23,** **2024** until **July 23,** **2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **231631**

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

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent Via Email to: [redacted]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JANUARY 23, 2024

[redacted]
Columbia Hanover Opco, LLC
[redacted]

RE: The Vero at Bethlehem
4700 Bath Pike
Bethlehem, Pennsylvania
18017 License #: 231631

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on September 12, 2023, September 13, 2023, December 7, 2023, and December 12, 2023 of the above facility, the violations specified on the enclosed Licensing Inspection Summaries (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 (231630) dated June 5, 2023 to June 5, 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 June 5, 2023, to June 5, 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 January 23, 2024 to July 23, 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.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide

to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[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

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

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summaries

cc: [redacted]

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

Facility Information

Name: *THE VERO AT BETHLEHEM* **License #**: *23163* **License Expiration**: *06/05/2024*

Address: *4700 BATH PIKE, BETHLEHEM, PA 18017*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *COLUMBIA HANOVER OPCO, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *02/09/2023* **Issued By**: *Hanover Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *148* **Waking Staff**: *111*

Inspection Information

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

Reason: *Incident, Interim* **Exit Conference Date**: *12/21/2023*

Inspection Dates and Department Representative

12/07/2023 - On-Site: [redacted]

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *140* **Residents Served**: *85*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *1st floor* **Capacity**: *36* **Residents Served**: *33*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *84*

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

Have Mobility Need: *63* **Have Physical Disability**: *1*

Inspections / Reviews

12/07/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/11/2024*

01/22/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *01/22/2024*
Reviewer: [redacted]
Follow-Up Type: *Bypass Document Submission*

01/22/2024 - Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *01/22/2024*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident 1 sustained an injury which required a visit to the hospital for stitches on 11-25-23 at 2:40pm. The incident was not reported to the Department until 11-27-23 at 2pm.

Through an interview with the home's administrator, it was determined that on October 15th, 2023, and Oct 17th, 2023, the home's fire alarm was activated, as the residents of the Memory care unit pulled the fire alarm on both days resulting in a response by EMS and the fire department. There was no fire in the home. The Incidents were not reported to the Department.

On 11-24-23 at 7pm a gas leak was discovered in the 2nd floor laundry room of the home and emergency services were dispatched. The incident was not reported to the Department until 11-26-23 at 2pm.

Plan of Correction ***Accept [redacted] - 01/22/2024)***

Regional Health Care Director provided education on reportable incidents to Residence director on 12/18/23. Education provided included Legend Senior Living policy 02-01-0130P Reportable Events and 55 Pa Code 2600.16c regarding the required 24-hour maximum time frame for state reporting of incidents. LSL Policy Number 02-01-0130P and 55 Pa Code 2600.16c training to be provided to Leadership team, Manager on duty and all staff to ensure their understanding of reportable events and timely/accurate reporting to DHS by 01/18/2024. Health care Director/ Designee will monitor incident reports daily to ensure compliance with 24-hour state reporting requirement. Residence Director/Designee to monitor all building events and report to DHS in accordance with 55 Pa code 2600.16c. Residence director/Designee to complete audit for regulatory compliance of all incident reports dated after last inspection date of 12/07/23 to be completed with immediate reporting in accordance with 55 Pa code 2600.16c. All incidents' reports to be reviewed for compliance daily by Residence Director/Designee to ensure proper state reporting for the next 90 days.

Proposed Overall Completion Date: 01/18/2024

Licensee's Proposed Overall Completion Date: *01/18/2024*

Not Implemented [redacted] - 01/22/2024)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident home contract for Resident #8 dated 6-1-23 is not signed by the resident. It is not notated that the resident refused or was unable to sign.

Plan of Correction ***Accept ([redacted] 01/16/2024)***

Senior Vice President provided education on contracts and resident signature requirement to Residence Director on

25b - Contract Signatures (continued)

12/29/23. Education included review of 55 Pa Code 2600.25b Contract Signatures. Residence Director to provide training to Customer Service Associate on 55 Pa Code 2600.25b Contract Signatures by 01/18/2024. Customer Service associate/designee to audit all contracts dated after last inspection date of 12/07/23 for signatures by 01/31/2024. Residence Director to review all new contracts for regulatory compliance at weekly RD/CSA meeting for the next 90 days.

Administrator will monitor for ongoing compliance [redacted]

Proposed Overall Completion Date: 01/31/2024

Licensee's Proposed Overall Completion Date: *01/31/2024*

63a - First Aid/CPR Training

3. 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

The home had a census of 85 residents on 11-18-23 and 11-19-23 and was required to have 2 staff members certified in CPR and First Aid on all shifts. There was only 1 staff member certified in CPR/FIRST Aid in the home on 11-18-23 from 3-11pm and on 11-19-23 from 3-3:30pm

Plan of Correction ***Directed*** [redacted] ***- 01/16/2024)***

Senior Vice President provided education on First Aide/CPR requirement for staff to Residence Director on 12/28/23. Education included 55 Pa Code 2600.63a First Aide/CPR Training. Residence Director to provide education to Customer Service Associate on 55 Pa Code 2600.63a CPR certified staff/resident ratio by 1/18/24. Customer Service Associate/Designee to audit staff files for current CPR certifications and schedule training for all certification/recertification needs by 2/18/24. For the next 90 days staff schedule will be reviewed weekly for upcoming week by Residence Director at weekly RD/HCD meeting to ensure compliance with DHS requirements of 1 First aide/CPR certified staff member per 50 residents at all times.

Proposed Overall Completion Date: 02/18/2024

Within 15 days of receipt of this directed plan of correction:
Customer Service Associate/Designee to audit staff files for current CPR certifications and schedule training for all certification/recertification needs. A tracking form will be created to monitor First Aid and CPR certifications/expiration dates. The form will be available to the Department for review upon request. Staff schedule will be reviewed weekly for upcoming week by Residence Director at weekly RD/HCD meeting to ensure compliance with DHS requirements of 1 First aide/CPR certified staff member per 50 residents at all times.

Directed Completion Date: *02/01/2024*

103e - Left Overs

4. Requirements

103e - Left Overs *(continued)*

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

The dry good storage in the home's main kitchen was found to have a 36-ounce container of potato buds that was open and not dated when opened.

A 1-pound container of domino brand confection sugar was found open and not dated when opened.

Plan of Correction ***Directed [redacted] - 01/16/2024)***

Violation immediately corrected. Items labeled/dated and/or disposed of in accordance with 55 Pa Code 2600.103e. Residence Director Provided education on food storage label and dating requirements to Culinary Services Director/Designee on 01/09/24. Education included Legend Senior Living policy 06-01-0011p Food storage and 55 Pa code 2600.103e/g. Culinary Services Director/Designee to provide education/training on 55 Pa code 2600.103e to all culinary staff by 1/18/24. Audit of dry storage inventory for regulatory compliance to be completed by 01/31/24. Residence Director to monitor on going compliance by completing weekly inspections during RD/CSD meetings for the next 90 days.

Proposed Overall Completion Date: 04/18/2024

Within 5 days of receipt of this directed plan of correction:
Audit of all food storage areas will be completed for proper labeling and dating of food items. Weekly audits will be completed in these areas for 90 days. Documentation of these audits will be kept for the Departments review upon request. The Administrator will monitor for ongoing compliance.

Directed Completion Date: *01/22/2024*

Not Implemented [redacted] - 01/22/2024)

103g - Storing Food

5. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

The dry good storage in the home's main kitchen was found to have a 36-ounce container of potato buds that was open.

1 pound container of domino brand confection sugar was found open in the home's kitchen

Plan of Correction ***Directed [redacted] - 01/16/2024)***

Violation immediately corrected. Items disposed of and replaced in accordance with 55 Pa Code 2600.103g. Residence Director provided education on food storage requirements to Culinary Services Director/Designee on 01/09/24. Education included Legend Senior Living policy 06-01-0011p Food storage and 55 Pa code 2600.103e/g. Culinary Services Director/Designee to provide education/training on 55 Pa code 2600.103g to all culinary staff by 1/18/24. Audit of dry storage inventory for regulatory compliance to be completed by 01/31/24. Residence Director

103g - Storing Food (continued)

to monitor on going compliance by completing weekly inspections during RD/CSD meetings for the next 90 days .

Proposed Overall Completion Date: 04/18/2024

Within 5 days of receipt of this directed plan of correction:
Audit of all food storage areas will be completed for proper labeling and dating of food items. Weekly audits will be completed in these areas for 90 days. Documentation of these audits will be kept for the Departments review upon request. The Administrator will monitor for ongoing compliance.

Directed Completion Date: *01/22/2024*

Not Implemented [redacted] - 01/22/2024)

125a - Combustible Storage

6. Requirements

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

Description of Violation

An empty box of dryer sheets was found behind the dryer in the 1st floor resident laundry room, posing a possible fire hazard.

Plan of Correction ***Accept [redacted] - 01/22/2024)***

Violation corrected immediately. Item removed from rear dryer.
Residence Director provided education on proper storage and/or disposal of combustible/flammable materials to Maintenance Director on 1/09/24. Education included review of 55 Pa code 2600.125a. Fire safety education to be provided to residents during resident council meeting on 1/29/24. Education on 55 Pa code 2600.125a to be provided to housekeeping department and all staff by 1/18/24. Maintenance Director to complete random audits weekly for the next 90 days. Residence Director to review audit at weekly RD/MD meetings and ensure compliance with 55 Pa Code 2600.125a. Residence Director to complete monthly laundry room walkthrough inspections through 4/31/24.

Proposed Overall Completion Date: 04/18/2024

Licensee's Proposed Overall Completion Date: *04/18/2024*

132a - Monthly Fire Drill

7. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

There is no documentation that the home conducted a fire drill in November 2023.

Plan of Correction ***Directed [redacted] - 01/16/2024)***

Senior Vice President provided education on monthly Fire drills to Residence Director on 12/29/23. Education included Legend Senior Living Policy 04-05-0030P Fire drills and 55 Pa Code 2600.132a. Residence Director reviewed Legend Senior Living Policy 04-05-0030P Fire drills and 55 Pa Code 2600.132a. with Maintenance Director on 1/09/24. Fire Drills to be conducted in accordance with 55 Pa Code 2600.132a monthly. January fire drill

132a - Monthly Fire Drill (continued)

scheduled. Compliance to be monitored monthly by Residence Director during weekly RD/MD meetings.

Proposed Overall Completion Date: 03/31/2024

Within 3 days upon receipt of this directed plan of correction:
A schedule will be created for the monthly fire drills which will be kept by the Administrator and Maintenance director. A copy of this schedule will be kept for the Departments review upon request. The Administrator will oversee the fire drills are being conducted monthly as required.

Directed Completion Date: *01/20/2024*

Not Implemented [redacted] - 01/22/2024)

141a - Medical Evaluation

8. 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 evaluation for the Documentation of Medical Evaluation for Resident #2, admitted [redacted]-23, was completed on 5-10-23, greater than 60 days prior to admission.

Plan of Correction ***Accept ([redacted] - 01/22/2024)***

Regional Health Care Director provided education on documentation of medical evaluation requirements to Residence Director on 12/19/23. Education included review of 55 Pa Code 2600.141a. Residence Director to review 55 Pa Code 2600.141a with Assistant Health Care Director and all Licensed staff to ensure understanding of complete and accurate Document of Medical Evaluation requirement by 1/18/24. Residence Director/Designee will audit all residents' files dated after last inspection of 12/07/23 to ensure compliance with 55 Pa Code 2600.141a by 2/18/24 with Immediate Physician notification of any discrepancies found and request to correct in accordance with 55 Pa code 2600.141a.

Proposed Overall Completion Date: 02/18/2024

Licensee's Proposed Overall Completion Date: *02/18/2024*

141a 1-10 Medical Evaluation Information

9. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

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

The Documentation of Medical Evaluation dated [redacted]-23 for resident #2 does not contain documentation of the resident's temperature.

The Documentation of Medical Evaluation for Resident #3, dated [redacted]-23, does not document if the resident's immunizations are current.

Plan of Correction ***Accept [redacted] - 01/22/2024)***

Resident #2 item missing was corrected late and the temperature was added. The physician was made aware and it was noted
Resident #3 items missing was corrected and immunization record was noted. The physician was made aware and it was noted.
Regional Health Care Director provided education on documentation of medical evaluation requirements to Residence Director on 12/19/23. Education included review of 55 Pa Code 2600.141a. Residence Director to review 55 Pa Code 2600.141a with Assistant Health Care Director and all Licensed staff to ensure understanding of complete and accurate Document of Medical Evaluation requirement by 1/18/24. Residence Director/Designee will audit all residents' files dated after last inspection of 12/07/23 to ensure compliance with 55 Pa Code 2600.141a by 2/18/24 with Immediate Physician notification of any discrepancies found and request to correct in accordance with 55 Pa code 2600.141a.

Proposed Overall Completion Date: 02/18/2024

Licensee's Proposed Overall Completion Date: *02/18/2024*

185a - Implement Storage Procedures

10. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #4 has a prescription for Nystatin 100,000 U/GM powder. The prescription was not available in the medication cart at the time of inspection.

Plan of Correction ***Directed (- 01/16/2024)***

Violation corrected immediately via pharmacy delivery same day.
Resident #4 medication placed in cart for use according to prescribers' orders.
Regional Health Care Director provided education on medication administration and storage to Residence Director by 12/19/23. Education included Legend Senior Living Policy 10-03-0020P and review of 55 Pa code 2600.185a/187d. Residence Director to provide education to Assistant Health Care Director, all Licensed staff and Med Techs on Legend senior Living Policy 10-03-0020P and review 55 Pa Code 2600.185a/187d by 1/18/24.
Assistant Health Care Director/Designee will complete audit of all med carts for prescribed orders and medication availability, accurate electronic transcription and administration instruction labels by 3/1/24 with all discrepancies found immediately communicated to physician with request to resolve. Weekly med cart audits to continue through 90 days. Residence Director to monitor at weekly RD/HCD meeting.

Proposed Overall Completion Date: 02/29/2024

Within 30 days of receipt of this directed plan of correction:
Assistant Health Care Director/Designee will complete audit of all med carts for prescribed orders and medication availability, accurate electronic transcription and administration instruction labels with all discrepancies found immediately communicated to physician with request to resolve. Weekly med cart audits to continue through 90 days. Documentation of weekly audits will be kept for the Departments review upon request. Administrator will monitor for ongoing compliance.

Directed Completion Date: *02/16/2024*

187d - Follow Prescriber's Orders

11. Requirements

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

Description of Violation

Resident #5 has a prescription for Cohlestryramine Light Packets. The pharmacy label lists the directions as: Dissolve 1 packet in 3oz of liquid and drink before meals 6-am to 2pm. The Medication Administration Record lists the instructions as: Mix 1 packet in 4-6oz of liquid and take orally every morning. The home is administering the medication as per The Medication Administration Record which is incorrect.

Resident #9's Benztropine 1 mg. daily tab was to be titrated to 0.5 mg. 1 tab. daily for 14 days before being discontinued. The home administered the resident 's Benztropine 0.5 mg tab. for 7 days but failed to contact the pharmacy to complete the physician's order to titrate the medication 14 days prior to discontinuing the medication.

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

Plan of Correction ***Directed [redacted] - 01/16/2024)***

Violation corrected immediately for Resident #5. Administration instructions reference sticker placed on manufacturer box to ensure administration according to prescribers' orders.
Regional Health Care Director provided education on medication administration and storage to Residence Director by 12/19/23. Education included Legend Senior Living Policy 10-03-0020P and review of 55 Pa code 2600.185a/187d. Residence Director to provide education to Assistant Health Care Director, all Licensed staff and Med Techs on Legend senior Living Policy 10-03-0020P and review 55 Pa Code 2600.185a/187d by 1/18/24.
Assistant Health Care Director/Designee will complete audit of all med carts for prescribed orders and medication availability, accurate electronic transcription and administration instruction labels by 3/1/24 with all discrepancies found immediately communicated to physician with request to resolve. Weekly med cart audits to continue through 90 days. Residence Director to monitor at weekly RD/HCD meeting.

Proposed Overall Completion Date: 02/29/2024

Within 30 days of receipt of this directed plan of correction:
Assistant Health Care Director/Designee will complete audit of all med carts for prescribed orders and medication availability, accurate electronic transcription and administration instruction labels with all discrepancies found immediately communicated to physician with request to resolve. Weekly med cart audits to continue through 90 days. Documentation of weekly audits will be kept for the Departments review upon request. Administrator will monitor for ongoing compliance.

Directed Completion Date: *02/16/2024*

227d - Support Plan Medical/Dental

12. 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

Resident #6 cannot hear the fire alarms and had a bed shaker installed to alert the resident should the fire alarms activate. The Resident Assessment Support Plan for Resident #6, signed by staff on 8-15-23, was not updated to reflect the installation of a bed shaker.

Plan of Correction ***Accept [redacted] - 01/16/2024)***

Resident # 6 support plan was updated to include the bed shaker installation for not being able to hear the fire alarm.
Regional Healthcare Director provided education to Residence Director on 01/05/24 on change of condition resident assessment support plan revision and accurate documentation of provided/contracted care services in the RASP.. Education included Legend Senior Living Policy 10-01-0050P and review of 55 Pa Code 2600.227d Support plan Medical/Dental. Residence Director and Health Care Director Specialist provided education to Assistant Health Care Director on LSL 10-01-0050P and review of 55 Pa Code 2600.227d on 01/08/24. By 01/31/24 AHCD to complete audit of change of condition assessments and corresponding RASP revision completed after last inspection date of 12/07/23. Each audited rasp will be reviewed for accurate care services documentation. All discrepancies found to

227d - Support Plan Medical/Dental (continued)

be corrected immediately. RD to review change of condition assessments and corresponding RASP revision weekly at RD/HCD meeting for the next 90days to ensure compliance with 55 Pa Code 2600.227d.

Licensee's Proposed Overall Completion Date: *02/29/2024*

227g -Support Plan Signatures

13. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The Resident Assessment and Support Plan for Resident #9 dated [redacted]1-23 and for Resident #7 dated [redacted]-24-23 were not signed by the residents. It was not documented that the residents refused or were unable to sign.

The Resident Assessment and Support Plans for Resident #2 dated [redacted]-1-23 and for Resident #6 dated [redacted]-15-23, were not dated by the residents.

Plan of Correction ***Directed [redacted] - 01/16/2024)***

Resident #7 was corrected late for not wanting to sign the support plan and the appropriate box was checked
Resident # 9 was corrected late for not wanting to sign the support plan and the appropriate box was checked

Regional Health care Director provided education on 01/05/24 to Residence Director on the importance that all residents have the right to participate in their plan of care and sign their Support Plan, refusal to sign must be documented. Education included Legend Senior Living Policy 10-01-0150P and review of 55 Pa Code 2600.227g. Health Care Director Specialist provided education on LSL policy 10-01-0150P and review of 55 Pa code 2600.227g to Assistant Health Care Director on 01/08/24. There will be a complete audit conducted by the RD/AHCD/Wellness Nurse or designee for current resident signatures and dates, or refusal to sign/participate by 2/29/24. If discrepancies are identified the appropriate RASP will be updated in accordance with 55 Pa Code 2600.227g.

Residence Director to review weekly for 4 weeks all completed RASPs for new and existing residents.

Proposed Overall Completion Date: 02/29/2024

Within 30 days of this directed plan of correction:
There will be a complete audit conducted by the RD/AHCD/Wellness Nurse or designee for current resident signatures and dates, or refusal to sign/participate. If discrepancies are identified the appropriate RASP will be updated in accordance with 55 Pa Code 2600.227g. Audits will be documented and be made available to the Department upon request. The Administrator will monitor for ongoing compliance.

Directed Completion Date: *02/16/2024*

231c - Preadmission Screening

14. Requirements

231c - Preadmission Screening *(continued)*

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 #2 was admitted to the home's Secured Dementia Unit on [redacted]-28-23. The cognitive preadmission screening was completed on 8-16-23 greater than 72 hours prior to admission.

Plan of Correction ***Directed ([redacted] - 01/16/2024)***

New Cognitive admission Pre screen completed along with DME and MME. This resident remains appropriate for SDCU.
Regional Health Care Director provided education on Pre admission screening requirements to Residence Director on 1/05/24. Education included review of 55 Pa Code 2600.231c Preadmission Screening completion requirement of 72 hours maximum prior to admission to secured dementia unit. Residence Director to review 55 Pa Code 2600.231c with Assistant Health Care Director and all licensed staff by 1/18/24. Assistant Health Care Director/Designee to complete audit of all Secured Dementia Unit resident files for completed cog screens with any discrepancies found immediately communicated to physician with request to resolve by 3/1/24. Residence Director to review all new SDCU pre screens with Assistant Health Care Director at weekly RD/HCD meeting for the next 90 days.

Proposed Overall Completion Date: 03/01/2024

Within 30 days of receipt of this directed plan of correction:
Assistant Health Care Director/Designee to complete audit of all Secured Dementia Unit resident files for completed cog screens with any discrepancies found immediately communicated to physician. Documentation of audits will be kept for review by the Department upon request. Residence Director to review all new SDCU pre screens with Assistant Health Care Director at weekly RD/HCD meeting for the next 90 days. Administrator will monitor for ongoing compliance.

Directed Completion Date: *03/01/2024*

234d - Support Plan Revision

15. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident #2 called 911 from the home multiple times on [redacted]-24-23 to report being held hostage, and emergency services were dispatched. The Resident Assessment Support plan for the resident was not updated to reflect the resident's behaviors regarding the incident.

Plan of Correction ***Accept [redacted] - 01/16/2024)***

Resident #2 RASP addendum was updated to support [redacted] behavior of calling 911 on several occasions that the emergency services were dispatched.
Regional Healthcare Director provided education to Residence Director on 01/05/24 on change of condition resident assessment support plan revision.
Education included Legend Senior Living Policy 10-01-0050P and review of 55 Pa Code 2600.234d Support plan Revision. Residence Director and Health Care Director Specialist provided education to Assistant Health Care

234d - Support Plan Revision (continued)

Director on LSL 10-01-0050P and review of 55 Pa Code 2600.234d on 01/08/24. By 01/31/24 AHCD to complete audit of change of condition assessments and corresponding RASP revision completed after last inspection date of 12/07/23. All discrepancies found to be corrected immediately. RD to review change of condition assessments and corresponding RASP revision weekly at RD/HCD meeting for the next 90days to ensure compliance with 55 Pa Code 2600.234d.

Licensee's Proposed Overall Completion Date: *01/31/2024*

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

Facility Information

Name: *THE VERO AT BETHLEHEM* **License #**: *23163* **License Expiration**: *06/05/2024*

Address: *4700 BATH PIKE, BETHLEHEM, PA 18017*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *COLUMBIA HANOVER OPCO, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *02/09/2023* **Issued By**: *Hanover Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *112* **Waking Staff**: *84*

Inspection Information

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

Reason: *Complaint, Incident, Interim* **Exit Conference Date**: *09/13/2023*

Inspection Dates and Department Representative

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

09/13/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *140* **Residents Served**: *75*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *n/a* **Capacity**: *36* **Residents Served**: *32*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *75*

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

Have Mobility Need: *37* **Have Physical Disability**: *2*

Inspections / Reviews

09/12/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/14/2023*

10/27/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/11/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/03/2023*

11/14/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/11/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/20/2023*

01/16/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/11/2023*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

3c - Post Current License

1. Requirements

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

Description of Violation

The home does not have the PA code Chapter 2600 regulations posted in a public conspicuous area of the home.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

The community corrected this during onsite inspection by placing the 2600 regulations copy in a sleeve on the licensure board which is conspicuous and available to the public with notation "Do not Remove," Residence Director [redacted] will monitor weekly for 8 weeks beginning 10/9/2023 to ensure it remains posted.

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

Implemented [redacted] - 01/16/2024)

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

The homes fire alarm system was not operative from 7/11-8/1/23, the home did not submit an incident report to the Department regarding implementing their emergency procedures.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

On 10/12/23, Residence Director [redacted] educated all community staff members as to the need to report all incidents listed under 16c, including inoperable smoke detectors or fire alarms immediately to Residence Director and Regional Director of Operations for the purpose of reporting to BHSL. Residence Director [redacted] or designee to round daily for 60 days beginning 10/9/2023 to ensure fire alarm and smoke detector system remains operable by viewing the annunciator panel for trouble signals. If the panel did not work, 30 -minute fire checks would be conducted by making rounds in the community looking for smoke. The residence would also have an alternate sounding mechanism such as a bull horn to alert residents of an emergency. The community also received a letter from [redacted] stating the alarm system worked during 7/11-8/1.

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

Not Implemented [redacted] - 01/16/2024)

25a - Written Contract and Review

3. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #1 was admitted to the home on [redacted]-10-23. The resident home contract was signed by the resident on 6-22-23.

25a - Written Contract and Review *(continued)*

Plan of Correction ***Accept [redacted] - 10/27/2023)***

Residence director [redacted] audit all current resident charts to ensure that signatures reflect lease signing and explanation of resident contract to the resident and the resident's designated person, if any prior to signature by 10/16/2023. Residence Director Christina Price to meet with all residents and designated persons, as applicable prior to or within 24 hours after admission as apartments are leased.

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

Implemented [redacted] - 01/16/2024)

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 member A hired [redacted] high school diploma was not made available until 9/13/23 which is past the 30 day provisional hiring date.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

Health Care Director [redacted] audited all Direct Care Staff member charts to ensure that a current HS diploma, GED or active registry status on the PA nurse aide registry was on file within 30 days of hire by [redacted]/15/2023. [redacted] or designee to audit new hire charts bi-weekly for 8 weeks beginning 10/9/2023 to ensure compliance with this regulation.

Licensee's Proposed Overall Completion Date: *10/13/2023*

Implemented [redacted] - 01/16/2024)

63a - First Aid/CPR Training

5. 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 9/1/23, 9/2/23 and 9/3/23 the home served 76 residents and were required to have 2 individuals certified in first aid and CPR. On 9/1/23 there was 1 staff member certified in CPR and 1st aid from 7pm-9pm and no staff certified in First Aid from 9pm to 7am. On 9/2/23 there was 1 staff member certified in First Aid from 7pm-11pm and one from 3am to 7am. On 9/3/23 there was 1 staff member certified in First Aid from 9pm-11pm and one from 3am to 7am.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

The home hosted a CPR/First Aid Class on 9/25/2023 and will host a subsequent class on 11/10/2023. Health Care Director [redacted] or designee will audit schedule weekly for 8 weeks beginning 10/9/2023 ensure that at least 1 staff person for every 50 residents is trained in first aid and certified in obstructed airway techniques and CPR is present in the home at all times.

Licensee's Proposed Overall Completion Date: *10/13/2023*

Not Implemented [redacted] - 01/16/2024)

65a - FS Orientation 1st Day

6. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

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

Description of Violation

Direct care staff member A hired [redacted] 23, B hired [redacted] /23, C hired [redacted] /23 and D hired [redacted] /23 did not receive the first day fire safety training on or before the first day worked.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

Residence Director [redacted] or designee to audit employee and volunteer charts to ensure that they have received and signed off on first day fire safety training checklist by 10/16/2023. Residence Director [redacted] trained staff identified in survey visit on fire safety and emergency procedures on 10/11/2023. [redacted] or designee to audit charts weekly for 8 weeks beginning 10/9/2023 upon new hire orientation to ensure that all staff and volunteers receive their first day fire safety training.

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

Implemented [redacted] - 01/16/2024)

65b - Rights/Abuse 40 Hours

7. Requirements

2600.

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

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

Description of Violation

Direct care staff member A hired [redacted] /23, C hired [redacted] /23, E hired [redacted] 23 and F hired [redacted] /23 did not receive training in resident rights, The Older Adult Protective Services Act, emergency medical plan and reporting of reportable incidents and conditions within the first 40 hours worked.

Ancillary staff member G hired [redacted] /21/23 did not receive training in resident rights, emergency medical plan and reporting of reportable incidents and conditions within the first 40 hours worked.

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

Plan of Correction ***Accept (10/27/2023)***

Residence Director [redacted] or designee to audit current employee and volunteer charts to ensure that they have received and signed off on first 40 hours training checklist. Residence Director [redacted] scheduled to complete staff training on deficient associates identified by 10/13/2023. [redacted] or designee to audit charts weekly for 8 weeks beginning 10/9/2023 upon new hire orientation to ensure that all staff and volunteers receive their first 40 hour training.

Licensee's Proposed Overall Completion Date: *10/13/2023*

Implemented 01/16/2024)

85d - Trash Receptacles

8. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

The garbage can on the right side of the front preparing station in the kitchen was not closed. Upon inspection the lid was inoperable.

Plan of Correction ***Accept - 11/14/2023)***

Chef [redacted] replaced the lid of the trash can identified by surveyor immediately on 9/15/2023. Maintenance Director [redacted] or Designee to round community daily for 60 days beginning 10/9/2023 with audit tool to ensure that all trash cans are covered per regulation. Designee will immediately remove a trash can from the kitchen if a lid is broken in the future. All dining room staff were educated on the importance of garbage can lids being closed in the kitchen on 11/1/23. Chef, cooks, and dishwashers will inspect and monitor garbage can lids daily to ensure ongoing compliance.

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

Implemented - 01/16/2024)

88a - Surfaces

9. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

Above the right side of the kitchen counter, a large ceiling tile was missing from the drop-down ceiling, exposing an open area of piping. The corresponding tile had leak stains. Kitchen staff reported the tile was removed due to a leak from the air-conditioning unit.

Plan of Correction ***Accept - 11/14/2023)***

The ceiling tile missing was corrected on site on 9/13/2023 by Maintenance Tech [redacted]. The repair to the air conditioning unit was completed on 9/27/2023 by Integrity Roofing Company. Maintenance Tech [redacted] or Designee to round community weekly for 8 weeks on audit tool beginning 10/9/2023 to ensure floors, walls, ceilings, windows, doors, and other surfaces are clean, in good repair, and free of hazards. RD, Chef, or designee will monitor ongoing compliance during daily safety check walk through to ensure this will not happen again.

88a - Surfaces *(continued)*

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

Implemented [redacted] - 01/16/2024)

91 - Telephone Numbers

10. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

Resident #2 did not have the emergency phone numbers posted on or near the telephone in the residents room.

Plan of Correction ***Accept ([redacted] - 11/14/2023)***

Emergency Telephone numbers were place room for Resident #2 during onsite inspection by housekeeper [redacted] on 9/13/2023. Residence director or designee to audit rooms and common area telephones weekly for 8 weeks beginning 10/9/2023 to ensure that all telephones with outside line access have emergency numbers and personal care home complaint hotline posted. Maintenance Director, RD or housekeeping designee will make sure emergency numbers are posted the DAY OF MOVE IN as part of their "move in checklist" process to ensure ongoing compliance.

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

Implemented [redacted] - 01/16/2024)

95 - Furniture and Equipment

11. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The kitchen walk-in refrigerator had a water leak appearing to come from the cooling unit.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

The leak identified was repaired on 9/27 by Fountainhead. Maintenance Director [redacted] or designee to round community weekly for 8 weeks beginning 10/9/2023 to ensure that all equipment and furnishings are in good repair. Designee will immediately report any concerns immediately to the RD to ensure on-going compliance.

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

Implemented [redacted] - 01/16/2024)

103g - Storing Food

12. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

The kitchen ice cream freezer contained several 5-gallon containers of ice cream that did not have a date of their initial use. One of the containers had a lid that was displaced.

103g - Storing Food *(continued)*

Plan of Correction ***Accept [redacted] - 10/27/2023)***

Residence Director [redacted] educated all current dining staff members as to the importance of keeping food in closed or sealed containers and ensuring that the date the items are opened must be documented on the item on 9/15/2023. Chef [redacted], or designee to monitor food containers daily for 60 days beginning 10/9/2023 to ensure they are covered and dated appropriately.

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

Not Implemented [redacted] - 01/16/2024)

123b - Emergency Procedures Posted

13. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The emergency procedures for the local municipality and the homes emergency procedures were not posted in a public conspicuous area of the home.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

Residence Director [redacted] corrected this on site and posted the home's emergency procedures and municipality's emergency procedures on the second floor near the resident computer area on 9/13/23. Residence Director [redacted] or designee to round weekly for 8 weeks beginning 10/9/2023 to ensure that the home's emergency procedures remain posted. RD or designee will continue to make sure the binder is accessible to residents and not removed from the second floor computer area by checking on daily walk through. This will ensure ongoing compliance.

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

Implemented [redacted] - 01/16/2024)

125a - Combustible Storage

14. Requirements

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

Description of Violation

A plastic smoke detector cover was located behind the dryer under the duct in the laundry room near Room #233, posing a possible fire hazard.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

The smoke detector cover identified was removed by Maintenance Director [redacted] on site on 9/13/2023. Maintenance Director, [redacted] or designee will community daily for 60 days beginning 10/9/2023 to ensure no combustible or flammable materials are located near heat sources or hot water heaters. After audit, MD/RD, housekeepers, or designee will continue to make this a best practice to check laundry rooms daily for any combustible materials during daily morning walk through.

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

Not Implemented [redacted] - 01/16/2024)

130e - Hearing Impairment

15. Requirements

2600.
130.e. If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

Description of Violation

The RASP for resident #3 dated 8-10-23 includes that the resident is hard of hearing and requires a white dry erase board in order to communicate. The resident's bedroom does not include a signaling device approved by a fire safety expert so the resident can be immediately alerted in the event of a fire.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

Bed shaker apparatus to wake resident who is hard of hearing was contracted through fire alarm company [redacted] Fire on 10/11/2023 and was installed on 11/8/2023. [redacted], Assistant Health Care Director or designee to round daily for 60 days after install date to ensure that the unit is operational. Going forward, RD or designee will immediately install a bed shaker if community identifies a resident with significant hearing loss during pre-assessment process.

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

Implemented [redacted] - 01/16/2024)

130g - Smoke Detector Repair

16. Requirements

2600.
130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

On 7/11/23 the homes fire alarms system was disabled and not operative. The fire alarm system was not repaired until 8/1/23.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

Residence Director [redacted] educated all community staff members as to the need to report inoperable smoke detectors or fire alarms immediately to Residence Director and Regional Director of Operations for the purpose of completing repair within 48 hours from the time the detector or alarm was found inoperable on 10/12/2023. Residence Director [redacted] or designee to round daily for 60 days beginning 10/9/2023 to ensure fire alarm and smoke detector system remains operable.

Licensee's Proposed Overall Completion Date: *10/12/2023*

Implemented [redacted] - 01/16/2024)

130h - Inoperable Smoke Detector

17. Requirements

2600.
130.h. The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

On 7/11/23 the homes fire alarms system was disabled and not operative. The fire alarm system was not repaired

130h - Inoperable Smoke Detector (continued)

until 8/1/23. The homes inoperable smoke detector policy notes a fire watch should be completed every 30 minutes until the system is up and operating properly. The fire watch should be documented in the associate communication logs. The home did not complete the fire watch every 30 minutes as per their policy from 7/11-8/1/23.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

Residence Director [redacted] held an all staff inservice on 10/12/2023 to educate team members on community's fire watch procedure. Residence Director [redacted] placed blank "Fire Watch" documentation for 30 minute checks in the communication log on 10/13/2023 along with home's fire watch policy. Residence Director [redacted] or designee to audit the communication log weekly for 8 weeks beginning 10/16/2023 to ensure that blanks and instructions remain in place for future reference for all associates to access in the event of fire watch.

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

Implemented ([redacted] - 01/16/2024)

132a - Monthly Fire Drill

18. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The home did not conduct a fire drill in July 2023.

Plan of Correction ***Accept ([redacted] - 11/14/2023)***

On 9/22/2023 [redacted], Residence Director facilitated a sleeping hours fire drill in the community. For the months of October, November and December [redacted] or Designee will hold the monthly fire drill on or before the 25th of the month. Maintenance Director or RD are responsible for conducting and documenting the drills monthly on an ongoing basis. RD added drills to outlook calendar every month before the 25th with no end date and will ensure proper execution of the drills.

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

Not Implemented [redacted] - 01/16/2024)

132c - Fire Drill Records

19. Requirements

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

Description of Violation

The fire drills conducted on 6/28/23 at 8:05 am and 8/18/23 at 3 pm do not include the amount of time it took to evacuate in minutes and seconds, the number of residents evacuated and the exit routes used.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

On 9/22/2023 [redacted], Residence Director facilitates a sleeping hours fire drill in the community and documented the time it took to evacuate in minutes and seconds as well as the number of residents evacuated and exit routes used on the BHSL recommended form. For the months of October, November and [redacted] will hold the monthly fire drill on or before the 25th of the month to ensure that the Residence

132c - Fire Drill Records (continued)

Director audits the drill documentation and all required information is recorded. Community will use the forms recommended by BHSL with proper details going forward to ensure compliance. RD or designee will make sure Maintenance Director log is accurate after each drill.

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

Implement[redacted] ([redacted] - 01/16/2024)

141a 1-10 Medical Evaluation Information

20. 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

The Documentation of Medical Evaluation dated[redacted]-23, for resident #4 does not contain information regarding the resident's height, weight, or pulse rate.

Plan of Correction ***Accept[redacted] 10/27/2023)***

Health Care Director[redacted] corrected DME for resident #4 on 9/15/2023. Health Care Director[redacted] or Designee to audit all current resident DMEs for completeness by 10/16/2023. Health Care Director[redacted] or Designee to audit resident charts monthly for three months beginning Oct 9 2023 to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *10/16/2023*

Not Implemented[redacted]/16/2024)

171b4 - Staff Training

21. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
4. At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation).

Description of Violation

Ancillary staff member G drives the home's vehicles with residents. Staff member G has not been trained in the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation).

171b4 - Staff Training *(continued)*

Plan of Correction ***Accept [redacted] - 10/27/2023)***

Staff member G is no longer employed by the home. Residence Director [redacted] audited all staff responsible for transporting residents have documentation of direct care staff training and orientation on 10/11/2023. Beginning 10/9/2023 Residence Director [redacted] to audit new transportation staff member charts upon hire for 60 days to ensure that documentation of direct care staff training is on file.

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

Implemented ([redacted] - 01/16/2024)

182b - Prescription Medication

22. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Direct care staff member H completed the modified medication administration course on 9/9/22. The initial medication administration course was not completed by 8/1/23.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

Health Care Director [redacted] is a Train the Trainer and facilitated the full medication administration course to Direct Care Staff Member H on 9/15/2023 and 9/16/2023 audited all current med tech files to ensure that documentation of the initial medication administration course was complete by 9/20/2023. Beginning 10/9/2023 Health Care Director [redacted] to review new associate files upon hire for 60 days to ensure that documentation of the initial medication administration course is on file. Staff member H completed the initial medication administration course on 9/15/9/16.

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

Implemented [redacted] - 01/16/2024)

183a - Original Containers and Injections

23. Requirements

2600.

183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

It has been determined through staff interviews that Resident #5's pregabalin 75mg capsules and resident #6's alprazolam .5mg tablets were from an outside pharmacy and came to the home packaged in bottles. The home's pharmacy provided the home with blister packs so they could repackage the medications. The staff took the medications out of the original containers and repackaged it into new containers that did not come from the pharmacy.

183a - Original Containers and Injections *(continued)*

Plan of Correction ***Accept [redacted] - 11/14/2023)***

Community Pharmacy Partner replaced all repackaged medication by 10/12/2023. Health Care Director [redacted] or designee to audit cart bi-weekly beginning 10/9/2023 for 8 weeks to ensure all prescription medications, OTC medications, and CAM are kept in their original labeled container. Nurse's and MT meeting held 10/4/2023 where Health Care Director [redacted] reviewed 183a requirements. Going forward, the HCD and RD will ensure that the community will never allow staff or pharmacy partner to repackage medications from original containers. Empty blister packs are banned from the premises.

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

Implemented [redacted] - 01/16/2024)

183d - Prescription Current

24. 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

Resident #7's lantus solostar pen was opened 8/13/23, expired on 9/10/23 and was still being used by the home.

Resident #8's 3 blister packs of Tylenol 500mg ES 2 tablets every 8 hours as needed was located in the medication cart. This is not a current order and was discontinued on 8/30/23.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

Medications identified by surveyor for residents 7 and 8 were removed from the cart and destroyed by Health Care Director [redacted] 9/13/2023 with surveyor on site. Nurse's and MT meeting held 10/4/2023 where Health Care Director [redacted] reviewed 183d requirements. Health care director [redacted] or designee to perform cart audit bi weekly beginning week of 10/9/2023 for 60 days to ensure continued compliance. HCD, AHCD or Regional Nurse will ensure ongoing compliance by conducting weekly cart audits.

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

Implemented ([redacted] - 01/16/2024)

184a - Resident's Meds Labeled

25. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #9's ozempic and lantus solostar pens did not include the staff persons initials who opened the pen.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

The medication identified for resident #9 was destroyed with surveyor on site on 9/13/2023 by Health Care Director [redacted] and a new pen initialed by LPN [redacted]. Nurse's and MT meeting held 10/4/2023 where Health Care Director [redacted] reviewed the importance of initialing any opened medication. Health care director [redacted] or designee to perform cart audit bi weekly beginning week of 10/9/2023 for 60 days to ensure continued compliance.

184a - Resident's Meds Labeled *(continued)*

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

Implemented [redacted] - 01/16/2024)

184b - Labeling OTC/CAM

26. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

Resident #5's 81mg of aspirin did not include the residents name on the bottle.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

The medication identified for resident #9 was previosly identified with resident initals and apartment number. This was corrected on site with surveyor present by LPN [redacted] on 9/13/2023 when [redacted] wrote the full resident name on the bottle. Nurse's and MT meeting held 10/4/2023 where Health Care Director [redacted] reviewed the importance of labeling OTC and CAM medications with full resident names. Health care director [redacted] or designee to perform cart audit bi weekly beginning week of 10/9/2023 for 60 days to ensure continued compliance.

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

Implemented [redacted] - 01/16/2024)

187c - Refusal of Medication

27. 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

Resident #7 has an order for estradiol .01% cream intravaginally three times weekly. The resident refused the medication on 9/4 and 9/11/23. The prescriber was not notified regarding the refusals.

Plan of Correction ***Accept [redacted] 10/27/2023)***

Notification of refusals were faxed to PCP for resident #7 on 9/13/2023 by Health Care [redacted] The resident requested and physician ordered the medication to be self administered on 9/18/2023. Nurse's and MT meeting held 10/4/2023 where Health Care Director [redacted] reviewed the requirement to notify the prescriber upon refusal within 24 hours. Health Care Director [redacted] or Designee to monitor Quickmar Refusal Report daily to ensure documentation of physician notification is present for all refusals for 60 days starting the week of 10/9/2023

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

Implemented [redacted] - 01/16/2024)

187d - Follow Prescriber's Orders

28. Requirements

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

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

Description of Violation

Resident #10 has an order for midodrine 5mg tablet three times daily, hold for systolic blood pressure more than 120. On 9/1/23 at 2pm and 8pm and 9/4/23 at 2pm the blood pressure was not taken.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

Blood pressure for resident #9 was taken as ordered on 9/1 at 2p and 8p and 9/4 at 2p but was documented under a different medication parameter for the same resident. The blood pressure taken indicated a hold for systolic blood pressure of more than 120. Nurse's and MT meeting held 10/4/2023 where Health Care Director [redacted] reviewed the requirement to document following the prescriber's directors for every medication. Health Care Director [redacted] or Designee to monitor the mar parameter based medications twice weekly for appropriate documentation for 60 days beginning the week of 10/9/2023.

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

Not Implemented [redacted] /16/2024)

190b - Insulin Injections

29. Requirements

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

Description of Violation

Direct care staff member A completed the diabetes patient education program on 7/22/22. The staff member has been completing diabetic care since 7/23/23 and is not trained to do so.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

Diabetes patient education was provided at the community on 9/29/23 by [redacted] to DC staff member A and other team members. Health Care Director [redacted] audited the charts for all current direct care staff members completing diabetic care on 9/29/2023 to ensure compliance. Health Care Director [redacted] to audit charts monthly beginning October 9 2023 to ensure continued compliance. RD, HCD, or designee will ensure ongoing compliance by making sure Med techs are diabetic trained at time of hire during the on-boarding process . If not, we will contact diabetic trainer, [redacted] to provide education prior to allowing med tech to provide diabetic care.

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

Implemented [redacted] - 01/16/2024)

224a - Preadmission Screen Form

30. 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.

224a - Preadmission Screen Form *(continued)*

Description of Violation

The Preadmission Screening Form for resident #4, admitted [redacted]-23, does not list the date of completion. It is unable to be determined if the Preadmission Screening was completed timely.

Plan of Correction ***Accept [redacted] - 10/27/2023)***

The pre-admission screening form was completed late on [redacted]/13/2023 with verbiage that this was corrected upon state survey. Health Care Director [redacted] or designee to complete audit of all current resident charts for Pre-screen completion by 10/16/2023. Health Care Director [redacted] or designee to audit pre-screen paperwork upon admission beginning 10/11/2023 to ensure completion for new residents.

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

Implemented [redacted] - 01/16/2024)

227d - Support Plan Medical/Dental

31. 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 Resident Assessment and Support Plan (RASP) for resident #11 was not updated after an incident on 8-23-23 when the resident eloped from the home. The residents current needs for 24-hour supervision were not identified in the most current RASP dated 6-8-23. Notes from the chart include that the resident was receiving psychiatric care and assistance from a Behavior Specialist to assist with emotional regulation. However, this was not included in the residents most recent RASP.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

The RASP for resident #11 was corrected and updated on 9/14/2023 by Health Care Director [redacted]. Health Care Director [redacted] audited all current RASPS by 10/9/2023 to ensure they are complete. Health Care Director or designee to audit resident charts monthly for three months beginning 10/9/2023 to ensure a complete and accurate RASP is present. HCD, AHCD and RD will monitor ongoing compliance by discussing any significant changes daily in PULSE meeting after reviewing communication binder. If a significant change occured, such as elopement, private duty being implemented, behavioral care needed, or other changes that impact the course of care needed for the resident, the RASP will immediately be updated by the designated nursing professional.

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

Not Implemented [redacted] - 01/16/2024)

227g -Support Plan Signatures

32. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The RASP dated 6-10-23 for resident #12 does not include the residents signature.

227g -Support Plan Signatures *(continued)*

Plan of Correction ***Accept [redacted] - 10/27/2023)***

The signature for resident #12 on the RASP was obtained by Health Care Director [redacted] on 9/14/2023. Health Care Director [redacted] audited all current RASPS by 10/9/2023 to ensure they are complete and signed by the individuals who participate in the development of the plan. Health Care Director or designee to audit resident charts monthly for three months beginning 10/9/2023 to ensure a complete and accurate RASP is present.

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

Not Implemented [redacted] - 01/16/2024)

231c - Preadmission Screening

33. 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

The Cognitive Screening section of the Preadmission Screening Form for resident #4, admitted [redacted]-22-23, does not list the date the Cognitive Screening was completed.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

Community corrected pre-admission screening for resident #4 with late date of 9/14/2023, completed by Health Care Director [redacted]. Health Care Director [redacted] completed the audit of current SDCU residents to ensure compliance by 9/29/2023. Health Care Director [redacted] or designee to audit pre-screen paperwork upon admission beginning 10/11/2023 for 60 days to ensure completion for new residents. HCD or RD will check all pre-screens for accuracy on day of move-in to ensure compliance.

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

Not Implemented [redacted] - 01/16/2024)

231g - Non-Dementia Admission

34. Requirements

2600.
231.g. An individual who does not have a primary diagnosis of Alzheimer's disease or other dementia may reside in the secured dementia care unit if desired by the resident.
3. The individual shall have access to and be able to follow directions for the operation of the key pads or other lock-releasing devices to exit the secured dementia care unit.

Description of Violation

Resident #3 resides in the Secure Dementia Care Unit and does not have a diagnosis of Dementia. The resident did not have knowledge of how to operate the keypads used to exit the Secure Dementia Care unit.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

Resident #3 was recently diagnosed with cognitive impairment and determined by the physician that Memory care is necessary and providing the code is not recommended as of 11/8/2023. In the event of a future resident without a dementia diagnosis who resides in Memory Care, AHCD or RD would ensure the resident was given the code and educated on how to operate the key pads on day of move in.

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

231g - Non-Dementia Admission *(continued)*

Not Implemented ([redacted]/16/2024)

233c - Key-Locking Devices

35. 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 electronic keypad located next to Room #10 reads [redacted] however the code to operate the key locking device is 1379.

Repeat Violation: 5/17/23

Plan of Correction ***Accept [redacted] - 10/27/2023)***

The code for posted for the keypad near room #10 was corrected on site on 9/13/2023 by Maintenance Tech [redacted]. Residence Director or designee to round weekly for 8 weeks beginning 10/9/2023 to ensure all codes posted operate the corresponding key locking device.

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

Implemented [redacted] 01/16/2024)

234a - Admission Support Plan

36. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

The Resident Assessment Support Plan for Resident #4, admitted [redacted]22-23, is not dated by the resident and page 1 does not contain dates the Assessment or Support Plan were finalized.
The Assessment for the Resident Assessment Support Plan for resident #1, admitted [redacted]-10-23, was completed on 6-10-23 however the Resident Assessment Support Plan was not finalized until 7-26-23.

Plan of Correction ***Accept[redacted] - 10/27/2023)***

The RASP for resident 4 was corrected with late date of 9/14/2023. No further action was taken on the RASP for resident #1. Health Care Director [redacted] audited all current SDCU RASPS by 10/9/2023 to ensure they are complete and dated within compliance. Health Care Director or designee to audit resident charts upon admission for 60 days beginning 10/9/2023 to ensure a complete and accurate RASP is present and developed within 72 hours of admission.

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

Implemented[redacted] - 01/16/2024)

234d - Support Plan Revision

37. Requirements

234d - Support Plan Revision *(continued)*

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Residents #1 and #4 were involved in an incident on [redacted] 24-23 and were put on 30-minute checks by staff. The Resident Assessment Support Plans for both residents were not updated to include the incident, or the initiation of 30-minute checks.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

The RASP for resident 4 and resident #1 was corrected with late date of 9/14/2023 to reflect the 30 minute checks that took place from 8/24/23 to 8/27/2023. Health Care Director [redacted] audited all current SDCU RASPS by 10/9/2023 to ensure they are complete and capture changes in condition. Health Care Director or designee to audit resident chart upon change in condition for 60 days beginning 10/9/2023 to ensure a complete and accurate RASP is present and reflective of the change. HCD or RD will ensure compliance by communicating any significant changes daily when the communication binder details are discussed at morning meeting. If change of condition or incident is noted, nurse will immediately update the support plan to reflect changes.

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

Not Implemented [redacted] - 01/16/2024)