Department of Human Services
Bureau of Human Service Licensing

July 6, 2021

[REDACTED] ASSOCIATE EXECUTIVE DIRECTOR
ARHC WHWCHPA01 TRS LLC
1361 EAST BOOT ROAD
EXECUTIVE DIRECTOR
WEST CHESTER, PA 19380

RE: WELLINGTON COURT AT HERSHEY'S MILL
1361 EAST BOOT ROAD
WEST CHESTER, PA, 19380
LICENSE/COC#: 14136

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/10/2021, 06/14/2021 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: *WELLINGTON COURT AT HERSHEY'S MILL* **Licen e #**: *14136* **Licen e Expiration Date**: *03/23/2022*
Addre : *1361 EAST BOOT ROAD, WEST CHESTER, PA 19380*
County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: *484-653-1200* **Email**: [redacted]

Legal Entity

Name: *ARHC WHWCHPA01 TRS LLC*
Address: *1361 EAST BOOT ROAD, EXECUTIVE DIRECTOR, WEST CHESTER, PA, 19380*
Phone: *4846531200* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *01/31/2008* **Issued By**: *East Goshen TWP*
Type: *Other* **Date**: *02/10/2015* **Issued By**: *East Goshen TWP*

Staffing Hours

Re ident Support Staff: *0* **Total Daily Staff**: *75* **Waking Staff**: *56*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *06/14/2021*

Inspection Dates and Department Representative

06/10/2021 - On-Site: [redacted]
06/14/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *74* **Residents Served**: *51*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Re ident : *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *51*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *24* **Have Physical Disability**: *1*

Inspections / Reviews

06/10/2021 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *07/02/2021*

7/2/2021 POC Submi ion

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/06/2021*

7/6/2021 - Document Submission

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

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

According to the Carbon Monoxide Alarms Standards Act of 9/23/16, a carbon monoxide detector shall be installed in close proximity of, but not less than 15 feet from, any fossil fuel burning device. The homes main laundry area utilizes gas powered dryers.
On 6/14/21 there were no carbon monoxide detectors present in the laundry room or anywhere near by the laundry area.

Plan of Correction **Accept**

A Carbon Monoxide Detector was placed in the Laundry Room, not less than 15 feet from the washers and dryers picture is attached). Additionally, the batteries in the Carbon Monoxide Detector will be changed every 3 months as ndicated by the audit sheet hung near the Detector (picture is attached). The audit will be the responsibility of the Plant Operations Director and the audit sheets will be audited monthly for compliance. The audits will be discussed at the quarterly QI meeting.

Completion Date: *06/25/2021*

Document Submission **Implemented**

A Carbon Monoxide Detector was placed in the laundry Room, not less than 15 feet from the Washers and Dryers pic is attached).

25b - Contract Signatures

1. **Requirements**

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 [redacted] for resident #1 was not signed by the resident.

Plan of Correction **Accept**

The contract was signed by the Resident #1 (attached). Additionally, the Director of Marketing and the marketing staff, who review with the resident and participate in the signing of the contract, were in-serviced by the Associate Executive Director which requires the resident to sign.
All current contracts will be reviewed by Personal Care Staff, and will determine if all contracts have been signed. Any discrepancies will be reported to the Executive Director. Audits will be conducted by the Assistant Administrator weekly x 4 and then monthly x 4 until compliance is maintained.

Completion Date: *07/16/2021*

Document Submission **Implemented**

The contract was signed by the resident (attached).

54a - Direct Care Staff

1. **Requirements**

2600.

54a - Direct Care Staff *(continued)*

54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person A, who is an agency aid, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry on file with the home.

Plan of Correction **Accept**

The high school diploma for staff person A was obtained from the Agency (Attached). Wellington will require, before an Agency staff person can begin care, to have all the necessary paperwork completed. The Administrator will keep a file with all paperwork required by regulation for any outside Agency. The Administrator will inform via email to the Business Office Manager of any potential Agency hires. The Business Office Manager will be responsible to provide the necessary orientation.
The Agency in question has also been informed via email this regulation. The Business Office Manager will audit 10% of agency files every month for compliance.

Completion Date: *06/25/2021*

Document Submission **Implemented**

High school diploma for staff person A was obtained (attached).

65a - FS Orientation 1st Day

1. **Requirements**

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Repeat Violation

The following staff persons did not receive the any of the required orientation topics required by this regulation.
Staff person A, whose first day of work was is not documented in staff person's file.
Staff person B, whose first day of work was
Staff person C, whose first day of work was

Repeat violation date: 12/9/19.

65a - FS Orientation 1st Day *(continued)*

Plan of Correction **Accept**

Staff person A, B, & C will receive an orientation in general fire safety and emergency preparedness. This orientation will be conducted by the Plant Operations Director.
The Business Office Manager, who is responsible for Human Resources, will ensure all staff members, whether employed by Wellington or through an agency receive the required orientation and documented in the individual file. The Business Office Manager will audit weekly x 4 and then monthly x 4 until compliance is maintained. Any discrepancies will be reported to the Executive Director and addressed.

Completion Date: *07/16/2021*

Document Submission **Implemented**

Staff persons A,B, & C will receive an orientation in general fire safety and emergency preparedness.

65b - Rights/Abuse 40 Hours

1. **Requirements**

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Repeat Violation

The following staff persons did not receive the any of the required training topics required by this regulation on or prior to their 40th hour worked.
Staff person A, whose first day of work was is not documented in staff person's file.
Staff person B, whose first day of work was
Staff person C, whose first day of work was

Repeat violation date: 12/9/19

Plan of Correction **Accept**

Staff person A, B, & C will have an orientation in Resident rights, Emergency medical plan, Mandatory reporting of abuse, and reporting of reportable incidents and conditions. This orientation will be conducted by the Associate Executive.
The Business Office Manager, who is responsible for Human Resources, will ensure all staff members whether employed by Wellington or through an agency receive the required orientation and it is documented in the ndividual's file. The Business Office Manager will conduct audits weekly x 4 and then monthly x 4 until compliance s maintained.

Completion Date: *07/16/2021*

Document Submission **Implemented**

Staff persons A, B & C will have an orientation in Resident rights, Emergency Medical plan, Mandatory reporting of abuse, and reporting of reportable incidents and conditions.

65d - Initial Direct Care Training

1. **Requirements**

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   i. Safe management techniques.
   ii. ADLs and IADLs

Description of Violation

Direct care staff person A, whose hire date is not documented in their file, has provided unsupervised ADL services to residents of the home. However, the home does not have documentation that the staff person completed and passed the Department-approved direct care training course and test.

Direct care staff person D, hired on [redacted] has been providing unsupervised ADL services since their date of hire. However, the home does not have documentation that the staff person completed and passed the Department-approved direct care training course and competency test.

Plan of Correction **Accept**

Direct care staff person A did complete and passed the Department-approved direct care training course and test attached). It was not available at the time of the survey. It was completed on 3/26/2021 prior to [redacted] providing care. Direct care staff person D will complete and pass the Department-approved direct care training course and test. The Business Office Manager will conduct audits weekly x 4 and then monthly x 4 until compliance is maintained. During the initial orientation, the Business Office Manager, who is responsible for Human Resources, will ensure all newly hired resident care givers in Personal Care complete and pass the Department-approved direct care training course and test.

Completion Date: *07/16/2021*

Document Submission **Implemented**

The Direct care staff person completed and passed the Department-approved direct care training course. Staff Person D will complete the Department-approved direct care training course.

103f - Refrigerator/Freezer Temps

1. **Requirements**

2600.

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

Description of Violation

On 6/14/21 at 9:30am the temperature in the ice cream freezer in the service area off the dining room was 30 degrees Fahrenheit. At 12:40pm it was 10 degrees F.

103f - Refrigerator/Freezer Temps *(continued)*

Plan of Correction **Accept**

The refrigerator was repaired on 6/14/2021 by an outside vendor. The Cook Supervisor and Director of Dining Services will check temperatures during the morning shift and the evening shift. The Director of Dining or the Cook Supervisor will also log the temperatures on the daily log sheet.
All dining staff have been in-serviced by the Director of Dining Services to the correct temperatures in all refrigerators, including the ice cream box on 6/25/2021 (Attached). The daily log will be reviewed by the Director of Dining weekly during weekly management meeting.

Completion Date: *06/25/2021*

Document Submission **Implemented**

The refrigerator was repaired by an outside vendor so the refrigerator is now at 0 F or below.

103g - Storing Food

1. **Requirements**

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 6/14/21 there was a piping bag containing a white icing and a clear plastic tub of mixed fruit in the refrigerator in the service area off the dining room that was opened and unsealed and undated.

Additionally, on 6/14/21, in the ice cream freezer in the dry food storage area there were two 3-gallon containers of ice cream that were opened and unsealed.

Plan of Correction **Accept**

The piping bag was thrown away on 06/14/21. Additionally, on 6/14/21, the two 3-gallon containers of ice cream that were opened and unsealed were closed and sealed.
The Director of Dining in-serviced all staff (attached) to Label, Date and Seal all unopened containers. Weekly audits will be conducted by the Director of Dining or ■ designee and discussed at the weekly management meeting.
The Director of Dining or the closing manager will check all refrigerators daily to ensure all items are closed and dated.

Completion Date: *06/25/2021*

Document Submission **Implemented**

The piping bag was thrown away. The two 3-gallon containers of ice cream lids were sealed

107d - Procedure Emergency Management Agency Submission

1. **Requirements**

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency management agency since 2019.

107d - Procedure Emergency Management Agency Submission *(continued)*

Plan of Correction **Directed**

The written emergency procedures will be submitted to Chester County Emergency Management Department at

DPOC - SP - 07-01-2021 - Emergency procedures will be reviewed, updated, and summitted annually in accordance with regulation 2600.107d. Home will make documentation of submission available for Department review.

Completion Date: *07/16/2021*

Document Submission **Implemented**

The emergency procedures were submitted to Chester County Emergency Management.

141a 1-10 Medical Evaluation Information

1. **Requirements**

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 #2's medical evaluation dated did not include medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

Plan of Correction **Accept**

Resident #2 medical evaluation did include medication regimen, contraindicated medications , medication side effects and the ability to self-administer medications. However, it was not attached to the medical evaluation. It was ncluded on the chart.
Please see the information (attached). All current resident medical records will be audited by the Assistant Administrator. Any discrepancies will be reported to the Executive Director. Audits of the medical records including the medical evaluation will be conducted monthly and will be reported to the QI Committee quarterly.
The Administrator will ensure, when a medical evaluation is returned, all paperwork is included.

Completion Date: *07/23/2021*

Document Submission **Implemented**

Resident #2 medical evaluation attached which includes medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

141b1 - Annual Medical Evaluation

1. **Requirements**

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

Description of Repeat Violation

Resident #3's most recent medical evaluation was completed on 3/31/21. The resident's previous medical evaluation was completed on 5/25/18.

Repeat violation date: 12/9/19

Plan of Correction **Accept**

All current resident medical records will be audit by the Assistant Administrator. Any discrepancies will be reported to the Executive Director. A calendar will be completed by the Assistant Administrator to ensure timely medical evaluation sent to the respective physicians.
Audits of medical records will be conducted monthly by the Assistant Administrator and findings will be reported to the QI Committee quarterly.

Completion Date: *07/16/2021*

Document Submission **Implemented**

All medical evaluations will be completed annually.

162c Menus Posted

1. **Requirements**

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 6/10/21 and 6/14/21 the home's menu was not posted in a conspicuous and public place in the home.

Plan of Correction **Accept**

Menus are now posted for current week and for one week in advance (see attachments).
The Director of Dining Service will change weekly on the first day of the week (Sunday) in order that a current week and one week in advance is available to the residents. Quarterly reports will be made to the QI Committee quarterly.

Completion Date *06/29/2021*

Document Submission **Implemented**

Menus were posted for the current week and one week in advance

183b - Meds and Syringes Locked

1. **Requirements**

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 6/14/21, a bottle of Metamucil fiber powder and a tube of Neosporin antibiotic ointment were unlocked, unattended, and accessible in resident #4's bedroom.

183b - Meds and Syringes Locked *(cont nued)*

Plan of Correction **Accept**

Resident #4 was educated on the regulation that medications are not allowed in a resident's room unless they are self medicating. Resident #4 is not self medicating. All nurses and med techs were in serviced by the Assistant Administrator and the Associate Executive Director to the requirement that medications are not to be left unattended in a resident's room (attached).
Room Inspections will be completed monthly by the Resident Care Aides and documented on the "Room Audit Chart" to ensure compliance. Any discrepancies will be reported to the Charge Nurse on Duty and the Administrator.
Additionally, a meeting is scheduled on July 6, 2021 with all residents and their families to explain the Department of Health Personal Care Medication guidelines.

Completion Date *07/16/2021*

Document Submission **Implemented**

Medications were removed from the resident #4 bedroom.

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

Resident #3 is prescribed glucose checks to be completed 4 times a day. The following dates have readings recorded on the glucose log that do not match the corresponding readings in the meter.
6/1/21 at 16:40 meter reading of 148- glucose log has no recorded reading
6/3/21 at 14:27 meter reading of 245- glucose log has a recorded reading of 247 at 5pm
6/6/21 at 13:58 meter reading of 272- glucose log has a recorded reading of 276 at 5pm
6/6/21 at 18:01 meter reading of 179- glucose log has a recorded reading of 175 at 9pm
6/8/21 at 9:10 meter reading of 214- glucose log has a recorded reading of 212 at 12pm
6/8/21 at 14:21 meter reading of 317- glucose log has a recorded reading of 316 at 5pm
6/11/21 at 8:47 meter reading of 207- glucose log has a recorded reading of 218 at 12pm
6/11/21 at 18:31 meter reading of 215- glucose log has a recorded reading of 216 at 9pm
6/12/21 at 18:19 meter reading of 183- glucose log has a recorded reading of 185 at 9pm

Plan of Correction **Accept**

All nurses were in-serviced/ educated by the Assistant Administrator (attached) on recording the correct meter reading on the glucose log. Glucometer will be audited by night shift nurses/ med techs daily for accuracy. Audit results will be reviewed by the Assistant Administrator daily and the audits will be reviewed by the QI Committee quarterly. Any discrepancies will be reported to the Executive Director immediately.

Completion Date: *06/28/2021*

Document Submission **Implemented**

Nurses were in serviced and a procedure for safe storage, access, security and distribution of use of medications and medical equipment by trained staff persons.
Procedure and in serviced is attached.

187d Follow Prescriber's Orders

1. **Requirements**

187d - Follow Prescriber's Orders *(continued)*

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

Description of Violation

Resident #3 is prescribed the following sliding scale insulin dose: Inject 4 times a day as per sliding scale: 201-250 =2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, call MD if >400.

On the following dates, the incorrect amount of insulin was administered.
6/1/21 @ 5:00pm- meter reading of 202, MAR indicates no insulin units were administered. resident should have received 2 units.
6/3/21 @ 5:00pm- the MAR has a recorded reading of 247, the corresponding meter reading of 245, MAR indicates no insulin were administered, resident should have received 2 units
6/4/21 @ 9:00pm- meter reading of 237, MAR indicates no insulin units were administered, resident should have received 2 units
6/5/21 @ 5:00pm – Meter reading of 276, MAR indicates no insulin units were administered, resident should have received 4 units
6/5/21 @ 9:00pm- Meter reading of 249, MAR indicates no insulin units were administered, resident should have received 2 units
6/6/21 @ 12:00pm- Meter reading of 233, MAR indicates no insulin units were administered, resident should have received 2 units
6/6/21 @ 5:00pm MAR has a recorded reading of 276, the corresponding meter reading is 272, the MAR indicates no insulin units were administered, resident should have received 2 units
6/8/21 @ 12:00pm-MAR has a recorded reading of 212, the corresponding meter reading is 214, the MAR indicates no insulin units were administered, resident should have received 2 units
6/8/21 @ 8:00am- Meter reading of 279, MAR indicates that no insulin units were administered, resident should have received 4 units
6/10/21 @ 12:00pm- Meter reading of 31, MAR indicates no insulin units were administered, resident should have received 6 units
6/10/21 @ 9:00pm-Meter reading of 220, MAR indicates no insulin units were admin stered, resident should have received 2 units

Resident #4 was prescribed Antibiotic Ointment to be applied to affected toes once daily. The order was received in the home on 6/8/21 however the staff did not administer this medication until 6/10/21. Resident #4 reported that they had to administer their own treatment for 2 days.

Plan of Correction **Accept**

The nurses and med-techs were in-serviced by the Assistant Administrator (attached) to follow the prescriber orders including sliding scale insulin. The assistant administrator will audit weekly x 3 months to ensure compliance. Orders were transcribed in EMAR to trigger documentation of insulin administered. Any discrepancies will be reported to the Administrator and the Executive Director. Audits will be presented to the QI committee quarterly.

Completion Date: *06/28/2021*

Document Submission **Implemented**

Nurses and med-techs were in-services to follow the prescriber orders (attached).

191 - Resident Right to Refuse

1. **Requirements**

191 - Resident Right to Refuse *(continued)*

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

Description of Violation

Resident #5, admitted [redacted] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction **Accept**

A statement has been added to Resident's Rights in Appendix F: "A resident has the right to question or refuse a medication if the resident believes there may be a medication error (attached).
All residents will sign again the Resident's Rights in Appendix F with the additional information concerning the right to refuse medication.
The Director of Marketing and the marketing team was in-serviced to the new Appendix F by the Associate Executive Director.

Completion Date: *07/30/2021*

Document Submission **Implemented**

A statement was added to Resident's Rights in Appendix F. Resident #5 was educated concerning [redacted] rights to refuse medication signature attached).

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 #5 was admitted to the home on [redacted]; however, the resident's preadmission screening form was completed on [redacted].

Plan of Correction **Accept**

All resident's will have Preadmission screen form completed at the time of the pre admission assessment and placed n chart, prior to admission. At the morning meeting with marketing and PC administration, the potential resident move ins will be reviewed and dates determined to complete the Preadmission Screening Form. The Administrator will be responsible for scheduling all preadmission screenings

Completion Date: *07/23/2021*

Document Submission **Implemented**

All preadmission screening forms will be completed with the necessary timeframe.

225a - Assessment 15 Days

1. **Requirements**

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

225a - Assessment 15 Days *(continued)*

Description of Repeat Violation

An assessment was not completed for resident #2, who was admitted to the home on

An assessment was not completed for resident #5, who was admitted to the home on

Repeat Violation date: 12/9/19

Plan of Correction **Accept**

Resident #2 was admitted to Community . Had a significant fall, and was sent to Hospital . Resident then transferred to Skilled rehab and returned to community Support plan completed 6/11/21 (attached). Resident #5 support plan completed (attached). All charts will be audited by the Administrator or designee to ensure current residents have a current support plan. Residents who do not have a support plan, administrator will create one with the resident and the Responsible party if the resident agrees. The next support plan will be due 380 days after the new support plan, unless there is a significant change.

Completion Date: *07/30/2021*

Document Submission **Implemented**

Resident #2 and Resident #5 support plans were completed. They are attached.

225c - Additional Assessment

1. **Requirements**

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #3's most recent assessment is dated 6/18/19.

Resident #6's current assessment is dated 2/10/21 however the previous assessment is dated 5/8/19. The resident did not have an annual assessment in 2020.

Plan of Correction **Accept**

Resident #3 support plan was updated and reviewed and signed by resident (attached). All charts will be audited by the Administrator or her designee to ensure current residents have a current support plan. Residents who do not have a support plan, administrator will create one with the Resident and the Responsible party if the resident agrees. The next support plan will be due 380 days after the new support plan, unless there is a significant change.

Completion Date: *07/23/2021*

Document Submission **Implemented**

Resident #3 support plan was update, reviewed and signed by residents (attached).

227g -Support Plan Signatures

1. **Requirements**

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

227g -Support Plan Signatures *(continued)*

Description of Violation

Resident #1 participated in the development of his/her support plan on [redacted]. However, the resident did not sign the support plan.

Plan of Correction **Accept**

The Assistant Administrator explained to the resident the support plan and it was signed by Resident #1 (attached). All current resident support plans will be audited by the Administrator or [redacted] designee to determine if all support plans are signed and dated.
The Administrator and the Assistant Administrator understand that all support plans must include the resident, and if the resident agrees, a family member. All parties should sign the support plan; however, the resident must sign. Signatures will be gathered at Resident Initial or Annual Care Conferences. The Administrator will review each support plan for signature after the support plan is completed.

Completion Date: *07/30/2021*

Document Submission **Implemented**

Resident #1 support plan was signed by the resident. (attached).

252 - Record Content

1. **Requirements**

2600.

252. Content of Resident Records - Each resident's record must include the following information:
    1. Name, gender, admission date, birth date and Social Security number.
    2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
    3. A photograph of the resident that is no more than 2 years old.
    4. Language or means of communication spoken or used by the resident.
    5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.

Description of Violation

Resident #2's record does not include a photograph of the resident that is no more than 2 years old.

Plan of Correction **Accept**

Resident #2 picture was taken (attached). All current resident charts will be audited to by the Administrator or [redacted] designee to ensure there is a picture of every resident. Additionally audits will be conducted by the administrator or [redacted] designee every 3 months to determine if pictures have been included in the chart.

Completion Date: *07/30/2021*

Document Submission **Implemented**

Resident #2 picture was taken (attached).