

Department of Human Services  
Bureau of Human Service Licensing

July 28, 2022

[REDACTED], ADMINISTRATOR  
[REDACTED]  
[REDACTED]

RE: COMMONWEALTH SENIOR LIVING  
AT WILLOW GROVE  
1120 YORK ROAD  
WILLOW GROVE, PA, 19090  
LICENSE/COC#: 13994

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/16/2022, 06/23/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,  
[REDACTED]

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: *COMMONWEALTH SENIOR LIVING AT WILLOW GROVE* License #: *13994* License Expiration: *10/08/2022*  
Address: *1120 YORK ROAD, WILLOW GROVE, PA 19090*  
County: *MONTGOMERY* Region: *SOUTHEAST*

**Administrator**

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

**Legal Entity**

Name: *MCAP WILLOW GROVE OPERATOR LLC*  
Address: *PO BOX 2064 COMMONWEALTH SR LIV, ATTN LADONNA LEWIS, CHARLOTTESVILLE, VA, 22902*  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *I-2* Date: *05/21/2014* Issued By: *Upper Moreland Twp*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *83* Waking Staff: *62*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal* Exit Conference Date: *06/23/2022*

**Inspection Dates and Department Representative**

06/16/2022 - On-Site: [REDACTED]  
06/23/2022 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *122* Residents Served: *60*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Sweet Memories* Capacity: *52* Residents Served: *20*

**Hospice**

Current Residents: *3*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *56*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *1*  
Have Mobility Need: *23* Have Physical Disability: *1*

## Inspections / Reviews

06/16/2022 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *07/15/2022*

07/16/2022 - POC Submission

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *07/27/2022*

07/28/2022 - Document Submission

Reviewer: [REDACTED] Follow-Up Type: *Not Required*

## 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 [REDACTED] at [REDACTED], Resident #1, fell in their room and required treatment at the emergency room. The home did not report this incident to the department until 4/4/22 at 1:45pm.

On [REDACTED] Resident #2, fell in their room and required treatment at the emergency room. The home did not report this incident to the department until 4/4/22 at 1:45pm.

#### Plan of Correction

**Accept**

All reportable incident reports will be reported initially to the regional office within the first 24 hours. The RCD/ED will send the initial report to the regional office during business days. During holidays and weekends staff will be instructed to notify RCD/ED to ensure compliance within reporting hours. Education will be provided about reporting process for all staff.

**Completion Date:** 06/22/2022

#### Document Submission

**Implemented**

All reportable incident reports will be reported initially to the regional office within the first 24 hours. The Resident Care Director and/or Executive Director will send the initial report to the regional office during business days. During holidays and weekends staff will be instructed to notify Resident Care Director and/or Executive Director to ensure compliance within reporting hours. Education will be provided about reporting process for all staff.

## 26a - Quality Management Plan

### 1. Requirements

2600.

26.a. The home shall establish and implement a quality management plan.

#### Description of Violation

The home does not have a quality management plan.

#### Plan of Correction

**Accept**

Quality Management Plan is being developed and will be implemented. Going forward the PCHA and Maintenance Director will update Quality Management Plan, establish on going meetings, review areas for quality improvement with community team. Team will put a plan in place to correct areas needing improvement.

**Completion Date:** 08/31/2022

#### Document Submission

**Implemented**

The Executive Director will establish, update and review the Quality Management Plan. The Executive Director will establish ongoing meetings with community team to review areas for quality improvement. Executive Director will put a plan in place to correct areas needing improvement.

## 51 - Criminal Background Check

### 1. Requirements

2600.

**51 - Criminal Background Check (continued)**

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**

Staff person A and staff person B began working in the home in [REDACTED]. Both staff persons do not reside in Pennsylvania. There is no FBI background check on file for either staff person.

Staff Person C began working in the home on [REDACTED]. Staff person's Pennsylvania Criminal Background check was not completed until [REDACTED]

**Plan of Correction****Accept**

Going to get fingerprinted Monday [REDACTED] @ 10 AM for those that are not Pennsylvania residents.

Staff that are Pennsylvania residents will have a Pennsylvania Criminal Background completed during the new hire process moving forward. Moving forward all associates will have appropriate background checks.

**Completion Date:** 07/18/2022

**Document Submission****Implemented**

All out of state staff members are now compliant with FBI background checks.

Staff members that are Pennsylvania residents or staff that have not lived in Pennsylvania for the prior two years shall have a Pennsylvania Criminal Background completed during the new hire process moving forward. Executive Director and Business Office Manager will monitor to ensure compliance.

**54a - Direct Care Staff****1. Requirements**

2600.

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.

**Description of Violation**

Direct care staff person C, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

**Plan of Correction****Accept**

All staff will supply all qualifying documents and business office will ensure compliance prior to scheduling new hire orientation.

**Completion Date:** 06/16/2022

**Document Submission****Implemented**

All staff upon hire will supply qualifying documents and Business Office Manager and Executive Director will ensure compliance prior to scheduling new hire orientation. Employee files will be audited and missing documents will be corrected. Executive Director and Business Office Manager shall monitor to ensure ongoing compliance.

**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.

**65d - Initial Direct Care Training (continued)**

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

**Description of Violation**

Direct care staff person C, hired on [REDACTED] began providing unsupervised ADL services on within a week of hire date. . However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

**Plan of Correction****Accept**

Business Office will audit all associates files to ensure compliance for all community positions. Upon hiring all staff will supply qualifying documents, including completion and passing of the approved direct care training course and business office will ensure compliance prior to scheduling new hire orientation.

**Completion Date:** 07/31/2022

**Document Submission****Implemented**

Business Office Manager and Executive Director will audit all associate files to ensure compliance for all community positions. Upon hiring all staff will supply qualifying documents, including completion and passing of the approved direct care training course and business office will ensure compliance prior to scheduling new hire orientation.

**82c - Locking Poisonous Materials****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**

A stick of Suave Deodorant, a stick of Secret Deodorant and a tube of Crest Toothpaste, with a manufacture's label indicating "Contact poison control or seek medical help immediately if swallowed", was unlocked, unattended, and accessible to residents in room 218. Not all the residents of the home, including both residents in room 218, have been assessed capable of recognizing and using poisons safely.

**Plan of Correction****Accept**

A full room check was completed in memory care to ensure compliance. Going forward ARCD or designee will perform weekly inspections of the memory care community to ensure compliance. Education provided for care staff on regulation 82.c

**Completion Date:** 07/22/2022

**Document Submission****Implemented**

Rounds will be completed in memory care to ensure compliance. Going forward Resident Care Director or designee will perform weekly inspections of the memory care community to ensure ongoing compliance. Education provided for care staff on regulation 82.c

**85a - Sanitary Conditions****1. Requirements**

2600.

- 85.a. Sanitary conditions shall be maintained.

**85a - Sanitary Conditions (continued)****Description of Violation**

*On 6/23/22 at approximately 9:30am, there is strong odor or urine in resident #5's room and there is a pile of what appears to be used incontinence products on the end of residents bed.*

*On 6/23/22 at approximately 9:30am, there is a bottle of Drug Buster chemical present in the bottle drawer of the 3 Short medication cart. The bottle is leaking a dark gray colored liquid that has spilled down the sides of the bottle and onto the bottom surface of the drawer.*

*On 6/23/22 at approximately 11:00am, there was a smear of dried blood present on the wall of the bathroom and on the handrail next to the toilet in Resident #3's room.*

*On 6/23/22 at approximately 11:30am there was a brownish/orange colored sticky dry spill under rolling carts at back of the walk in refrigerator in the main kitchen area. There was also several wilted lettuce leaves on floor.*

**Plan of Correction****Accept**

*Room rounds are being completed throughout the shift by designated person to ensure no foul odors and any used incontinent products are disposed of properly.*

*Weekly cart checks to be completed to ensure bottles of drug buster are being disposed when needed*

*Education for all staff on regulation and how to ensure proper compliance*

**Completion Date:** 07/22/2022

**Document Submission****Implemented**

*All areas identified during the inspection have been cleaned. Room rounds will be completed throughout each shift by Resident Care Director and/or designated person to ensure no foul odors and proper disposal of any used incontinent products.*

*Weekly cart audits to be completed to ensure sanitary conditions.*

*Education for all staff on regulation 85.a. and how to ensure ongoing compliance. Resident Care Director will monitor for ongoing compliance.*

**93a - Handrails****1. Requirements**

2600.

93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

**Description of Violation**

*The exterior steps outside of the 1st short hall exit door near the generator has a hand rail that has broken off and is lying on the ground next to the steps.*

**Plan of Correction****Accept**

*Maintenance Director is in the process of seeking proposals to secure the handrail. Handrail will be properly secured. Caution sign has been posted until the rail is repaired. Moving forward all rails will be checked and discussed at the Quality Management meetings.*

**Completion Date:** 08/31/2022

**Document Submission****Implemented**

*Maintenance Director is in the process of seeking proposals to secure the handrail. Handrail will be properly*

**93a - Handrails (continued)**

secured. Caution sign has been posted until the rail is repaired. Moving forward all rails will be checked and discussed at the Quality Management meetings.

**97 - Elevators/Lifting Devices****1. Requirements**

2600.

97. Elevators and Stair Glides - Each elevator and stair glide must have a certificate of operation from the Department of Labor and Industry or the appropriate local building authority in accordance with 34 Pa. Code Chapter 405 (relating to elevators and other lifting devices).

**Description of Violation**

The elevator 3 does not have a certificate of operation from the Department of Labor and Industry or appropriate local building authority.

**Plan of Correction****Accept**

Inspection for Elevator 3 was conducted, but updated certificate was not forwarded to the community and unavailable during license renewal. Inspection company notified and certificate is being sent to the community. Maintenance Director will audit certificates to ensure all documents are available at the community.

**Completion Date:** 07/22/2022

**Document Submission****Implemented**

Inspection for Elevator 3 was conducted and passed, but updated certificate was not forwarded to the community and unavailable during license renewal. Inspection company notified and certificate is being sent to the community. Maintenance Director and Executive Director will audit certificates to ensure all documents are valid and available at the community.

**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. The date the procedures was last sent to the local EMA is unknown.

**Plan of Correction****Accept**

Written emergency procedures will be updated by the PCHA and Maintenance Director and submitted to the local emergency management agency. PCHA and Maintenance Director will submit updated plan annually.

**Completion Date:** 07/22/2022

**Document Submission****Implemented**

Written emergency procedures will be updated by the Executive Director and Maintenance Director and submitted to the local emergency management agency. Executive Director and Maintenance Director will submit updated plan annually.

**121a - Unobstructed Egress****1. Requirements**

2600.

**121a - Unobstructed Egress (continued)**

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

**Description of Violation**

*On 6/16/22 at 2:35pm, 1st floor Long Hall emergency exit is obstructed. The door is equipped with a push bar opener however the door cannot be pushed open without using excessive force due to the door sticking in the doorjamb or threshold.*

**Plan of Correction****Accept**

*Maintenance Director adjusted door day of inspection to reduce door sticking. Director will add door to preventive maintenance list to ensure door is easy to open.*

**Completion Date:** 06/16/2022

**Document Submission****Implemented**

*Maintenance Director adjusted door day of inspection to reduce door sticking. Maintenance Director will add door to preventive maintenance list to ensure door is easy to open at all times. Executive Director and Maintenance Director will continue to monitor for ongoing compliance.*

**124 - Notice to Fire Department****1. Requirements**

2600.

124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

**Description of Violation**

*The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.*

**Plan of Correction****Accept**

*The home notified the local fire department in writing of the address of the home, location of the bedrooms and assistance needed to evacuate in an emergency. Written notification was received by the fire department and confirmation documents are available.*

**Completion Date:** 06/21/2022

**Document Submission****Implemented**

*The executive director notified the local fire department in writing of the address of the home, location of the bedrooms and assistance needed to evacuate in an emergency. Written notification was received by the fire department and confirmation documents are available.*

**132a - Monthly Fire Drill****1. Requirements**

2600.

132.a. An unannounced fire drill shall be held at least once a month.

**Description of Violation**

*An unannounced fire drill was not held during in the months of January 2022 to June 2022.*

**Plan of Correction****Accept**

*Monthly fire drills are in place and will continue monthly conducted by Maintenance Director and or designee.*

**Completion Date:** 06/24/2022

132a - Monthly Fire Drill (*continued*)**Document Submission****Implemented**

*The Executive Director has in-serviced the team on the regulation as they relate to fire drills. Monthly fire drills are in place and will be conducted by Maintenance Director and or designee. Executive Director will monitor for ongoing compliance.*

## 132b - Safety Inspection/Fire Drill

**1. Requirements**

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

**Description of Violation**

*The home did not have a fire drill observed by a fire safety expert by 12/31/2021 and has not had one done to date. The home has not had a fire safety inspection completed since January 2020.*

**Plan of Correction****Accept**

*A Fire Safety Inspection was conducted on September 13, 2021. Interim PCHA received copy the day of inspection. PCHA and or Maintenance Director will schedule annually fire safety inspections and inspection results will be kept and available for review.*

**Completion Date:** 06/16/2022

**Document Submission****Implemented**

*The Fire Safety Expert completed an observed drill as required by the regulation. A copy of inspection was not available at time of inspection. Executive Director and Maintenance Director will schedule fire safety inspections annually and inspection results will be kept onsite and available for review.*

## 132c - Fire Drill Records

**1. Requirements**

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

**Description of Violation**

*The fire drill record for the drill conducted on 12/30/2021 does not include the exit route used, the number of residents in the home at the time of the drill.*

**Plan of Correction****Accept**

*Current fire drill records include exit route and number of residents in the home. Moving forward the designee conducting the drills will include all required information on the monthly fire drill record.*

**Completion Date:** 05/24/2022

**Document Submission****Implemented**

*Current fire drill records include exit route and number of residents in the home. Moving forward the Maintenance Director or designee conducting the drills will include all required information per the regulation on fire drill record.*

## 132d - Evacuation

**1. Requirements**

132d - Evacuation (continued)

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill on 12/30/21 at 2:50pm, all residents of the home did not evacuate to a public thoroughfare or a fire safe area and there was no head count of residents completed by staff.

Plan of Correction

Accept

Residents are evacuating to a public thoroughfare or fire safe area. Resident and staff head counts are being conducted. Moving forward the designee conducting the drills will include all required information on the monthly fire drill record.

Completion Date: 06/24/2022

Document Submission

Implemented

All staff have been in-serviced on the proper process for conducting fire drills and accounting for each person in the building. Residents are evacuating to a public thoroughfare or fire safe designated area. Moving forward the Maintenance Director or designee conducting the drills will include all required information on the monthly fire drill record.

132e - Fire Drill Sleeping Hours

1. Requirements

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The home has not completed a fire drill during sleeping hours from December 2021 to June 2022.

Plan of Correction

Accept

Home will be compliant with conducting fire drills during sleeping hours, once every 6 months. Moving forward the designee conducting the drills will include all required information on the monthly fire drill record, including drills during sleeping hours.

Completion Date: 09/30/2022

Document Submission

Implemented

Home will be compliant with conducting fire drills during sleeping hours, once every 6 months. Moving forward the Maintenance Director or designee conducting the drills will include all required information on the monthly fire drill record, including drills during sleeping hours every 6 months. Next scheduled drill will be during sleep hours.

141b1 - Annual Medical Evaluation

1. Requirements

2600.

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

Description of Violation

Resident #3's most recent medical evaluation was completed on [redacted].  
Resident #4's most recent medical evaluation was completed on [redacted].  
Resident #5's most recent medical evaluation was completed on [redacted].  
Resident #6's most recent medical evaluation was completed on [redacted].

**141b1 - Annual Medical Evaluation (continued)**

Resident #7's most recent medical evaluation was completed on [REDACTED]

**Plan of Correction****Accept**

Charts Audited for DME dates noted. New DME sent to physician to complete for any dates out of compliance. Going forward calendar made to keep track of when annual DME need completed. Beginning of each month designated person will send DME to physicians get completed

**Completion Date:** 08/11/2022

**Document Submission****Implemented**

Charts Audited for DME dates noted. New DME request has been sent to physician to complete for any DME dates that are out of compliance.

Going forward the nurse will ensure annual DME and significant change DMEs are complete.

**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 6/16/22 at 2:30pm, the second floor memory care medication cart was unlocked, unattended, and accessible.

Resident #8 self administers medications. Resident #8's room was unlocked at the time of inspection and medications are present on a desk by residents tv. Resident #8 reports that they do not keep medications in a locked area and they do not lock their door to their apartment when not present.

**Plan of Correction****Accept**

Education to Med aides about keeping med cart locked at when they are unattended.

Any resident that self-administers will be instructed to obtain a lock box to ensure that medications are stored in compliance with the regulation. RCD/ARCD periodically check that medications are stored appropriately within residents room

**Completion Date:** 07/15/2022

**Document Submission****Implemented**

Education to Medication aides about proper locking of the medication when it is unattended. The medication aide was counseled on proper procedures for securing medications at all times.

Any resident that self-administers will be instructed to obtain a lock box to ensure that medications are stored in compliance with the regulation. Resident Care Director will periodically check that medications are stored appropriately within residents room. Executive Director and Resident Care Director will ensure on-going compliance.

**183e - Storing 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.

**183e - Storing Medications (continued)****Description of Violation**

On 6/23/22, 5 loose pills were observed in the 3 Short medication cart, 6 loose pills were observed in the 3 Long medication cart, and 2 loose pills and an accumulation of miralax powder in the back and corner of a drawer were observed in the 1 Short medication cart

**Plan of Correction****Accept**

Medication carts were fully clean of any loose medications or accumulation of powders  
Going forward medication carts will be cleaned by weekly by a designated person.

**Completion Date:** 07/15/2022

**Document Submission****Implemented**

Medication carts were fully cleaned of any loose medications or accumulation of powders  
Going forward medication carts will be cleaned by weekly by a designated person.  
Executive Director and Resident Care Director will monitor to ensure on-going compliance.

**183f - Discontinued Medications****1. Requirements**

2600.

183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

**Description of Violation**

A bottle of [REDACTED] belonging to resident #9 was found in the bottom drawer of the 3 Long medication cart. The bottle has a printed expiration date of 3/2022.

**Plan of Correction****Accept**

Full cart audit will be completed on all carts. Any expired medication that is found will be replaced with current medications.  
Going forward designated person will complete monthly medication checks on each cart to make sure all medications are current.

**Completion Date:** 07/22/2022

**Document Submission****Implemented**

Full medication cart audits were conducted on 7/15 by the new pharmacy. Any expired medication that was identified has been disposed of.  
Going forward the Resident Care Director and Executive Director will complete monthly medication checks on each cart to make sure all medications are current.

**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.

185a - Implement Storage Procedures (continued)

Description of Violation

Resident #5 is ordered to have glucose checks done 3 times a day at 6:45am, 11am and 6pm. The following instances of glucometer readings that do not match the glucose log recordings were observed:

- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]

Resident #11 is ordered to have glucose checks done 3 times a day at 6:30am, 11am and 4pm. The following instances of glucometer readings that do not match the glucose log recordings were observed:

- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]

Plan of Correction

Accept

Training will be held for all medication aides and nurses on how to properly read a glucometer and document correct readings. Diabetic training being scheduled for all medication aides. Going forward night shift designee will check date and times on glucometers to make sure they are properly calibrated. Diabetic readings will be checked and compared to the machines monthly.

Completion Date: 08/11/2022

Document Submission

Implemented

In-service Training has been conducted with all persons administering medications on the proper glucometer. Diabetic training has been completed for all medication aides. Going forward Resident Care Director or Designee will check date and times on glucometers to make sure they are properly calibrated. Diabetic readings will be checked and compared to the machines weekly.

187b - Date/Time of Medication Admin.

1. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1 is prescribed [Redacted] take 1 tablet by mouth daily at 8am and daily at 2pm. This medication was administered on [Redacted] however Resident #1's narcotic declining inventory log was not initialed as administered.

Resident #7 is prescribed [Redacted] - take 1 tablet by mouth twice daily. This medication was administered on [Redacted] however Resident #7's narcotic declining inventory log

**187b - Date/Time of Medication Admin. (continued)**

was not initialed as administered.

Resident #10 is prescribed [REDACTED] take 1 tablet by mouth every 8am for [REDACTED] This medication was administered [REDACTED] however Resident #10's narcotic declining inventory log was not initialed as administered.

**Plan of Correction****Accept**

Narcotic books were audited to make sure all medications were appropriately signed out. Training held with all staff who pass medication about how to document narcotics when they are being given and how to use a count sheet. Going forward narcotic books will be audited monthly to make sure medications are being signed out correctly.

**Completion Date:** 08/11/2022

**Document Submission****Implemented**

Narcotic books were audited to make sure all medications were appropriately signed out. Training held with all medication aides about how to document narcotics when they are being given and how to use a count sheet. Going forward narcotic books will be audited monthly to make sure medications are being signed out correctly. Resident Care Director will monitor for ongoing compliance.

**187d - Follow Prescriber's Orders****1. Requirements**

2600.

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

**Description of Violation**

Resident #7 is prescribed [REDACTED] - take 1 tablet by mouth twice daily. This medication was not administered on 6/2/22, 6/3/22, 6/4/22 and 6/5/22 because the medication was not present in the home.

Resident #7 is prescribed a [REDACTED] to be applied daily. This medication is not present on the medication cart on 6/23/22.

Resident #5 is ordered to have glucose checks done 3 times a day at 6:45am, 11am and 6pm On 6/9/22 at 11am, 6/14/22 at 11am, 6/14/22 at 4pm, 6/15/22 at 11am, there is no reading in the residents glucometer indicating that the glucose check was not completed.

Resident #11 is ordered to have a glucose check done 3 times daily scheduled for 6:30a, 11a and 4pm. On 6/1/22 at 6:30am and 6/9/22 at 11am, there is no glucose reading in residents glucometer indication an glucose check was not completed.

Resident #12 is ordered to have glucose checks done twice daily at 6am and 8pm. On 6/18/22, 6/19/22 and 6/22/22 there is no glucose reading in residents glucometer. indicating that a glucose check was not done.

**Plan of Correction****Accept**

Medication carts were audited to make sure all medications that are on the MAR are available in the cart. Med staff education on requirement of following physician orders. Diabetic training being scheduled for all medication aides. Going forward exception and medication administration reports will be checked daily to ensure correct administration as ordered by physician. Training held on the importance of reordering medication in a timely manner and notification process if a medication has not come in before they are unavailable.

**187d - Follow Prescriber's Orders (continued)****Completion Date:** 08/11/2022**Document Submission****Implemented**

Medication carts were audited to make sure all medications that are on the MAR are available in the cart. Training was provided to medication aides on requirement of following physician orders. Diabetic training being scheduled for all medication aides.

Going forward exception and medication administration reports will be checked daily by Resident Care Director or designee to ensure correct administration as ordered by physician. Additional training was held on the importance of reordering medication in a timely manner and notification process if a medication has not come in before they are unavailable. The resident care director will monitor for ongoing compliance.

**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 5/10/21; however, a preadmission screening was not completed.

**Plan of Correction****Accept**

Charts were audited for Preadmission screening. Note made in Resident 3 chart about missing screening and placed in chart as per inspectors' recommendation.

Going forward preadmission screening will be complete at initial assessment and placed in chart.

**Completion Date:** 07/15/2022**Document Submission****Implemented**

Charts were audited for Preadmission screening. Note made in Resident 3 chart about missing screening and placed in chart as per inspectors' recommendation.

Going forward preadmission screening will be complete at initial assessment and placed in chart. Executive Director will monitor for ongoing compliance.

**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 was completed on [REDACTED]

Resident #4's most recent assessment was completed on [REDACTED]

Resident #5's most recent assessment was completed on [REDACTED]

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

**225c - Additional Assessment (continued)**

Resident #7's most recent assessment was completed on 8/25/20.

**Plan of Correction****Accept**

Chart audit completed. All out of date RASP were completed.

Going forward, designated person will keep calendar to track when annual RASP need completed.

Completion Date: 08/11/2022

**Document Submission****Implemented**

Chart audit completed. All out of date RASP were completed.

Going forward, Resident Care Director or designee will ensure assessments and RASP are completed per the regulation

**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.

**Description of Violation**

Resident #3 participated in the development of his/her support plan on [REDACTED] However, the resident did not sign the support plan.

**Plan of Correction****Accept**

Chart Audit completed to review RASP and to ensure signatures.

Going forward all RASP will be reviewed and signed at the time of review. If unable to sign RASP it will be noted on the RASP in signature block.

Completion Date: 08/11/2022

**Document Submission****Implemented**

Chart Audit completed to review RASP and to ensure proper signatures.

Going forward all RASP will be reviewed and signed at the time of review. If unable to sign RASP it will be noted on the RASP in signature block. Executive Director will ensure ongoing compliance.

**231f - Assessed Annually****1. Requirements**

2600.

231.f. In addition to the requirements in § 2600.225 (relating to initial and annual assessment), the resident shall also be assessed annually for the continuing need for the secured dementia care unit.

**Description of Violation**

Resident #4 was assessed for the need for Secure Dementia Care Unit (SDCU) on [REDACTED] and was not assessed again.

**Plan of Correction****Accept**

All SDCU charts were audit. New SDCU assessments sent to physician for any out-of-date SDCU assessments found.

Going forward calendar made to keep track of when SDCU assessments need completed. Beginning of each month designated person will send SDCU assessment to physicians get completed.

Completion Date: 08/11/2022

231f - Assessed Annually *(continued)***Document Submission****Implemented**

*All SDCU charts were audited. New SDCU assessments sent to physician for any out-of-date SDCU assessments found.*

*Going forward Resident Care Director and/or designee will ensure SDCU assessments are completed. Each month the Resident Care Director/Executive Director will monitor for ongoing compliance.*

## 233c - Key-Locking Devices

**1. Requirements**

2600.

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

**Description of Violation**

*The directions for operating the home's locking mechanism are not conspicuously posted near the emergency exit door in the 2nd floor short hall way of the Secure Dementia Care Unit (SDCU).*

**Plan of Correction****Accept**

*Directions are posted conspicuously near the emergency door on the 2nd floor. During daily, weekly and monthly walk throughs Maintenance Director will check to ensure signs are posted.*

**Completion Date:** 06/27/2022

**Document Submission****Implemented**

*The postings were taken down for hallway painting at the time of inspection.*

*Signs have been posted conspicuously at the emergency doors on the 2nd floor. During daily, weekly, and monthly walk throughs the Maintenance Director and Executive Director will check to ensure signs are posted.*