Department of Human Services
Bureau of Human Service Licensing

April 15, 2021

[redacted], MANAGING DIRECTOR
WATERMARK BELLINGHAM LLC
2020 WEST RUDASILL ROAD
TUCSON, AZ 85704

RE: THE WATERMARK AT BELLINGHAM
1615 EAST BOOT ROAD
WEST CHESTER, PA, 19380
LICENSE/COC#: 14688

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/22/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Shawn Parker

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY

Facility Information

Name: *THE WATERMARK AT BELLINGHAM* **Licen e #**: *14688* **Licen e Expiration Date**: *06/08/2021*
Addre : *1615 EAST BOOT ROAD, WEST CHESTER, PA 19380*
County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: *(610) 436-6663* **Email**: [redacted]

Legal Entity

Name: *WATERMARK BELLINGHAM LLC*
Address: *2020 WEST RUDASILL ROAD, TUCSON, AZ, 85704*
Phone: *6108398920* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/26/2000* **Issued By**: *Dept of L&I*

Staffing Hours

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

Inspection

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:
Rea on: *Monitoring* **Exit Conference Date**: *02/22/2021*

Inspection Dates and Department Representative

02/22/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *37*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *The Garden* **Capacity**: *24* **Residents Served**: *5*

Hospice

Current Re ident : *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *37*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *10* **Have Physical Disability**: *1*

Inspections / Reviews

02/22/2021 - Partial

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *03/15/2021*

4/12/2021 POC Submi ion

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/14/2021*

4/15/2021 - Document Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Not Required*

25c4 - Payment Responsibility

1. Requirements

2600.

25.c. At a minimum, the contract must specify the following:

4. The party responsible for payment.

Description of Violation

The resident-home contract , dated [redacted] for resident #2 does not specify the party responsible for payment.

The resident-home contract , dated [redacted] for resident #3 does not specify the party responsible for payment.

Plan of Correction **Accept**

This Plan of Correction is submitted to meet requirements established by state law. This Plan of Correction constitutes this facility's demonstration of compliance for the deficiencies cited. Submission of this Plan of Correction s not an admission that a deficiency existed or that one was correctly cited.

• Audit performed on all contracts for current residents of Personal Care/Secure Dementia Care Units. Results reviewed in community monthly Quality Assurance Committee

• Education provided to sales/marketing team to include required documentation and identification of party(s) responsible for payments upon move-in

• Audit of all contracts for residents moving in after 2/22/2021 will be reviewed at monthly Quality Assurance Committee for three months or until compliance achieved.

Completion Date: *04/16/2021*

Document Submission **Implemented**

Education provided to all parties responsible for completion of residency contracts and the regulatory requirement of naming the financial responsible party within the body of the document. Attendance sheet attached. completed 4/12/2021.

Audit of all current resident contracts complete 4/14/2021.

Audit of all resident contracts completed between 02/22/2021 and 04/14/2021.

Both audits are set for review with quality assurance committee in May.

Resident contracts for all new residents of community will be audited by Marketing Director or designee on monthly basis and reviewed with Quality Assurance Committee.

51 - Criminal Background Check

1. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Criminal Background Checks for staff members A, B, and C were completed over 180 days since the staff members were hired.

51 - Criminal Background Check *(continued)*

Plan of Correction **Accept**

• Effective 10/01/2021, with new ownership through Watermark Communities, policies and protocols implemented to ensure the completion of a criminal history check prior to start of employment.
• Human Resource Director or designee will perform audit of all employees hired on or after 10/01/2021 for completed criminal history check. Outcomes reviewed with monthly facility Quality Assurance Committee.
• Audits will continue to be reviewed for three months or until compliance is achieved

Completion Date: *06/01/2021*

Document Submission **Implemented**

Audit of criminal background check for current employees since Watermark Communities on 10/01/2020 with full compliance.
Human Resource Director or designee will continue to audit all new hire files for compliance and review outcomes with Quality Assurance Committee monthly.

141b2 - Medical Evaluation Changes

1. Requirements

2600.
141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

As of 11/20/2020, Resident #1's health condition worsened to the point the resident had to be put on hospice. before annual medical evaluation changes and a new medical evaluation was not completed. The resident did not receive a new Documented Medical Evaluation (DME).

Plan of Correction **Accept**

• Documented Medical Evaluation for Resident #1 was completed by physician and attached for review
• Education of regulatory documentation compliance provided to Resident Services Director and Program Director along with copy of 2600.141b2
• Provided copy of Regulation 141b2 to Medical Provider for review.
• Resident Services Director or designee will perform monthly audit of thirty (30%) percent resident charts for medical evaluation compliance.
• Audit results will be reviewed at facility monthly Quality Assurance Committee meeting for three months or until compliance is achieved

Completion Date: *06/15/2021*

Document Submission **Implemented**

Education with regulatory requirements regarding residents and the Documented Medical Evaluation provided to Resident Service Director and Program Director on 04/06/2021.
Portion of current resident files audited and reviewed with Quality Assurance Committee on 4/7/2021
Meeting to be arranged with physician to review regulatory requirements 141b2.

224a - Preadmission Screen Form

1. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #3 was admitted to the home on [redacted]. However, the resident's preadmission screening form was completed on 9/23/2020.

Plan of Correction **Accept**

• Audit of current resident preadmission screen forms completed with results to be reviewed with Quality mprovement Committee.
• Education regarding documents required prior to move-in provided to Resident Services Director, Program Director and Sales Team.
• Audit of all new move-in documentation will be completed by Program Director or designee and reviewed at monthly Quality Improvement Committee meeting for three months or until compliance is achieved.

Completion Date: *06/15/2021*

Document Submission **Implemented**

Review of regulatory requirement 224a provided to Resident Service Director, Program Director (4/6/2021)and Marketing Department 4/12/2021).
Percentage of resident files audited for compliance and discussed with Quality Assurance Committee.

227h - Support Plan Refuse Sign

1. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #1's support plan dated 11/20/2020 was not signed by the resident or the residents designated person. The home did not make a notation regarding the resident not to signing the support plan.

Plan of Correction **Accept**

• Support Plan for Resident #1 reviewed and signed by designated resident representative. Please see attached.
• Due to COVID-19 visitation restrictions, ability for representatives of those residents unable to sign support plans were limited.
• Electronic means of communication have been secured for as many resident representatives as able to prevent future limitations.
• Education provided to Resident Services Director and Program Director regarding the need to document all resident or representative refusals to sign support plan.
• Thirty percent (30%) of Resident service plans to be audited monthly by Program Director or designee and reviewed by facility Quality Assurance Committee meeting for three months or until compliance is achieved.

Completion Date: *06/15/2021*

227h - Support Plan Refuse Sign *(continued)*

Document Submission **Implemented**

Signed signature page of Resident #1 Support Plan provided in attached
Database created with email/electronic communication for responsible parties of current residents.
Reviewed 227h with Resident Service Director and Program Director with education of obtaining acknowledgement through signature of resident / resident representative.
Audit of Resident/Representative signature with Support Plan initiated. Results to be reviewed with Quality Assurance Committee.

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 persons A and B, work in the homes Secure Dementia Care Unit (SDCU). Their 6 hour additional annual training related to dementia care weren't available in the home.

Plan of Correction **Accept**

• As of 10/01/2020 with new ownership through Watermark Communities, protocols have been instituted to ensure required orientation and annual staff trainings
• Employment standards are based in the timely completion of all required trainings.
• Policy and skill training completion continues to be audited routinely through Human Resources Director or designee and reported through monthly Quality Assurance Committee meetings.
• Program Director or designee will secure annual dementia-specific training programs for associates assigned to the secured dementia care unit in order to ensure compliance with required additional six (6) hours of annual dementia-specific training.

Completion Date: *07/01/2021*

Document Submission **Implemented**

Audits initiated for staff completion rate of dementia-specific training for staff assigned to Secure Dementia Care Unit. Results to be reviewed with Quality Assurance Committee.
Additional dementia-specific training for all direct care staff identified through corporate resources and scheduled for summer 2021.
Training of direct care staff persons A and B to complete six (6) hours of dementia training initiated. Completion date set for 5/14/2021.