pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **RAPPS SENIOR CARE LLC**
LEGAL ENTITY

To operate **WOODBRIDGE PLACE**
NAME OF FACILITY OR AGENCY

Located at **1191 RAPPS DAM ROAD, PHOENIXVILLE, PA 19460**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

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 **125** (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 21**

This certificate is granted in accordance with the Public Welfare 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 **November 19, 2019** until **November 19, 2020**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **143590**

Robert E. Robinson
ISSUING OFFICER

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 628 – 7/19

November 19, 2019

Mr. Robert W. Chapin, Jr.
President
Rapps Senior Care, LLC
Attn: Bill Snow
1000 Legion Place, Suite 1600
Orlando, Florida 32801

RE: Woodbridge Place
1191 Rapps Dam Road
Phoenixville, Pennsylvania 19460
License #: 143590

Dear Mr. Chapin:

As a result of the Department's Bureau of Human Services Licensing annual inspection on July 24, 25, and 29, 2019 of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosure
Violation Report

Violation Report

Facility Information

Name: *WOODBRIDGE PLACE* **License Number:** *14359*
Address: *1191 RAPPS DAM ROAD,, PHOENIXVILLE, PA 19460*
County: *CHESTER* **Region:** *SOUTHEAST*

Administrator

Name: *Deb Bodnar* **Phone:** *4843020005* **Email:** *executivedirector@woodbridgeplace.com*

Legal Entity

Name: *RAPPS SENIOR CARE LLC*
Address: *1000 LEGION PLACE, SUITE 1600, ATTN BILL SNOW, ORLANDO, FL, 32801*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/01/1996* **Issued By:** *COPA L&I*

Staffing Hours

Resident Support Staff: *139* **Total Daily Staff:** *278* **Waking Staff:** *209*

Inspection

Type: *Full* **BHA Docket #:** **Notice:** *Unannounced*
Reason: *Renewal,Provisional*

Inspection Dates and Department Representative

07/24/2019 - On-Site: Jennie Heinberg, Michele Swisher

07/25/2019 - On-Site: Jennie Heinberg, Michele Swisher

07/29/2019 - On-Site: Jennie Heinberg, Michele Swisher

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served:** *85*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Life Guidance* **Capacity:** *20* **Residents Served:** *18*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *83*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *54* **Have Physical Disability:** *0*

25b - Contract Signatures

Regulations

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, dated 2/27/2019, for resident #3 was not signed by the resident.

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.)

ATTACHED

Legal Entity Representative

Deb Bodnar
Signature

DEB BODNAR, SR. EXECUTIVE DIRECTOR
Printed Name and Title

9-26-19
Date

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

The above plan of correction is approved as of 10/17/19 (Date)

Plan of correction implementation status as of 10/17/19 (Date)

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

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

2600.25(b)

Woodbridge Place will comply with regulation 2600.25(b). The Resident Agreement will 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. The contract for Resident #3 was reviewed with the resident and signatures (initials) were obtained. **Completed: 7-31-2019 Attachment: 1**

Resident Agreements were reviewed for all Woodbridge Place residents admitted after 2-15-2018 (Date of Change of Ownership) by the Director of Community Relations. Any issues identified regarding signatures were corrected with the resident involved. **Completed: 9/24/19 Attachment: 2**

The Director of Community Relations was inserviced by the Sr. Executive Director relating to the importance of attempting to obtain a resident's signature on admission contract documentation. Emphasis was placed on the procedure for follow through with signatures. The resident will be approached x3 to sign the agreement. Each time a resident refuses, the Director of Community Relations will document the date of the attempt as well as the resident's reason for refusal to sign. The Director of Community Relations will document her signature/initials for each attempt. **Completed: 7-31-2019. Attachment: 3**

To ensure ongoing compliance with signatures on the Resident's Agreement, each new Resident Agreement will be reviewed by the Wellness Office Coordinator for resident signatures or documentation of resident refusal (or inability to sign). Any issues identified as a result of this review will be discussed with the Director of Community Relations for immediate follow-up and correction. Outcomes of this review will be discussed by the Director of Community Relations at the Quality Assurance Meeting scheduled for **9-25-2019. Attachment 4**

Deb Bodnar

DEB BODNAR

SR EXECUTIVE DIRECTOR

9-26-19

41e - Signed Statement

Regulations

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #3's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

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.)

ATTACHED

Legal Entity Representative

Deb Bodnar
Signature

DEB BODNAR SR. EXECUTIVE DIRECTOR
Printed Name and Title

9-26-19
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2600.41 e

Woodbridge Place will comply with regulation 2600.41(e) and have a statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in 2600.41(d) and 44(a) (or documentation of efforts made to obtain signatures and will be kept in the resident's record.) Resident #3 was approached and signed indicating receipt of the Residents Rights and Complaint Procedures. **Completed: 7-31-2019 Attachment 1**

All resident admitted after 2-15-2018 (Date of Change of Ownership) had their Woodbridge Place Resident Agreement reviewed. Any issues identified have been corrected with the resident involved. **Completed: 9-24-2019 Attachment: 2**

The Director of Community Relations was inserviced by the Sr. Executive Director relative to the procedure for obtaining signatures on the Resident Agreement. Inservicing emphasized the importance of attempting to obtain the resident's signature on all areas of the Agreement, as well as the importance of the resident understanding how to make a complaint known, who to register a complaint and the time frames for complaint resolution. Any Resident Agreement that does not have the Resident Rights or Community Complaint Procedures signed by the resident will be approached by the Director of Community Relations for signature. The resident will be approached x3 to sign the Agreement. Each time a resident refuses, the Director of Community Relations will document the date of the attempt as well as the reason for a resident's refusal to sign. The Director of Community Relations will document her signature/initials for each attempt. **Completed: 7-31-2019 Attachment: 3**

To ensure ongoing compliance with signatures acknowledging receipt of Resident Rights and Complaint Procedures, each new Resident Agreement will be reviewed by the Wellness Office Coordinator for resident signatures or documentation of resident refusal (or inability) to sign. Any issues identified as a result of this review will be discussed with the Director of Community Relations for immediate correction. Outcomes of this review will be discussed at the Quality Assurance Meeting by the Director of Community Relations scheduled for **9-25-2019 . 4**

DEB BODNAN
Sr. Executive Director
9-26-19

57c - 2 Hours/Day

Regulations

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 7/7/2019, there were 85 residents in the home, including 54 residents with mobility needs, requiring a total minimum of 139 hours of direct care service. On this date, only 126.5 hours of direct care staffing was provided.

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.)

In order to ensure sufficient staffing hours are provided to residents with mobility needs, direct care staff will be available 2 hours per day to provide personal care services. **Completed: 7/29/19.**

The Resident Care Coordinator reviewed each resident's support plan to ensure that mobility needs are coordinated with the RASP. Direct care staff schedules were reviewed for the following 7 days. Staffing adjustments were made as necessary. **Completed: 7/30/2019.**

The Resident Care Coordinator will review, and/or update a resident's mobility needs every Monday, upon admission and change of condition. Additional direct care staffing hours will reflect the needs of the resident as specified in each resident's assessment and support plan. **Completed: 7/30/2019**

The Resident Care Coordinator will discuss outcomes of staffing hour reviews and interventions implemented. (i.e. hiring of additional staff) at the Quality Assurance Meeting scheduled on: **9-25-2019 Attachment 4**

The director/designee will review the staffing schedule weekly to ensure minimum dire care service hours are available for the care of residents, starting immediately. (SW 10/17/19)

Legal Entity Representative

Deb Bodnar — Signature

Deb Bodnar Sr. Executive Director — Printed Name and Title — 9-26-19 Date

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103f - Refrigerator/Freezer Temps

Regulations

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There was no thermometer in the refrigerator or freezer in the first floor café area.

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.)

Woodbridge Place will ensure that food requiring refrigeration will be stored at or below 40F. Frozen food will be kept at or below 0F. Thermometers will be in refrigerators and freezers that store the Community's food supply. The refrigerator/freezer located in the Café did not have a thermometer in either compartment. Thermometers were obtained immediately. Thermometers were zip tagged in both compartments. **Completed: 7/29/2019 Attachment: 5.**

All refrigerators and freezers that store the community's food supply were checked by dietary staff for the presence of thermometers. No other issues identified. **Completed: 7/29/2019**

All appliances that store the community 's food supply will be checked daily by the dietary staff for the presence of a thermometer. Any appliance not containing a thermometer will have one immediately put into place. All dietary staff will be inserviced relating to temp sheet and thermometers. **Completed: August 12, 2019. Attachment: 6**

The Dietary Manager will have the responsibility for compliance with this regulation. Any concerns relative to this audit will be addressed by the Dietary Manager for intervention. Copies of the temperature sheets will be made available at the Quality Assurance Meeting scheduled for: **9-25-2019 Attachment 4**

Legal Entity Representative

Deb Bodnar (signature) — Signature

Deb Bodnar Sr. Executive Director — Printed Name and Title — 9-26-19 — Date

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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 #1's medical evaluation did not include the resident's ability to self administer 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.)

ATTACHED

Legal Entity Representative

Deb Bodnar — Signature

DEB BODNAR, SR. EXECUTIVE DIRECTOR — Printed Name and Title

9-26-19 — Date

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2600.141a

A resident of Woodbridge Place 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. Resident 1 had their DME amended to reflect the ability to administer her own medications. **Completed: 7-24-2019 Attachment: 7**

All Medical Evaluations (DME's) were reviewed to ensure documentation on the DME of a resident's medication administration status. All DME's contained documentation relating to medication administration status. **Completed: 7-24-2019**

All residents who have indicated a preference to self-administer their medication will be assessed upon admission, annually and as needed, (change of condition) by Wellness Staff. This will ensure each resident can administer their own medications safely. Any resident deemed capable of administering their own medications will have their name added to the Resident Medication Self Administration Log. **Completed: 7-29-2019 Attachment 8.**

The Director of Nursing will have the responsibility of ensuring ongoing compliance with this regulation.
Outcomes of this procedure will be reviewed by the Director of Nursing at the Quality Assurance meeting scheduled for **9/25/2019. Attachment 4**

Deb Bodnar

Deb Bodnar, Sr. Executive Director

9-26-19

171b5 - First Aid Kit

Regulations

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the bus used to transport residents does not include a breathing shield.

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.)

In the event of an emergency, in order to ensure that Woodbridge Place has the equipment needed to provide first aid, this Community will have a first aid kit that includes: non-porous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers in a first aid kit. Woodbridge Place had 3 complete first aid kits in each of the 3 med rooms and passenger vehicle. The breathing shield, which was not present in the first aid kit on the bus has been added. **Completed: 7-29-2019**

All first aid kits in the Community and vehicles have the required components. **Completed: 7-29-2019.**

The 3 first aid kits in the 3 med rooms and the first aid kit in the community bus and passenger vehicle are zip tied. When a zip tie is broken, the items will be reviewed by the med tech/nursing staff/transportation aid, Activity Director and will be replaced as needed. In addition, every 6 months, the 5 first aid kits will be opened by the med techs/nursing staff, Transportation Aid, Activity Director and contents examined for continued use. Any items not able to be used will be replaced and the first aid kits will be re-zip tied. nursing staff, med techs, Activities Director and Transportation Aid have been inserviced r/t to Community procedure. **Completed: 8/10/2019. Attachment: 9.** The DON will be responsible for compliance with this regulation. Outcomes of community procedure will be reviewed at the Quality Assurance Meeting scheduled for **9-25-2019**. **Attachment 4.**

Legal Entity Representative

Deb Bodnar
Signature

Deb Bodnar, Sr. Executive Director
Printed Name and Title

9/26/19
Date

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

184b - Resident's Meds Labeled

Regulations

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

On 7/29/2019, a box of Claritin 5mg Redi-tab, belonging to resident#6 was in the medication cart and was not labeled with the resident 6's name.

A bottle of Acetaminophen 500mg tablets was located in the third drawer of the medication cart. The bottle had no name or other label to identify which resident the medication belonged to.

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.)

ATTACHED

Legal Entity Representative

Deb Bodnar
Signature

Deb Bodnar Sr Executive Director
Printed Name and Title

9-26-19
Date

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Reg 184 (b) .

Claritin 5 mg Redi tab, belonging to resident #6 was in the med cart and not labeled with resident 6's name. The Claritin Redi tabs for resident 6 was immediately identified and labeled with resident #6 name. A bottle of Acetaminophen 500 mg tablets was located in the 3rd drawer of the medication cart without a name to identify the resident. The bottle of Acetaminophen 500 mg tablets was identified as belonging to Resident # 6. The Acetaminophen bottle was immediately labeled with resident 6's name **Completed: 7-29-2019**

Nursing Staff and Med Tech's reviewed all the OTC/CAM medication in the medication carts for proper identification. There were no further issues identified. **Completed: 7-29-2019**

Education was provided by Eric L Wegman RPH BCGP. The following topics were discussed: Medication Storage and Labeling, Review of Glucose Monitoring , Documentation and Sliding Scale Insulin Dosing . In addition, each Med Tech and Licensed Nursing Staff have been provided with their own personal copy of the regulation 2600 181(a) to 191. Medication carts are checked daily by Med Techs and Licensed Staff for OTC/CAM identification labeling with resident's name. The Director of Nursing will check random Medication Carts to verify the labeling of OTC/CAM medications. Any issues noted by the Med Techs/Licensed Nursing Staff are reported to the Director of Nursing, identified and corrected immediately. **Completed: 8-1-2019. Attachment: 10.**

Any labeling/identification issues identified with OTC/CAM medications have been reported to the DON and corrected immediately. As of an audit on medication carts on 9/24/2019, all OTC/CAM medications are identified and labeled. The DON has responsibility for continued compliance with this regulation. Results of this audit will be reviewed at the Quality Assurance Meeting scheduled for **9-25-2019.**
Attachment 4

Deb Bodnar
Deb Bodnar
Sr. Executive Director
9/26/19

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

Resident #5 has an order for glucose checks 3 times daily and to administer Novolg 100 units/ml according to sliding scale directions with meals. the sliding scale directions are : 0-120 = 0 units, 121-150= 4 units, 151-200= 6 units, 201-250= 10 units, and over 250 is 14 units.

On 7/15 the MAR has a reading of 197 recorded at noon; however, there is no reading in the glucometer matching this date and time.
On 7/15 there is a glucometer reading of 341 at 3:56pm; however, this reading is not recorded on the MAR- there are no initials on the MAR for this date and time indicating that medication administered.

On 7/19 there is no reading in the glucometer and no recorded number of the MAR for the 12:00PM glucometer check. There is a notation that states "no insulin required" however there is no reading recorded to verify that no insulin was needed.

On 7/22 at 4:49pm, the glucometer has a reading of 360; however, this reading is not recorded on the MAR- there are no initials on the MAR for this date and time indicating that medication was not administered.

On 7/24 at 11:09am, there is a reading in the glucometer of 251; however, the MAR is recorded as 250. Resident received the incorrect dose of insulin based on the sliding scale directions. Resident should have received 14 units, but only received 10units based on the recorded number of 250.

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

ATTACHED

Legal Entity Representative

Signature

DEB BODNAR SR. EXECUTIVE DIRECTOR — Printed Name and Title

9-26-19 — Date

185a - Implement Storage Procedures *(continued)*

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Deb Bodnar

DEB BODNAR
Sr EXECUTIVE Director
9-26-19

2600.185a

Woodbridge Place will develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons. **Completed: 7-29-2019.**

Resident #5 has an order for glucose checks 3 times daily and to ad minister Novolog 100 units /ml according to sliding scale directions with meals. The sliding scale directions are: 0-120 = 0 units, 121-150=4 units, 151-200 =6 units, 201 -250 =10 units and over 250 = 14 units. On 7/17the MAR has a reading of 197 recorded at noon; however, there is no reading in the glucometer matching this date and time. On 7/15 there is a glucometer reading of 341 at 3:56 PM: however, this reading is not recorded on the MAR There are no initials on the MAR indicating that the medication was administered. On 7/19 there is no reading in the glucometer and no recorded number of the MAR for the 12PM glucometer check. There is a notation that states "no insulin" required. However here is no reading recorded to verify that no insulin was needed. On 7/22 at 4:49 PM the glucometer has a reading 360; however, this reading is not recorded on the MAR- there are no initials on the Mar for this date and time indicating that the medication was not administered. On 7/24 at 11:09 am there is a reading in the glucometer of 251: however, the MAR is recorded at 250. The resident received the incorrect dose of insulin based on the sliding scale direction. Resident should have received 14 units but only received 10 units based on the recorded number of 250. The Nurse assigned to Resident 5 is no longer employed at Woodbridge Place. PCP was notified of errors of administered insulin. No new orders received. All glucometers in the Community were checked for accuracy. There were no concerns identified. **Completed: 7-29-2019.**

Education was provided by Eric L Wegman RPH BCGP. The following topics were discussed: Medication Storage and Labeling, Review of Glucose Monitoring , Documentation and Sliding Scale Insulin Dosing . The educator emphasized with all Med Techs and Nursing Staff to double check the glucose measurement per physician's order sliding scale dosing and MAR documentation. In addition, each Med Tech and Licensed Nursing Staff have been provided with their own personal copy of the regulation 2600 181(a) to 191. In order to ensure that initials/and glucometer readings are recorded, Omission Reports are printed following each shift. Corrections are made immediately as applicable. Omission reports are located in the DONs office for review. **Completed: 8-1-2019. Attachment: 10.**

Outcomes of the Omission Reports and Vital report for glucose reading are reviewed against the MAR and sliding scale order daily by Licensed Nursing Staff and Medication Technicians. In addition, Omission Records and Vital Reports for glucose readings on glucometers and MAR documentation will be checked weekly. Any issues identified as per the Omission Report and Vital Report will be discussed with the staff person involved and an intervention will result up to and including termination. The DON has the responsibility for compliance with this regulation. Outcomes will be discussed at the Quality Assurance Meeting scheduled on **9-25-2019. Attachment: 4**

The administraion will conduct a training on the importance of not sharing glucometers and the risks associated with sharing among residents by November 25, 2019. (slw10/17/19)

Deb Bodnar

Deb Bodnar SRED

9/26/19

187d - Follow Prescriber's Orders

Regulations

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

Description of Violation

Resident #5 has an order to have glucose checks 3 times daily and to administer Novolg 100 units/ml according to sliding scale directions with meals Sliding scale directions are : 0-120 = 0 units, 121-150= 4 units, 151-200= 6 units, 201-250= 10 units, and over 250 is 14 units.

On 7/22 at 4:49pm, the glucometer has a reading of 360; however, this reading is not recorded on the MAR- there are no initials on the MAR for this date and time indicating that medication was not administered.

On 7/24 at 11:09am, there is a reading in the glucometer of 251; however, the MAR is recorded as 250. Resident# 5 received the incorrect dose of insulin based on the sliding scale directions. Resident #5 should have received 14 units, but only received 10units based on the recorded number of 250.

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.)

ATTACHED

Legal Entity Representative

Deb Bodnar
Signature

DEB BODNAR SR. EXECUTIVE DIRECTOR 9-26-19
Printed Name and Title Date

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- [ ] Partially Implemented - Inadequate Progress
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The above plan of correction was approved by SLW (Initials)

2600.187d

Woodbridge Place will follow the direction of the prescriber.

On 7/22 Resident #5 has an order for glucose checks 3 times daily and to ad minister Novolog 100 units /ml according to sliding scale directions with meals. The sliding scale directions are: 0-120 = 0 units, 121-150=4 units, 151-200 =6 units, 201 -250 =10 units and over 250 = 14 units On 7/22 at 4:49 PM the glucometer has a reading 360; however, this reading is not recorded on the MAR- there are no initials on the Mar for this date and time indicating that the medication was not administered. On 7/24 at 11:09 am there is a reading in the glucometer of 251: however, the MAR is recorded at 250. The resident received the incorrect dose of insulin based on the sliding scale direction. Resident should have received 14 units but only received 10 units based on the recorded number of 250. PCP was notified of errors in errors of administration no new orders received. Glucometer was checked for accuracy and no issues were identified.

Education was provided by Eric L Wegman RPH BCGP. The following topics were discussed: Medication Storage and Labeling, Review of Glucose Monitoring , Documentation and Sliding Scale Insulin Dosing . The educator emphasized with all Med Techs and Nursing Staff to double check the glucose measurement per physician's order sliding scale dosing and MAR documentation. In addition, each Med Tech and Licensed Nursing Staff have been provided with their own personal copy of the regulation 2600 181(a) to 191. In order to ensure that initials/and glucometer readings are recorded, Omission Reports are printed following each shift. Corrections are made immediately as applicable. Omission reports are located in the DONs office for review. **Completed: 8-1-2019. Attachment: 10.**

Outcomes of the Omission Reports and Vital report for glucose reading are reviewed against the MAR and sliding scale order daily by Licensed Nursing Staff and Medication Technicians. In addition, Omission Records and Vital Reports for glucose readings on glucometers and MAR documentation will be checked weekly by the DON. Any issues identified as per the Omission Report and Vital Report will be discussed with the staff person involved and an intervention will result up to and including termination. The DON has responsibility for continued compliance. Outcomes will be discussed at the Quality Assurance Meeting scheduled on **9-25-2019. Attachment: 4**

Deb Bolnar
Sr. ED
9/26/19

191 - Resident Right to Refuse

Regulations

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #3 admitted on 3/2/2019, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

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.)

ATTACHED

Legal Entity Representative

Deb Bodnar
Signature

DEB BODNAR Sr. Executive DIRECTOR
Printed Name and Title

9-26-19
Date

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The above plan of correction is approved as of 10/17/19 (Date)

Plan of correction implementation status as of 10/17/19 (Date)

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2600.191

Woodbridge Place will comply with regulation 2600.41(e) and have a statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in 2600.41(d). (or documentation of efforts made to obtain signatures and will be kept in the resident's record.) Resident 3 was approached and has signed, indicating receipt of the Residents Rights and their right to refuse a medication if the resident believes there may be a medication error. **Completed: 7-31-2019 Attachment: 1**

All resident admitted after 2-15-2018 (Date of Change of Ownership) had their Woodbridge Place Resident Agreement reviewed. Any issues identified were corrected with the resident involved.
Completed: 9/24/2019 Attachment: 2

The Director of Community Relations was inserviced by the Sr. Executive Director relative to the procedure for obtaining signatures on the Resident Agreement. Inservicing emphasized the importance of attempting to obtain the resident's signature on all areas of the Agreement, as well as the importance of the resident understanding how to make a complaint known, who to register a complaint and the timeframes for complaint resolution. Any Resident Agreement that does not have a Resident Rights or Community Complaint Procedures signed by the resident will be approached by the Director of Community Relations for signature. The resident will be approached x3 to sign the Agreement. Each time a resident refuses, the Director of Community Relations will document the dates of the attempts as well as the reason for a resident's refusal to sign. The Director of Community Relations will document her signature/initials for each attempt. **Completed: 7-31-2019 Attachment: 3**

To ensure ongoing compliance with signatures acknowledging receipt of Resident Rights and Complaint Procedures, each new Resident Agreement will be reviewed by the Wellness Office Coordinator for resident signatures or documentation of resident refusal (or inability) to sign. Any issues identified as a result of this review will be discussed with the Director of Community Relations for immediate correction. Outcomes of this review will be discussed at the Quality Assurance Meeting by the Director of Community Relations scheduled for **9-25-2019**
Attachment: 4

Deb Bodner

Deb Bodner, Sr. Executive Director

9/26/19

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 #2 was admitted to the Secure Dementia Care Unit (SDCU) on 6/2/18. However, the resident #2's written cognitive preadmission screening was completed on 5/22/2018.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any atta[illegible] the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed i[illegible] [illegible] which the steps will be completed.)

Woodbridge Place completed a written cognitive prescreen in excess of 3 days (72 hours) prior to a resident's admission.

Woodbridge Place will, within 72 hours prior to a resident's admission to a secured dementia unit, complete a written cognitive preadmission screening, in conjunction with a physician or geriatric assessment team and document on the form provided by DHS. **Completed: 7-29-2019.**

As of 7/29/2019, the Wellness Office Coordinator implemented an audit which provides the date of a resident's admission and date of the cognitive pre-admission prescreening. All cognitive preadmission screenings will be completed within 72 hours prior to the resident's admission to the secured dementia care unit. The Director of Community Relations will communicate with the Support Plan Team/Assessment Team via email and at AM Meeting of all residents' projected date of admissions. Inservicing relating to this regulation and procedure was conducted. **Completed: 7-29-2019 Attachment: 11**

Outcomes of this audit will be reviewed prior to each resident's admission for timeliness by the Wellness Office Coordinator. Any issues identified will be corrected immediately by the Wellness Office Coordinator and any additional interventions discussed at the Quality Assurance Meeting scheduled on **9-25-2019. Attachment 4**

Legal Entity Representative

Deb Bodnar	Deb Bodnar Sr. Executive Director	9-26-19
Signature	Printed Name and Title	Date

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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 #4 was admitted to the Secure Dementia Care Unit (SDCU) on 4/26/2019. 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.)

Woodbridge Place will ensure that all residents who are admitted or transferred to the Secured Dementia Unit in the Community will have documentation that the resident/resident's designated person have not objected to the resident's admission/transfer to the secured dementia unit. This will ensure that residents and their designated person know that a secured setting has been chosen. Resident 4's transfer to the dementia unit document was signed. **Completed: 7-26-2019 Attachment: 12.**

Following a review of Administrative Records, all newly admitted or transferred residents to the secured dementia care unit since the CHOW (February 15, 2018), have a document in their file indicating that the resident/resident's designated person have not objected to the resident's admission/transfer to the secured dementia unit. **Completed: 7-23-2019 Attachment: 13** The Director of Community Relations was inserviced relative to regulation 231(e) documentation requirements. **Completed: 7-29-2019 Attachment: 14.** The date of admission and date of signature indicating that the resident/resident's responsible party has not objected to the resident's transfer or admission to the dementia care unit are now documented on a log by the Wellness Office Coordinator. This log will be completed by the Wellness Office Coordinator following each secured dementia care unit admission. Any issues identified will be corrected immediately by the Director of Community Relations. Outcomes of this procedure will be discussed at the upcoming Quality Assurance Meeting scheduled for **9-25-2019. Attachment: 4**

Legal Entity Representative

Signature

Deb Bodner Sr. Executive Director — Printed Name and Title — 9/26/19 Date

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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 #2 was admitted to the Secure Dementia Care Unit (SDCU) on 6/2/2018. However, the resident's initial support plan was completed on 5/28/2018.

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 car[illegible] completed immediately include dates by which the steps will be completed.)

Woodbridge Place completed a support plan in excess of 3 days (72 hours) prior to a resident's admission.

Woodbridge Place will, within 72 hours of admission, or within 72 hours prior to the resident's admission to a secured dementia unit, a support plan will be developed, implemented and documented in the resident record. **Completed: 7-29-2019.**

As of 7/29/2019, the Resident Care Coordinator has implemented an audit which provides the date of a resident's admission and date of support plan completion. All residents admitted to the secured dementia care unit will have their support plans completed, documented and implemented within 72 hours of admission or within 72 hours prior to the resident's admission to the secured dementia care unit. **Attachment: 15**

Outcomes of this audit will be reviewed following each resident's admission for timeliness by the Resident Care Coordinator. Any issues identified will be corrected immediately by the Resident Care Coordinator. Additional interventions will be discussed at the Quality Assurance Meeting scheduled on **9-25-2019 Attachment: 4**

The administrator will provide training to the admissions/care coordinator on the importance of timely completion of the residents Support Plan no later than November 25, 2019. (sw 11/17/19)

Legal Entity Representative

Deb Bodnar
Signature

Deb Bodnar Sr. Executive Director
Printed Name and Title

9-26-19
Date

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