



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**CERTIFICATE OF COMPLIANCE**

This certificate is hereby granted to CAMBRIDGE VILLAGE ASSOCIATES  
LEGAL ENTITY

To operate CAMBRIDGE VILLAGE PERSONAL CARE HOME  
NAME OF FACILITY OR AGENCY

Located at 1600 DARLINGTON ROAD, BEAVER FALLS, PA 15010  
(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 100  
(MAXIMUM CAPACITY)  
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

**Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 24**

Restrictions: \_\_\_\_\_

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 January 3, 2020 until January 3, 2021,  
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **401620**

Robert E. Robinson  
ISSUING OFFICER

[Signature]  
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.



Mailing Date: January 3, 2020

Ms. Cindy Hopkins  
Administrator  
Cambridge Village Associates  
1600 Darlington Road  
Beaver Falls, Pennsylvania 15010

RE: Cambridge Village Personal Care Home  
Certificate #: 401620

Dear Ms. Hopkins:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on October 22, 2019 and December 5, 2019, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Hancock", written over a white background.

Kevin Hancock  
Deputy Secretary  
Office of Long-term Living

Enclosures  
License  
Licensing Inspection Summary

## Violation Report

### Facility Information

Name: *CAMBRIDGE VILLAGE PERSONAL CARE HOME*  
Address: *1600 DARLINGTON ROAD,, BEAVER FALLS, PA 15010*  
County: *BEAVER*                      Region: *WESTERN*

License Number: *40162*

### Administrator

Name: *Cindy Hopkins*                      Phone: *7248461400*                      Email: *INFO@CAMBRIDGE-VILLAGE.COM*

### Legal Entity

Name: *CAMBRIDGE VILLAGE ASSOCIATES*  
Address: *1600 DARLINGTON ROAD, BEAVER FALLS, PA, 15010*

### Certificate(s) of Occupancy

Type: *C-2 LP*                      Date: *04/09/1998*                      Issued By: *L&I*

### Staffing Hours

Resident Support Staff: *0*                      Total Daily Staff: *103*                      Waking Staff: *77*

### Inspection

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

### Inspection Dates and Department Representative

*10/22/2019 - On-Site: Debora McConnell, Trish Barlett, Lori Gillette*

### Resident Demographic Data as of Inspection Dates

#### General Information

License Capacity: *100*                      Residents Served: *79*

#### Secured Dementia Care Unit

In Home: *Yes*                      Area: *SDCU*                      Capacity: *24*                      Residents Served: *22*

#### Hospice

Current Residents: *5*

#### Number of Residents Who:

Receive Supplemental Security Income: *0*                      Are 60 Years of Age or Older: *79*  
Diagnosed with Mental Illness: *0*                      Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *24*                      Have Physical Disability: *0*

81b - Resident Personal Equipment

Regulations

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #1 has a bed cane on his bed to assist with repositioning/transferring. There is a gap measuring approximately 2 inches between the bed cane railing and the mattress, posing an entrapment hazard.

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.)

1. IMMEDIATE: BED CANE WAS REMOVED 10-22-19
2. ADMINISTRATOR & MAINTENANCE WENT THROUGH ENTIRE BUILDING REMOVING ALL BED CANES. 10-23-19
3. ADMINISTRATOR NOTIFIED PHYSICAL THERAPY, PHYSICIANS, RESIDENT & FAMILY MEMBERS AND STAFF THAT BED CANES ARE NO LONGER PERMITTED DUE TO RISK OF INJURIES. 10-23-19
4. ADDENDUMS WERE ADDED TO ALL SUPPORT PLANS REFLECTING COMPLETION ON 10-24-19. DOCUMENTATION SHALL BE KEPT.
5. NEW POLICY WAS PUT INTO PLACE PROHIBITING BED CANES. SEE ATTACHMENT #1 10-23-19
6. ADMINISTRATOR AND/OR DESIGNEE TO MONITOR WEEKLY DOCUMENTATION & FINDINGS REPORTED TO ADMINISTRATION IMMEDIATELY & REVIEW QUARTERLY @ QUALITY ASSURANCE TO MAINTAIN COMPLIANCE.

11/25/19

Legal Entity Representative

*Cindy Hopkins* Adm  
Signature

Cindy Hopkins Adm 11/7/19  
Printed Name and Title Date

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The above plan of correction is approved as of

11/12/19  
(Date)

Plan of correction implementation status as of

12/5/19  
(Date)

Implemented

The above plan of correction was approved by

*[Signature]*  
(Initials)

Not Implemented

105g - Lint Removal and Duct Cleaning

Regulations

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

There was an accumulation of lint measuring approximately 1/4" thick, in the lint trap of the dryer in the second floor laundry room.

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.)

1. IMMEDIATELY: MAINTENANCE REMOVED LINT FROM RESIDENT'S PERSONAL LAUNDRY DRYER.
2. SIGNS WERE POSTED IN LAUNDRY ROOM TO REMIND RESIDENTS TO CLEAN FILTER OUT AFTER EACH USE. 10-25-19
3. ADMINISTRATOR AND/OR DESIGNEE WILL EDUCATE RESIDENTS ON THE RISK OF FIRE HAZARDS @ RESIDENT COUNCIL ON 11-19-19.
4. MAINTENANCE TO CHECK DRYER LINT DAILY X 1 MONTH THEN WEEKLY THEREAFTER & REPORT FINDINGS IMMEDIATELY TO ADMINISTRATOR AND/OR DESIGNEE. DOCUMENTATION SHALL BE KEPT. SEE ATTACHMENT # 243
5. ADMINISTRATOR AND/OR DESIGNEE TO MONITOR & REVIEW QUARTERLY @ QUALITY TO MAINTAIN COMPLIANCE.

Legal Entity Representative

*Cindy Hopkins ADM*  
Signature

Cindy Hopkins ADM  
Printed Name and Title

11/7/19  
Date

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(Date)

Implemented

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(Initials)

Not Implemented

123c - Evacuation Diagrams

Regulations

2600.

123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The evacuation diagram in the secured dementia care unit (SDCU) does not indicate the line of travel to the exits.

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.)

1. IMMEDIATE: MAINTENANCE DIRECTOR AND ADMINISTRATOR POSTED NEW EVACUATION DIAGRAM IN SECURED UNIT WITH THE LINE OF TRAVEL TO EXITS.
2. MAINTENANCE & ADMINISTRATOR WENT THROUGH ENTIRE BUILDING MAKING SURE ALL EVACUATION DIAGRAMS INDICATED THE LINE OF TRAVEL TO EXITS. 10-25-19
3. ADMINISTRATOR AND/OR DESIGNEE TO DO WEEKLY CHECKS X 1 MONTH THEN MONTHLY THEREAFTER. ALL FINDINGS TO BE REPORTED IMMEDIATELY TO ADMINISTRATOR. DOCUMENTATION TO BE KEPT.
4. ADMINISTRATOR AND/OR DESIGNEE TO MONITOR QUARTERLY @ QUALITY TO MAINTAIN COMPLIANCE.

Legal Entity Representative

*Cindy Hopkins ADM*  
Signature

Cindy Hopkins ADM  
Printed Name and Title

11/7/19  
Date

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(Date)

Implemented

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(Initials)

Not Implemented

141b1 - Annual Medical Evaluation

Regulations

2600.  
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's most recent medical evaluation was completed on 6/19/18.

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.)

1. IMMEDIATE: A NEW UPDATED DME WAS OBTAINED FROM RESIDENT'S PCP. SEE ATTACHMENT # 5
2. AT THE BEGINNING OF EVERY MONTH, A LIST WILL BE CREATED BY ADMINISTRATOR AND/OR DESIGNEE OF ALL RESIDENTS THAT NEED AN ANNUAL DME. AFTER AN IN-PERSON EVALUATION IS COMPLETED BY PCP, A NEW YEARLY DME SHALL BE OBTAINED.
3. ADMINISTRATOR AND/OR DESIGNEE TO FOLLOW UP WITH PCP TO ENSURE TIMELY COMPLETION OF DME. DOCUMENTATION SHALL BE KEPT. SEE ATTACHMENT # 4
4. A MONTHLY LOG WILL BE KEPT IN "DME" NOTEBOOK INDICATING WHICH DME'S NEED TO BE OBTAINED BY IN-HOUSE MEDICAL DIRECTOR & WHICH NEED SENT OUT TO PCP. ADMINISTRATOR AND/OR DISIGNEE TO REVIEW ALL DME'S TO ENSURE THAT ALL REQUIRED ELEMENTS ARE ON FORMS & PLACE IN CORRECT CHARTS. SEE ATTACHMENT # 4
5. ADMINISTRATOR AND/OR DESIGNEE TO REVIEW QUARTERLY @ QUALITY TO MAINTAIN COMPLIANCE.

Legal Entity Representative

Cindy Hopkins  
Signature

Cindy Hopkins Adm 11/7/19  
Printed Name and Title Date

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(Date)

Implemented

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(Initials)

Not Implemented

144c1 - Smoking Area Guidelines

Regulations

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

- 1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

There is no ashtray or fireproof trash receptacle in the home's interior smoking area in the staff lounge. Resident #3 indicated she puts water in a styrofoam cup to extinguish lit cigarettes.

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.)

- 1. IMMEDIATE: MAINTENANCE PURCHASED PROPER ASHTRAY WITH COVER & PLACED A FIRE PROOF RECEPTACLE IN SMOKING AREA. SEE ATTACHMENT# 697
- 2. ADMINISTRATOR EDUCATED RESIDENT #3 ON NOT USING WATER IN A STYROFOAM CUP BUT TO USE PROPER ASHTRAY. 10-23-19
- 3. ADMINISTRATOR EDUCATED STAFF TO MAKE SURE RESIDENT #3 IS USING PROPER ASHTRAY.
- 4. INSERVICE WILL BE HELD ON 11-7-19 TO EDUCATE STAFF ON SMOKING POLICY. DOCUMENTATION SHALL BE KEPT.
- 5. ADMINISTRATOR AND/OR DESIGNEE TO MONITOR DAILY X 1 MONTH ~~THEN MONTHLY~~ 11/25/19 ~~THEREAFTER~~. ALL FINDINGS SHALL BE REPORTED IMMEDIATELY TO ADMINISTRATOR. DOCUMENTATION SHALL BE KEPT. SEE ATTACHMENT # 8
- 6. ADMINISTRATOR AND/OR DESIGNEE TO MONITOR QUARTERLY @ QUALITY TO MAINTAIN COMPLIANCE.

Legal Entity Representative

Cindy Hopkins ADM  
Signature

Cindy Hopkins ADM  
Printed Name and Title

11-7-19  
Date

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Implemented

The above plan of correction was approved by [Signature] (Initials)

Not Implemented

183b - Meds and Syringes Locked

Regulations

2600.

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

Description of Violation

There was a bottle of Nystatin, unlocked and accessible in resident #4's room.

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.)

1. IMMEDIATE: BOTTLE OF NYSTATIN WAS REMOVED FROM ROOM.
2. MAINTENANCE PUT A LOCKED DRAWER WITH KEY ON RESIDENT #4 NIGHT STAND. 10-24-19
3. RESIDENT #4 WAS GIVEN KEY TO LOCKED DRAWER & EDUCATED ON KEEPING ANY/ALL MEDICATIONS ALLOWED @ BEDSIDE LOCKED UP @ ALL TIMES.
4. ADMINISTRATOR AND/OR DESIGNEE TO RE-EDUCATE STAFF @ INSERVICE ON 11-7-19 ON IMPORTANCE OF KEEPING ALL MEDICATIONS ALLOWED @ BEDSIDE LOCKED UP @ ALL TIMES. DOCUMENTATION SHALL BE KEPT.
5. ADMINISTRATOR AND/OR DESIGNEE TO DO WEEKLY ROOM CHECKS X 1 MONTH THEN MONTHLY THEREAFTER. ALL/ANY FINDINGS SHALL BE REPORTED TO ADMINISTRATOR AND/OR DESIGNEE IMMEDIATELY. DOCUMENTATION SHALL BE KEPT: *SEE ATTACH # 9*
6. ADMINISTRATOR AND/OR DESIGNEE TO MONITOR QUARTERLY @ QUALITY TO MAINTAIN COMPLIANCE.

Legal Entity Representative

*Cindy Hopkins ADM*  
Signature

*Cindy Hopkins ADM*  
Printed Name and Title

*11-7-19*  
Date

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11/12/19  
(Date)

Plan of correction implementation status as of

12/5/19  
(Date)

Implemented

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*[Signature]*  
(Initials)

Not Implemented

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, Nystatin prescribed to resident #4, was in resident #4's room. This medication was discontinued in July 2019.

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.)

1. IMMEDIATE: LPN REMOVED NYSTATIN FROM RESIDENT #4'S ROOM & DISPOSED OF IT.
2. ADMINISTRATOR AND/OR DESIGNEE SHALL CHECK MEDICATIONS THAT ARE MARKED "MAY KEEP @ BEDSIDE" WEEKLY TO ENSURE THAT THEY ARE CURRENT & NOT EXPIRED. DOCUMENTATION SHALL BE KEPT. SEE ATTACHMENT # 10
3. ADMINISTRATOR AND/OR DESIGNEE SHALL CHECK DAILY X 1 MONTH THEN WEEKLY THEREAFTER, THAT ALL "MAY KEEP @ BEDSIDE" MEDICATIONS ARE IN LOCKED DRAWER. NURSING TO REPORT ALL/ANY FINDINGS TO ADMINISTRATOR. DOCUMENTATION SHALL BE KEPT. SEE ATTACHMENT # 10
4. ADMINISTRATOR AND/OR DESIGNEE TO HAVE INSERVICE ON 11-7-19 TO RE-EDUCATE STAFF ABOUT "MAY KEEP @ BEDSIDE" MEDICATIONS. DOCUMENTATION SHALL BE KEPT.
5. ADMINISTRATOR TO MONITOR QUARTERLY @ QUALITY TO MAINTAIN COMPLIANCE.

Legal Entity Representative

*Cindy Hopkins ADM*  
Signature

Cindy Hopkins ADM 11-7-19  
Printed Name and Title Date

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 (Date)  Implemented (Date)

The above plan of correction was approved by *[Signature]*  Not Implemented  
 (Initials)

187a - Medication Record

**Regulations**

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

**Description of Violation**

Resident #5 is prescribed Debrox 6.5% Ear Drops, 5 drops each ear daily as needed. However, the resident's October 2019 medication administration record (MAR) indicates 5-10 drops in each ear twice daily 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.)

1. IMMEDIATE: LPN PUT A "CHANGE OF DIRECTIONS" STICKER ON DROPS & VERIFIED ORDER WITH PCP & PHARMACY.
2. ADMINISTRATOR SPOKE TO PHARMACY REGARDING MEDICATIONS THAT ARE ORDERED FOR A CERTAIN AMOUNT OF DAYS THEN DISCONTINUED OR CHANGED TO PRN ACCORDING TO RX.
3. ADMINISTRATOR RE-EDUCATED & RE-TRAINED STAFF ON 11-7-19 TO START CHECKING "START" & "END" DATES ON MEDICATION. FINDINGS SHALL BE REPORTED TO ADMINISTRATOR & PHARMACY IMMEDIATELY. DOCUMENTATION SHALL BE KEPT. SEE ATTACHMENT # //
4. TO BE MONITORED QUARTERLY @ QUALITY TO MAINTAIN COMPLIANCE.

**Legal Entity Representative**

*Cindy Hopkins ADM*  
Signature

Cindy Hopkins ADM  
Printed Name and Title

11-7-19  
Date

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(Date)

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(Date)

Implemented

The above plan of correction was approved by (Initials)

Not Implemented

226a - Mobility Assessment

**Regulations**

2600.

226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

**Description of Violation**

The mobility assessment for resident #2, dated 7/9/19, indicates the resident requires minimal physical or oral assistance to evacuate and is mobile. However, multiple staff indicate the resident is unable to evacuate without staff assistance and requires a wheelchair to evacuate.

**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.)

1. IMMEDIATE: A NEW DME & SUPPORT PLAN WERE UPDATED ON 10-23-19 FOR SIGNIFICANT CHANGE TO MEET RESIDENT #2'S MOBILITY NEED. SEE ATTACHMENT # 5 & 16
2. NAME OF RESIDENT #2 WAS ADDED TO FIRE DRILL RECORD ON 10-23-19. SEE ATTACHMENT # 12
3. RE-EDUCATE & RE-TRAIN STAFF ON IMPORTANCE OF BEING MORE THOROUGH WITH SPECIFIC DETAILS OF RESIDENT'S MOBILITY NEEDS ON 11-7-19. DOCUMENTATION SHALL BE KEPT.
4. ADMINISTRATOR AND/OR DESIGNEE TO REVIEW QUARTERLY @ QUALITY TO MAINTAIN COMPLIANCE.

BY 12/15/19- THE ASSESSMENTS OF ALL CURRENT RESIDENTS WILL BE REVIEWED TO ENSURE THEY ARE COMPLETE AND ACCURATE, INCLUDING MOBILITY NEEDS. - JRW 11/25/19

**Legal Entity Representative**

*Cindy Hopkins ADM*  
Signature

CINDY HOPKINS ADM  
Printed Name and Title

11-7-19  
Date

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(Date)

Implemented

The above plan of correction was approved by *[Signature]*  
(Initials)

Not Implemented

227d - Support Plan Medical/Dental

Regulations

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The support plan for resident #1, dated 9/12/19, does not address the type and frequency of services provided by hospice, started approximately 9/26/18, or the resident's history of falls and need for fall mats, a perimeter mattress and bed/chair alarm.

The support plan for resident #5, dated 6/13/19, does not address the responsible party for provision of catheter care 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.)

1. IMMEDIATE: A NEW SUPPORT PLAN WAS COMPLETED ON 10-23-19 FOR RESIDENT #1 WITH MORE DETAILS & SPECIFICS TO RESIDENT'S NEEDS. SEE ATTACHMENT# 13
2. IMMEDIATE: AN ADDENDUM WAS ADDED TO SUPPORT PLAN ADDRESSING CATHETER CARE & RESPONSIBILITIES. (EMPTYING BAG & CHANGING CATHETER MONTHLY) SEE ATTACHMENT# 14
3. ADMINISTRATOR RE-EDUCATED LPNS TO GO INTO MORE DETAILS & BE MORE SPECIFIC WITH RESPONSIBILITIES OF UNIQUE NEEDS. DOCUMENTATION SHALL BE KEPT. 10-24-19
4. ADMINISTRATOR AND/OR DESIGNEE TO REVIEW/DOUBLE CHECK EACH OTHER'S SUPPORT PLANS BEFORE FINALIZING.
5. ADMINISTRATOR TO REVIEW QUARTERLY @ QUALITY TO MAINTAIN COMPLIANCE.

BY 12/15/19- THE SUPPORT PLANS OF ALL CURRENT RESIDENTS WILL BE REVIEWED TO ENSURE THEY ARE COMPLETE AND ACCURATE, AND INCLUDE ALL RESIDENT CARE NEEDS AND SERVICES. -- JRW 11/25/19

Legal Entity Representative

*Cindy Hopkins Ann*  
Signature

Cindy Hopkins Ann  
Printed Name and Title

11-7-19  
Date

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(Date)

Implemented

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(Initials)

Not Implemented

236 - Staff Training

**Regulations**

2600.

236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

**Description of Violation**

Direct care staff person A, who works in the SDCU did not receive any of the 6 hours of training in dementia care and services required in addition to the 12 hours of annual training specified in §2600.65, 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.)

1. IMMEDIATE: STAFF PERSON "A" WAS ON LOA WHEN TRAINING WAS DONE.
2. STAFF PERSON "A" ATTENDED 6 HR. TRAINING ON 10-23-19 & 10-24-19. DOCUMENTATION SHALL BE KEPT. SEE ATTACHMENT # 15
3. ADMINISTRATOR AND/OR DESIGNEE WILL DOCUMENT AND MONITOR ATTENDANCE AFTER EACH INSERVICE.
4. AN INSERVICE BOOK WITH ALL INFO (FROM INSERVICES) WILL BE KEPT IN ADMINISTRATOR'S OFFICE. ADMINISTRATOR WILL VIDEO TAPE THE 6 HR. DEMENTIA TRAINING TO SHOW TO STAFF MEMBERS WHO DID NOT ATTEND. DOCUMENTATION SHALL BE KEPT.
5. MONITORED QUARTERLY @ QUALITY TO MAINTAIN COMPLIANCE.

**Legal Entity Representative**

*Cindy Hopkins* *ADM*  
Signature

CINDY HOPKINS ADM 11-7-19  
Printed Name and Title Date

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(Date)  Implemented (Date)

The above plan of correction was approved by *[Signature]*  Not Implemented  
(Initials)