



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: April 8, 2022

[REDACTED]
[REDACTED]
Rapps Senior Care, LLC
[REDACTED]
[REDACTED]
[REDACTED]

RE: Woodbridge Place
1191 Rapps Dam Road
Phoenixville, Pennsylvania 19460
License #: 143591

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection October 7 and 8, 2021, November 9, 2021, and January 13, 2022, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 143590 dated November 19, 2021, to November 19, 2022, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated November 19, 2021, to November 19, 2022, is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a) (2) ;(3); (4) ;(5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from April 8, 2022 to October 8, 2022.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date:

55 Pa. Code Chapter 2600 or 2800 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
187 c	II	74	\$5	\$370	5 calendar days from mailing date of this letter
187 d	II	74	\$5	\$370	5 calendar days from mailing date of this letter
185 a	II	74	\$5	\$370	5 calendar days from mailing date of this letter
190 a	II	74	\$5	\$370	5 calendar days from mailing date of this letter
225 c	III	74	\$3	\$222	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

[REDACTED]

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[REDACTED]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,



Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

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

Facility Information

Name: *WOODBIDGE PLACE* License #: *14359* License Expiration:
Address: *1191 RAPPS DAM ROAD, PHOENIXVILLE, PA 19460*
County: *CHESTER* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *RAPPS SENIOR CARE LLC*
Address: *1000 LEGION PLACE, SUITE 1600, ATTN BILL SNOW, ORLANDO, FL, 32801*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *07/01/1995* Issued By: *Commonwealth of PA*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *98* Waking Staff: *74*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *10/08/2021*

Inspection Dates and Department Representative

10/07/2021 - On-Site: [REDACTED]

10/08/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* Residents Served: *73*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Unit* Capacity: *125* Residents Served: *73*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *71*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *25* Have Physical Disability: *0*

Inspections / Reviews

10/07/2021 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/04/2021*

Inspection Dates and Department Representative (*continued*)

10/07/2021 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *01/04/2022*

3c - Post Current License

General Provisions

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 10/07/2021, a copy of 55 Pa Code Chapter 2600 was not posted in a conspicuous and public place in the home.

Plan of Correction

Accept

The new Executive Director printed a copy of Chapter 2600 Regulations. These regulatory guidelines were added to the binder at the Concierge desk for review by visitors, residents and the public at large.

Compliance with this requirement will be reviewed as part of the Quality Assurance process, for at least the next three months, to ensure awareness of this requirement and review of the posting.

Completion Date: 10/08/2021 Licensee's Proposed Date of POC Implementation

Implemented 3/8/22

18 - Compliance With Laws

General Requirements

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

On 10/07/2021, there was no influenza poster posted in a conspicuous and public place in the home.

Plan of Correction

Accept

The new Executive Director obtained a copy of the mandated Influenza Poster and posted it in the locked bulletin board in the resident common area by the community mailboxes and in the staff lounge.

Woodbridge Place has also hosted two Influenza clinics, sponsored by our pharmacy to encourage influenza vaccination.

Compliance with this requirement will be reviewed as part of the Quality Assurance process, for at least the next three months, to ensure awareness of this requirement and review of the posting.

Completion Date: 10/11/2021 Licensee's Proposed Date of POC Implementation

Implemented 3/8/22

19 - Review Waiver

General Requirements

1. Requirements

General Requirements (continued)

2600.

19.e. The home shall notify the affected resident and designated person of the approval or denial of the waiver. A copy of the waiver request and the Department's written decision shall be posted in a conspicuous and public place within the home.

Description of Violation

The home was granted a waiver on 4/21/2003. On 10/07/2021, the waiver was not posted in a prominent and public location in the home.

Plan of Correction

Woodbridge Place respectfully disputes this citation.

Accept

The requested waiver related to 2620.61(13) was indeed granted on 4/21/2003. This waiver was not transferrable in circumstances where there has been a change of ownership.

Therefore, in 2006 when Atria assumed responsibility of Woodbridge Place from Newtown Senior Living an application was made for a waiver. However, on 12/6/2006 in a letter from [redacted] DPW's Director, Woodbridge Place was notified that a waiver was no longer required, as the standards of licensure of a Secured Dementia Unit under 2600.131-2600.239 supersede this waiver. These standards remain in place for Woodbine Senior Living and Woodbridge Place.

Woodbridge Place has no current waivers to post under this regulatory standard.

Completion Date: 10/08/2021

Violation Withdrawn

Update: 12/14/2021

B

Date: 12/14/21

Withdrawn 12/14/21 [redacted]

28e - Death of a Resident

General Requirements

1. Requirements

2600.

28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident 1 passed away on [redacted]. Resident 1's personal belongings were removed from [redacted] room on [redacted] however, a refund was not issued until [redacted].

Resident 2 passed away on [redacted]. Resident 2's personal belongings were removed from [redacted] room on [redacted]; however, a refund was not issued until [redacted].

Resident 3 passed away on [redacted]. Resident 3's personal belongings were removed from [redacted] room on [redacted] however, a refund was not issued until [redacted].

General Requirements (continued)

Plan of Correction

Accept

A new Business Office Coordinator has been hired on [REDACTED]. [REDACTED] first day of training included education regarding regulation 2600.28.

Move out forms will be completed by the clinical department or reception at the time that keys are returned to the community when a resident vacates. This form will be submitted to the Business Office Coordinator and financial move out forms will be sent timely to Woodbine Corporate office to initiate a refund.

Copies of the check register will be kept in all closed files for proof of future compliance.

Progress with refunds will be monitored and discussed at Quality Assurance Meetings to ensure the plans effectiveness. If the plans effectiveness is in question, a new plan will be executed to ensure the violation does not occur again.

Completion Date: 12/01/2021 Licensee's Proposed Date of POC Implementation

Not Implemented 3/8/22 [REDACTED]

42s - Privacy

Resident Rights

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 [REDACTED], cameras capturing and recording video was present at the entrance of the facility. However, there was no sign notifying of the cameras recording.

Plan of Correction

Accept

As explained at time of survey, the cameras present throughout the building are not active and possess no ability to record. However, signage did not exist indicating the presence of potential recording equipment.

The new management team purchased and posted signage at the entrance of the community and loading dock to increase the awareness of potential recording devices,

Compliance with this requirement will be reviewed as part of the Quality Assurance process, for at least the next three months, to ensure awareness of this requirement and review of the posting.

Completion Date: 11/01/2021 Licensee's Proposed Date of POC Implementation

Not Implemented 3/8/22 [REDACTED]

57c - 2 Hours/Day

Staffing

1. Requirements

Staffing (continued)

2600.

57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On [REDACTED], there were 73 residents in the home, including 25 residents with mobility needs, requiring a total minimum of 98 hours of direct care service. On this date, only 87.5 hours of direct care staffing was provided.

On [REDACTED], there were 73 residents in the home, including 25 residents with mobility needs, requiring a total minimum of 98 hours of direct care service. On this date, only 90 hours of direct care staffing was provided.

Plan of Correction

Accept

Staff scheduling has been reassigned to the new Resident Care Director, who has been trained in the regulatory requirements related to 2600.57.

The new Resident Care Director and new Executive Director have contracted with several external agencies for support from nurses and certified care staff to supplement Woodbridge Place staffing, as required. to meet the census and immobility calculations.

The Resident Care Director will review staffing levels on a daily basis to ensure compliance with the imposed standards and will present to the Executive Director and Department Head team at daily morning meeting.

The Executive Director and Department Heads will review staffing trends at Quality Assurance Meetings to ensure that recruitment efforts and supplemental staffing contracts continue to provide the hours that are required as the resident populous changes.

Completion Date: 11/01/2021 Licensee's Proposed Date of POC Implementation

Not Implemented 3/8/22 [REDACTED]

57d - Waking Hours

Staffing

1. Requirements

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On [REDACTED], a total of 73.5 hours of direct care was required. However, only 61.5 of the required hours were provided during waking hours.

On [REDACTED], a total of 73.5 hours of direct care was required. However, only 64 of the required hours were provided during waking hours.

Plan of Correction

Accept

Staff scheduling has been reassigned to the new Resident Care Director, who has been trained in the regulatory

Staffing (continued)

requirements related to 2600.57 including awake hours.

The new Resident Care Director and new Executive Director have contracted with several external agencies for support from nurses and certified care staff to supplement Woodbridge Place staffing, as required. to meet the census and immobility calculations.

The Resident Care Director will review staffing levels on a daily basis to ensure compliance with the imposed standards and will present to the Executive Director and Department Head team at daily morning meeting.

The Executive Director and Department Heads will review staffing trends at Quality Assurance Meetings to ensure that recruitment efforts and supplemental staffing contracts continue to provide the hours that are required as the resident populous changes.

Completion Date: 11/01/2021 Licensee's Proposed Date of POC Implementation Not Implemented 3/8/22

82c - Locking Poisonous Materials

Physical Site

1. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On [REDACTED], there was an Olay Complete daily moisturizer sunscreen (4.0 FL Oz) with a manufacturer's label indicating "if product is swallowed, get medical help or contact a poison control center right away". It was unlocked, unattended, and accessible to resident 4. Not all the residents of the home, including resident 4, have been assessed as being capable of [REDACTED].

On [REDACTED] there was a McKesson fluoride toothpaste net wet 2.75 oz. with a manufacturer's label indicating "if product is swallowed, get medical help or contact a poison control center immediately". It was unlocked, unattended, and accessible to resident 4. Not all the residents of the home, including resident 4, have been assessed as being capable of [REDACTED].

Physical Site (continued)

Plan of Correction

Accept

The daily moisturizer and toothpaste were removed from the unlocked cabinet and stored in a locked area. The Resident Care Director and Personal Care Staff completed a thorough search of all other [redacted] residents rooms to ensure that there were not other unsecured chemicals.

The Resident Care Director will re-educate the [redacted] Lead Care Manager on the importance of assuring that all chemicals or potentially poisonous materials are consistently secured in a locked area to prevent any potential hazard. The Lead Care Manager will instruct all team members on the importance of assuring that all chemicals or potentially poisonous materials, are consistently locked to prevent any potential hazard. The Lead Care Manager, or designee, will complete end of shift rounds to ensure compliance.

This Plan of Correction will be reviewed as part of the Quality Assurance review process by the Executive Director and Department Heads to ensure it is effective, changes will be made as necessary.

Completion Date: 12/03/2021 Licensee's Proposed Date of POC Implementation

Not Implemented 3/8/22 [redacted]

85a - Sanitary Conditions

Physical Site

1. Requirements

- 2600.
- 85.a. Sanitary conditions shall be maintained.

Description of Violation

On 10/07/2021, the ice cream freezer sliding door in the main kitchen has black, dark substances that look like mold around the sliding freezer door.

Plan of Correction

Accept

The dining staff defrosted and cleaned the ice cream freezer upon discovery of the aforementioned substance.

The new Culinary Services Director, who was not in place at the time of this violation, is overseeing the monthly defrosting of the ice cream freezer and daily cleaning to prevent any further violations related to sanitary conditions.

This Plan of Correction will be reviewed as part of the Quality Assurance review process by the Executive Director and Department Heads to ensure it is effective, changes will be made as necessary.

Completion Date: 10/07/2021 Licensee's Proposed Date of POC Implementation

Not Implemented 3/8/22 [redacted]

85d - Trash Receptacles

Physical Site

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 10/07/2021 at 10:50 am, there was a full, uncovered, unattended trash can in the kitchen.

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

Plan of Correction

Accept

The surveyor immediately provided on site training to the Culinary Service Department regarding the need for a covered trashcan.

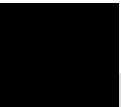
The Maintenance Director ordered a new covered receptacle for the Culinary Department.

The new Culinary Director, who was not in place at the time of this violation, continues to reinforce the parameters of infection control and cleanliness for the kitchen and dining room.

The Plan of Correction will be reviewed during Quality Assurance Meetings and refined as required to consistently enforce these expectations.

Completion Date: 11/05/2021 *Licensee's Proposed Date of POC Implementation*

Not Implemented 3/8/22



91 - Telephone Numbers

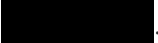
Physical Site

1. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in rooms 

Plan of Correction

Accept

Emergency numbers have been placed in the rooms in question. The Housekeeping Department completed a survey of the community to ensure that all phones had the required numbers posted.

The Maintenance Director reviewed the requirement with the Housekeeping and Maintenance Team for weekly assessment of compliance with this regulation as rooms are individually cleaned weekly to prevent further violations.

This Plan of Correction will remain a part of the Quality Assurance review process and will be amended, as required, if it is found to be ineffective.

Completion Date: 12/06/2021 *Licensee's Proposed Date of POC Implementation*

Not Implemented 3/8/22



96a - First Aid Kit

Physical Site

1. Requirements

Physical Site (continued)

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the facility's van does not include a pair of tweezers.

Plan of Correction

Accept

Tweezers were immediately added to the first aid kit for the van.

The Van Driver will be responsible for monthly auditing of the van and car's first aid kit. The kit will be zip tied with easy access ties to ensure the continuity of the kit and alert staff if items have been used, allowing for replacement and reassessment.

The Van Driver will report the results of his monthly audit to the Maintenance Director for immediate replacement of any outstanding items.

The Plan of Correction will be reviewed during Quality Assurance Meetings and amended as necessary, based on findings.

Completion Date: 11/05/2021 Licensee's Proposed Date of POC Implementation

Not Implemented 3/8/22

101j7 - Lighting/Operable Lamp

Physical Site

1. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident 5, in room [REDACTED] does not have access to a source of light that can be turned on or off at the bedside.

Plan of Correction

Accept

This was immediately corrected at time of survey. The resident preferred to have [REDACTED] next to bed. The [REDACTED] was relocated, with [REDACTED] approval, and [REDACTED] bedside table and lamp were moved closer to [REDACTED].

This Plan of Correction will be reviewed at the Quality Assurance Planning Meeting to determine potential trends related to this singular violation to prevent it from occurring again.

Completion Date: 10/08/2021 Licensee's Proposed Date of POC Implementation

Not Implemented 3/8/22

103a - Kitchen

Physical Site

1. Requirements

2600.

103.a. A home shall have access on the grounds to an operable kitchen with a refrigerator, sink, stove, oven, cooking equipment and cabinets or shelves for storage. If the kitchen is not in the home, the home shall have a kitchen area with a refrigerator, cooking equipment, a sink and food storage space.

Description of Violation

The home kitchen stove hood has not been serviced since June 2019.

Plan of Correction

Accept

The new Maintenance Director contacted several vendors to obtain contractual quotes for the regular, preventative maintenance servicing of the hood. A new vendor is being hired and will be providing regular service to Woodbridge Place to prevent any further oversight.

This Plan of Correction will be reviewed at Quality Assurance meetings to guarantee regular cleanings within the community. If the new vendor is not timely or effective, new service agreements will be considered.

Completion Date: 12/31/2021 Licensee's Proposed Date of POC Implementation Not Implemented 3/8/22

103f - Refrigerator/Freezer Temps

Physical Site

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 10/07/2021 at 10:52, the temperature in the main kitchen freezer was 12 degrees Fahrenheit.

On 10/07/2021 at 10:54, the temperature in the small kitchen freezer was 8 degrees Fahrenheit.

Plan of Correction

Accept

The new Maintenance Director continued to monitor freezer temperatures on the date in question, as a purveyor food delivery occurred this same date. When temperatures did not return to 0 or below, the Maintenance Director contacted a vendor to assess the temperature in the freezer.

The freezer was repaired on 10/8/21 and the new Culinary Services Director, and the Culinary team, has monitored temperatures daily with no further violations of these standards.

This singular violation will be reviewed at the Quality Assurance Meeting to ensure that this intervention prevented further violations from occurring again.

Completion Date: 10/08/2021 Licensee's Proposed Date of POC Implementation Not Implemented 3/8/22

141b1 - Annual Medical Evaluation

Resident Health

1. Requirements

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

Description of Violation

The annual medical evaluation for Resident 6's, who was admitted on [REDACTED] was not found.

Plan of Correction

Accept

The new Director of Nursing is completing a comprehensive audit of medical evaluations on all current residents.

Medical evaluations determined to be non-compliant with significant change or annual requirements will be updated and appointments will be made with the new medical provider at the community to meet with the residents and complete the required documentation.

The tickler file developed by the new Director of Nursing will be reviewed and monitored by the Executive Director and department managers at the Quality Assurance Meeting to ensure that it is effective in maintaining our compliance with regulatory requirements. If it is determined that the tickler file is no longer effective, it will be amended and a new POC will be implemented to ensure the violation does not happen again.

Completion Date: 12/02/2021 Licensee's Proposed Date of POC Implementation

Not Implemented 3/8/22 [REDACTED]

162c - Menus Posted

Nutrition

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 10/07/2021, there was no menu posted for the current week 10/03/2021-10/09/2021 or the following week 10/17/2021-10/23/2021. The menus posted were from 09/06/2021 to 09/12/2021 and 09/13/2021 to 09/19/2021.

Plan of Correction

Accept

Updated menus were posted on 10/8/21.

The new Culinary Services Director, or his designee, is posting the menus to remain compliant with this regulation.

Compliance with this requirement will be reviewed as part of the Quality Assurance process, for at least the next three months, to ensure continued awareness of this requirement and review of the posting by the new Executive Director and the new management team members.

Completion Date: 10/08/2021 Licensee's Proposed Date of POC Implementation

Not Implemented 3/8/22 [REDACTED]

181f - Record of Medication

Medications

1. Requirements

2600.

181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On [REDACTED], resident 6's record did not include a current list of medications.

Plan of Correction

Accept

Resident #6 does not [REDACTED] medication.

The new Director of Nursing is completing a comprehensive audit of medical evaluations on all current residents.

Medical evaluations determined to be non-compliant with significant change or annual requirements will be updated and appointments will be made with the new medical provider at the community to meet with the residents and complete the required documentation. This includes a comprehensive review of current medications.

The tickler file developed by the new Director of Nursing will be reviewed and monitored by the Executive Director and department managers at the Quality Assurance Meeting to ensure that it is effective in maintaining our compliance with regulatory requirements. If it is determined that the tickler file is no longer effective, it will be amended and a new POC will be implemented to ensure the violation does not happen again.

Completion Date: 12/02/2021 Licensee's Proposed Date of POC Implementation

Not Implemented 3/8/22 [REDACTED]

183e - Storing Medications

Medications

1. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On [REDACTED] there was an [REDACTED], [REDACTED] on the 2nd floor medication cart.

On [REDACTED] there were two loose pills on the Memory Unit med carts.

Plan of Correction

Accept

The loose pills were immediately removed from the cart at the time of survey.

The new Resident Care Director and Director of Nursing were unable to determine the date that the [REDACTED] [REDACTED] was opened; therefore, [REDACTED] was discarded and replaced.

The new Resident Care Director and new Director of Nursing provided training to all the Medication Technicians regarding dating medications and medication cart cleanliness.

Medications (continued)

The Director of Nursing has implemented regular medication cart audits to be conducted by Certified Medication Technicians to ensure that carts are clean, orderly, all medications that are to be dated are compliant and expired or discontinued or loose medications are removed from the cart.

The community pharmacy was also contacted to complete a comprehensive cart analysis to match medication orders to cart medication compliance and to audit labeling and dating of medications housed in the community carts.

The Director of Nursing will also complete a random audit of carts prior to the Quality Assurance Meeting, in addition to the structured audit above. The results of the primary and secondary audit will be presented during the Quality Assurance Meeting and the Executive Director and Department Managers will review the effectiveness of the current POC. If this plan is determined to be ineffective, immediate amendments will occur to ensure that the violation does not occur again.

Completion Date: 12/01/2021 Licensee's Proposed Date of POC Implementation

Not Implemented 3/8/2

185a - Implement Storage Procedures

Medications

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 the following dates, resident 7's [redacted] did not match the resident's MAR:

- On [redacted], the MAR for resident 7 has a recorded [redacted]. The reading is not recorded on the [redacted].
- On [redacted], the MAR for resident 7 had a recorded [redacted]. The reading is not recorded on the [redacted].
- On [redacted], the MAR for resident 7 had a recorded [redacted]. The reading is not recorded on the [redacted].
- [redacted] the MAR for resident 7 has a recorded [redacted]. The reading is not recorded on the [redacted].
- [redacted], the MAR for resident 7 had a recorded [redacted]. The reading recorded on the [redacted].
- On [redacted], the MAR for resident 7 does not have a [redacted]. The reading recorded on the [redacted].

Plan of Correction

Accept

The new Director of Nursing completed a comprehensive review of all [redacted] to ensure that each resident had a labeled [redacted] assigned to each person individually.

[redacted] were assessed to be in working order, calibrated and proper use of the [redacted] that coincide with each [redacted]. After assessing these devices, Woodbridge Place requested [redacted] from the pharmacy to avoid the potential for additional violations moving forward. Licensee's Proposed Date of POC Implementation

Not Implemented 3/8/22

Medications (continued)

The new Director of Nursing and new Wellness Nurse have calibrated each new device and labeled each with the residents name for use only with the labeled resident.

Training was conducted by the new Director of Nursing and new Resident Care Director and several Medication Technicians were formally retrained in via courses sponsored by the Bureau.

The new Wellness Nurse will be responsible for weekly audits of the to ensure that they are calibrated properly, supplies are readily available and MAR recordings match the calibrated device.

The Director of Nursing will be responsible for random secondary audits and results of the primary and secondary audits will be provided to the Executive Director and Managing Directors at Quality Management Meeting. Results will be assessed and if this plan is not proving to be effective, it will be immediately amended to ensure that this violation does not occur again.

Completion Date: 12/01/2021 Licensee's Proposed Date of POC Implementation Not Implemented 3/8/22

185b - Medication Procedures

Medications

1. Requirements

2600.

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

1. Documentation of the receipt of controlled substances and prescription medications.

Description of Violation

Present on the 2nd floor med cart for resident 2 were three packs of . There was no documentation for the receipt of .

Medications (continued)

Plan of Correction

Accept

The new Director of Nursing immediately contacted the pharmacy to obtain the appropriate [redacted] sheets for this medication.

The new Director of Nursing also requested that the community pharmacy complete a comprehensive cart analysis to match medication orders to cart medication compliance and to review [redacted] measures.

The new Director of Nursing also completed an assessment of use of [redacted] and made formal recommendations to the new nurse practitioner servicing Woodbridge Place regarding [redacted] that have not been used in the last thirty days. Several of these identified medications were subsequently discontinued.

The Director of Nursing has implemented regular medication cart audits to be conducted by Certified Medication Technicians to ensure that carts are clean, orderly, all medications that are to be dated are compliant and expired or discontinued or loose medications are removed from the cart. [redacted] forms are also reviewed as a part of this review/audit.

This Plan of Correction will be reviewed at Quality Assurance meetings by the Executive Director and Department Managers in order to determine continued effectiveness. The plan will be amended and a new POC implemented if this plan is determined to be ineffective.

Completion Date: 12/02/2021 Licensee's Proposed Date of POC Implementation Not Implemented 3/8/22 [redacted]

190a - Completion Medication Course

Medications

1. Requirements

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person A, who has not successfully completed the Department-approved medication administration course, administered medications to resident 5, including the following:

- On [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

Plan of Correction

Accept

Staff member A is no longer employed at the community.

Medications (continued)

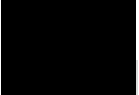
The new Director of Nursing has reviewed all Medication Technicians training to ensure that all Medication Technicians possess the proper training records.

The Director of Nursing will continue to audit Medication Technicians training on a monthly basis to ensure that practicums and MAR reviews are completed timely.

Results of the audits will be reviewed during Quality Assurance Meetings to determine if the POC, as implemented, is effective. Should the plan be determined to be noncompliant in any way, a new POC will be implemented and monitoring will continue to ensure that a violation does not happen again.

Completion Date: 11/01/2021 *Licensee's Proposed Date of POC Implementation*

Not Implemented 3/8/22



225c - Additional Assessment

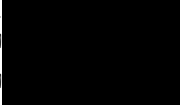
Services

1. Requirements

- 2600.
- 225.c. The resident shall have additional assessments as follows:
 1. Annually.

Description of Violation

*Resident 6's most recent assessment was completed on [REDACTED]
Resident 8's most recent assessment was completed on [REDACTED]*



Plan of Correction

Accept

The new Director of Nursing is completing a comprehensive audit to determine Assessment compliance for all current residents.

Assessments determined to be non-compliant with significant change or annual requirements will be updated and appointments will be scheduled to review the assessment with residents and their responsible parties.

The tickler file developed by the new Director of Nursing will be reviewed and monitored by the Executive Director and department managers at the Quality Assurance Meeting to ensure that it is effective in maintaining our compliance with regulatory requirements. If it is determined that the tickler file is no longer effective, it will be amended and a new POC will be implemented to ensure the violation does not happen again.

Completion Date: 12/06/2021 *Licensee's Proposed Date of POC Implementation*

Not Implemented 3/8/22



231e - No Objection Statement

Secured Dementia Care Units

1. Requirements

2600.

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident 9 was admitted to the [REDACTED] The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction

Accept

Resident 9 signed the required documentation on [REDACTED].

Resident 9 was appointed a [REDACTED] in the month of [REDACTED].

The [REDACTED] now in place, will be contacted to review and sign the same document, per the regulatory requirement.

Compliance with this requirement will be reviewed by the Executive Director and department managers as part of the Quality Assurance process. The new Marketing Director will be responsible for a random audit of at least one [REDACTED] residents chart per meeting to ensure continued awareness, auditing and compliance and will present [REDACTED] findings to ensure that this POC remains effective.

Completion Date: 12/31/2021 Licensee's Proposed Date of POC Implementation

Not Implemented 3/8/2 [REDACTED]