



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail gary.achilles@hcr-manorcare.com
Sent via e-mail licensure-support@hcr-manorcare.com
March 31, 2020

Mr. Gary Achilles
Executive Director
Arden Courts Warminster of Hatboro PA, LLC
333 North Summit Street, 16th Floor
Toledo, Ohio 43604

RE: Arden Courts of Warminster
779 West County Line Road
Hatboro, Pennsylvania 19040
License #: 129960

Dear Mr. Achilles:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on October 22, 2019 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Sandra Wooters

Sandra Wooters, MHS, ACG
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

11/27/2019 WED 10:46 FAX

002/156

Violation Report

Facility Information

Name: ARDEN COURTS OF WARMINSTER
Address: 779 WEST COUNTY LINE ROAD,, HATBORO, PA 19040
County: BUCKS Region: SOUTHEAST

License Number: 12996

Administrator

Name: Gary Achilles Phone: 2159575182 Email: LICENSURE-SUPPORT@HCR-MANORCARE.COM

Legal Entity

Name: ARDEN COURTS WARMINSTER OF HATBORO PA LLC
Address: 333 NORTH SUMMIT ST, 16TH FLOOR, TOLEDO, OH, 43604

Certificate(s) of Occupancy

Type: C-2 LP Date: 03/29/2000 Issued By: Dpt. of L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 47 Waking Staff: 35

Inspection

Type: Full Reason: Renewal BHA Docket #: Notice: Unannounced

Inspection Dates and Department Representative

10/22/2019 - On-Site: David Carrion, Youn Hie Chung

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 60 Residents Served: 46

Secured Dementia Care Unit

In Home: No Area: Capacity: 60 Residents Served: 46

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 46
Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 1 Have Physical Disability: 0

*X UPDATE: Gary Achilles GARY ACHILLES
Executive Director 3-30-2020*

*Gary Achilles GARY ACHILLES
Executive Director*

11/27/2019 WED 10:46 FAX

003/156

ARDEN COURTS OF WARMINSTER

12996

42s - Privacy

Regulations

2600.

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

Description of Violation

On 10/08/19, at 2:00 pm, the Ombudsman observed a staff person pull down a residents pants and adjust the residents underwear in Berry Ridge Unit hallway.

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.)

Please see attached

Legal Entity Representative

Gary Achille
Signature

GARY ACHILLE'S EXECUTIVE DIRECTOR 11-27-19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/31/2020
(Date)

Plan of correction implementation status as of 3/31/2020
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

* UPDATE: *Please see attached*

Gary Achille GARY ACHILLE'S
Executive Director 3-30-2020

42s

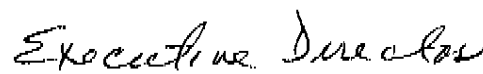
- Prior to the exit conference, the Ombudsman spoke privately to the survey team. Arden Courts staff was not present for this exchange. Following the exit conference, the Ombudsman confirmed the date of her observation, described below, as September 16, 2019. We are not aware of details surrounding an incident on October 10, 2019.
 - On September 16, 2019, our community's Ombudsman observed a resident, who was just showered and dressed, exit the shower room while disrobing in the hallway. The Ombudsman shared her observations with the ED. In turn, later that same day, the ED met with the caregiver working with the resident to discuss the Ombudsman's feedback. The caregiver reported that she immediately pulled up the resident's continence product and pants which were already around his knees and ankles at the time. We believe the caregiver's actions were resident centered, appropriate and swift. Her actions prevented a possible fall from happening, while preserving the resident's privacy and dignity at a moment's notice.
 - The staff of Arden Courts of Warminster appreciates its relationship with our local Ombudsman and always works with the Ombudsman in a spirit of cooperation and partnership to better serve our mutual residents. In this situation, we do not agree that a violation be assessed to the community by the survey team, approximately 5 weeks after the fact, for something that was neither witnessed or investigated by them or brought to the attention of the Department at the time of the occurrence.
 - We respectfully ask that violation 2600.42s be removed for the above reasons.
-

UPDATE:

- Following the community's Immediate Investigation and actions taken above, in-services were held with all staff to review resident rights. Please see attached.
- Additionally, monthly meetings with direct care staff will be held in April, May and June 2020 with the Executive Director and/or the Resident Services Coordinator to review and discuss regulation 42s. An agenda item for each of these meetings will include discussion concerning a resident's right to privacy of self and possessions, including the privacy to be provided during bathing, dressing, changing and medical procedures.
- To confirm staff compliance and staff awareness of this regulation, random observations will be made by the Executive Director and/or RSC, with real-time training provided when needed.
- Observations and follow up will be discussed during the quarterly Quality Management meeting.



GARY ACHILLES



3-30-2020

11/27/2019 WED 10:47 FAX

006/156

ARDEN COURTS OF WARMINSTER

12996

65e - 12 Hours Annual Training

Regulations

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person A received only 10.5 hours of annual training in training year 2018.

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.)

Please see attached

Legal Entity Representative

Gary Achilles
Signature

GARY ACHILLES, EXECUTIVE DIRECTOR
Printed Name and Title

11-27-19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/31/2020
(Date)

Plan of correction implementation status as of 3/31/2020
(Date)

The above plan of correction was approved by slw
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

* UPDATE: *Please see attached*

Gary Achilles, GARY ACHILLES
Executive Director 3-30-2020

65e

- In February 2019, a routine audit of 2018 team member training records was conducted by Romayne Higgins, Administrative Services Coordinator. It was determined that team member A received 10.5 hours of training, excluding the following topics which were made up on February 20, 2019:
 1. Fire Safety
 2. Infection Control and General Principles of Cleanliness and Hygiene Associated with Immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and hydration and safe management techniques.
 - To make sure team member A has all mandatory trainings for 2019, the above training sessions were completed again on November 21, 2019 for the 2019 training year. Please see attached.
 - During the week of November 4-8, 2019, an audit of 2019 mandatory training records for all team members was conducted by Romayne Higgins, Administrative Services Coordinator. One additional team member was identified as not completing all mandatory training sessions. The second team member's training was completed as well. Please see attached.
-

UPDATE:

- In addition to the above immediate actions taken, a systematic approach to monitoring and tracking 12-hours of annual training compliance will be instituted. Going forward, semi-annual audits will be conducted by the Administrative Services Coordinator in the second and fourth quarters of the calendar year. The Executive Director and/or designee will verify the audits for compliance.
- Direct care staff annual training records will also be audited by the Executive Director and/or designee randomly throughout the year to maintain compliance with regulation 65e, with real time training provided to the Administrative Services Coordinator as needed.
- In the event training is found to be missing, applicable training will be provided and documented accordingly.

Gary Achilles *Executive Director*

GARY ACHILLES

3-30-2020

11/27/2019 WED 10:53 FAX

024/156

ARDEN COURTS OF WARMINSTER

12996

65f - Training Topics

Regulations

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, safe management techniques during training year 2018.

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.)

Please see attached

Legal Entity Representative

Gary Achilles
Signature

GARY ACHILLES, EXECUTIVE DIRECTOR
Printed Name and Title

11-27-19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/31/2020
(Date)

Plan of correction implementation status as of 3/31/2020
(Date)

The above plan of correction was approved by slw
(initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

* UPDATE: *Please see attached*

Gary Achilles
Executive Director 3-30-2020

65f

- In February 2019, a routine audit of 2018 team member training records was conducted by Romayne Higgins, Administrative Services Coordinator. It was determined that team member A received 10.5 hours of training, excluding the following topics which were made up on February 20, 2019:
 1. Fire Safety
 2. Infection Control and General Principles of Cleanliness and Hygiene Associated with Immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and hydration and safe management techniques.
 - To make sure team member A has all mandatory trainings for 2019, the above training sessions were completed again on November 21, 2019 for the 2019 training year. Please see attached.
 - During the week of November 4-8, 2019, an audit of 2019 mandatory training records for all team members was conducted by Romayne Higgins, Administrative Services Coordinator. One additional team member was identified as not completing all mandatory training sessions. The second team member's training was completed as well. Please see attached.
-

UPDATE:

- In addition to the above immediate actions taken, a systematic approach to monitoring and tracking annual training topic compliance will be instituted. Going forward, semi-annual audits will be conducted by the Administrative Services Coordinator in the second and fourth quarters of the calendar year. The Executive Director and/or designee will verify the audits for compliance.
- Direct care staff annual training records will also be audited by the Executive Director and/or designee randomly throughout the year to maintain compliance with regulation 65f, with real time training provided to the Administrative Services Coordinator as needed.
- In the event training is found to be missing, applicable training will be provided and documented accordingly.

Gary Achilles Executive Director

GARY ACHILLOS

3-30-2020

11/27/2019 WED 10:59 FAX

041/156

ARDEN COURTS OF WARMINSTER

12996

65g - Annual Training Content

Regulations

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Staff person A did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations during training year 2018.

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.)

Please see attached

Legal Entity Representative

Gary Achilles
Signature

GARY ACHILLES EXECUTIVE DIRECTOR
Printed Name and Title

11-27-19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of *3/31/2020*
(Date)

Plan of correction implementation status as of *3/31/2020*
(Date)

Fully Implemented

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

Partially Implemented - Adequate Progress

Partially Implemented - Inadequate Progress

Not Implemented

** UPDATE: Please see attached*
Gary Achilles
Executive Director
3-30-2020

65g

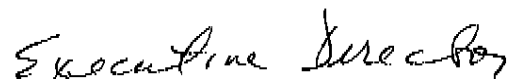
- In February 2019, a routine audit of 2018 team member training records was conducted by Romaine Higgins, Administrative Services Coordinator. It was determined that team member A did not complete the 2018 Fire Safety training, which was made up on February 20, 2019.
 - To make sure team member A completed Fire Safety training for 2019, team member A attended Fire Safety training November 21, 2019. Please see attached.
 - During the week of November 4-8, 2019, an audit of 2019 mandatory training records for all team members was conducted by Romaine Higgins, Administrative Services Coordinator. One additional team member was identified as not completing Fire Safety training. The second team member's training was completed on November 21, 2019 as well. Please see attached.
-

UPDATE:

- In addition to the above immediate actions taken, a systematic approach to monitoring and tracking annual training content compliance will be instituted. Going forward, semi-annual audits will be conducted by the Administrative Services Coordinator in the second and fourth quarters of the calendar year. The Executive Director and/or designee will verify the audits for compliance.
- Direct care staff annual training records will also be audited by the Executive Director and/or designee randomly throughout the year to maintain compliance with regulation 65g, with real time training provided to the Administrative Services Coordinator as needed.
- In the event training is found to be missing, applicable training will be provided and documented accordingly.



GARY ACHILLES



3-30-2020

11/27/2019 WED 11:01 FAX

049/156

ARDEN COURTS OF WARMINSTER

12996

85a - Sanitary Conditions

Regulations

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 10/22/19, at 2:30 pm, feces was observed on the floor and smeared on the toilet of bedroom #16 in the Cloverfield Wing. The sheets were soiled with brown substance.

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.)

Please see attached

Legal Entity Representative

Gary Achilles
Signature

GARY ACHILLES EXECUTIVE DIRECTOR
Printed Name and Title

11-27-19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/31/2020
(Date)

Plan of correction implementation status as of 3/31/2020
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

* UPDATE: *Please see attached*

Gary Achilles GARY ACHILLES
Executive Director 3-30-2020

85a

- Room 16 was immediately cleaned on October 22, 2019 by Caregiver, Tramilah Johnson. Please see attached.
 - Building Services Coordinator (Bill McDonald) and Housekeeping staff (Elizabeth Thome and John Camp) were provided in-service training on October 29, 2019 concerning 2600.85a. Please see attached.
 - The Deep Cleaning Checklist is being used as the audit tool for properly cleaning the Room 16. Please see attached.
 - Starting October 28, 2019 through December 30, 2019, Room 16 will be cleaned 2 times per week and documented using the Deep Cleaning Checklist.
 - Resident's RASP was updated on October 29, 2019, via RASP Addendum, to reflect continence care monitoring, room cleanliness and communication between care staff and housekeeping staff in the unlikely event of a continence accident in Room 16. Please see attached.
-

UPDATE:

- In addition to the above immediate actions taken, a systematic approach to monitoring and maintaining sanitary conditions has been instituted. Every occupied resident room is being thoroughly cleaned on a weekly basis by trained housekeepers. A Resident Room Deep Cleaning Checklist has been instituted to standardize sanitation consistency community-wide. Going forward, the Building Services Coordinator or designee will complete random room checks to ensure compliance and sign the checklist as well. Please see attached.
- From the period February 7, 2020 through May 31, 2020, The Executive Director or designee will make random rounds of the community to ensure compliance with regulation 85a. is being maintained. Please see attached.
- Starting February 7, 2020, all staff are being in-serviced on regulation 85a by the Executive Director or designee. In-servicing is underway and projected to conclude on April 15, 2020. Please see attached. In-servicing includes a general overview of what constitutes sanitary conditions and a general overview of what constitutes unsanitary conditions including feces, urine, bodily fluids such as blood, mucus, vomit or semen, rotten or spoiled foods, the presence of mold or mildew, pungent odors and generally unclean surfaces.

Gay Schiller Executive Director

GARY SCHILLER

3-30-2020

11/27/2019 WED 11:08 FAX

065/196

ARDEN COURTS OF WARMINSTER

12996

183d - Prescription Current

Regulations

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 10/22/19, Haloperidol Oral Solution .25 ml prescribed for resident #1, was in the home's medication cart; however, the medication was discontinued on 05/24/19.

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.)

Please see attached

Legal Entity Representative

Gary Achilles
Signature

GARY ACHILLES EXECUTIVE DIRECTOR 11-27-19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/31/2020
(Date)

Plan of correction implementation status as of 3/31/2020
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

* UPDATE: *Please see attached*

Gary Achilles GARY ACHILLES
Executive Director 3-30-2020

183d

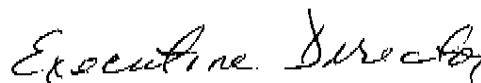
- A discontinued medication was found in one of the med carts. It was immediately removed from the med cart at the time of the survey. Please see attached.
 - On October 24, 2019, the discontinued medication was properly disposed of and documented. Please see attached.
 - Beginning November 5, 2019, all med carts are being audited weekly by the RSC or designee to ensure that discontinued medications are being removed in a timely manner. Please see attached.
 - Med techs and licensed nurses were in-serviced on November 19, 2019 by David January RN/Quality Assurance Consultant for HCR ManorCare and Arden Courts on Regulation 2600.183d. Please see attached.
-

UPDATE:

- In addition to the above immediate actions taken, a systematic approach to monitoring MARs for accuracy has been instituted. A nurse completes the weekly Medication Cart Audit attesting to each of the following: the Medication Observation Record was reviewed for completeness; Expired or discontinued medications were removed and reordered if needed (routine and PRN), medications are available as ordered/labeled correctly (routine, PRN and OTC), and infection control has been conducted (bottles are clean, meds are kept in labeled baggies and separated accordingly). Going forward, the Resident Services Coordinator or designee will attest to the accuracy of the Medication Cart Audit by completing random audits and signing the audit tool as well. Please see attached.
- Additionally, the above process will be incorporated as part of the final MAR to Medication Cart Audit at the time of the monthly recaps.



GARY ACHILLES



3-30-2020

11/27/2019 WED 11:16 FAX

088/156

ARDEN COURTS OF WARMINSTER

12996

183e - Storing Medications

Regulations

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

There were 8 unidentified loose pills found in the County Hall medication cart.

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.)

Please see attached

Legal Entity Representative

Gary Achilles
Signature

GARY ACHILLES EXECUTIVE DIRECTOR
Printed Name and Title

11-27-19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/31/2020
(Date)

Plan of correction implementation status as of 3/31/2020
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

* UPDATE : *Please see attached*

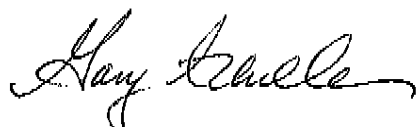
Gary Achilles GARY ACHILLES
Executive Director 3-30-2020

183e

- Loose pills were immediately removed from the med cart at the time of the survey. Please see attached.
 - Beginning November 5, 2019, all med carts are being audited weekly by the RSC or designee to ensure that loose pills are being removed in a timely manner. Please see attached.
 - On November 7, 2019, RSC spoke to the owner of Horsham Pharmacy about the packaging issue. The owner of Horsham Pharmacy has in-serviced his staff on sealing the medication packages more securely.
 - Med techs and licensed nurses were in-serviced on November 19, 2019 by David January RN/Quality Assurance Consultant for HCR ManorCare and Arden Courts on Regulation 2600.183e. Please see attached.
-

UPDATE:

- On January 16, 2020, the Executive Director and owner of Horsham Pharmacy discussed additional steps to institute a systematic approach to prevent pills from being dislodged from their packaging, including:
 1. Pharmacy staff being re-in-serviced about packaging protocols.
 2. Med Techs and Nurses will contact the pharmacy if they find a weak blister pack for immediate pick up and repackaging.
 3. Pharmacy providing one additional medication cart to allow for additional medication storage space.These measures have been very successful, with no loose pills found in the medication carts since the weekly audit conducted on March 6, 2020 to date.
Please see attached.
- Going forward, the Resident Services Coordinator or designee will attest to the accuracy of the Medication Cart Audit by completing random audits and signing the audit tool as well. Please see attached.

 Executive Director

GARY ACHILLES

3-30-2020

11/27/2019 WED 11:24 FAX

110/156

ARDEN COURTS OF WARMINSTER

12996

185a - Implement Storage Procedures

Regulations

2600.

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

Description of Violation

On 10/22/19, resident #2's glucometer was not calibrated to the correct date and time.

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.)

Please see attached

Legal Entity Representative

Gary Achilles
Signature

GARY ACHILLES EXECUTIVE DIRECTOR
Printed Name and Title

11-27-19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX

The above plan of correction is approved as of *3/31/2020*
(Date)

Plan of correction implementation status as of *3/31/2020*
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

** UPDATE: Please see attached*

Gary Achilles
GARY ACHILLES
Executive Director 3-30-2020

185a

- A glucometer was determined to be reading glucose levels properly; however, the date/time function was not properly calibrated.
 - On October 24, 2019, the glucometer in question was properly calibrated for date/time. Please see attached.
 - Effective November 5, 2019, the RSC or designee now checks weekly for proper glucometer calibration of date/time. Please see attached.
 - Med techs and licenses nurses were in-serviced on November 19, 2019 by David January RN/Quality Assurance Consultant for HCR ManorCare and Arden Courts on Regulation 2600.185a, with emphasis to licensed nurses on correct calibration of glucometers. Please see attached.
-

UPDATE:

- In addition to the above immediate actions taken, a systematic approach to monitoring glucometers for accuracy has been instituted.
- All glucometers are checked for proper calibration of date/time, documented weekly via the above referenced Diabetic Monitoring form, and signed off by the nurse performing the audit. Please see attached.
- Going forward, the Resident Services Coordinator (RSC) or designee will also randomly check glucometers for accuracy and sign the audit tool as well. Should a discrepancy be noted, the RSC will immediately rectify the situation and in-serve the nurse as needed.

Gary Achilles *Executive Director*

GARY ACHILLES

3-30-2020

11/27/2019 WED 11:27 FAX

119/156

ARDEN COURTS OF WARMINSTER

12996

187b - Date/Time of Medication Admin.

Regulations

2600.

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

Description of Violation

Resident #2 is prescribed Docusate Sodium. Resident 2's October 2019 medication administration record does not include the initials of the staff person who administered Docusate Sodium on 10/22/19 at 1:00 pm.

Resident #2 is prescribed Novolog 100 units. Resident 2's October 2019 medication administration record does not include the initials of the staff person who administered Novolog 100 units on 10/08/19 at 5:00 pm.

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.)

Please see attached

Legal Entity Representative

Gary Achilles Signature GARY ACHILLES, EXECUTIVE DIRECTOR Printed Name and Title 11-27-19 Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/31/2020 (Date) Plan of correction implementation status as of 3/31/2020 (Date)

The above plan of correction was approved by *slw* (Initials) Fully Implemented
 Partially Implemented - Adequate Progress
 Partially Implemented - Inadequate Progress
 Not Implemented


* UPDATE : *Please see attached*
Gary Achilles, GARY ACHILLES
Executive Director 3-30-2020

187b

- Two medications were administered that were not properly documented in real time on the MAR.
 - Beginning October 30, 2019, all MARs are being audited weekly by the RSC or designee to ensure that proper documentation is in place. Please see attached.
 - Med techs and licensed nurses were in-serviced on November 19, 2019 by David January RN/Quality Assurance Consultant for HCR ManorCare and Arden Courts on Regulation 2600.187b. Please see attached.
-

UPDATE:

- In addition to the above immediate actions taken, a systematic approach to monitoring MARs for accuracy has been instituted. A nurse completes the weekly Medication Cart Audit attesting to the following: the Medication Observation Record was reviewed for completeness; Expired or discontinued medications were removed and reordered if needed (routine and PRN), medications are available as ordered/labeled correctly (routine, PRN and OTC), and infection control has been conducted (bottles are clean, meds are kept in labeled baggies and separated accordingly). Going forward, the Resident Services Coordinator or designee will randomly attest to the accuracy of the Medication Cart Audit by completing random audits and signing the audit tool as well. Please see attached.
- Additionally, the above process will be incorporated as part of the final MAR to Medication Cart Audit at the time of the monthly recaps.
- The Shift Change MOR Review tool has been implemented. Please see attached.

 Executive Director
GARY ACHILLES 3-30-2020

11/27/2019 WED 11:31 FAX

129/156

ARDEN COURTS OF WARMINSTER

12996

187d - Follow Prescriber's Orders

Regulations

2600.

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

Description of Violation

Resident #2's glucometer has no blood sugar readings on 10/8/19 at 9:00 pm.

Resident #3's is prescribed Lorazepam 2 mg twice daily. On 10/6/19, resident #3 was administered Lorazepam 2 mg 3 times.

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.)

Please see attached

Legal Entity Representative

Gary Achilles
Signature

GARY ACHILLES, EXECUTIVE DIRECTOR
Printed Name and Title

11-27-19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/31/2020
(Date)

Plan of correction implementation status as of 3/31/2020
(Date)

Fully Implemented

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

Partially Implemented - Adequate Progress

Partially Implemented - Inadequate Progress

Not Implemented

** UPDATE: Please see attached*

*Gary Achilles, GARY ACHILLES
Executive Director 3-30-2020*

187d

- One accu-check on October 8, 2019 was not documented on the MAR and one additional dose of Lorazepam was given on October 6, 2019.
 - Beginning October 30, 2019, all MARs are being audited weekly by the RSC or designee to ensure that they are complete, accurate and compliant. Please see attached.
 - On October 23, 2019, the nurse who provided the additional dose of Larazepam was provided additional educated by the RSC. Additionally, on November 25, 2019, the nurse was also counseled by the ED around performance improvement relative to medication administration and following PCP orders. Please see attached.
 - Med techs and licensed nurses were in-serviced on November 19, 2019 by David January RN/Quality Assurance Consultant for HCR ManorCare and Arden Courts on Regulation 2600.187d. Please see attached.
-

UPDATED:

- In addition to the above immediate actions taken, a systematic approach to monitoring MARs for accuracy has been instituted. A nurse completes the weekly Medication Cart Audit attesting to the following: the Medication Observation Record was reviewed for completeness; Expired or discontinued medications were removed and reordered if needed (routine and PRN), medications are available as ordered/labeled correctly (routine, PRN and OTC), and infection control has been conducted (bottles are clean, meds are kept in labeled baggies and separated accordingly). Going forward, the Resident Services Coordinator or designee will randomly attest to the accuracy of the Medication Cart Audit by completing random audits and signing the audit tool as well. Please see attached.
- Additionally, the above process is will be incorporated as part of the final MAR to Medication Cart Audit at the time of the monthly recaps.
- The Shift Change MOR Review tool has been implemented. Please see attached.

Gary Archuleta Executive Director

GARY ARCHULETA

3-30-2020

11/27/2019 WED 11:35 FAX

140/156

ARDEN COURTS OF WARMINSTER

12996

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 12/08/2018, for resident #4 does not address behavioral problems of resident lifting heavy objects, moving them throughout the home and sustaining injuries.

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.)

Please see attached

Legal Entity Representative

Gary Achilles
Signature

GARY ACHILLES EXECUTIVE DIRECTOR
Printed Name and Title

11-27-19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX

The above plan of correction is approved as of 3/31/2020
(Date)

Plan of correction implementation status as of 3/31/2020
(Date)

Fully Implemented

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

Partially Implemented - Adequate Progress

Partially Implemented - Inadequate Progress

Not Implemented

* UPDATE : *Please see attached*

Gary Achilles GARY ACHILLES
Executive Director 3-30-2020

234b

- In February 2018, Resident A started demonstrating increased behaviors as noted by the staff. An updated DME was completed to reflect the change in condition. A corresponding RASP addendum to reflect the care being provided to address the identified needs was not in the record. On October 28, 2019, Resident A's RASP was updated, via addendum, to identify the occasional behaviors expressed by the resident and the care strategies performed by the staff to address the resident's needs. A support plan meeting was held on October 29, 2019 with the resident's husband/POA, Executive Director, Resident Services Coordinator and Program Services Coordinator to discuss the dementia process, the resident's progression within the disease, typical behaviors demonstrated by the resident at times, and the care strategies provided by the staff to address her expressions of need. Please see attached.
- The 2019 files of all residents present in the community on the date of the annual survey were audited to ensure that Change in Status DMEs also have corresponding RASP updates to reflect the care being provided to address the identified needs. Three files were identified with Change in Status DMEs. All three resident files had corresponding RASP addendums in place to reflect the care strategies being performed by the staff to address the changes. Please see attached.
- On October 28, 2019, all Coordinators were in-serviced on regulation 2600.234b. Please see attached.
- To expedite the process, effective October 28, 2019 changes in a resident's condition are being discussed at morning meetings, with corresponding RASP addendums completed within five calendar days.
- The reviews and updates will be documented on the RASP update log and kept for review by the Department.

Update:

- In addition to the above immediate actions taken, a systematic approach for addressing behavioral changes has been instituted.
- On February 10, 2020 and March 2, 2020, all Coordinators and nurses were in-serviced on regulation 2600.234b. Please see attached.
- Additionally, monthly meetings with direct care staff will be held in April, May and June 2020 with the Executive Director and/or the Resident Services Coordinator to review and discuss regulation 234b. An agenda item for each of these meetings will include discussion concerning the process to immediately address changes in behavior, including: 1. When changes in behavior are identified, the observer notifies one or more of the following: Resident Services Coordinator (RSC), nurse on duty, caregiver, coordinator or administrator of his/her observations; 2. Should the resident require immediate attention, the RSC, nurse on

Executive Director
 GARY ACHILLOS 3-30-2020

duty, caregiver, coordinator or administrator will immediately intervene and discuss strategies that would benefit the resident for implementation by the care and/or other appropriate staff; 3. Resident changes are also communicated to the PCP to determine medical interventions (if deemed necessary) and next steps; and 4. The POA is also notified. Behavioral changes and interventions to be implemented will be discussed with the POA and appropriate staff.

- Changes in resident condition are reviewed at daily stand up meetings, with corresponding RASP addendums completed within five calendar days. Care plan updates are recorded on a tracking log and filed in both the medical chart and administrative file. Please see attached.

Gary Achilles, Executive Director

GARY ACHILLES 3-30-2020

11/27/2019 WED 11:38 FAX

150/156

ARDEN COURTS OF WARMINSTER

12996

253d - Records Audit/Litigation

Regulations

2600.

253.d. Records required under this chapter that are not part of the resident records shall be kept for a minimum of 3 years or until any audit or litigation is resolved.

Description of Violation

Med Tech training records for 2018 were accidentally disposed.

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.)

Please see attached

Legal Entity Representative

Gary Achilles
Signature

GARY ACHILLES EXECUTIVE DIRECTOR
Printed Name and Title

11-27-19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3/31/2020
(Date)

Plan of correction implementation status as of 3/31/2020
(Date)

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

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

* UPDATE: *Please see attached*

Gary Achilles GARY ACHILLES
Executive Director 3-30-2020

253d.

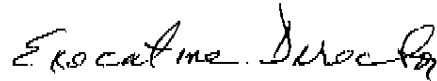
- During the annual survey, the Executive Director, Gary Achilles, communicated to the survey team, that the 2018 Med Observation records were accidentally shredded.
 - All Coordinators were In-serviced on Regulation 2600.253d on October 23, 2019. Please see attached.
 - All staff members will be in-serviced on Regulation 2600.253d on or before December 31, 2019. Please see attached.
-

Update:

- In addition to the above immediate actions taken, a systematic approach for addressing records that are not part of the resident records has been instituted.
- A binder has been created to house all required documentation of the medication administration course requirements now located in the Executive Director Office for safekeeping.
- The Iron Mountain shredding bins are now located in the Administrative areas of the community, thereby preventing immediate access to shredding documents.



GARY ACHILLES



3-30-2020