



Sent via e-mail r.chapin@bridgeig.com
Sent via e-mail mia.johnson@junipercommunities.com
February 27, 2020

Mr. Robert W. Chapin, Jr.
Manager
Abington Senior Care, LLC
1000 Legion Place, Suite 1600
Orlando, Florida 32801

RE: The Terrace at Chestnut Hill
495 East Abington Avenue
Philadelphia, Pennsylvania 19118
License #: 141570

Dear Mr. Chapin:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on October 10, 11, 15, 16, 17, and 29, 2019 and November 8 and 12, 2019 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

A handwritten signature in black ink that reads "Mia Johnson". The signature is written in a cursive, flowing style.

Mia Johnson
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: THE TERRACE AT CHESTNUT HILL

License Number: 14157

Address: 495 EAST ABINGTON AVENUE,, PHILADELPHIA, PA 19118

County: PHILADELPHIA

Region: SOUTHEAST

Administrator

Name: LaMia Johnson

Phone: 2152475307

Email: Mia.Johnson@Junipercommunities.com

Legal Entity

Name: ABINGTON SENIOR CARE LLC

Address: 1000 LEGION PLACE, SUITE 1600, ATTN - BILL SNOW, ORLANDO, FL, 32801

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 161

Waking Staff: 121

Inspection

Type: Partial

BHA Docket #:

Notice: Unannounced

Reason: Complaint, Incident

Inspection Dates and Department Representative

On 10/21/19, The Wellness Team began using EHR 24hr Summary which allows the team to track resident transfers to the hospital via EMT services. This summary is reviewed by Wellness Team daily to ensure compliance with 24hr reporting requirements. Education on the new process was provided to all staff on 11/19/19. Director of Wellness (DOW) to audit daily with oversight from Executive Director (ED). See Attachment A. B.

10/11/2019 - On-Site: Tahesia Thomas

10/16/2019 - On-Site: Tahesia Thomas

10/17/2019 - On-Site: Tahesia Thomas

10/15/2019 - Off-Site: Tahesia Thomas

10/29/2019 - Off-Site: Tahesia Thomas

11/08/2019 - Off-Site: Tahesia Thomas

11/12/2019 - Off-Site: Tahesia Thomas

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 122

Residents Served: 85

Secured Dementia Care Unit

In Home: Yes

Area: Memory Care

Capacity: 45

Residents Served: 34

Hospice

Current Residents: 1

Resident Demographic Data as of Inspection Dates (continued)

Number of Residents Who:

Receive Supplemental Security Income: 0
Diagnosed with Mental Illness: 0
Have Mobility Need: 76

Are 60 Years of Age or Older: 84
Diagnosed with Intellectual Disability: 0
Have Physical Disability: 3

16c - Written Incident Report

Regulations

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 10/11/19, resident #1 was sent to the hospital via EMT services. The home did not report this incident to the department until 10/15/19.

On 10/07/19, resident #2 was sent to the hospital via EMT services. The home did not report this incident to the department until 10/11/19.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

On 10/21/19, The Wellness Team began using EHR 24hr Summary which allows the team to track resident transfers to the hospital via EMT services. This summary is reviewed by Wellness Team daily to ensure compliance with 24hr reporting requirements. Education on the new process was provided to all staff on 11/6/19. Director of Wellness (DOW) to audit daily with oversight from Executive Director (ED). See Attachment A, B and C.

Maintain documentation of audits for Department review. 2/27/20 *MJ*

Legal Entity Representative

Signature *[Handwritten Signature]*

Printed Name and Title LaMica Johnson ED Date 12/14/19

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The above plan of correction is approved as of 2/27/20 (Date) Plan of correction implementation status as of 2/27/20 (Date)

Implemented

The above plan of correction was approved by *MJ* (Initials)

Not Implemented

42b - Abuse

Regulations

2600.

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

Description of Violation

Resident #1 who resides in the SDCU, has a stage 4 wound ulcer. On 9/9/19, the home received new orders from resident's PCP to have the wound cleaned and dressing changed daily and as needed. The resident missed 16 days of her wound being cleaned and dressing changed from 9/9/19-10/6/19. The home failed to ensure that the doctor's orders in caring for the wound was followed.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

On 10/6/19 and 10/14/19, new wound orders were received from physician and followed by Wellness Team and home care provider each time. In addition, on Oct, 14, 2019 the Wellness Team received wound care training from its company's regional RN to ensure proper care of resident wounds. On Oct 17, 2019, the Wellness Team implemented Connect4life program which helps facilitate communication between outside providers and the community and coordinate resident care needs. Training was provided to Wellness Team immediately. Wellness Team meets weekly with outside providers. Wellness Team were formally reeducated on the new policy on 11/6/19 directly from the RCG. Home care providers servicing residents were educated via teleconference held 10/22/19 by ED and DOW. ED and DOW review weekly ongoing. See Attachments A, D, and E.

Maintain documentation of audits for Department review. 2/27/20 *MDJ*

Legal Entity Representative

[Signature]
Signature

LaMia Johnson, ED
Printed Name and Title

12/14/19
Date

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(Date)

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(Date)

Implemented

The above plan of correction was approved by *MDJ*
(Initials)

Not Implemented

65a - FS Orientation 1st Day

Regulations

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

Staff persons A and B whose first day of work was 5/14/19; staff person C whose first day of work was 7/3/19; staff person D whose first day of work was 7/10/19; staff person E whose first day of work was 5/10/19, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Staff persons A, B, C, and D are no longer employed at the community. Staff person E received trainings on the above cited topics on 3/11/19. All staff received trainings on same on 11/6/19. On 10/28/19, the HR team completed a full audit of all employee files. Files were updated/corrected. An orientation and training checklist listing all regulation required trainings with sign-off from staff and educator was implemented to ensure compliance with regulations. HR team is now using Relias, instead of paper documentation to track trainings. HR to audit 1st day orientation prior to class dismissal to ensure required topics are completed. See Attachments A, F, G, and H.

Maintain documentation of audits for Department review. 2/27/20 *WJ*

Legal Entity Representative

[Handwritten Signature]

Signature

Lamia Johnson, ED

Printed Name and Title

12/14/19

Date

65a - FS Orientation 1st Day (continued)

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(Date) (Date)
 Implemented

The above plan of correction was approved by MCJ
(Initials) Not Implemented

65b - Rights/Abuse 40 Hours

Regulations

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

Staff persons A, B, C, D and E have completed his/her 40th scheduled work hour. However, these staff persons did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101—10225.5102), and reporting of reportable incidents and conditions.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Staff persons A, B, C, and D are no longer employed at the community. Staff person E received trainings on the above cited topics on 3/11/19. All staff received trainings on same on 11/6/19. On 10/28/19, the HR team completed a full audit of all employee files. Files were updated/corrected. An orientation and training checklist listing all regulation required trainings with sign-off from staff and educator was implemented to ensure compliance with regulations. HR team is now using Relias, instead of paper documentation to track trainings. HR to audit 2nd day orientation prior to class dismissal to ensure required topics are completed. See Attachments A, F, G, and I.

Maintain documentation of audits for Department review. 2/27/20 *MLJ*

Legal Entity Representative

[Signature]
Signature

Lamia Johnson, ED
Printed Name and Title

12/14/19
Date

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(Date)

Implemented

The above plan of correction was approved by *MLJ*
(Initials)

Not Implemented

65d - Initial Direct Care Training

Regulations

2600.

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

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
 - i. Safe management techniques.
 - ii. ADLs and IADLs
 - iii. Personal hygiene.
 - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
 - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
 - vi. Implementation of the initial assessment, annual assessment and support plan.
 - vii. Nutrition, food handling and sanitation.
 - viii. Recreation, socialization, community resources, social services and activities in the community.
 - ix. Gerontology.
 - x. Staff person supervision, if applicable.
 - xi. Care and needs of residents with special emphasis on the residents being served in the home.
 - xii. Safety management and hazard prevention.
 - xiii. Universal precautions.
 - xiv. The requirements of this chapter.
 - xv. Infection control.
 - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person D, hired on 07/10/19; direct care staff person E, hired on 5/10/19, provided unsupervised ADL services. However, the home does not have documentation that staff persons completed and passed the Department-approved direct care training.

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

2600.

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

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
 - i. Safe management techniques.
 - ii. ADLs and IADLs
 - iii. Personal hygiene.
 - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
 - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
 - vi. Implementation of the initial assessment, annual assessment and support plan.
 - vii. Nutrition, food handling and sanitation.
 - viii. Recreation, socialization, community resources, social services and activities in the community.
 - ix. Gerontology.
 - x. Staff person supervision, if applicable.
 - xi. Care and needs of residents with special emphasis on the residents being served in the home.
 - xii. Safety management and hazard prevention.
 - xiii. Universal precautions.
 - xiv. The requirements of this chapter.
 - xv. Infection control.
 - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.


Description of Violation

Direct care staff person D, hired on 07/10/19; direct care staff person E, hired on 05/10/19, provided unsupervised ADL services. However, the staff persons did not complete the initial direct care staff person training.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Staff person D is no longer employed at the community. Staff person E was removed from the schedule until community received Department-approved direct care training documentation dated 10/21/19. See Attachment J.
Staff person D is no longer employed at the community. Staff person E received trainings on the above cited topics on 3/11/19. See Attachment F.

Maintain documentation of audits for Department review. 2/27/20 

65d - Initial Direct Care Training (continued)

Legal Entity Representative

Signature 

Printed Name and Title Lamia Johnson ED


Date 12/14/19

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Implemented

The above plan of correction was approved by 
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Not Implemented

85a - Sanitary Conditions

Regulations

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 10/10/19, the 2nd and 3rd floors of the SDCU had a strong urine odor in the common areas and hallways.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

On 10/10/19, SDCU Common areas and hallway were immediately cleaned. SDCU housekeeping were reeducated to adhere to housekeeping assignments properly on 11/6/19. Environmental Service Director to audit completion of assignments weekly and as needed. See Attachment K.

Maintain documentation of audits and education for Department review. 2/27/20 *MLJ*

Legal Entity Representative

Signature *[Handwritten Signature]*

Printed Name and Title *Lamia Johnson, ED*

Date *12/14/19*

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(Date)

Implemented

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Not Implemented

103b - Clean/Sanitized Kitchen Surfaces

Regulations

2600.

103.b. Kitchen surfaces must be of a nonporous material and cleaned and sanitized after each meal.

Description of Violation

On 10/16/19, the ice cream freezer shelf surfaces were sticky with ice cream residue.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

On 10/16/19, the ice cream freezer was defrosted and thoroughly cleaned. Kitchen staff were reeducated to adhere to kitchen cleaning schedule 11/6/19. New ice cream container covers were ordered and community is awaiting delivery as there is a back order. Director of Dietary to audit weekly and as needed. See Attachments A, L, and M.

Maintain documentation of audits and education for Department review. 2/27/20 *MJ*

Legal Entity Representative

Signature *[Handwritten Signature]*

Printed Name and Title *Lamia Johnson, RD*

Date *12/14/19*

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(Date)

Implemented

The above plan of correction was approved by *MJ*
(Initials)

Not Implemented

103g - Storing Food

Regulations

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

Description of Violation

On 10/16/19, a 5 lbs. box of brownie mix and a 20 lbs box of navy bean were opened and unsealed in the kitchen's pantry shelf.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

On 10/16/19, brownie mix and navy beans were discarded immediately. Acting Dietary Director audited pantry to ensure future compliance. Kitchen staff were reeducated on proper storage containers on 11/6/19. Audits to be completed weekly by Dietary Director to ensure compliance. See Attachments A and N.

Maintain documentation of audits and education for Department review. 2/27/20 *MG*

Legal Entity Representative

Signature *[Handwritten Signature]*

LaMica Johnson, ED
Printed Name and Title

12/14/19
Date

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(Date)

Implemented

The above plan of correction was approved by *MG*
(Initials)

Not Implemented

103i - Outdated Food

Regulations

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 10/16/19, dented 6 lbs. cans of diced tomatoes and marinara sauce were observed in the kitchen's pantry.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

On 10/16/19, dented cans were immediately disposed. Acting Dietary Director audited pantry to ensure future compliance. Kitchen staff were reeducated on disposal of dented cans on 11/6/19. Audits to be completed weekly by Dietary Director to ensure compliance. See Attachments A and O.

Maintain documentation of audits and education for Department review. 2/27/20 *MJ*

Legal Entity Representative

Signature *[Handwritten Signature]*

Printed Name and Title *Lamia Johnson, ED*

Date *12/14/19*

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(Date)

Plan of correction implementation status as of *2/27/20*
(Date)

Implemented

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(Initials)

Not Implemented

141a 1-10 Medical Evaluation Information

Regulations

2600.

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

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

Description of Violation

Resident #2's medical evaluation did not include the most current list of prescribed medication.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Resident #2 received a medical evaluation on 4/5/19 and an updated medication list was reprinted and attached. The DOW is now using EMR to track and maintain timely completion and inclusion of all required evaluations and attachments. Wellness team were reeducated on 11/6/19. DOW to complete monthly audits to ensure future compliance. See Attachments A and P.

Maintain documentation of audits and education for Department review. 2/27/20 *MJ*

Legal Entity Representative

[Handwritten Signature]
Signature

Lamia Johnson, ED
Printed Name and Title

12/19/19
Date

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(Date) (Date)

Implemented

The above plan of correction was approved by *MJ*
(Initials)

Not Implemented

141b2 - Medical Evaluation Changes

Regulations

2600.

141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

The home did not have a new medical evaluation completed to address resident #1's new medical condition.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Dispute. See Attachment 1 medical evaluation for Resident #1 dated 5/15/19.

Legal Entity Representative


Signature

LAMIA JOHNSON, ED
Printed Name and Title

12/14/19
Date

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(Date)

Implemented

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Not Implemented

187d - Follow Prescriber's Orders

Regulations

2600.

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

Description of Violation

The home failed to follow prescriber's order to have resident #1's wound treated as prescribed. Orders were as follows: order dated 09/09/19 - wound treated daily and as needed; was not treated on 9/14 and 9/15; order dated 09/16/19 - wound treated daily; was not treated on 9/17, 9/20, 9/21, 9/22, 9/24, 9/25, 9/26, 9/28, 9/29, 9/31, 10/1, 10/2, 10/3 and 10/5. Order was changed on 10/06/19 - wound treated three times a week and as needed.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

On 10/6/19 and 10/14/19, new wound orders were received from physician and followed by Wellness Team and home care provider. On Oct 17, 2019, the Wellness Team implemented Connect4life program which helps facilitate communication between outside providers and the community and coordinate resident care needs. Training was provided to Wellness Team immediately. Home care providers servicing residents were educated via teleconference held 10/22/19 by ED and DOW. Wellness Team meets weekly with outside providers. Wellness Team were formally reeducated on the new policy on 11/6/19 directly from the RCG. ED and DOW review weekly ongoing. See Attachments A, D, Q, and R.

Maintain documentation of audits and education for Department review. 2/27/20 *mgj*

Legal Entity Representative

Signature *[Handwritten Signature]*

LAMIA Johnson, ED
Printed Name and Title

12/14/19
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(Date)

Implemented

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(Initials)

Not Implemented

188b - Medication Error Reporting

Regulations

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 Vitamin D3. However, the home's staff failed to report the medication errors on the following days: 09/06-09/12/19, 09/16-09/18/19, and 09/21-09/26/19 and 09/28/19.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Med techs were educated to notify Wellness Team immediately when family has not provided medication as agreed. Wellness team prints the med error report daily from EHR to ensure reporting of any med errors in a timely manner. See Attachments A and S.

Maintain documentation of audits and education for Department review. 2/27/20 *MJ*

Legal Entity Representative

Signature *[Handwritten Signature]*

Printed Name and Title Lamia Johnson, ED Date 12/14/19

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Implemented

The above plan of correction was approved by *MJ* (Initials)

Not Implemented

225c - Additional Assessment

Regulations

2600.

225.c. The resident shall have additional assessments as follows:

- 1. Annually.
- 2. If the condition of the resident significantly changes prior to the annual assessment.
- 3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

The home failed to have an updated RASP that addresses resident #1's medical condition.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Dispute. See Attachment U RASP for Resident #1 dated 5/15/19.

Legal Entity Representative


Signature

Lamia Johnson, ED
Printed Name and Title

12/14/19
Date

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Implemented

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Not Implemented

227c - Support Plan Revision

Regulations

2600.

227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

According to staff member D, resident #3 as well as other residents refuse personal hygiene care. However, resident #3's support plan does not address this behavior or how the home will meet the residents needs.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Support plan for Resident #3 was updated on 10/14/19 by Wellness Team. On 10/21/19, DOW implemented a communication log for care givers to document resident care concerns. Wellness Team reviews daily and assesses residents for accuracy in care needs change. If applicable, support plan is updated accordingly. All staff received education concerning use of communication log on 11/6/19. See Attachments A, V, and W.

Maintain documentation of audits and education for Department review. 2/27/20 *MG*

Legal Entity Representative

Signature *[Handwritten Signature]*

Printed Name and Title Lamia Johnson, ED Date 12/14/19

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Implemented

The above plan of correction was approved by *MG* (Initials)

Not Implemented

227g -Support Plan Signatures

Regulations

2600.

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

Description of Violation

Resident #4 participated in the development of her support plan on 3/17/2018. However, the assessor did not sign the support plan.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Assessor is no longer employed at the community. Resident #4 is no longer a resident at the community. DOW and/or ED to review documentation of all support plans once completed and/or updated.

Maintain documentation of audits for Department review. 2/27/20 *MJ*

Legal Entity Representative

[Signature]
Signature

Lamia Johnson ED
Printed Name and Title

2/14/19
Date

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231b - Medical Evaluation

Regulations

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

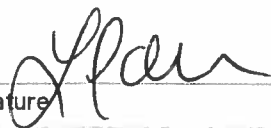
Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on 05/15/2019; however, the home failed to have a medical evaluation completed.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Dispute. See Attachment T medical evaluation for Resident #1 dated 5/15/19.

Legal Entity Representative

Signature 

Printed Name and Title Lamia Johnson, ED

Date 12/14/19

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231c - Preadmission Screening

Regulations

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 #1 was admitted to the Secure Dementia Care Unit (SDCU) on 05/15/2019. However, the home failed to have a written cognitive preadmission screening completed.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Preadmission screening was completed on 10/14/19. Admission checklist created and implemented to ensure all required documentation is present prior to resident admission to SDCU. Admissions and Wellness staff were reeducated on 11/6/19. Ongoing, DOW and/or ED to audit resident files prior to admission. See Attachments A, X, Y, and Z.

Maintain documentation of education for Department review. 2/27/20 *MJ*

Legal Entity Representative

[Signature]
Signature

Lamia Johnson, ED
Printed Name and Title

12/14/19
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231e - No Objection Statement

Regulations

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on 05/15/2019. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Dispute. See Attachment AB for Resident #1 signed documentation.

Legal Entity Representative

Signature 

Printed Name and Title Lamia Johnson, ED Date 12/14/19

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 Not Implemented

234a - Admission Support Plan

Regulations

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


Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on 05/15/2019. However, the home failed to complete the initial support plan.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Dispute. See Attachment U RASP for Resident #1 support plan dated 5/15/19

Legal Entity Representative

Signature 

Printed Name and Title LAMIA JOHNSON, ED


Date 12/14/19

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234b - Support Plan Needs Elements

Regulations

2600.

234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated 01/2/2019, for resident #2 does not address their vision needs.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Support plan for Resident #2 addressing vision needs was completed on 10/16/19 by Wellness Team. DOW to review completed support plans as they occur with Wellness Team to ensure resident's physical, medical, social, cognitive, and safety needs are addressed appropriately. Wellness Team were reeducated on 11/6/19. DOW and/or ED to audit monthly. See Attachments A and BC.

Maintain documentation of audits and education for Department review. 2/27/20 *MJ*

Legal Entity Representative

[Signature]
Signature

Lamia Johnson, ED
Printed Name and Title

12/14/19
Date

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252 - Record Content

Regulations

2600.

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

Description of Violation

Resident #4's record is missing documentation from 2016-2017 calendar years.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Wellness team were educated on record retention and disposal on 11/6/19. Wellness team shall maintain resident's record for a minimum of 3 years. DOW to thin files biannually and retain in-house storage. See Attachments A and CD.

Maintain documentation of education for Department review. 2/27/20 *MJ*

Legal Entity Representative

[Signature]
Signature

Lamia Johnson, ED
Printed Name and Title

12/14/19
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