



pennsylvania
DEPARTMENT OF HUMAN SERVICES

**Sent via e-mail fhoch@brookdale.com
September 10, 2020**

Ms. Annal Munoz
Assistant Secretary
Brookdale Senior Living Communities, Inc.
6737 W. Washington Street, Suite 2300
Milwaukee, Wisconsin 53214

RE: Brookdale Northampton
65 Richboro Newtown Road
Richboro, Pennsylvania 18954
License #: 127140

Dear Ms. Munoz:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on March 9 and 10, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Claire Mendez

Claire Mendez
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *BROOKDALE NORTHAMPTON*

License Number: *12714*

Address: *65 RICHBORO-NEWTOWN ROAD,, RICHBORO, PA 18954*

County: *BUCKS*

Region: *SOUTHEAST*

Administrator

Name: *Francie Hoch*

Phone: *2153576565*

Email: *fhoch@BROOKDALE.COM*

Legal Entity

Name: *BROOKDALE SENIOR LIVING COMMUNITIES INC*

Address: *111 WESTWOOD PLACE, SUITE 400, BRENTWOOD, TN, 37027*

Certificate(s) of Occupancy

Type: *C-2 LP*

Date: *04/23/1993*

Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0*

Total Daily Staff: *114*

Waking Staff: *86*

Inspection

Type: *Full*

BHA Docket #:

Notice: *Unannounced*

Reason: *Renewal*

Inspection Dates and Department Representative

03/09/2020 - On-Site: Youn Hie Chung, David Carrion

03/10/2020 - On-Site: Youn Hie Chung, David Carrion

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120*

Residents Served: *75*

Secured Dementia Care Unit

In Home: *Yes*

Area: *Clare Bridge*

Capacity: *23*

Residents Served: *21*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *75*

Diagnosed with Mental Illness: *3*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *39*

Have Physical Disability: *1*

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 12/27/2019, for resident #1 was not signed by the resident.

Repeated Violation: 3/18/19

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

Francie K Hoch
Signature

Francie K. Hoch, Executive Director
Printed Name and Title
Date 4-2-20

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

The above plan of correction is approved as of 4/8/2020
(Date)

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(Date)

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(Initials)

Implemented
 Not Implemented

42b - Abuse

Regulations

2600.

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

Description of Violation

On 01/01/2020, resident #2, who resides in the home's Secured Dementia Care Unit, went missing for about 2 hours and 15 minutes. She was last seen around 03:00 PM. The home's magnetic door locks had failed to re-engage after a false alarm cleared by the fire department. The home discovered the resident's absence around 04:00 PM and started the search. Around 05:15 PM, the resident was returned by the police. A neighbor had found the resident sitting in his car and reported to the police. It was cloudy with a high temperature around 39 degrees Fahrenheit. She was wearing light indoor clothes and shoes. The resident's face and pants were spotted with mud but no injuries or harms were noted. The home sent the resident to a hospital as a precautionary measure. The home failed to provide the 24 hour supervision the resident requires and is entitled to in the home's SDCU, and they failed to ensure that all of the door locks were engaged.

Plan of Correction (POC)

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Please see attached

Legal Entity Representative

Signature: *Francie K. Hoch*, ED Printed Name and Title: Francie K. Hoch Date: 4-2-20

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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.
- 3. Care for residents with dementia and cognitive impairments.
- 5. Personal care service needs of the resident.
- 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 topics 3, 5, and 7 during training year 2019. Direct care staff person B did not receive training in topics 1 and 5 during training year 2019.

Plan of Correction (POC)

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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.
- 3. Resident rights.
- 4. The Older Adult Protective Services Act (35 P.S. § 10225.101—10225.5102).
- 5. Falls and accident prevention.

Description of Violation

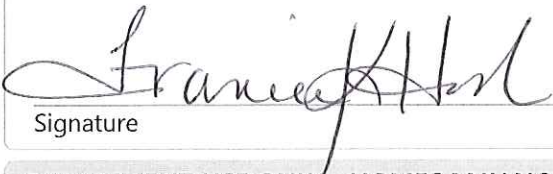
Staff person A did not receive training in topics 1, 3, and 4 during training year 2019.
 Staff person B did not receive training in topics 1, 3 and 5 during training year 2019.
 Staff person C did not receive training in topic 1 during training year 2019.
 Staff person D did not receive training in topics 1, 3, 4, and 5 during training year 2019.

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103i - Outdated Food

Regulations

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was a box of Quaker Grits with an expiration date of 05/27/2019 and a can of Glenview Farms Evaporated Milk with an expiration date of 03/14/2019 in the home's dry goods storage.

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121a - Unobstructed Egress

Regulations

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 03/09/2020 at 10:00 AM, a chest of drawers about 4 feet high blocked the exit door to the stairwell in the home's Secured Dementia Care Unit.

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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 #3's initial medical evaluation did not include medical information pertinent to diagnosis and treatment in case of an emergency or medication list.

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182c - Medication Administration

Regulations

2600.

182.c. Medication administration includes the following activities, based on the needs of the resident:

- 3. Remove the medication from the original container.

Description of Violation

Resident #4 is prescribed Alprazolam 0.25 mg in the morning and 0.5 mg at bed time. On 03/09/2020 at 09:00 PM, the resident was given Alprazolam 0.25 mg instead of the prescribed Alprazolam 0.5 mg. Staff E who administered this medication failed to check the right dose before administering the medication.

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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 03/10/2020, Hydrocotisone Acetate 25 mg Rectal Suppository (with a label "twice daily for 14 days" dispensed on 07/02/2019) which is not a current order for resident #5 and Geri-Care Ear Drops (with a label "administer at bed time for 7 days" dispensed on 01/14/2020) which is not a current order for resident #6 were still in the home's Vans Sant corridor medication cart.

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4/02/20
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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

On 03/10/2020, resident #4's Novolog FlexPen was open but there was no open/discard date specified.

Plan of Correction (POC)

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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 #4 is prescribed Hydralazine HCL 25 mg as needed. Resident #7 is prescribed Alprazolam 0.25 mg and Meclizine HCL 12.5 mg as needed. On 03/10/2020, these medications were not available.

Plan of Correction (POC)

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185b - Medication Procedures

Regulations

2600.

185.b. At a minimum, the procedures must include:

- 1. Documentation of the receipt of controlled substances and prescription medications.
- 2. A process to investigate and account for missing medications and medication errors.

Description of Violation

On 03/10/2020, a zip lock bag with a label for resident #8 (one dose of Ondansetron 4 mg to be administered at 07:00 AM on 03/06/2020 for nausea prevention) was found in resident #9's room. Resident #9 self-administers his medications. The home's med-techs receive, store, and administer medications. The home failed to correctly document the receipt of this prescription medication or investigate and account for this misplaced medication.

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Signature

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- Not Implemented

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 #6 is prescribed Oxycodone/APAP 10-325 mg every 6 hours as needed. Resident #6's medication administration record does not include the initials of the staff person who administered this medication on 03/03/2020 at 01:30 PM . Resident #7 is prescribed Tramadol 50 mg as needed. The staff who administered this med on 03/01/2020 at 01:00 PM failed to initial the MAR. Resident #10 is prescribed Oxycodone 5 mg as needed. She was given one on 03/07/2020 at 06:40 PM but there is no staff initials for this administration.

Resident #8 was prescribed Ondansetron 4 mg one time only at 07:00 AM on 03/06/2020. The resident was not administered this medication (the one time dose was found in another resident's room on 03/10/2020). However, staff F entered the initials without actually administering this medication.

Plan of Correction (POC)

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 Not Implemented

187d - Follow Prescriber's Orders

Regulations

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

Description of Violation

Resident #4 is prescribed Alprazolam 0.5 mg at bed time. However, resident #4 was administered Aprazolam 0.25 mg on 03/09/2020 at 09:00 PM. Resident #8 was prescribed Ondansetron 4mg at 07:00 AM on 03/06/2020. However, the resident was not administered this medication.

Plan of Correction (POC)

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(Initials)

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 Not Implemented

227g -Support Plan Signatures

Regulations

2600.

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

Description of Violation

Resident #9's support plan dated 06/19/2018 was not signed by anybody.

Plan of Correction (POC)

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231c - Preadmission Screening

Regulations

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on 07/29/2019. However, the date of the resident's written cognitive pre-admission screening was overwritten, making it impossible to determine if it was done timely. The printed name of person completing the screening was not filled out.

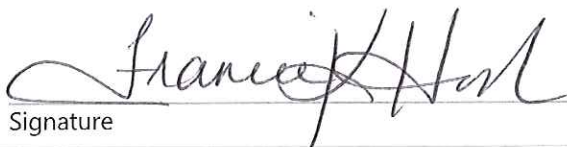
Repeated Violation: 3/18/19

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233c - Key-Locking Devices

Regulations

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the exit door to the enclosed courtyard in the Secure Dementia Care Unit (SDCU) or near the gate used as an exit from the courtyard to the outside.

Plan of Correction (POC)

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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 07/29/2019. However, the resident's initial support plan was completed on 08/04/2019.

Plan of Correction (POC)

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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 B, who works in the Secure Dementia Care Unit (SDCU), had only 2 hours of training in dementia care during training year 2019.

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Legal Entity Representative

Francis Hoch
Signature

Francis Hoch, ED 4-2-20
Printed Name and Title Date

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251b - Record Entries Legible

Regulations

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

The date of resident #2's cognitive pre-screening was overwritten with ink.

Plan of Correction (POC)

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Brookdale Northampton

Plan of Correction

The following is the Plan of Correction for Brookdale Northampton regarding the Statement of Deficiency dated March 23, 2020 for the full renewal survey on March 9-10, 2020. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective

Regulation 2600.25(b)

Immediately: Signature of Residents #1 was obtained and placed in their contract folder by the Sales Manager.

March 11, 2020-The Executive Director retrained with the Sales Manager in regard to obtaining resident signatures on the contract at the time of each admission. Electronic signature for the Legal representative and Executive Director are currently the community policy. The resident signature will be obtained in writing on move-in so the system can be updated to include a resident signature electronically.

The Executive Director or designee will review each resident contract/administrative file within 48 hours of admission to ensure all required signatures are in place and verify there is no further action required.

Evidence: Copy of the signed agreement, training log attendance sheet

Completion Date: March 11, 2020

Regulation 2600.42.b

Immediately: Resident #2 was sent to the hospital on return to the community as a precautionary measure. The physician and family were notified. The incident was reported to the Bucks County Area Agency on Aging and to the Department of Human Services.

January 2, 2020- The Executive Director reviewed the incident and conducted an internal investigation to review the incident.

January 9, 2020 -The Executive Director conducted an all staff meeting with review of the fire emergency policy and missing resident policy. Developed a Code Red (fire emergency) and Code Green (missing resident emergency) guidelines were re-trained on the Code Red and Code Green guidelines and these guidelines were posted in each Care Station throughout the Community.

Ongoing-These guidelines are now included as part of the fire and emergency management training provided to all associates upon hire and when indicated. The Executive Director will review the training records monthly of all staff to verify if any further action is warranted.

Evidence: Copies of the Code Red and Code Green guidelines, training attendance documentation

Completion Date: March 9, 2020

Regulation 2600.65.f

February 20, 2020-Direct Care Staff Person A completed training topic 7.

March 12, 2020-Direct Care Staff Person A completed training topic 3.

Direct Care Staff Person A has been assigned training topic 5 in our LMS system and will complete upon return from FMLA prior to return to work.

Direct Care Staff Person B has been assigned training topic 1 in our LMS system and completed the training on April 2, 2020.

Direct Care Staff Person B has been assigned training topic 5 in our LMS system and completed the training on April 2, 2020.

All staff will be required to complete the annual required training per training schedule. This training will continue to be available through the monthly All Staff meetings as well as on the Brookdale training system via the computer. The Business Office Coordinator or designee will pull reports on documented training monthly for Department Heads to review.

As part of the Quality Management Review, the Executive Director, Business Office Manager and the Management Team will review training compliance to ensure associates are completing all required training to verify if any further action is warranted.

Evidence: Individual training manuscripts for Direct Care Staff persons A and B, Training schedule

Completion Date: Direct Care Staff Person B has completed the needed trainings effective **April 2, 2020**. Direct Care Staff person A will return from FMLA on **June 16, 2020** and will be required to complete all training before going back to work with the residents. Evidence of these trainings will be submitted to the department on completion.

Regulation 2600.65.g

Staff Person A completed training on topic 1 and 3 on January 9, 2020. She will complete training topic 4 upon return from FMLA in June 2020.

Staff Person B completed training topics 1 and training topic 3 on April 2, 2020. She completed training topic 5 on March 12, 2020.

Staff Person C completed training topic 1 on January 9, 2020

Staff Person D is a pool associate. She will be required to come in to complete all required training before returning to work in the kitchen. She did complete training on 3/4/20.

All staff will be required to complete the annual required training. This training will be available through the monthly All Staff meetings as well as on the Brookdale training system via the computer.

As part of the Quality Management Review, the Executive Director, Business Office Coordinator and the Management Team will review training compliance monthly to verify associates are completing all required training and determine if any further action is warranted.

Evidence: Individual training manuscripts for Staff persons A, B, C and D.

Completion Date: All other training has been completed April 2, 2020 except Staff person A who will return from FMLA on June 16th and will be required to complete all training before going back to work with the residents.

Regulation 2600.103.i

Immediately: Expired items were disposed of by the Cook.

Immediately- The Lead Cook audited the entire dry goods storage room to verify all items were within expiration date.

March 24, 2020 Executive Director retrained the appropriate staff on the community policy regarding food storage.

The Dining Services Director put a system in place for rotation of dry goods when new items come in on delivery. Older items will be rotated to the front and any expired items will be disposed of at that time.

Dining Services Director completed an additional inspection of dry good area and will conduct a full inspection of expiration dates on a monthly basis.

Ongoing-The Executive Director will review the audits results to verify if any further action is warranted.

Evidence: Attendance log for training

Completion Date: March 24, 2020

Regulation 2600.121.a

Immediately: The chest of drawers was removed and the lock on the door was fixed to ensure the door is secure.

March 11, 2020- The Executive Director reviewed with the management team the community policy regarding a blocked egress and the need for all members of the management team to be vigilant and remove any items that may be blocking an egress as soon as they see it.

The Maintenance Manager completes a weekly walk through of the building to ensure all areas of egress are free of obstruction. The Executive Director will review the results of these audits to verify if any further action is warranted.

Evidence: Walk through check list attached, training attendance sheet

Completion Date: March 30, 2020

Regulation 2600.141.a

Immediately- The medication list that originally came with the medical evaluation was found in the medical record and reviewed with the prescriber for accuracy. Prescriber verified the list was correct and it was then attached to the medical evaluation.

March 27, 2020- The District Director of Clinical Services re-trained the appropriate clinical staff on the community policy regarding all elements required for acceptance of the medical evaluation including the importance of keeping the pages secured together in the medical record.

Ongoing- The Health and Wellness Director or designee will review all newly acquired medical evaluations for inclusion of the necessary elements. Based on review of the findings of these medical evaluations as submitted, the Health and Wellness Director or designee will verify if any further action is warranted.

Evidence- training attendance sheet

Completion Date: April 1, 2020

Regulation 2600.182.c.

Immediately- The prescriber was notified and informed the resident had no ill effects noted.

March 11, 2020 the Health and Wellness Coordinator submitted the reportable of this incident to DHS.

March 26, 2019- Health and Wellness Coordinator re-educated the appropriate staff on the community policy regarding Administration of Medications.

Ongoing- The Health and Wellness Coordinator or designee will continue to audit the eMAR's for medication administration according to prescriber orders weekly. Based on review of these findings of these assessments the Health and Wellness Director will verify if any further action is warranted.

Evidence- training attendance sheet

Completion Date: April 1, 2020

Regulation 2600.183.d

Immediately- The medications were removed from the medication cart and disposed of according to the community policy.

March 28, 2020- Health and Wellness Coordinator re-educated the appropriate staff on the community policy regarding Medications Administration and medication disposal following discharge.

Ongoing- The Health and Wellness Coordinator or designee will continue to complete weekly cart audits on all carts. The Health and Wellness Coordinator or Health and Wellness Director will review the audits to verify if any further action is warranted for 2 months.

Evidence- training attendance sheet.

Completion Date: April 1, 2020

Regulation 2600.183.e

Immediately-The Medication was discarded and reordered.

March 28, 2020- The Health and Wellness Coordinator retrained the appropriate staff on the Medication Administration policy including following the manufacturer's instructions following opening.

The Health and Wellness Coordinator or designee will conduct a weekly cart audit to ensure all medications are labeled according to manufacturer's directions for administration.

Ongoing- The Health and Wellness Director will review the results of these audits for 2 months to verify if any further action is warranted.

Evidence- training attendance sheet

Completion Date: April 1, 2020

Regulation 2600.185.a

Immediately-The medication order was verified by the prescriber and reordered from the pharmacy.

March 28, 2020- The Health and Wellness Coordinator retrained the appropriate staff on the Medication Administration policy including assurance that all medications ordered are available for administration.

The Health and Wellness Coordinator or designee will conduct a weekly cart audit to ensure all medications are available as ordered.

Ongoing- The Health and Wellness Director will review the results of these audits for 2 months to verify if any further action is warranted.

Evidence- training attendance sheet

Completion Date: April 1, 2020

Regulation 2600.185.b

Immediately-The medication was removed from Resident #9's room. A review was completed by the Health and Wellness Coordinator of the process followed regarding pharmacy deliveries.

March 28, 2020- The Health and Wellness Coordinator retrained the appropriate staff on the Medication Administration policy including assurance that all medications ordered are available for administration with the community policy on receipt of medication deliveries from the pharmacy.

The Health and Wellness Coordinator or designee will conduct a weekly cart audit to ensure all medications are available as ordered.

Ongoing- The Health and Wellness Director will review the results of these audits for 2 months to verify if any further action is warranted.

Evidence- training attendance sheet

Completion Date: April 1, 2020

Regulation 2600.187.b

Immediately-The prescriber was notified of the medication omission and that there were no ill effects to the resident.

March 28, 2020- The Health and Wellness Coordinator retrained the appropriate staff on the Medication Administration policy including assurance that all medications ordered are available for administration with the community policy. The community process for acceptance of medications from the pharmacy was also reviewed.

The Health and Wellness Coordinator or designee will conduct a weekly cart audit to ensure all medications are available as ordered.

Ongoing- The Health and Wellness Director or designee will review the results of these audits for 2 months to verify if any further action is warranted.

Evidence- training attendance sheet

Completion Date: April 1, 2020

Regulation 2600.187.d

Immediately- The prescriber was notified and that there were no ill effects.

March 28, 2020- The Health and Wellness Coordinator retrained the appropriate staff on the Medication Administration policy including assurance that all medications are administered according to prescriber orders. A reportable incident was submitted to DHS.

The Health and Wellness Coordinator or designee will conduct a weekly cart audit to ensure all medications are available as ordered as well as audit of the medication record for missed administrations.

Ongoing- The Health and Wellness Director will review the results of these audits for 2 months to verify if any further action is warranted.

Evidence- training attendance sheet

Completion Date: April 1, 2020

Regulation 2600.227.g

Immediately- The support plan, which was unchanged from prior assessment 6 months ago, was reviewed with the resident and his signature was obtained.

March 12, 2020- Ten support plans chosen randomly, were reviewed by the District Director of Clinical Services for signatures which were all present.

March 27, 2020- The District Director of Clinical Services retrained the appropriate clinical staff on the community policy regarding signatures after support plan reviews with the resident even though there is no change in the current plan.

Ongoing- Health and Wellness Coordinator or designee will conduct a monthly review of completed assessments that month for signatures of the resident.

Ongoing- The Health and Wellness Director or designee will review the results of these audits for 2 months to verify if any further action is warranted.

Evidence- training attendance sheet, signed support plan

Completion Date: April 1, 2020

Regulation 2600.231.c

March 27, 2020- The District Director of Clinical Services retrained the appropriate staff on the community policy regarding the process for reviewing the pre-screens when obtained from another facility for clear documentation as well as verifying all areas are filled out according to community policy.

Ongoing- Health and Wellness Coordinator and or designee will review of all prescreens prior to move-in for accuracy and completion of the form according to policy.

Ongoing- The Health and Wellness Director or designee will review the results of these audits for 3 months to verify if any further action is warranted.

Evidence- training attendance sheet

Completion Date: April 1, 2020

Regulation 2600.233.c

Immediately: The signs displaying codes with instructions for opening the locking mechanism were replaced on the wall. They had been removed due to building renovation which included painting of the area where signs were hung.

March 10, 2020- The Executive Director retrained the management staff regarding the community policy on signage/directions posting for opening a locked egress.

Ongoing- Maintenance Technician or designee will round and audit weekly noting signage is in place for locking mechanisms in the SDU will be tracked in our electronic maintenance tracking system.

The Executive Director will review the results of these audits to verify if any further action is warranted.

Evidence- training attendance sheet, Signs were in place and viewed by representatives of DHS during the licensing inspection.

Completion Date: March 9, 2020

Regulation 2600.234.a

March 27, 2020- The District Director of Clinical Services retrained the appropriate clinical staff on the community policy regarding timely completion of the support plan for resident in the secure dementia unit within 72 hours of admission.

Ongoing- Health and Wellness Coordinator or designee will conduct a monthly review of completed assessments and support plans for the residents in the secure dementia unit for timely submission for 3 months.

Ongoing- The Health and Wellness Director or designee will review the results of these audits for months to verify if any further action is warranted.

Evidence- training attendance sheet

Completion Date: April 1, 2020

Regulation 2600.236

April 2, 2020 - Staff person B completed 4 additional hours of Dementia Training.

All staff who work in the Secure Dementia unit will be required to complete 6 hours of Dementia training annually. This training will be available through the monthly All Staff meetings as well as on the Brookdale training system via the computer. It is tracked on a community spreadsheet.

An audit was completed by the Dementia Care Coordinator to verify all trainings were completed.

As part of the Quality Management Review, the Executive Director, Business Office Coordinator and the Management Team will review training compliance for associates regarding completion all required training. The Executive Director will verify if any further action is warranted monthly.

Evidence: Individual training manuscript for Staff Person B.

Completion Date: 04/02/20

Regulation 2600.251

March 27, 2020- The District Director of Clinical Services retrained the appropriate staff on the community policy regarding the process for reviewing all pre-screens when obtained from another facility for clear documentation as well as verifying all areas are filled out according to community policy.

Ongoing- Health and Wellness Coordinator or designee will conduct a monthly review of all prescreens prior to move-in for accuracy and completion of the form according to policy. All prescreen will be reviewed by 2 staff when residents are accepted from another community prior to move-in.

Ongoing- The Health and Wellness Director or designee will review the results of these audits for 3 months to verify if any further action is warranted.

Evidence- training attendance sheet

Completion Date: April 1, 2020