

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

December 7, 2022

[REDACTED]
WATERMARK BELLINGHAM LLC
[REDACTED]
[REDACTED]

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

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/30/2022, 07/01/2022, 07/06/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: THE WATERMARK AT BELLINGHAM **License #:** 14688 **License Expiration:** 02/11/2023

Address: 1615 EAST BOOT ROAD, WEST CHESTER, PA 19380

County: CHESTER **Region:** SOUTHEAST

Administrator

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

Legal Entity

Name: WATERMARK BELLINGHAM LLC

Address: [REDACTED]

Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I 2 **Date:** 01/06/2021 **Issued By:** East Goshen Township

Type: C 2 LP **Date:** 02/09/2001 **Issued By:** Commonwealth of PA, L&I

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 60 **Waking Staff:** 45

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**

Reason: Renewal **Exit Conference Date:** 07/06/2022

Inspection Dates and Department Representative

06/30/2022 On Site [REDACTED]

07/01/2022 On Site [REDACTED]

07/06/2022 On Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 80 **Residents Served:** 36

Secured Dementia Care Unit

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

Hospice

Current Residents: 9

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 35

Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0

Have Mobility Need: 24 **Have Physical Disability:** 1

Inspections / Reviews

06/30/2022 - Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 07/31/2022

Inspections / Reviews (*continued*)

08/02/2022 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/06/2022

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 09/03/2022

10/20/2022 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/06/2022

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 10/27/2022

12/07/2022 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/06/2022

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

Per the Care Facility Carbon Monoxide Alarms Standards Act of Jun. 23, 2016; Carbon Monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance.

The Carbon Monoxide detector for the boiler room across the hall from [REDACTED] is not hard wired to electricity and did not have a battery in the battery compartment.

POC Submission

Accept

**A new battery was placed in this detector on 07/06/2022 by the Maintenance Department, the date is was discovered to be missing.*

**All Carbon Monoxide Detectors were checked by the Maintenance Department for batteries and tested during July 2022.*

**Carbon Monoxide Detectors are tested every 6 months and recorded in TELS by the Maintenance Department. The next scheduled check/test is October 2022. The Director of Plant Operations, or designee, will review results in Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: 07/29/2022

Document Submission

Implemented [REDACTED] - 09/30/2022)

**A new battery was placed in this detector on 07/06/2022 by the Maintenance Department, the date is was discovered to be missing.*

**All Carbon Monoxide Detectors were checked by the Maintenance Department for batteries and tested during July 2022.*

**Carbon Monoxide Detectors are tested every 6 months and recorded in TELS by the Maintenance Department. The next scheduled check/test is October 2022. The Director of Plant Operations, or designee, will review results in Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: 07/29/2022

25b - Contract Signatures

2. 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]/21, for resident #1 was not signed by the resident.

POC Submission

Accept

**Resident was approached to sign [REDACTED] contract on [REDACTED]/2022. [REDACTED] was unable to sign due to cognitive decline. This was documented on the contract.*

**All Memory Care resident contracts were audited by the Administrator for compliance with signatures on 07/27/2022. All Personal Care resident contracts are being audited by the Business Office Director, or designee, for completion. This audit will be completed by 08/19/2022 (Attachment A).*

25b - Contract Signatures (continued)

**All new Personal Care and Memory Care resident contracts will be reviewed on a monthly basis for completion by the Business Office Director, or designee. Results will be reviewed in Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: 08/19/2022

Document Submission**Implemented (MJ - 09/30/2022)**

**Resident was approached to sign [REDACTED] contract on [REDACTED]/2022. She was unable to sign due to cognitive decline. This was documented on the contract.*

**All Memory Care resident contracts were audited by the Administrator for compliance with signatures on 07/27/2022. All Personal Care resident contracts are being audited by the Business Office Director, or designee, for completion. This audit will be completed by 08/19/2022 (Attachment A).*

**All new Personal Care and Memory Care resident contracts will be reviewed on a monthly basis for completion by the Business Office Director, or designee. Results will be reviewed in Quality Assurance Meetings as scheduled.*

***Due to open positions that occurred within the Marketing and Business Office Departments after the annual survey, the administrative file audit is still in progress. These positions have now been filled and we have set a new completion date of 10/21/2022.*

Licensee's Proposed Overall Completion Date: 09/28/2022

28f - Resident's Funds and 30-day Refund**3. Requirements**

2600.

28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident #2 was discharged on [REDACTED]/22. The home did not provide the required refund until [REDACTED]/22.

POC Submission**Accept**

**The Business Office Director, or designee, is currently auditing the discharge records for residents beginning with anuary 2022 to present for compliance. The audit will be completed by 08/26/2022.*

**The Business Office Director, or designee, will continue to track resident discharges ongoing with date of discharge and date of refund on the Resident Refund Tracker (Attachment B) to monitor for compliance. Results will be reviewed in Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: 08/26/2022

Document Submission**Implemented [REDACTED] - 09/30/2022)**

**The Business Office Director, or designee, is currently auditing the discharge records for residents beginning with January 2022 to present for compliance. The audit will be completed by 08/26/2022.*

**The Business Office Director, or designee, will continue to track resident discharges ongoing with date of discharge and date of refund on the Resident Refund Tracker (Attachment B) to monitor for compliance. Results will be reviewed in Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: 08/26/2022

41e - Signed Statement

4. Requirements

2600.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

POC Submission

Accept

*Resident was approached to sign the acknowledgement on [REDACTED]/2022. [REDACTED] was unable to sign due to cognitive decline. This was documented on the form.

*All Memory Care resident contracts were audited by the Administrator for compliance with signatures on 07/27/2022. All Personal Care resident contracts are being audited by the Business Office Director, or designee, for completion. This audit will be completed by 08/19/2022 (Attachment A).

*All new Personal Care and Memory Care resident contracts will be reviewed on a monthly basis for completion by the Business Office Director, or designee. Results will be reviewed in Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/19/2022

Document Submission

Implemented ([REDACTED] - 09/30/2022)

*Resident was approached to sign the acknowledgement on [REDACTED]/2022. [REDACTED] was unable to sign due to cognitive decline. This was documented on the form.

*All Memory Care resident contracts were audited by the Administrator for compliance with signatures on 07/27/2022. All Personal Care resident contracts are being audited by the Business Office Director, or designee, for completion. This audit will be completed by 08/19/2022 (Attachment A).

*All new Personal Care and Memory Care resident contracts will be reviewed on a monthly basis for completion by the Business Office Director, or designee. Results will be reviewed in Quality Assurance Meetings as scheduled.

**Due to open positions that occurred within the Marketing and Business Office Departments after the annual survey, the administrative file audit is still in progress. These positions have now been filled and we have set a new completion date of 10/21/2022.

Licensee's Proposed Overall Completion Date: 09/28/2022

42s - Privacy

5. 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 07/06/22, the bathroom window in room [REDACTED] did not have shades, blinds, or shutters.

POC Submission

Accept

*Blinds were installed in the bathroom window of room [REDACTED] on [REDACTED]/2022 (Attachment C).

*All PC and MC rooms will be inspected for window coverings in both the living spaces and the bathrooms by 08/05/2022, by the Administrator, or designee. Window coverings will be installed by the Maintenance Department

42s - Privacy (continued)

where needed by 08/19/2022.

*Nursing staff will report any issues with window coverings to the Administrator, or designee, to submit work orders for the Maintenance Department. The Marketing Director will report any window covering needs in vacant apartments to the Plant Operations Director as needed. Apartment needs will be reviewed in the Apartment Make Ready Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/19/2022

Document Submission

Implemented (████ - 09/30/2022)

*Blinds were installed in the bathroom window of room █████ on █████/2022 (Attachment C).

*All PC and MC rooms will be inspected for window coverings in both the living spaces and the bathrooms by 08/05/2022, by the Administrator, or designee. Window coverings will be installed by the Maintenance Department where needed by 08/19/2022.

*Nursing staff will report any issues with window coverings to the Administrator, or designee, to submit work orders for the Maintenance Department. The Marketing Director will report any window covering needs in vacant apartments to the Plant Operations Director as needed. Apartment needs will be reviewed in the Apartment Make Ready Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/19/2022

54a - Direct Care Staff**6. 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.
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, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

POC Submission

Accept

*Staff Person A provided a copy of █████ high school diploma on █████/2022. It has been placed in █████ personnel file (Attachment D).

*The Human Resource Director, or designee, is conducting an audit of all Personal Care and Memory Care staff to ensure compliance with required documentation. This audit will be completed by 08/31/2022 (Attachment E).

*The Human Resource Director, or designee, will audit new employee files on a monthly basis for compliance and review results in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/31/2022

Document Submission

Implemented (████ - 09/30/2022)

*Staff Person A provided a copy of █████ high school diploma on █████/2022. It has been placed in █████ personnel file (Attachment D).

*The Human Resource Director, or designee, is conducting an audit of all Personal Care and Memory Care staff to

54a - Direct Care Staff (continued)

ensure compliance with required documentation. This audit will be completed by 08/31/2022 (Attachment E).
*The Human Resource Director, or designee, will audit new employee files on a monthly basis for compliance and review results in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/31/2022

60a Staff/Support Plan

7. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident s assessment and support plan.

Description of Violation

On [redacted] 22, at approximately [redacted] PM, and on [redacted] /22 at approximately [redacted] AM, residents in the secured dementia care unit or "The Gardens" were not receiving any type of physical or mental stimulation other than watching television. According to staff interviews, these services are not typically provided in The Gardens due to lack of staffing in the home. In a discussion with the Administrator it was stated that direct care staff in The Gardens are asked to provide direct care, administer medications, assist with meals and activities, sometimes with only one staff member working in The Gardens.

POC Submission

Accept

*Staffing in Memory Care was increased from one direct care staff to two direct care staff on [redacted] /2022 during waking hours to support the needs of the residents in the absence of dining servers and activities assistants while hiring for open positions.

*The Resident Care Director, or designee, will monitor the schedule for appropriate staffing on a daily basis. Staffing will be adjusted as needed based on census and the addition of support services as the dining server positions and activities assistant positions are filled.

* The Resident Care Director, or designee, will review Memory Care Staffing in Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 07/07/2022

Document Submission

Implemented [redacted] 09/30/2022)

*Staffing in Memory Care was increased from one direct care staff to two direct care staff on [redacted] /2022 during waking hours to support the needs of the residents in the absence of dining servers and activities assistants while hiring for open positions.

*The Resident Care Director, or designee, will monitor the schedule for appropriate staffing on a daily basis. Staffing will be adjusted as needed based on census and the addition of support services as the dining server positions and activities assistant positions are filled.

* The Resident Care Director, or designee, will review Memory Care Staffing in Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 07/07/2022

65a - FS Orientation 1st Day

8. Requirements

65a - FS Orientation 1st Day (continued)

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 Violation

Staff person A, whose first day of work was [REDACTED] 2021, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Staff person B, whose first day of work was [REDACTED] /2022, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Repeat Violation: 07/08/2021

POC Submission**Accept**

*Staff Person A and Staff Person B attended New Hire Orientation on [REDACTED] /2022 to complete the 1st day requirements. Documentation of the education has been placed in their personnel files. Original New Hire Orientation training forms for both Staff Person A and Staff Person B were located as well on [REDACTED] 2022 Attachment F).

*The Human Resource Director, or designee, is conducting and audit of all Personal Care and Memory Care staff to ensure compliance with required documentation. This audit will be completed by 08/31/2022 (Attachment E).

*The Human Resource Director, or designee, will audit new employee files on a monthly basis for compliance and review results in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/31/2022

Document Submission**Implemented [REDACTED] 09/30/2022)**

*Staff Person A and Staff Person B attended New Hire Orientation on [REDACTED] 2022 to complete the 1st day requirements. Documentation of the education has been placed in their personnel files. Original New Hire Orientation training forms for both Staff Person A and Staff Person B were located as well on [REDACTED] /2022 Attachment F).

*The Human Resource Director, or designee, is conducting and audit of all Personal Care and Memory Care staff to

65a - FS Orientation 1st Day (continued)

ensure compliance with required documentation. This audit will be completed by 08/31/2022 (Attachment E).
 *The Human Resource Director, or designee, will audit new employee files on a monthly basis for compliance and review results in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/31/2022

65b Rights/Abuse 40 Hours**9. 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 Violation

Staff person A completed his/her 40th scheduled work hour in [REDACTED] 2021. However, this staff person did not complete training in the following topics: emergency medical plan.

Staff person B completed his/her 40th scheduled work hour in [REDACTED] 2022. However, this staff person did not complete training in the following topics: emergency medical plan.

POC Submission**Accept**

*Staff Person A and Staff Person B attended New Hire Orientation on [REDACTED] 2022 to complete the 1st day requirements. Documentation of the education has been placed in their personnel files. Original New Hire Orientation training forms for both Staff Person A and Staff Person B were located as well on [REDACTED] /2022 Attachment F).

*The Human Resource Director, or designee, is conducting and audit of all Personal Care and Memory Care staff to ensure compliance with required documentation. This audit will be completed by 08/31/2022 (Attachment E).

*The Human Resource Director, or designee, will audit new employee files on a monthly basis for compliance and review results in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/31/2022

Document Submission**Implemented [REDACTED] - 09/30/2022)**

*Staff Person A and Staff Person B attended New Hire Orientation on [REDACTED] /2022 to complete the 1st day requirements. Documentation of the education has been placed in their personnel files. Original New Hire Orientation training forms for both Staff Person A and Staff Person B were located as well on [REDACTED] /2022 Attachment F).

*The Human Resource Director, or designee, is conducting and audit of all Personal Care and Memory Care staff to ensure compliance with required documentation. This audit will be completed by 08/31/2022 (Attachment E).

*The Human Resource Director, or designee, will audit new employee files on a monthly basis for compliance and review results in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/31/2022

82c - Locking Poisonous Materials

10. 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

Drug Disposal Formula, with a manufacture's label indicating "If ingested, contact physician immediately and Contact poison control center 1-800-222-1222", was unlocked, unattended, and accessible to residents in the secured dementia care unit or "The Gardens". Not all the residents of the home, including residents in The Gardens, have been assessed capable of recognizing and using poisons safely.

Repeat Violation: 07/08/2021

POC Submission

Accept

**The containers of Drug Disposal Formula were immediately removed from the unlocked nursing staff and moved to a secured nursing supply closet on [REDACTED] 2022.*

**Staff were provided with education regarding securing poisonous materials in the SDCU and securing the nursing offices on 07/25/2022 and 07/29/2022, by the Resident Care Director, or designee (Attachment G).*

**The Resident Care Director, or designee, will provide all new employees with education regarding securing poisonous materials in the SDCU within their initial 40 hours of training.*

**The Administrator, Resident Care Director, or designee, will complete daily rounds of the SDCU to ensure compliance with this regulation for 30 days, providing documentation of rounds on the 24 Hour Report. If compliance with this regulation is found at the 30 days, rounds will be then be documented quarterly. Results will be reviewed in the Quality Assurance Meetings as schedule.*

Licensee's Proposed Overall Completion Date: 07/29/2022

Document Submission

Implemented [REDACTED] - 09/30/2022)

**The containers of Drug Disposal Formula were immediately removed from the unlocked nursing staff and moved to a secured nursing supply closet on [REDACTED]/2022.*

**Staff were provided with education regarding securing poisonous materials in the SDCU and securing the nursing offices on 07/25/2022 and 07/29/2022, by the Resident Care Director, or designee (Attachment G).*

**The Resident Care Director, or designee, will provide all new employees with education regarding securing poisonous materials in the SDCU within their initial 40 hours of training.*

**The Administrator, Resident Care Director, or designee, will complete daily rounds of the SDCU to ensure compliance with this regulation for 30 days, providing documentation of rounds on the 24 Hour Report. If compliance with this regulation is found at the 30 days, rounds will be then be documented quarterly. Results will be reviewed in the Quality Assurance Meetings as schedule.*

Licensee's Proposed Overall Completion Date: 07/29/2022

88a - Surfaces

11. Requirements

2600.

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

88a - Surfaces (continued)

Description of Violation

The outside deck in the secured dementia care unit or "The Gardens" is in disrepair. There are several tripping hazards, including raised nails, uneven boards and the concrete path leading into the facility from the deck is uneven where the path meets the door frame.

POC Submission**Accept**

**The uneven boards and the raised nails were repaired by the Maintenance Department on 07/11/2022. The residents are being provided with physical assistance by the caregivers when traversing the uneven concrete path near the doorway until it is repaired.*

**The Plant Operations Director contacted IDC Services LLC for a quote to replace the outside deck boards with new composite decking, as well as repair the uneven concrete. The quote was received on 07/26/2022 (Attachment H). Repairs will be scheduled to begin once the needed materials have been delivered to the community.*

**The Plant Operations Director, or designee, will provide updates on the SDCU outside deck repair project in the Quality Assurance Meetings as scheduled.*

Completion Date: To Be Determined

Licensee's Proposed Overall Completion Date: 09/02/2022

Document Submission**Implemented [REDACTED] 09/30/2022)**

**The uneven boards and the raised nails were repaired by the Maintenance Department on 07/11/2022. The residents are being provided with physical assistance by the caregivers when traversing the uneven concrete path near the doorway until it is repaired.*

**The Plant Operations Director contacted IDC Services LLC for a quote to replace the outside deck boards with new composite decking, as well as repair the uneven concrete. The quote was received on 07/26/2022 (Attachment H). Repairs will be scheduled to begin once the needed materials have been delivered to the community.*

**The Plant Operations Director, or designee, will provide updates on the SDCU outside deck repair project in the Quality Assurance Meetings as scheduled.*

Completion Date: To Be Determined

**Outside deck repairs were completed during the week of 08/19/2022. Please see the attached photos (Attachment 1) showing the repairs.*

Licensee's Proposed Overall Completion Date: 08/19/2022

89b - Hot Water Temperature

12. Requirements

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 07/06/22, at 12:24 PM, the hot water temperature at the kitchen sink in room A101 measured 127.4 degrees Fahrenheit and at 2:04 PM it was 100.0 degrees Fahrenheit.

On 07/06/22, at 12:36 PM, the hot water temperature at the 2nd floor public bathroom sink measured 127.7 degrees Fahrenheit and at 2:00 PM it was 103.4 degrees Fahrenheit.

89b - Hot Water Temperature (continued)

POC Submission

Accept

*The Maintenance Department immediately adjusted the water temperature in Personal Care, bringing the water temperatures below 120 degrees when retested on 07/06/2022.

*The Plant Operations Director, or designee, monitors the water temperatures of identified apartments/public rooms on a daily basis completing all rooms by the end of the month. The temperature log is maintained by the Maintenance Supervisor. Adjustments needed to the water temperature are made upon discovery.

*The Plant Operations Director, or designee, will continue to monitor water temperatures ongoing and report results in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 07/06/2022

Document Submission

Implemented (redacted) 10/03/2022)

*The Maintenance Department immediately adjusted the water temperature in Personal Care, bringing the water temperatures below 120 degrees when retested on 07/06/2022.

*The Plant Operations Director, or designee, monitors the water temperatures of identified apartments/public rooms on a daily basis completing all rooms by the end of the month. The temperature log is maintained by the Maintenance Supervisor. Adjustments needed to the water temperature are made upon discovery.

*The Plant Operations Director, or designee, will continue to monitor water temperatures ongoing and report results in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 07/06/2022

91 - Telephone Numbers

13. 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 room (redacted)

POC Submission

Accept

*The Plant Operation Director, or designee, placed a sticker on the phone in room (redacted) with the required emergency telephone numbers on 07/07/2022.

*The Plant Operations Director, or designee, will inspect resident rooms for telephones and required emergency telephone numbers. This inspection will be completed by 08/26/2022. Emergency telephone number stickers will be placed on all phones found without during the inspection.

*The Plant Operations Director, or designee, will ensure that an emergency telephone number sticker is placed on all phones during new move ins to the community, as well as monitor for stickers during monthly resident room inspections. Results will be reviewed in Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 07/07/2022

Document Submission

Implemented (redacted) - 10/03/2022)

*The Plant Operation Director, or designee, placed a sticker on the phone in room (redacted) with the required

91 - Telephone Numbers (continued)

emergency telephone numbers on [REDACTED]/2022.

*The Plant Operations Director, or designee, will inspect resident rooms for telephones and required emergency telephone numbers. This inspection will be completed by 08/26/2022. Emergency telephone number stickers will be placed on all phones found without during the inspection.

*The Plant Operations Director, or designee, will ensure that an emergency telephone number sticker is placed on all phones during new move ins to the community, as well as monitor for stickers during monthly resident room inspections. Results will be reviewed in Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/26/2022

93a - Handrails

14. Requirements

2600.

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

Description of Violation

The ramp leading to the roadway from the personal care common area patio is broken, leaving this ramp without a handrail.

POC Submission

Accept

*In the event of an emergency evacuation that makes use of this patio area and ramp, residents will be provided with physical assistance by community staff to walk down the ramp safely to the roadway until the repairs to the handrail are completed.

*The Plant Operations Director contacted Heritage Fence Company for a quote to replace the ramp handrail leading from to the roadway from the personal care common area patio. The quote was received on 07/22/2022

Attachment I). Repairs will be scheduled to begin once the needed materials have been delivered to the community.

*The Plant Operations Director, or designee, will provide updates on the ramp handrail repair project in the Quality Assurance Meetings as scheduled.

Completion Date: To Be Determined

Licensee's Proposed Overall Completion Date: 09/02/2022

Implemented ([REDACTED] - 12/07/2022)

95 - Furniture and Equipment

15. Requirements

2600.

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

Description of Violation

The walk in freezer in the basement has a door that does not completely close. This causes the temperature inside the freezer to rise and also causes frosting on items within the freezer and the floor.

POC Submission

Accept

*The Dining Services Director, or designee, is monitoring the closure of the walk in freezer door and temperature log to reduce the risk of the temperature rising and frosting building throughout dining service hours (Attachment J).

*The Plant Operations Director contacted Direct Supply to obtain a quote to repair the walk in freezer door. The

95 - Furniture and Equipment (continued)

quote was received on 07/11/2022 (Attachment K). Repairs will be scheduled to begin once the needed materials have been delivered to the community.

*The Plant Operations Director, or designee, will provide updates on the walk in freezer door repair project in the Quality Assurance Meetings as scheduled.

Completion Date: To Be Determined

Licensee's Proposed Overall Completion Date: 09/02/2022

Document Submission

Implemented (█) - 10/03/2022)

*The Dining Services Director, or designee, is monitoring the closure of the walk in freezer door and temperature log to reduce the risk of the temperature rising and frosting building throughout dining service hours (Attachment J).

*The Plant Operations Director contacted Direct Supply to obtain a quote to repair the walk in freezer door. The quote was received on 07/11/2022 (Attachment K). Repairs will be scheduled to begin once the needed materials have been delivered to the community.

*The Plant Operations Director, or designee, will provide updates on the walk in freezer door repair project in the Quality Assurance Meetings as scheduled.

Completion Date: To Be Determined

*Repairs to the Walk In Freezer door were completed on 08/03/2022. Please see the attached photo, work order and temperature log (Attachment 2) from the time period of the repair.

Licensee's Proposed Overall Completion Date: 08/03/2022

100a - Exterior - Free of Hazards

16. Requirements

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The patio off the common area in personal care or "The Inn" is littered with items such as chairs, an old refrigerator box, bedframes, an unused flag stand and empty planter pots.

POC Submission

Accept

*The Administrator submitted a work order on 07/07/2022 to have the items listed in the violation description removed from the patio off of the common area in personal care, as well as to have the patio power washed.

*The Maintenance Department removed all items from the patio and power washed the patio furniture and the concrete surface on 07/11/2022 (Attachment L).

*The Administrator, or designee, will monitor the patio for routine cleaning and submit work orders as needed. The Administrator, or designee, will review any cleaning or repair needs in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 07/11/2022

Document Submission

Implemented (█) 10/03/2022)

*The Administrator submitted a work order on 07/07/2022 to have the items listed in the violation description removed from the patio off of the common area in personal care, as well as to have the patio power washed.

*The Maintenance Department removed all items from the patio and power washed the patio furniture and the

100a - Exterior - Free of Hazards (continued)

concrete surface on 07/11/2022 (Attachment L).

*The Administrator, or designee, will monitor the patio for routine cleaning and submit work orders as needed. The Administrator, or designee, will review any cleaning or repair needs in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 07/11/2022

103f Refrigerator/Freezer Temps**17. 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 [REDACTED]/22, at approximately [REDACTED] PM, the temperature in the basement walk in freezer was 10 degrees Fahrenheit due to the door of the freezer being broken and not closing completely.

POC Submission**Accept**

*The Dining Services Director, or designee, is monitoring the closure of the walk in freezer door and temperature log to reduce the risk of the temperature rising and frosting building throughout dining service hours (Attachment J).

*The Plant Operations Director contacted Direct Supply to obtain a quote to repair the walk in freezer door. The quote was received on 07/11/2022 (Attachment K). Repairs will be scheduled to begin once the needed materials have been delivered to the community.

*The Plant Operations Director, or designee, will provide updates on the walk in freezer door repair project in the Quality Assurance Meetings as scheduled.

Completion Date: To Be Determined

Licensee's Proposed Overall Completion Date: 09/02/2022

Document Submission**Implemented [REDACTED] - 10/03/2022)**

*The Dining Services Director, or designee, is monitoring the closure of the walk in freezer door and temperature log to reduce the risk of the temperature rising and frosting building throughout dining service hours (Attachment J).

*The Plant Operations Director contacted Direct Supply to obtain a quote to repair the walk in freezer door. The quote was received on 07/11/2022 (Attachment K). Repairs will be scheduled to begin once the needed materials have been delivered to the community.

*The Plant Operations Director, or designee, will provide updates on the walk in freezer door repair project in the Quality Assurance Meetings as scheduled.

Completion Date: To Be Determined

*Repairs to the Walk In Freezer door were completed on 08/03/2022. Please see the attached photo, work order and temperature log (Attachment 2) from the time period of the repair.

Licensee's Proposed Overall Completion Date: 08/03/2022

121a - Unobstructed Egress

18. Requirements

2600.

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

Description of Violation

On 07/06/22, at approximately 9:37 AM, several outdoor chairs were lined up outside the home's personal care common area patio door obstructing a safe evacuation path.

On 07/06/22, at approximately 11:46 AM, a locked exterior door marked "NOT AN EXIT" blocked egress from the home's secure dementia care unit emergency exit door #5.

POC Submission**Accept**

**On 07/06/2022, the Administrator with the assistance of the dining staff relocated the outdoor chairs from in front of the common area patio door to the patio tables, leaving a clear and safe evacuation path (Attachment L).*

**The Administrator, or designee, will monitor the patio for unobstructed egress between the patio doors and the ramp leading to the parking lot. The Administrator, or designee, will submit work orders as needed. The Administrator, or designee, will review safety concerns with relation to egresses in the Quality Assurance Meetings as scheduled.*

**The Plant Operations Director inspected the exterior door labeled "NOT AN EXIT" and the outdoor area that this door leads to. The Plant Operations Director found that the outdoor area is not a safe evacuation path and the sign on the door is correct. The sign remains in place (Attachment M).*

**The Plant Operations Director then removed the "EXIT" sign directing residents and staff toward this exterior door from Door #5 in the secured dementia care unit, replacing it with a "NOT AN EXIT" sign on 07/13/2022 (Attachment M).*

**The Plant Operations Director, or designee, will inspect all doors labeled "EXIT" to ensure the doors lead to safe evacuation paths during the monthly building inspections. Results will be reviewed in Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: 07/13/2022

Document Submission**Implemented** ██████████ **10/03/2022)**

**On 07/06/2022, the Administrator with the assistance of the dining staff relocated the outdoor chairs from in front of the common area patio door to the patio tables, leaving a clear and safe evacuation path (Attachment L).*

**The Administrator, or designee, will monitor the patio for unobstructed egress between the patio doors and the ramp leading to the parking lot. The Administrator, or designee, will submit work orders as needed. The Administrator, or designee, will review safety concerns with relation to egresses in the Quality Assurance Meetings as scheduled.*

**The Plant Operations Director inspected the exterior door labeled "NOT AN EXIT" and the outdoor area that this door leads to. The Plant Operations Director found that the outdoor area is not a safe evacuation path and the sign on the door is correct. The sign remains in place (Attachment M).*

**The Plant Operations Director then removed the "EXIT" sign directing residents and staff toward this exterior door from Door #5 in the secured dementia care unit, replacing it with a "NOT AN EXIT" sign on 07/13/2022 (Attachment M).*

**The Plant Operations Director, or designee, will inspect all doors labeled "EXIT" to ensure the doors lead to safe evacuation paths during the monthly building inspections. Results will be reviewed in Quality Assurance Meetings as scheduled.*

121a - Unobstructed Egress (continued)

Licensee's Proposed Overall Completion Date: 07/13/2022

132a - Monthly Fire Drill

19. Requirements

2600.

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

Description of Violation

The home currently has a third party hired to conduct their monthly fire drills. During these drills, not all residents are being evacuated. The "Record Of Fire Drill" form provided by the third party will list the number of residents in the part of the facility where the fire drill is being performed ("Memory Care" or "Assisted") and the number of residents evacuated will not match the number of residents in the home.

On the "Record Of Fire Drill" form dated 01/21/22 for Facility Name: Bellingham - Assisted, 35 residents are listed as being in the building but the number of residents evacuated is reported as "N/A".

POC Submission**Accept**

**The Plant Operations Director contacted Croker Fire Drill Corporation to schedule a meeting with their Fire Safety Expert assigned to the community to review the Department of Human Services requirements for monthly fire drill documentation.*

**The Fire Safety Expert from Croker will be at the community on 08/05/2022 to review the Department of Human Services requirements for monthly fire drill documentation with the Plant Operations Director and the Administrator.*

**The Plant Operations Director and the Administrator will be present for the monthly fire drill conducted after the meeting to ensure that the fire drill is being conducted as required, all residents are being evacuated and that the number evacuated on the documentation matches the number of residents in the home at the time of the fire drill.*

**The Plant Operations Director, or designee, will review all fire drill documentation for accuracy and completion each month and review results in the Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: 08/05/2022

Document Submission**Implemented [REDACTED] - 10/03/2022)**

**The Plant Operations Director contacted Croker Fire Drill Corporation to schedule a meeting with their Fire Safety Expert assigned to the community to review the Department of Human Services requirements for monthly fire drill documentation.*

**The Fire Safety Expert from Croker will be at the community on 08/05/2022 to review the Department of Human Services requirements for monthly fire drill documentation with the Plant Operations Director and the Administrator.*

**The Plant Operations Director and the Administrator will be present for the monthly fire drill conducted after the meeting to ensure that the fire drill is being conducted as required, all residents are being evacuated and that the number evacuated on the documentation matches the number of residents in the home at the time of the fire drill.*

**The Plant Operations Director, or designee, will review all fire drill documentation for accuracy and completion each month and review results in the Quality Assurance Meetings as scheduled.*

**The Plant Operations Director reviewed the state regulations regarding fire drills and documentation with Croker Fire Drill Corporation due to scheduling conflicts in coming out to our community. We are monitoring the monthly fire drill reports to ensure compliance with the state regulations.*

132a - Monthly Fire Drill (continued)

Licensee's Proposed Overall Completion Date: 08/31/2022

132b Safety Inspection/Fire Drill

20. 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 last fire safety inspection conducted by a fire safety expert was on 06/25/22. The previous fire safety inspection conducted by a fire safety expert was on 01/27/20.

The last fire drill observed by a fire safety expert was conducted on 02/14/20.

POC Submission

Accept

*The Administrator was unable to locate documentation of a fire inspection by a fire safety expert for the year 2021 in the community during the annual survey. The Plant Operations Director contacted Croker Fire Drill Corporation, third party who provides inspections and conducts drills, to obtain a copy of the 2021 fire inspection letter and observed fire drill report. They did not have record of the inspection or fire drill for the community for 2021.

*The fire safety expert from Croker did complete an inspection of the community and conduct an observed fire drill on 06/25/2022. The letter of inspection and copy of fire drill report were not available during the annual survey. The Plant Operations Director and the Administrator have been contacting Croker since the annual survey to obtain the letter of inspection and fire drill report. They have not been received as of 07/29/2022. They will be submitted upon receipt.

*The Plant Operations Director, or designee, will schedule the annual fire inspection and observed fire drill with the fire safety expert within 12 months of the last inspection and observed drill. Results will be reviewed in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/31/2022

Implemented (12/07/2022)

132c - Fire Drill Records

21. 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 home currently has a third party hired to conduct their monthly fire drills. The "Record Of Fire Drill" form provided by the third party does not include the exit route used during the drill.

132c - Fire Drill Records (*continued*)**POC Submission****Accept**

**The Plant Operations Director contacted Croker Fire Drill Corporation to schedule a meeting with their Fire Safety Expert assigned to the community to review the Department of Human Services requirements for monthly fire drill documentation.*

**The Fire Safety Expert from Croker will be at the community on 08/05/2022 to review the Department of Human Services requirements for monthly fire drill documentation with the Plant Operations Director and the Administrator.*

**The Plant Operations Director and the Administrator will be present for the monthly fire drill conducted after the meeting to ensure that the fire drill is being conducted as required, all residents are being evacuated and that the exit route is specified on the fire drill documentation accurately.*

**The Plant Operations Director, or designee, will review all fire drill documentation for accuracy and completion each month and review results in the Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: 08/05/2022

Document Submission**Implemented (█) - 10/03/2022)**

**The Plant Operations Director contacted Croker Fire Drill Corporation to schedule a meeting with their Fire Safety Expert assigned to the community to review the Department of Human Services requirements for monthly fire drill documentation.*

**The Fire Safety Expert from Croker will be at the community on 08/05/2022 to review the Department of Human Services requirements for monthly fire drill documentation with the Plant Operations Director and the Administrator.*

**The Plant Operations Director and the Administrator will be present for the monthly fire drill conducted after the meeting to ensure that the fire drill is being conducted as required, all residents are being evacuated and that the exit route is specified on the fire drill documentation accurately.*

**The Plant Operations Director, or designee, will review all fire drill documentation for accuracy and completion each month and review results in the Quality Assurance Meetings as scheduled.*

**The Plant Operations Director reviewed the state regulations regarding fire drills and documentation with Croker Fire Drill Corporation due to scheduling conflicts in coming out to our community. We are monitoring the monthly fire drill reports to ensure compliance with the state regulations.*

Licensee's Proposed Overall Completion Date: 08/31/2022

141a 1-10 Medical Evaluation Information

22. 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.

141a 1-10 Medical Evaluation Information (continued)

Description of Violation

Resident #3's medical evaluation dated [REDACTED]/22" did not include the resident's medication regimen.

POC Submission**Accept**

*The Resident Care Director attached a copy of Resident #3's medication regimen for May 2022 provided by Omnicare Pharmacy to [REDACTED] medical evaluation completed on [REDACTED]/2022 on [REDACTED]/2022.

*The Resident Care Director, or designee, will be conducting a full medical chart audit for all residents in Personal Care and Memory care to ensure that the required documentation is present in the chart and accurate. The audit will be completed by 08/31/2022 (Attachment O).

*The Resident Care Director, or designee, will audit all new medication evaluations, to include new admissions, internal transfers and significant changes, utilizing the reports in Point Click Care monthly to maintain compliance with documentation. Results will be reviewed in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/31/2022

Document Submission**Implemented ([REDACTED] 10/03/2022)**

*The Resident Care Director attached a copy of Resident #3's medication regimen for May 2022 provided by Omnicare Pharmacy to [REDACTED] medical evaluation completed on [REDACTED] 2022 on [REDACTED] 2022.

*The Resident Care Director, or designee, will be conducting a full medical chart audit for all residents in Personal Care and Memory care to ensure that the required documentation is present in the chart and accurate. The audit will be completed by 08/31/2022 (Attachment O).

*The Resident Care Director, or designee, will audit all new medication evaluations, to include new admissions, internal transfers and significant changes, utilizing the reports in Point Click Care monthly to maintain compliance with documentation. Results will be reviewed in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 09/01/2022

162c - Menus Posted

23. 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 07/06/22, the posted menus in the secure dementia unit's dining area were dated 05/22/22 to 05/28/22 and 06/19/22 to 06/25/22.

POC Submission**Accept**

*The Dining Services Supervisor replaced the menus posted in the secured dementia care unit with the menus for the current two week period at the time of the annual survey on 07/06/2022.

*The Dining Services Director, or designee, will update the menus in the secured dementia care unit weekly on Saturdays after dinner service for the next two week period.

*The Administrator, or designee, will monitor the posted menus for accuracy during daily rounds of the secured dementia care unit. Results will be reviewed in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 07/06/2022

162c - Menus Posted (continued)

Document Submission**Implemented (█ 10/03/2022)**

*The Dining Services Supervisor replaced the menus posted in the secured dementia care unit with the menus for the current two week period at the time of the annual survey on 07/06/2022.

*The Dining Services Director, or designee, will update the menus in the secured dementia care unit weekly on Saturdays after dinner service for the next two week period.

*The Administrator, or designee, will monitor the posted menus for accuracy during daily rounds of the secured dementia care unit. Results will be reviewed in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 07/06/2022

181f - Record of Medication

24. 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 ████ 22, resident #4's record did not include a current list of medications. The list in the resident's record did not include over 12 medications the resident was currently taking. Further, three medications listed on the resident's MAR ████ are not current. The resident was not aware that changes/additions need to be reported to the nursing staff when initiated following a doctor's appointment.

POC Submission**Accept**

*The Resident Care Director reviewed Resident #4's current list of medications in comparison to the medications the resident had in ████ apartment. All medications that were not on the medication list were removed from ████ apartment until orders could be obtained from ████ PCP. ████ medication list is now current.

*Resident #4 was provided with education regarding notifying the nursing department of any medical appointments ████ attends and providing the nursing department with any new orders for medications or treatments. This education occurred both during the interview on ████/2022 with ████ ████ DHS and with the Resident Care Director when reviewing ████ medications with ████ also on ████ 2022.

*The Resident Care Director, or designee, will review Resident #4's medication list in comparison to the medications stored in the resident's apartment, as well as complete the Self Administration of Medication Assessment (Attachment N) on a monthly basis to ensure that any new medications or changes have been updated. Results will be reviewed in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 07/29/2022

Document Submission**Implemented (█ - 10/03/2022)**

*The Resident Care Director reviewed Resident #4's current list of medications in comparison to the medications the resident had in ████ apartment. All medications that were not on the medication list were removed from ████ apartment until orders could be obtained from ████ PCP. ████ medication list is now current.

*Resident #4 was provided with education regarding notifying the nursing department of any medical appointments ████ attends and providing the nursing department with any new orders for medications or treatments. This education occurred both during the interview on ████/2022 with ████ ████ of DHS and with the Resident Care Director when reviewing her medications with her also on 07/06/2022.

*The Resident Care Director, or designee, will review Resident #4's medication list in comparison to the

181f - Record of Medication (continued)

medications stored in the resident's apartment, as well as complete the Self Administration of Medication Assessment Attachment N) on a monthly basis to ensure that any new medications or changes have been updated. Results will be reviewed in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 07/29/2022

185a - Implement Storage Procedures

25. 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 [redacted]/22, at [redacted] PM, resident #5's glucometer reported the date and time as [redacted]/22 at [redacted] PM. The glucometer is not calibrated to the correct date and time.

POC Submission

Accept

*All glucometers were calibrated to the correct date and time on 07/07/2022.

*The Resident Care Director provided the Medication Technicians and Nurses with education regarding the calibration of glucometers between 07/25/2022 and 07/29/2022 (Attachment P)

*The Resident Care Director, or designee, will calibrate glucometers on weekly basis documenting the calibration of the Blood Glucose Monitoring Log (Attachment P). Results will be reviewed in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 07/29/2022

Document Submission

Implemented [redacted] 10/03/2022)

*All glucometers were calibrated to the correct date and time on 07/07/2022.

*The Resident Care Director provided the Medication Technicians and Nurses with education regarding the calibration of glucometers between 07/25/2022 and 07/29/2022 (Attachment P)

*The Resident Care Director, or designee, will calibrate glucometers on weekly basis documenting the calibration of the Blood Glucose Monitoring Log (Attachment P). Results will be reviewed in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 07/29/2022

187a - Medication Record

26. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.

187a - Medication Record (*continued*)

7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #3 is prescribed several medications. However, the resident's [REDACTED] medication administration record does not indicate the diagnosis or purpose for 11 of the listed medications.

POC Submission**Accept**

*The Resident Care Director and LPN Supervisor contacted Resident #3's PCP for the diagnoses/purpose for the 11 medications missing this information on the MAR. The Resident Care Director and the LPN Supervisor updated the MAR with the diagnoses and faxed the orders to Omnicare Pharmacy to update their records for future MARs.

*The Resident Care Director, or designee, is conducting an audit of the MARs with the Nurses/LPNs. This audit will be completed by 08/26/2022 (Attachment Q).

*The Resident Care Director, or designee, will review all MARs during the monthly recaps at the end of each month. The residents' PCPs and Omnicare Pharmacy will be contacted with any changes/additions needed. Results will be reviewed in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/26/2022

Document Submission**Implemented ([REDACTED] 10/03/2022)**

*The Resident Care Director and LPN Supervisor contacted Resident #3's PCP for the diagnoses/purpose for the 11 medications missing this information on the MAR. The Resident Care Director and the LPN Supervisor updated the MAR with the diagnoses and faxed the orders to Omnicare Pharmacy to update their records for future MARs.

*The Resident Care Director, or designee, is conducting an audit of the MARs with the Nurses/LPNs. This audit will be completed by 08/26/2022 (Attachment Q).

*The Resident Care Director, or designee, will review all MARs during the monthly recaps at the end of each month. The residents' PCPs and Omnicare Pharmacy will be contacted with any changes/additions needed. Results will be reviewed in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 09/01/2022

190a - Completion Medication Course

27. 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 C, who has not maintained compliance with the Department-approved medications administration course by completing the annual practicum requirements, administered medications on [REDACTED]/2022, [REDACTED]/2022, [REDACTED]/2022 and [REDACTED]/2022 at [REDACTED] AM, to resident #6.

190a - Completion Medication Course (continued)

POC Submission

Accept

*Staff Person C was removed from the medication administration assignment on [redacted]/2022 for the [redacted] p shift. [redacted] was moved to a caregiver position. [redacted] was not permitted to work medication administration assignments while [redacted] annual practicum requirements were out of compliance.

*The Administrator audited the annual practicum requirements for all Medication Technicians on staff.

*Medication Administration Training was held and completed with a Department-Approved Medication Administration Trainer on [redacted]/2022 for Staff Person C and other Medication Technicians who were out of compliance with their annual practicum requirements (Attachment R).

*The Resident Care Director was trained as a Practicum Observer by the Department-Approved Medication Administration Trainer on [redacted] 2022 (Attachment R). The Resident Care Director will complete the required MAR Reviews and Med Pass Observations twice a year for each Medication Technician to ensure compliance with annual practicum requirements.

*The Resident Care Director, or designee, will provide updates on completion of Medication Technician annual practicum requirements in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 07/18/2022

Document Submission

Implemented [redacted] 10/03/2022)

*Staff Person C was removed from the medication administration assignment on [redacted]/2022 for the [redacted] shift. [redacted] was moved to a caregiver position [redacted] was not permitted to work medication administration assignments while [redacted] annual practicum requirements were out of compliance.

*The Administrator audited the annual practicum requirements for all Medication Technicians on staff.

*Medication Administration Training was held and completed with a Department Approved Medication Administration Trainer on [redacted]/2022 for Staff Person C and other Medication Technicians who were out of compliance with their annual practicum requirements (Attachment R).

*The Resident Care Director was trained as a Practicum Observer by the Department Approved Medication Administration Trainer on [redacted]/2022 (Attachment R). The Resident Care Director will complete the required MAR Reviews and Med Pass Observations twice a year for each Medication Technician to ensure compliance with annual practicum requirements.

*The Resident Care Director, or designee, will provide updates on completion of Medication Technician annual practicum requirements in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 07/18/2022

191 - Resident Right to Refuse

28. Requirements

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 #1, admitted [redacted] 21, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error. The could not provide signed documentation.

POC Submission

Accept

*Resident was approached to sign the acknowledgement on [redacted] 2022 [redacted] was unable to sign due to cognitive

191 - Resident Right to Refuse (continued)

decline. This was documented on the form.

*All Memory Care resident contracts were audited by the Administrator for compliance with signatures on 07/27/2022. All Personal Care resident contracts are being audited by the Business Office Director, or designee, for completion. This audit will be completed by 08/19/2022 (Attachment A).

*All new Personal Care and Memory Care resident contracts will be reviewed on a monthly basis for completion by the Business Office Director, or designee. Results will be reviewed in Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/19/2022

Document Submission

Implemented [REDACTED] 10/03/2022)

*Resident was approached to sign the acknowledgement on [REDACTED]/2022. [REDACTED] was unable to sign due to cognitive decline. This was documented on the form.

*All Memory Care resident contracts were audited by the Administrator for compliance with signatures on 07/27/2022. All Personal Care resident contracts are being audited by the Business Office Director, or designee, for completion. This audit will be completed by 08/19/2022 (Attachment A).

*All new Personal Care and Memory Care resident contracts will be reviewed on a monthly basis for completion by the Business Office Director, or designee. Results will be reviewed in Quality Assurance Meetings as scheduled.

**Due to open positions that occurred within the Marketing and Business Office Departments after the annual survey, the administrative file audit is still in progress. These positions have now been filled and we have set a new completion date of 10/21/2022.

Licensee's Proposed Overall Completion Date: 09/28/2022

224a - Preadmission Screen Form**29. 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 #7's preadmission screening form, dated [REDACTED]/22, does not include a determination that the needs of the resident can be met by the services provided by the home.

POC Submission

Accept

*The Resident Care Director completed the determination that the needs of Resident #7 can be met by the services provided by the home on 07/25/2022.

*The Resident Care Director, or designee, will be conducting a full medical chart audit for all residents in Personal Care and Memory care to ensure that the required documentation is present in the chart and accurate. The audit will be completed by 08/31/2022 (Attachment O).

*The Resident Care Director, or designee, will audit 5% of resident medical charts monthly to maintain compliance with documentation. Results will be reviewed in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/31/2022

224a - Preadmission Screen Form (continued)

Document Submission**Implemented () - 10/03/2022)**

*The Resident Care Director completed the determination that the needs of Resident #7 can be met by the services provided by the home on 07/25/2022.

*The Resident Care Director, or designee, will be conducting a full medical chart audit for all residents in Personal Care and Memory care to ensure that the required documentation is present in the chart and accurate. The audit will be completed by 08/31/2022 (Attachment O).

*The Resident Care Director, or designee, will audit 5% of resident medical charts monthly to maintain compliance with documentation. Results will be reviewed in the Quality Assurance Meetings as scheduled.

*Full medical chart audits are being completed by our PCHA Administrator. The audit is in progress. Due to our charts being fully paper (not electronic) and some having been thinned, the audit is taking longer than anticipated. Completion date has been set for 10/21/2022.

Licensee's Proposed Overall Completion Date: 09/28/2022

231c - Preadmission Screening

30. Requirements

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED] 21. However, the resident's written cognitive preadmission screening was completed on [REDACTED]/21.

POC Submission**Accept**

*The Resident Care Director and the LPN Supervisory were provided with education regarding the proper time frames for completing the Preadmission Screening by the Administrator on 07/06/2022.

*The Resident Care Director, or designee, will be conducting a full medical chart audit for all residents in Personal Care and Memory care to ensure that the required documentation is present in the chart and accurate. The audit will be completed by 08/31/2022 (Attachment O).

*The Resident Care Director, or designee, will audit 5% of resident medical charts monthly to maintain compliance with documentation. Results will be reviewed in the Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/31/2022

Document Submission**Implemented () - 10/03/2022)**

*The Resident Care Director and the LPN Supervisory were provided with education regarding the proper time frames for completing the Preadmission Screening by the Administrator on 07/06/2022.

*The Resident Care Director, or designee, will be conducting a full medical chart audit for all residents in Personal Care and Memory care to ensure that the required documentation is present in the chart and accurate. The audit will be completed by 08/31/2022 (Attachment O).

*The Resident Care Director, or designee, will audit 5% of resident medical charts monthly to maintain compliance with documentation. Results will be reviewed in the Quality Assurance Meetings as scheduled.

*Full medical chart audits are being completed by our PCHA Administrator. The audit is in progress. Due to our

231c - Preadmission Screening (continued)

charts being fully paper (not electronic) and some having been thinned, the audit is taking longer than anticipated. Completion date has been set for 10/21/2022.

Licensee's Proposed Overall Completion Date: 09/28/2022

231e - No Objection Statement**31. 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 #1 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]/21. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]/20. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

POC Submission**Accept**

*Resident #1 and #3 were approached to sign their acknowledgement forms on [REDACTED]/2022. They were unable to sign due to [REDACTED]. This was documented on their forms. The acknowledgement forms were then scanned to their designated persons for signatures.

*All Memory Care resident contracts were audited by the Administrator for compliance with signatures on 07/27/2022. All Personal Care resident contracts are being audited by the Business Office Director, or designee, for completion. This audit will be completed by 08/19/2022 (Attachment A).

*All new Personal Care and Memory Care resident contracts will be reviewed on a monthly basis for completion by the Business Office Director, or designee. Results will be reviewed in Quality Assurance Meetings as scheduled.

Licensee's Proposed Overall Completion Date: 08/19/2022

Document Submission**Implemented [REDACTED] 10/03/2022)**

*Resident #1 and #3 were approached to sign their acknowledgement forms on [REDACTED]/2022. They were unable to sign due to [REDACTED]. This was documented on their forms. The acknowledgement forms were then scanned to their designated persons for signatures.

*All Memory Care resident contracts were audited by the Administrator for compliance with signatures on 07/27/2022. All Personal Care resident contracts are being audited by the Business Office Director, or designee, for completion. This audit will be completed by 08/19/2022 (Attachment A).

*All new Personal Care and Memory Care resident contracts will be reviewed on a monthly basis for completion by the Business Office Director, or designee. Results will be reviewed in Quality Assurance Meetings as scheduled.

**Due to open positions that occurred within the Marketing and Business Office Departments after the annual survey, the administrative file audit is still in progress. These positions have now been filled and we have set a new completion date of 10/21/2022.

Licensee's Proposed Overall Completion Date: 09/28/2022

233d - Electronic/Magnetic System

32. Requirements

2600.

233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

The gate door leading to an unlevel wooded area behind the home from the secured dementia unit's exercise path are not locked with an electronic or magnetic locking system. The gate's locking mechanism is a simple latch with a spring; however, the door is not level to the frame and takes significant effort to close the door and engage the existing latch.

Further, this gate door was unlocked, wide open and unattended on [REDACTED]/22 at approximately [REDACTED] AM.

POC Submission**Accept**

**The gate leading to the unlevel wooden area behind the home is temporarily secured with a zip tie. Due to the unsafe path through the wooded area, this gate is not identified as an emergency exit from the SDCU's exercise path. There is another gate with a magnetic locking system.*

**The Plant Operations Director contacted Great Valley Lockshop Inc. and SMD for quotes to install the magnetic locking system on this gate. [REDACTED] received the quote from Great Valley Lockshop Inc. on 07/27/2022 (Attachment S). Repairs will be scheduled to begin once the needed materials have been delivered to the community.*

**The Plant Operations Director, or designee, will provide updates on the installation of the magnetic locking system for the SDCU gate in the Quality Assurance Meetings as scheduled.*

Completion Date: To Be Determined

Licensee's Proposed Overall Completion Date: 09/02/2022

Document Submission**Implemented [REDACTED] - 10/03/2022)**

**The gate leading to the unlevel wooden area behind the home is temporarily secured with a zip tie. Due to the unsafe path through the wooded area, this gate is not identified as an emergency exit from the SDCU's exercise path. There is another gate with a magnetic locking system.*

**The Plant Operations Director contacted Great Valley Lockshop Inc. and SMD for quotes to install the magnetic locking system on this gate. [REDACTED] received the quote from Great Valley Lockshop Inc. on 07/27/2022 (Attachment S). Repairs will be scheduled to begin once the needed materials have been delivered to the community.*

**The Plant Operations Director, or designee, will provide updates on the installation of the magnetic locking system for the SDCU gate in the Quality Assurance Meetings as scheduled.*

Completion Date: To Be Determined

**Great Valley Lockshop Inc. completed the installation of the magnetic locking system on the gate in the area of the SDCU walking path during the week of 09/05/2022. Please see attached photo showing installation of magnetic lock (Attachment 4)*

Licensee's Proposed Overall Completion Date: 09/05/2022

254a Records Discharge/Active

33. Requirements

2600.

254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

254a - Records Discharge/Active (continued)

Description of Violation

On [REDACTED] 22, the records for residents of the secured dementia care unit were unlocked, unattended, and accessible in the nurse's office.

POC Submission**Accept**

*The door to the nursing office in the secured dementia care unit was immediately closed and locked on [REDACTED] 2022 to secure the resident records.

*Staff were provided with education regarding securing the nursing office door in the SDCU to maintain confidentiality of resident records between 07/25/2022 and 07/29/2022, by the Resident Care Director, or designee (Attachment G).

*The Resident Care Director, or designee, will provide all new employees with education regarding securing the nursing office in the SDCU within their initial 40 hours of training.

*The Administrator, Resident Care Director, or designee, will complete daily rounds of the SDCU to ensure compliance with this regulation and report results in the Quality Assurance Meetings as schedule.

Licensee's Proposed Overall Completion Date: 07/29/2022

Document Submission**Implemented ([REDACTED] - 10/03/2022)**

*The door to the nursing office in the secured dementia care unit was immediately closed and locked on [REDACTED] /2022 to secure the resident records.

*Staff were provided with education regarding securing the nursing office door in the SDCU to maintain confidentiality of resident records between 07/25/2022 and 07/29/2022, by the Resident Care Director, or designee (Attachment G).

*The Resident Care Director, or designee, will provide all new employees with education regarding securing the nursing office in the SDCU within their initial 40 hours of training.

*The Administrator, Resident Care Director, or designee, will complete daily rounds of the SDCU to ensure compliance with this regulation and report results in the Quality Assurance Meetings as schedule.

Licensee's Proposed Overall Completion Date: 07/29/2022