

Department of Human Services
Bureau of Human Service Licensing

July 28, 2021

[REDACTED]
CARE HSL HARLEYSVILLE OPCO LLC
765 SKIPPACK PIKE
HERITAGE SENIOR LIVING
BLUEBELL, PA 19422

RE: BIRCHES AT ARBOUR SQUARE
691 MAIN STREET
HARLEYSVILLE, PA, 19438
LICENSE/COC#: 14266

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/04/2021, 02/05/2021, 02/17/2021, 02/19/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Mia Johnson

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

**Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC**

Facility Information

Name: *BIRCHES AT ARBOUR SQUARE* License #: *14266* License Expiration Date: *03/27/2021*
Address: *691 MAIN STREET, HARLEYSVILLE, PA 19438*
County: *MONTGOMERY* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: *2155413700* Email: [REDACTED]

Legal Entity

Name: *CARE HSL HARLEYSVILLE OPCO LLC*
Address: *765 SKIPPACK PIKE, HERITAGE SENIOR LIVING, BLUEBELL, PA, 19422*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *R-3* Date: *03/10/2009* Issued By: *Commonwealth of Pa*

Staffing Hours

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

Inspection

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *03/22/2021*

Inspection Dates and Department Representative

02/04/2021 - On-Site: [REDACTED]
02/05/2021 - On-Site: [REDACTED]
02/17/2021 - On-Site: [REDACTED]
02/19/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* Residents Served: *70*

Secured Dementia Care Unit

In Home: *Yes* Area: *Daybreak* Capacity: *25* Residents Served: *24*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *66*
Diagnosed with Mental Illness: *3* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *33* Have Physical Disability: *1*

Inspections / Reviews

02/04/2021 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *06/15/2021*

6/30/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *07/06/2021*

7/28/2021 - Document Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.

- 15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 12/25/20, resident #1 informed staff person A that staff person B pushed [redacted] call pendant into [redacted] chest and said do not call me again and stop pushing the call bell [redacted] don't feel well leave [redacted] alone. However, this allegation of abuse was not reported to the local area agency on aging until 2/19/21.

Plan of Correction

Accept

15 a

What: "On 12/25/20, resident #1 informed staff person A that staff person B pushed [redacted] call pendant into [redacted] chest and said do not call [redacted] again and stop pushing the call bell [redacted] don't feel well leave [redacted] alone. However, this allegation of abuse was not reported to the local area agency on aging until 2/19/21. "

Who: Staff Person B was an agency personnel member, and the agency was made aware of the reportable incident. Staff Person B was banned from the building. The Executive Director or Designee will ensure all staff are re-educated on OAPSA, incident reporting policies and procedures, and the expectation to complete incident reporting within 24 hours of all reportable incidents.

When: Training will be completed by June 30, 2021.

How: This training will include OAPSA information (Attachment A), the list of incidents which are reportable (Attachment B), the best practice of offering reports at change of shift to make it possible to follow up on any incidents (Attachment C), and how to complete reports to the Department (Attachment D). All staff will sign an Attendance Acknowledgement Sheet (Attachment E).

Ongoing: All incidents will be reviewed by the Resident Care Director or Designee to ensure they have been reported timely. On a monthly basis, the Resident Care Director or Designee will review all reportable incidents to ensure follow-up has occurred as needed (Attachment F). Reportable incidents are discussed at the Quarterly Quality Assurance Meetings to assess for patterns and trends.

Completion Date: 06/30/2021

Document Submission

Implemented

see attached

16c - Written Incident Report

1. Requirements

2600.

- 16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 12/25/20, resident #1 reported staff person B had pushed [redacted] call bell pendant into [redacted] chest and stated to [redacted] do not call me again and stop pushing the call bell [redacted] don't feel well leave me alone. The home did not report this incident to the Department until 2/19/21.

16c - Written Incident Report (continued)

Plan of Correction

Accept

16c

What: "On 12/25/20, resident #1 reported staff person B had pushed [redacted] call bell pendant into [redacted] chest and stated to [redacted] do not call [redacted] again and stop pushing the call bell [redacted] don't feel well leave [redacted] alone. The home did not report this incident to the Department until 2/19/21."

Who: Staff Person B was an agency personnel member, and the agency was made aware of the reportable incident. Staff Person B was banned from the building. The Executive Director or Designee will ensure all staff are re-educated on OAPSA, incident reporting policies and procedures, and the expectation to complete incident reporting within 24 hours of all reportable incidents.

When: Training will be completed by June 30, 2021.

How: This training will include OAPSA information (Attachment A), the list of incidents which are reportable (Attachment B), the best practice of offering reports at change of shift to make it possible to follow up on any incidents (Attachment C), and how to complete reports to the Department (Attachment D). All staff will sign an Attendance Acknowledgement Sheet (Attachment E).

Ongoing: All incidents will be reviewed by the Resident Care Director or Designee to ensure they have been reported timely. On a monthly basis, the Resident Care Director or Designee will review all reportable incidents to ensure follow-up has occurred as needed (Attachment F). Reportable incidents are discussed at the Quarterly Quality Assurance Meetings to assess for patterns and trends.

Completion Date: 06/30/2021

Document Submission

Implemented

see attached

18 - Compliance With Laws

1. Requirements

2600.

- 18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Order of the Secretary of the Pennsylvania Dept. of Health Directing Long-Term Care Facilities to Implement Measures for Use and Distribution of Personal Protective Equipment, dated August 18, 2020, requires:

The policies and procedures must, at a minimum, include distribution of respirators to staff providing direct patient care to COVID-19 positive and suspected cases and staff assigned to provide direct patient care in COVID-19 units.

Furthermore, on October 9, 2020 the Bureau of Human Services Licensing communicated its requirement that Personal Care Homes and Assisted Living Residences adhere to the Secretary's order.

Staff person A was not given the proper respirator mask to wear while providing care for a quarantined resident whom was exposed to the COVID-19 Virus.

18 - Compliance With Laws *(continued)***Plan of Correction****Accept**

18

What: "The Order of the Secretary of the Pennsylvania Dept. of Health Directing Long-Term Care Facilities to Implement Measures for Use and Distribution of Personal Protective Equipment, dated August 18, 2020, requires: The policies and procedures must, at a minimum, include distribution of respirators to staff providing direct patient care to COVID-19 positive and suspected cases and staff assigned to provide direct patient care in COVID-19 units. Furthermore, on October 9, 2020 the Bureau of Human Services Licensing communicated its requirement that Personal Care Homes and Assisted Living Residences adhere to the Secretary's order. Staff person A was not given the proper respirator mask to wear while providing care for a quarantined resident who was exposed to the COVID-19 Virus."

Who: The Executive Director, as Administrator, or Designee ensures there are adequate supplies in the community by reviewing the inventory of PPE weekly. All staff are informed of where PPE supplies are located on their initial shift in the building. At no time is there less than a supply adequate to meet COVID-related care needs for one month.

When: PPE supplies are inventoried on a weekly basis. Education about the location of supplies is done continuously, as new staff or agency personnel work in the community for the first time (Attachment G).

How: The Executive Director or Designee tracks supplies and orders additional supplies any time COVID-related care needs are in place and the supply is being depleted. There has never been a shortage of supplies.

Ongoing: The Executive Director or Designee will continue to confirm the inventory of PPE supplies on a weekly basis and order additional supplies as needed to ensure there is always at least a one-month supply for COVID-related care. New staff or agency personnel will be informed upon arrival of the location of all PPE supplies.

Completion Date: 06/14/2021

Document Submission**Implemented**

see attached

42b - Abuse

1. Requirements

2600.

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

42b - Abuse (continued)

Description of Violation

On the morning of 12/25/20, resident #1 pressed [REDACTED] call bell on multiple occasions for assistance from staff. On one of the calls staff person B stated to the resident stop pushing the call bell and then proceeded to push the call bell pendant into the residents chest. [REDACTED] also stated that [REDACTED] is tired and not feeling well and to leave [REDACTED] alone. The resident states [REDACTED] feels intimidated and doesn't feel comfortable pressing the call bell pendant as much now. [REDACTED] also states that when [REDACTED] does push the button that no one comes to help [REDACTED]. The residents call bell record shows multiple occasions where [REDACTED] is left waiting over 30 minutes for assistance.

On [REDACTED]/21, at approximately 1:00 am, resident #2 had an unwitnessed fall and was found laying on [REDACTED] bedroom floor in a pool of urine. The residents pillow was observed on the floor and saturated in urine. The resident screamed for help and no one came to [REDACTED] aid. The resident is unsure how long [REDACTED] was laying on the floor. Staff person C discovered the resident while doing room checks. Staff person D was observed asleep on 3 occasions that evening by multiple staff including a staff person C, a supervising Med Tech. Resident was sent to the hospital and admitted.

On [REDACTED]/21, resident #3 had an unwitnessed fall and was discovered laying on [REDACTED] bedroom floor in wet undergarments for an undetermined period of time. Resident #3 was transported to the hospital by way of EMS. On [REDACTED]/21, resident was sent out to the hospital due a change in mental status and was admitted. According to hospital records the resident suffered from sepsis, cellulitis of the groin, hypovolemic hypernatremia, mild acute kidney injury, and rhabdomyolysis. The resident also had rib fractures of the fifth and sixth rib possibly from the fall sustained on [REDACTED]/21.

On 2/4/21, at approximately 10:45 am, resident #4 was observed by a representative of the Department laying in dried feces and urine for a undetermined period of time. Resident stated that [REDACTED] asked for assistance early in the morning and was told by an unknown staff person that they were going to go get help and assistant was not provided. Resident #4 states that this happens frequently and often waits for care for long periods of time. Resident #4 also had a wound on [REDACTED] left leg covered by an old and heavily soiled bandage and a untreated open wound on [REDACTED] right leg.

On 2/19/21, at 9:43 am, a resident brought to the attention of the Department that resident #5 had been bleeding and was injured. The Department observed resident #5 with an open bleeding wound that measured about 1-2" inches in length that had began to scab over. The home was unaware of the residents injury.

42b - Abuse (continued)

Plan of Correction

Accept

42b

What: "On the morning of 12/25/20, resident #1 pressed [REDACTED] call bell on multiple occasions for assistance from staff. On one the of the calls staff person B stated to the resident stop pushing the call bell and then proceeded to push the call bell pendant into the resident's chest. [REDACTED] also stated that [REDACTED] is tired and not feeling well and to leave [REDACTED] alone. The resident states [REDACTED] feels intimidated and doesn't feel comfortable pressing the call bell pendant as much now. [REDACTED] also states that when [REDACTED] does push the button that no one comes to help [REDACTED]. The residents call bell record shows multiple occasions where [REDACTED] is left waiting over 30 minutes for assistance. On [REDACTED]/21, at approximately 1:00 am, resident #2 had an unwitnessed fall and was found lying on [REDACTED] bedroom floor in a pool of urine. The resident's pillow was observed on the floor and saturated in urine. The resident screamed for help and no one came to [REDACTED] aid. The resident is unsure how long [REDACTED] was laying on the floor. Staff person C discovered the resident while doing room checks. Staff person D was observed asleep on 3 occasions that evening by multiple staff including a staff person C, a supervising Med Tech. Resident was sent to the hospital and admitted. On [REDACTED]/21, resident #3 had an unwitnessed fall and was discovered laying on [REDACTED] bedroom floor in wet undergarments for an undetermined period of time. Resident #3 was transported to the hospital by way of EMS. On [REDACTED]/21, resident was sent out to the hospital due a change in mental status and was admitted. According to hospital records the resident suffered from sepsis, cellulitis of the groin, hypovolemic hypernatremia, mild acute kidney injury, and rhabdomyolysis. The resident also had rib fractures of the fifth and sixth rib possibly from the fall sustained on [REDACTED]/21. On 2/4/21, at approximately 10:45 am, resident #4 was observed by a representative of the Department laying in dried feces and urine for a undetermined period of time. Resident stated that [REDACTED] asked for assistance early in the morning and was told by an unknown staff person that they were going to go get help and assistant was not provided. Resident #4 states that this happens frequently and often waits for care for long periods of time. Resident #4 also had a wound on [REDACTED] left leg covered by an old and heavily soiled bandage and a untreated open wound on [REDACTED] right leg. On 2/19/21, at 9:43 am, a resident brought to the attention of the Department that resident #5 had been bleeding and was injured. The Department observed resident #5 with an open bleeding wound that measured about 1-2" inches in length that had begun to scab over. The home was unaware of the resident's injury."

Who: Staff Person B was an agency personnel member, and the agency was made aware of the incident. Staff Person B was banned from the building. Staff Person D was terminated on [REDACTED] 2021. A new call bell system was installed by the community on March 26, 2021. The Executive Director, as Administrator, monitors the new call bell system by reviewing daily reports, to ensure timely responses to calls for assistance. In addition, residents who are incontinent are checked by direct care staff for care at regular intervals, as defined in their RASPs. Skin checks will be completed by direct care staff at the time bathing assistance is provided. For those residents not requiring bathing assistance, skin integrity checks will be offered once monthly by direct care staff. Wound care is ordered by the physician, with the Resident Care Director managing the implementation of any care needed. Direct care staff will immediately report any new changes in skin integrity for further assessment (Attachment H). In addition, residents were oriented to the new call bell system at the time it was installed and were encouraged to wear/carry their pendants and use them any time assistance is needed.

When: Call bell report reviews occur daily. Incontinence checks are completed regularly as defined in each individual's RASP to meet their needs. Skin checks are completed at the time bathing assistance is provided, or on a monthly basis for residents who do not require bathing assistance. Wound care is provided as ordered by the physician, to meet each person's needs. Orientation to the new call bell system happened at the time it was installed. For new residents, it is completed at the time of admission.

How: The Executive Director or Designee reviews the daily call bell reports to monitor the length of time of response to each call bell notification. The Resident Care Director will monitor wound care management and assessment of skin integrity. Direct care staff will provide skin assessments at the time of bathing residents and will also offer skin assessments monthly to those residents not needing bathing assistance. Direct care staff will report immediately any changes in skin integrity for any residents. Orientation to the call bell system is done verbally and by demonstration.

Ongoing: All of these tasks will continue on an ongoing basis. Individual care needs and changes to care needs will be addressed by updating RASPs and alerting staff to changes during the end of shift report. Additional referrals for skin integrity concerns will be made as needed. All concerns related to individual care needs will be discussed during team meetings and care conferences. Any patterns or trends will be reviewed during Quarterly Quality Assurance Meetings.

42b - Abuse (*continued*)**Document Submission****Implemented***see attached*

42s - Privacy

1. Requirements

2600.

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

Description of Violation

On 2/4/21, staff person D, electronically disseminated photos of resident #4 and resident #6 to the home staff and agency staff persons in which violated the privacy of the residents.

Plan of Correction**Accept**

42s

What: "On 2/4/21, staff person D, electronically disseminated photos of resident #4 and resident #6 to the home staff and agency staff persons in which violated the privacy of the residents."

Who: Staff Person D was terminated on [REDACTED], 2021 upon investigation by the community. The Executive Director, as Administrator, or Designee will re-educate all staff on resident rights and specifically address privacy protection for all residents (Attachment I).

When: Training for all staff will be completed by June 30, 2021.

How: Training will be provided to review with all staff resident rights and discuss privacy specifically. All staff will sign an Attendance Acknowledgement Sheet (Attachment J).

Ongoing: Staff will continue to receive their initial rights training during their first shift in the community and will continue to receive the annual review training as well. Any concerns will be reviewed immediately, and any patterns or trends will be reviewed at the Quarterly Quality Assurance Meetings.

Completion Date: 06/30/2021

Document Submission**Implemented***see attached*

53c - Administrator Duties

1. Requirements

2600.

53.c. The administrator shall be responsible for the administration and management of the home, including the health, safety and well-being of the residents, implementation of policies and procedures and compliance with this chapter.

Description of Violation

Residents are being neglected and their needs are not being met. Staff person E the home's administrator has failed to be responsible for the administration and management of the home, including the health, safety and well-being of the residents, implementation of policies and procedures and compliance with this chapter. Staff Person E was unaware of what is going on in the home.

53c - Administrator Duties (continued)

Plan of Correction**Accept**

53c

What: "Residents are being neglected and their needs are not being met. Staff person E the home's administrator has failed to be responsible for the administration and management of the home, including the health, safety and well-being of the residents, implementation of policies and procedures and compliance with this chapter. Staff Person E was unaware of what is going on in the home."

Who: The Executive Director serving as Administrator at the time of this investigation is no longer employed by the home. A new Executive Director began serving as Administrator of the community on [REDACTED] 2021. The Regional Director of Operations of Heritage Senior Living has been engaged in the daily operations since the time of this investigation.

When: Following the exit conference for this investigation, the previous Executive Director resigned effective [REDACTED] 2021. [REDACTED] worked in the building with on-site daily support from the Regional Director of Operations and the Heritage Senior Living Quality Assurance Team until [REDACTED] 2021, when [REDACTED] was relieved of [REDACTED] position.

How: The Regional Director of Operations and the Heritage Senior Living Quality Assurance Team provided daily support on site to immediately begin assessing daily operations and correcting and improving areas of concern.

Ongoing: The Regional Director of Operations and the Heritage Senior Living Quality Assurance Team continued to provide daily support to the new Executive Director during the first three months of tenure as Administrator. As noted during the March 2, 2021 Annual Renewal Inspection, many corrections and improvements had already been made. Support continues in the form of both on-site visits and phone calls.

Completion Date: 02/26/2021

Document Submission**Implemented**

see attached

65e - 12 Hours Annual Training

1. Requirements

2600.

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

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

Description of Violation

Direct care staff person F received only 1.5 hours of annual training in training year 2019.

65e - 12 Hours Annual Training *(continued)***Plan of Correction****Accept**

65e

What: "Direct care staff person F received only 1.5 hours of annual training in training year 2019."

Who: The Business Office Manager will ensure Staff Person F completes all required training topics for the current year 2021.

When: All training will be completed by December 31, 2021.

How: Trainings will be completed both by using the Relias program and in-person trainings. These trainings will be coordinated using the Staff Training Plan for 2021 (Attachment K). The Business Office Manager will track trainings to ensure they are completed and will provide monthly updates to the ED and RCD.

Ongoing: The Business Office Manager will continue to audit a percentage of staff records each month, as part of the QA program (Attachment F). Any concerns will be brought to the immediate attention of the Executive Director. Any patterns or trends will be reviewed and discussed at the Quarterly Quality Assurance Meetings.

Completion Date: 12/31/2021

Document Submission**Implemented**

see attached

65f - Training Topics

1. Requirements

2600.

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

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

Description of Violation

Direct care staff person F did not receive training in care for residents with dementia and cognitive impairments, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, medication self-administration training, personal care service needs of the resident, safe management techniques, care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2019.

65f - Training Topics (*continued*)**Plan of Correction****Accept**

65f

What: "Direct care staff person F did not receive training in care for residents with dementia and cognitive impairments, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, medication self-administration training, personal care service needs of the resident, safe management techniques, care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2019."

Who: The Business Office Manager will ensure Staff Person F completes all required training topics for the current year 2021.

When: All training will be completed by December 31, 2021.

How: Trainings will be completed both by using the Relias program and in-person trainings. These trainings will be coordinated using the Staff Training Plan for 2021 (Attachment K). The Business Office Manager will track trainings to ensure they are completed and will provide monthly updates to the ED and RCD.

Ongoing: The Business Office Manager will continue to audit a percentage of staff records each month, as part of the QA program (Attachment F). Any concerns will be brought to the immediate attention of the Executive Director. Any patterns or trends will be reviewed and discussed at the Quarterly Quality Assurance Meetings.

Completion Date: 12/31/2021

Document Submission**Implemented***see attached*

65g - Annual Training Content

1. Requirements

2600.

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

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

65g - Annual Training Content (continued)

Description of Repeat Violation

Staff person F did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), resident rights, falls and accident prevention, new population groups that are being served at the home that were not previously served, if applicable during training year 2019.

Repeat Violation: 11/19/20

Plan of Correction

Accept

65g

What: "Staff person F did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), resident rights, falls and accident prevention, new population groups that are being served at the home that were not previously served, if applicable during training year 2019."

Who: The Business Office Manager will ensure Staff Person F completes all required training topics for the current year 2021.

When: All training will be completed by December 31, 2021.

How: Trainings will be completed both by using the Relias program and in-person trainings (Attachment L). These trainings will be coordinated using the Staff Training Plan for 2021 (Attachment K). The Business Office Manager will track trainings to ensure they are completed and will provide monthly updates to the ED and RCD.

Ongoing: The Business Office Manager will continue to audit a percentage of staff records each month, as part of the QA program (Attachment F). Any concerns will be brought to the immediate attention of the Executive Director. Any patterns or trends will be reviewed and discussed at the Quarterly Quality Assurance meetings.

Completion Date: 12/31/2021

Document Submission

Implemented

see attached

85a - Sanitary Conditions

1. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

85a - Sanitary Conditions (continued)

Description of Violation

On 2/4/21, room 230 a had brown substance on the wall near the entrance to the bedroom area.
On 2/17/21, room 22 had a strong odor of feces. There was also feces on rug in the bathroom.
On 2/17/21, there was a dirty rag with a brown substance on ground outside the home.
Resident #7 was administered Lantus Solos Injection Pen prescribed for and belonging to resident #8.

Plan of Correction

Accept

85a

What: "On 2/4/21, room 230 had a brown substance on the wall near the entrance to the bedroom area. On 2/17/21, room 22 had a strong odor of feces. There were also feces on rug in the bathroom. On 2/17/21, there was a dirty rag with a brown substance on ground outside the home. Resident #7 was administered Lantus Solos Injection Pen prescribed for and belonging to resident #8."
Who: The Maintenance Director assigned staff to clean and sanitize affected areas and dispose of the dirty rag found outside. An internal investigation by the Resident Care Director could not confirm a pen for one resident had been used to administer medications to another resident. However, it was determined it had been stored in the bag of another resident, which is addressed under 186b.
When: The assignment of staff to clean and sanitize the affected areas was done upon awareness of the condition of the areas. Staff education will happen on an ongoing basis.
How: Staff cleaned and sanitized the walls and rugs. The dirty rag was discarded. All staff will receive education to be observant of the environment, and immediately report any areas that need to be cleaned and/or sanitized. This will be reviewed in department staff meetings on an ongoing basis (Attachment M).
Ongoing: Staff training for all departments will happen periodically, to serve as a reminder to stay alert and observant and report any needs. Housekeeping staff will ensure they are thorough with cleaning efforts and will report any challenging tasks. The Maintenance Director will also assess any needs related to cleaning or odors while doing weekly room checks (Attachment F). Any concerns will be addressed immediately. Any noted patterns or trends will be reviewed and discussed at Quarterly Quality Assurance Meetings.

Completion Date: 06/14/2021

Document Submission

Implemented

see attached

85d - Trash Receptacles

1. Requirements

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 2/17/21, there was a full, uncovered, unattended trash can in the dining area of memory care.

85d - Trash Receptacles (*continued*)**Plan of Correction****Accept**

85d

What: "On 2/17/21, there was a full, uncovered, unattended trash can in the dining area of memory care."

Who: The Maintenance Director will monitor all trash cans during the daily building walk-through. The Memory Care Director will check trash cans for lids periodically throughout the day. Staff will be re-educated about the need for lids on trash cans and will be instructed to immediately notify the Maintenance Department if a lid is missing.

When: All staff will receive this education by June 30, 2021.

How: The Maintenance Director or Designee will review this with all staff by explaining the regulation and why it is an important requirement. All staff will sign an Attendance Acknowledgement Sheet (Attachment N).

Ongoing: Daily building walk-throughs will continue ongoing. Any concerns noted will be addressed promptly.

Patterns and trends will be reviewed and discussed at Quarterly Quality Assurance Meetings.

Completion Date: 06/30/2021

Document Submission**Implemented**

see attached

88a - Surfaces

1. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 2/4/21, room 230A had brown substance on the wall near the entrance to the bedroom area.

On 2/4/21, the wall of room 228B had damage and markings from the residents wheelchair.

On 2/17/21, the walls in the memory care activity area were stained and dirty.

On 2/17/21, the walls in pantry area were stained with food and dirty.

88a - Surfaces (continued)

Plan of Correction

Accept

88a

What: "On 2/4/21, room 230A had brown substance on the wall near the entrance to the bedroom area. On 2/4/21, the wall of room 228B had damage and markings from the resident's wheelchair. On 2/17/21, the walls in the memory care activity area were stained and dirty. On 2/17/21, the walls in pantry area were stained with food and dirty."

Who: The Maintenance Director immediately assigned housekeeping staff to clean and sanitize the affected areas. Walls requiring repairs and repainting will be scheduled to be completed by the Maintenance Director.

When: All cleaning and sanitation was completed immediately. Repairs and painting will be prioritized by level of need and will be completed by July 30, 2021.

How: The Maintenance Director will ensure the repairs and painting are completed, either by completing within the Maintenance Department or hiring a vendor to complete it. All staff will receive education to be observant of the environment, and immediately report any areas that need to be cleaned and/or sanitized. This will be reviewed in department staff meetings on an ongoing basis (Attachment M).

Ongoing: The Maintenance Director will assess needs for repairs or painting or any other needs during daily building walk-throughs. Daily building walk-throughs will continue on an ongoing basis. Any concerns noted will be addressed promptly. Patterns and trends will be reviewed and discussed at Quarterly Quality Assurance Meetings.

Completion Date: 07/30/2021

Document Submission

Implemented

see attached

95 - Furniture and Equipment

1. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The cabinet door in the pantry area of memory care had a large crack down the front.

Plan of Correction

Accept

95

What: "The cabinet door in the pantry area of memory care had a large crack down the front."

Who: The Maintenance Director repaired the cabinet door.

When: The door was repaired immediately (Attachment O).

How: The Maintenance Director repaired the cabinet door by gluing and sanding the crack. The exterior of the door is now smooth. During daily building walk-throughs, cabinets and all surfaces, furniture, and fixtures will be assessed to ensure they are in good repair.

Ongoing: During daily building walk-throughs, cabinets and all surfaces, furniture, and fixtures will be assessed to ensure they are in good repair. Concerns will be addressed immediately. Patterns and trends will be reviewed and discussed at Quarterly Quality Assurance Meetings.

Completion Date: 06/14/2021

Document Submission

Implemented

see attached

103i - Outdated Food

1. Requirements

2600.

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

Description of Violation

On 2/17/21, there were unlabeled, undated applesauce, apple juice and plates of cake in the refrigerator in the memory care unit.

Plan of Correction

Accept

103i

What: "On 2/17/21, there were unlabeled, undated applesauce, apple juice and plates of cake in the refrigerator in the memory care unit."

Who: The Dining Services Director or Designee will complete daily checks of refrigerators to ensure all items are appropriately covered, labeled, and dated for safe storage. All staff will be re-educated of this requirement and why it is important (Attachment P).

When: These checks will be conducted daily on an ongoing basis, at varying times of day.

How: The Dining Services Director or Designee will inspect the refrigerators to confirm all items are appropriately covered, labeled, and dated. Any items found to not meet the requirements will be removed and discarded by the staff member who finds it. Education will be provided as ongoing, and all staff will sign an Attendance Acknowledgement Form (Attachment Q).

Ongoing: These checks will be conducted daily on an ongoing basis. Any concerns will be addressed immediately. Any noted patterns or trends will be reviewed and discussed at Quarterly Quality Assurance Meetings.

Completion Date: 06/14/2021

Document Submission

Implemented

see attached

162b - Missed Meals

1. Requirements

2600.

162.b. When a resident misses a meal, food adequate to meet daily nutritional requirements shall be available and offered to the resident.

Description of Violation

Residents do not have access to meals after meal times if they miss a meal in the memory care unit.

162b - Missed Meals (*continued*)**Plan of Correction****Accept**

162b

What: "Residents do not have access to meals after mealtimes if they miss a meal in the memory care unit."

Who: The Resident Care Director determined food is available at all times, but a staff person interviewed didn't recall what was available and where to find it. The Dining Services Director will educate all staff as where to find food items between meals, and what is available (Attachment P).

When: Training will be completed by June 30, 2021.

How: Food is restocked by the dietary department daily; to include sandwiches, fruit, snacks, and drinks. These are available in multiple places in both personal care and memory care. The Dining Services Director will ensure dietary staff replenish the food supplies daily. The Dining Services Director will provide the training and staff will sign an Attendance Acknowledgement Form (Attachment Q).

Ongoing: The Dining Services Director will confirm food supplies are available as part of the daily check of the refrigerators when checking for proper storage, labels, and dates. Any concerns will be addressed immediately. Any noted patterns or trends will be reviewed and discussed at Quarterly Quality Assurance Meetings.

Completion Date: 06/30/2021

Document Submission**Implemented**

see attached

183d - Prescription Current

1. Requirements

2600.

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

Description of Repeat Violation

On 2/19/21, Novolog Pen prescribed for resident #9, was in the home's medication cart. However, the medication expired on 2/13/21.

Repeat Violation: 11/19/20

183d - Prescription Current (continued)

Plan of Correction

Accept

183d

What: "On 2/19/21, Novolog Pen prescribed for resident #9, was in the home's medication cart. However, the medication expired on 2/13/21."

Who: The Resident Care Director will ensure weekly medication cart audits are being completed as assigned (Attachment F). This includes ensuring all prescribed medications are available and that all discontinued and/or expired medications have been removed from the cart. Medication Technicians will be reminded of the regulatory requirement to remove discontinued and outdated medications.

When: Medication carts audits will be completed on a weekly basis, as part of the community's best practices (Attachments R and S). This will be on an ongoing basis.

How: The Resident Care Director will ensure staff are assigned to audit the medication carts and will discuss with them the findings of their audits. The Resident Care Director will also ensure Medication Technicians are completing the shift change responsibilities.

Ongoing: In addition to the weekly medication cart audits completed by Medication Technicians, the Pharmacy provider will complete supplemental audits no less than bi-annually. All findings are reported to the Executive Director, Vice President of Operations and Director of Quality Services as well as the Resident Care Director, and patterns or trends will be reviewed and discussed at Quarterly Quality Assurance Meetings.

Completion Date: 06/14/2021

Document Submission

Implemented

see attached

185a - Implement Storage Procedures

1. Requirements

2600.

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

Description of Violation

On 2/19/21, during the narcotics audit, staff left the medication cart unlocked and unattended with DHS representative for a period of 10 minutes.

185a - Implement Storage Procedures (*continued*)**Plan of Correction****Accept***185a*

What: "On 2/19/21, during the narcotics audit, staff left the medication cart unlocked and unattended with DHS representative for a period of 10 minutes."

Who: The Resident Care Director discussed with the staff person the need to follow the same protocol for securing medication carts regardless of who is nearby or what is happening. The Resident Care Director or Designee will provide re-education for all Medication Technicians as a reminder to always secure medication carts for which they are responsible, and to never assume or ask others to monitor carts for them.

When: This training will be completed by June 30, 2021.

How: The Resident Care Director or Designee will review these expectations and why they are important with all Medication Technicians (Attachment T). Staff will sign an Attendance Acknowledgement Form (Attachment U).

Ongoing: The Resident Care Director will periodically check medication carts to ensure they are secured, while performing daily rounds on first and second shift. Any concerns will be addressed immediately, and any patterns or trends will be reviewed at Quarterly Quality Assurance Meetings.

Completion Date: 06/30/2021

Document Submission**Implemented**

see attached

186b - Medication Used by Resident

1. Requirements

2600.

186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

Resident #7 was administered Lantus Solos Injection Pen prescribed for and belonging to resident #8.

186b - Medication Used by Resident *(continued)*

Plan of Correction

Accept

186b

What: "Resident #7 was administered Lantus Solos Injection Pen prescribed for and belonging to resident #8."

Who: The Resident Care Director or Designee will ensure weekly medication cart audits are being completed as assigned (Attachment F). This includes ensuring all pens and storage bags are labeled, and that pens are stored in the correct bags. Medication Technicians will be reminded of the importance of this, to ensure medication are not mixed between residents.

When: The pen was immediately returned to the correct storage bag. Medication carts audits will be completed on a weekly basis, as part of the community's best practices (Attachments R and S). This will be on an ongoing basis.

How: All insulin pens are labeled with the resident's name, as are the bags in which they are stored. In this instance, an agency staff member had been working, and placed a pen in the wrong bag when returning it to storage in the cart. An internal investigation could not confirm it was administered to another person.

The Resident Care Director or Designee will ensure staff are assigned to audit the medication carts and will discuss with them the findings of their audits. The Resident Care Director will also ensure Medication Technicians are completing the shift change responsibilities.

Ongoing: In addition to the weekly medication cart audits completed by Medication Technicians, the Pharmacy provider will complete supplemental audits no less than bi-annually. Any concerns will be reported to the Resident Care Director, and patterns or trends will be reviewed and discussed at Quarterly Quality Assurance Meetings.

Completion Date: 06/14/2021

Document Submission

Implemented

see attached

187d - Follow Prescriber's Orders

1. Requirements

2600.

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

Description of Violation

Resident #9 is prescribed Metoprol 12.5 mg. Resident #9 is prescribed to have blood pressure and pulse checks before administration of Metoprol 12.5 mg. On 2/1/21 through 2/10/21, blood pressure and pulse checks were not documented on the Medication Administration record.

187d - Follow Prescriber's Orders (*continued*)**Plan of Correction****Accept**

187d

What: "Resident #9 is prescribed Metoprolol 12.5 mg. Resident #9 is prescribed to have blood pressure and pulse checks before administration of Metoprolol 12.5 mg. On 2/1/21 through 2/10/21, blood pressure and pulse checks were not documented on the Medication Administration record."

Who: The Resident Care Director or Designee will provide re-education for Medication Technicians to ensure they are aware of orders for vital checks and other associated procedures related to medications, as well as reviewing the process to document the results (Attachment V).

When: This training will be completed by June 30, 2021.

How: The Resident Care Director or Designee will review with staff examples of procedures related to medications, such as blood pressure and glucometer readings. Staff will be reminded of where to find those orders, and how to document them when they are completed. They will be trained to report to the Resident Care Director any concerns with completing these tasks. Staff will sign an Attendance Acknowledgement Form (Attachment W).

Ongoing: The Resident Care Director will review the MARs as part of the resident records, of which approximately 5% are audited each quarter. In addition, Dashboard Alerts are reviewed throughout each day by the Resident Care Director and Memory Care Director. Patterns and trends are reviewed and discussed at Quarterly Quality Assurance Meetings.

Completion Date: 06/30/2021

Document Submission**Implemented**

see attached

236 - Staff Training

1. Requirements

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 F, who works in the Secure Dementia Care Unit (SDCU) had no training in dementia care during the 2019 training year.

236 - Staff Training (*continued*)**Plan of Correction****Accept**

236

What: "Direct care staff person F, who works in the Secure Dementia Care Unit (SDCU) had no training in dementia care during the 2019 training year."

Who: The Business Office Manager will ensure Staff Person F completes all required training topics for the current year 2021. In addition, the Executive Director and Resident Care Director will coordinate additional training so that Staff Person F completes the 12 hours required for 2021 and an additional 10.5 hours of supplemental training to complete the hours that had been required in 2019.

When: All training will be completed by December 31, 2021.

How: Trainings will be completed both by using the Relias program and in-person trainings. These trainings will be coordinated using the Staff Training Plan for 2021 (Attachment K) and input from the Executive Director and Resident Care Director to determine appropriate additional training. The Business Office Manager will track trainings to ensure they are completed and will provide monthly updates to the ED and RCD.

Ongoing: The Business Office Manager will continue to audit a percentage of staff records each month, as part of the QA program (Attachment F). Any concerns will be brought to the immediate attention of the Executive Director. Any patterns or trends will be reviewed and discussed at the Quarterly Quality Assurance Meetings.

Completion Date: 12/31/2021

Document Submission**Implemented**

see attached