Department of Human Services
Bureau of Human Service Licensing

October 11, 2022

[redacted]
CSW ARBOUR SQUARE IV DOYLESTOWN LP
[redacted]

RE: MERCER HILL AT DOYLESTOWN
2010 SOUTH EASTON ROAD
DOYLESTOWN, PA, 18901
LICENSE/COC#: 14872

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/15/2022 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**: *MERCER HILL AT DOYLESTOWN* **License #**: *14872* **License Expiration**: *02/18/2023*

**Addre** : *2010 SOUTH EASTON ROAD, DOYLESTOWN, PA 18901*

**County**: *BUCKS* **Region**: *SOUTHEAST*

## Administrator

**Name**: [redacted] **Phone**: [redacted] **Email**: [redacted]

## Legal Entity

**Name**: *CSW ARBOUR SQUARE IV DOYLESTOWN LP*

**Address**: [redacted]

**Phone**: [redacted] **Email**: [redacted]

## Certificate(s) of Occupancy

## Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *32* **Waking Staff**: *24*

## Inspection Information

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

**Reason**: *Complaint, Incident* **Exit Conference Date**: *08/15/2022*

## Inspection Dates and Department Representative

*08/15/2022 - On-Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *97* **Residents Served**: *25*

### Secured Dementia Care Unit

**In Home**: *Yes* **Area**: *Garden House* **Capacity**: *26* **Residents Served**: *5*

### Hospice

**Current Residents**: *0*

### Number of Residents Who:

**Receive Supplemental Security Income**: *0* **Are 60 Years of Age or Older**: *25*

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

**Have Mobility Need**: *7* **Have Physical Disability**: *0*

## Inspections / Reviews

### 08/15/2022 - Partial

**Lead In pector**: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *09/09/2022*

### 09/15/2022 POC Submi ion

**Reviewer**: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/26/2022*

## Inspections / Reviews *(continued)*

**10/11/2022** - **Document Submission**

**Reviewer**: *Shawn Parker* **Follow-Up Type**: *Not Required*

## 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.
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 B, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.*

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

*The High School transcript for Direct Care staff person B was obtained and filed in [redacted] record.*
*The General Manager performed an audit of all active Direct Care staff employee/agency files. A high school diploma, GED/active registry status on the PA Nurse Aid registry was located for each Direct Care Staff person/agency staff.*
*To ensure that the necessary hiring documents are present, the Hiring Document Audit tool will continue to be utilized for all new employees/agency staff. Upon hire the Business Office Director/Designee will be responsible for ensuring the necessary credentialing is present. Any documentation missing will be obtained before the staff person/agency staff starts work.*
*Outcomes of the new hire audit tool will be discussed by the Business Office Director at the Quality Assurance Meeting scheduled for 9/19/2022.*

**Completion Date:** *09/19/2022*

**Document Submission** ***Implemented***

*The High School transcript for Direct Care staff person B was obtained and filed in [redacted] record.*
*The General Manager performed an audit of all active Direct Care staff employee/agency files. A high school diploma, GED/active registry status on the PA Nurse Aid registry was located for each Direct Care Staff person/agency staff.*
*To ensure that the necessary hiring documents are present, the Hiring Document Audit tool will continue to be utilized for all new employees/agency staff. Upon hire the Business Office Director/Designee will be responsible for ensuring the necessary credentialing is present. Any documentation missing will be obtained before the staff person/agency staff starts work.*
*Outcomes of the new hire audit tool will be discussed by the Business Office Director at the Quality Assurance Meeting scheduled for 9/19/2022.*

## 65a - FS Orientation 1st Day

**1. Requirements**

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

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

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 B, whose first day of work was [redacted]/22, did not receive orientation on the following topics:*
*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.*

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

*Staff Person B received orientation on Fire Safety as outlined in 2600.65a*
*The General Manager performed an audit of all employee/agency files. Any missing Fire Safety Orientation was corrected with the employee/agency staff involved. A Fire Safety Orientation is now present in all employee/agency staff files.*
*To ensure that the fire safety orientation is completed, the Hiring Document Audit tool will continue to be utilized for all new employees/agency staff. Upon hire the Business Office Director/Designee will be responsible for ensuring the necessary Fire Safety orientation is present prior to or on the first day of work.*
*Outcomes of the new hire audit tool will be discussed by the Business Office Director at the Quality Assurance Meeting and scheduled for 9/19/2022.*

**Completion Date:** *09/19/2022*

**Document Submission** ***Implemented***

*Staff Person B received orientation on Fire Safety as outlined in 2600.65a*
*The General Manager performed an audit of all employee/agency files. Any missing Fire Safety Orientation was corrected with the employee/agency staff involved. A Fire Safety Orientation is now present in all employee/agency staff files.*
*To ensure that the fire safety orientation is completed, the Hiring Document Audit tool will continue to be utilized for all new employees/agency staff. Upon hire the Business Office Director/Designee will be responsible for ensuring the necessary Fire Safety orientation is present prior to or on the first day of work.*
*Outcomes of the new hire audit tool will be discussed by the Business Office Director at the Quality Assurance Meeting and scheduled for 9/19/2022.*

## 65b - Rights/Abuse 40 Hours

**1. Requirements**

2600.

## 65b - Rights/Abuse 40 Hours *(continued)*

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 B , whose first day of work was [redacted]22, did not complete training in the following topics:*

*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.*

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

*Orientation as outlined in 2600.65b (Resident's Rights/Abuse Hours) were obtained and placed in the staff B's personnel file.*
*The General Manager performed an audit of all staff, ancillary staff persons and substitute personnel. Missing orientation pertaining to 2600 65b, was provided to agency staff and is now included in each agency staff file.*
*To ensure that the necessary orientation is conducted and present, the Hiring Document Audit tool will continue to be utilized for all new employees. and substitute personnel. Upon hire the Business Office Director/Designee will be responsible for ensuring the necessary orientation documentation is present. Any orientation missing will be obtained within 40 scheduled working hours.*

*Outcomes of the Hiring Document audit tool will be discussed by the Business Office Director at the Quality Assurance Meeting scheduled for 9/19/2022.*

**Completion Date:** *09/19/2022*

**Document Submission** ***Implemented***

*Orientation as outlined in 2600.65b (Resident's Rights/Abuse Hours) were obtained and placed in the staff B's personnel file.*
*The General Manager performed an audit of all staff, ancillary staff persons and substitute personnel. Missing orientation pertaining to 2600 65b, was provided to agency staff and is now included in each agency staff file.*
*To ensure that the necessary orientation is conducted and present, the Hiring Document Audit tool will continue to be utilized for all new employees. and substitute personnel. Upon hire the Business Office Director/Designee will be responsible for ensuring the necessary orientation documentation is present. Any orientation missing will be obtained within 40 scheduled working hours.*

*Outcomes of the Hiring Document audit tool will be discussed by the Business Office Director at the Quality Assurance Meeting scheduled for 9/19/2022.*

## 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]. On [redacted] 22 at [redacted] pm, this medication was administered and not documented in the [redacted] log. On [redacted] /22 at [redacted] am, this medication was administered but not documented in on the medication administration record.*

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

*All residents will have their medications recorded at the time that the medication is administered.*
*To ensure EMAR documentation is complete, Med Techs and licensed nursing staff will print the On Shift Validation Report at the end of their shift.*
*The Regional Nurse/Designee will provide education to the Med Techs and licensed nursing staff on the process of printing the report after each shift, reviewing to ensure that all medications were administered and the Narcotics Log reviewed and then placing the report in the supervisors communication box. The RCD/GHD/Designee will review the On Shift Validation Report to make certain medications were administered per physician order and documented. The RCD/GHD/Designee will then sign the report. Narcotics administered will be cross referenced between the EMAR and Narcotic Log. Any issues identified on the On Shift Validation Report/Narcotics Log by the RCD/GHD/Designee will be discussed with the staff person involved for immediate correction and re-education.*
*Oversight of this process will be continued by the RCD/GHD/Designee daily for 3 months.*
*ssues identified with the implementation of this process will be discussed at the Quality Assurance Meeting scheduled for 9/19/2022.*

**Completion Date:** *09/19/2022*

**Document Submission** ***Implemented***

*All residents will have their medications recorded at the time that the medication is administered.*
*To ensure EMAR documentation is complete, Med Techs and licensed nursing staff will print the On Shift Validation Report at the end of their shift.*
*The Regional Nurse/Designee will provide education to the Med Techs and licensed nursing staff on the process of printing the report after each shift, reviewing to ensure that all medications were administered and the Narcotics Log reviewed and then placing the report in the supervisors communication box. The RCD/GHD/Designee will review the On Shift Validation Report to make certain medications were administered per physician order and documented. The RCD/GHD/Designee will then sign the report. Narcotics administered will be cross referenced between the EMAR and Narcotic Log. Any issues identified on the On Shift Validation Report/Narcotics Log by the RCD/GHD/Designee will be discussed with the staff person involved for immediate correction and re-education.*
*Oversight of this process will be continued by the RCD/GHD/Designee daily for 3 months.*
*ssues identified with the implementation of this process will be discussed at the Quality Assurance Meeting scheduled for 9/19/2022.*

**2. 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 was not administered the following medications as prescribed on [redacted] /22 and [redacted] /22 however they were initialed as given:*

[redacted] *take one tablet by mouth once daily*

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

[redacted] tab take one tablet by mouth once daily
[redacted] take one tablet by mouth every night
[redacted] take 2 tablet by mouth once daily
[redacted] 1 tablet by mouth once daily
[redacted] take one tablet by mouth once daily
[redacted] take two capsules by mouth once daily

Resident #2 was not administered the following medications as prescribed on [redacted]/22 and [redacted]/22 however they were initialed as given:

[redacted] take one tablet by mouth once daily
[redacted] apply to lower extremities and feet twice daily
[redacted] take one tablet by mouth once daily
[redacted] take 1 by mouth daily in the morning
[redacted] take one tablet by mouth every night
[redacted] take one tablet by mouth daily
[redacted] ake one tablet by mouth daily

Resident #3 was not administered the following medications as prescribed on [redacted]/22 and [redacted]/22 however they were initialed as given:

[redacted] take 1 tablet by mouth once daily
[redacted] take 1 tablet by mouth once daily
[redacted] 1 tablet by mouth once daily
[redacted] take 1 tablet by mouth once daily

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

All residents will have their medication recorded at the time that the medication is administered.
To ensure EMAR documentation is complete, Med Techs and licensed nursing staff will print the On Shift Validation Report at the end of their shift.
The Regional Nurse/Designee will provide education to the Med Techs and licensed nursing staff on the process of printing the report after each shift, reviewing to ensure that all medications were administered and the Narcotics Log reviewed. The report will then be placed in the supervisors communication box. The RCD/GHD/Designee will review the On Shift Validation Report to make certain medications were administered per physician order and documented. The RCD/GHD/Designee will then sign the report. Narcotics administered will be cross referenced between the EMAR and Narcotic Log. Any issues identified with the ON Shift Validation Report/Narcotics Log by the RCD/GHD/Designee will be discussed with the staff person involved for immediate correction and re-education.
Oversight of this process will be continued by the RCD/GHD/Designee daily for 3 months.
ssues identified with the implementation of this process will be discussed at the Quality Assurance Meeting scheduled for 9/19/2022.

**Completion Date:** 09/19/2022

**Document Submission** ***Implemented***

All residents will have their medication recorded at the time that the medication is administered.
To ensure EMAR documentation is complete, Med Techs and licensed nursing staff will print the On Shift Validation Report at the end of their shift.
The Regional Nurse/Designee will provide education to the Med Techs and licensed nursing staff on the process of printing the report after each shift, reviewing to ensure that all medications were administered and the Narcotics

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

*Log reviewed. The report will then be placed in the supervisors communication box. The RCD/GHD/Designee will review the On Shift Validation Report to make certain medications were administered per physician order and documented. The RCD/GHD/Designee will then sign the report. Narcotics administered will be cross referenced between the EMAR and Narcotic Log. Any issues identified with the ON Shift Validation Report/Narcotics Log by the RCD/GHD/Designee will be discussed with the staff person involved for immediate correction and re-education. Oversight of this process will be continued by the RCD/GHD/Designee daily for 3 months.*
*ssues identified with the implementation of this process will be discussed at the Quality Assurance Meeting scheduled for 9/19/2022.*

## 187d - Follow Prescriber's Orders

**1. Requirements**

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

**Description of Violation**

*Resident #1 was not administered the following medications as prescribed:*
[redacted] *take one tablet by mouth once daily on 7/13/22 and 7/14/22*
[redacted] *take one tablet by mouth once daily on 7/13/22 and 7/14/22*
[redacted] *take one tablet by mouth every night on 7/13/22, 7/14/22, 7/16/22*
[redacted] *take 2 tablet by mouth once daily on 7/13/22 and 7/14/22*
[redacted] *take 1 tablet by mouth once daily on 7/13/22, 7/14/22, 7/16/22*
[redacted] *take one tablet by mouth once daily on 7/13/22 and 7/14/22*
[redacted] *take two capsules by mouth once daily on 7/13/22 and 7/14/22*

*Resident #2 was not administered the following medications as prescribed:*
[redacted] *take 1 tablet by mouth once daily on 7/13/22*
[redacted] *take one tablet by mouth once daily on 7/13/22 and 7/14/22*
[redacted] *take one tablet by mouth once daily on 7/13/22 and 7/14/22*
[redacted] *take 1 by mouth daily in the morning on 7/13/22, 7/14/22, 7/27/22 and 7/28/22.*
[redacted] *one tablet by mouth every night on 7/13/22 and 7/14/22*
[redacted] *take one tablet by mouth daily on 7/13/22 and 7/14/22*
[redacted] *one tablet by mouth daily on 7/13/22 and 7/14/22*

*Resident #3 was not administered the following medications as prescribed on 7/1/22, 7/13/22, and 7/14/22:*
[redacted] *take 1 tablet by mouth once daily*
[redacted] *take 1 tablet by mouth once daily*
[redacted] *take 1 tablet by mouth once daily*
[redacted] *take 1 tablet by mouth once daily*

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

*All residents will have their medications administered as prescribed by the physician.*
*A Nursing Schedule will be completed at least 1 month in advance to make certain that there is a Med Tech or icensed nursing staff available to administer medications in the Community for each shift.*
*The RCD/GHD/Designee will conduct a daily review of the schedule to make certain that Med Techs or licensed nursing staff are scheduled for the following day. This process will be conducted at least 1 day in advance. In the*

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

*event that a shift is not covered, available Med Techs/licensed nursing staff will be contacted and asked for coverage. If Community staff is not available, contracted Nursing Agencies will be called for coverage. This process will be ongoing.*

*Any concerns relating to this process will be discussed at the weekly GM/RCD/GHD meeting for additional nterventions and solutions. Outcomes of the GM/RCD/GHD meeting will be reviewed at the Quality Assurance Meeting scheduled for 9/19/2022.*

**Completion Date:** *09/19/2022*

**Document Submission** ***Implemented***

*All residents will have their medications administered as prescribed by the physician.*

*A Nursing Schedule will be completed at least 1 month in advance to make certain that there is a Med Tech or icensed nursing staff available to administer medications in the Community for each shift.*

*The RCD/GHD/Designee will conduct a daily review of the schedule to make certain that Med Techs or licensed nursing staff are scheduled for the following day. This process will be conducted at least 1 day in advance. In the event that a shift is not covered, available Med Techs/licensed nursing staff will be contacted and asked for coverage. If Community staff is not available, contracted Nursing Agencies will be called for coverage. This process will be ongoing.*

*Any concerns relating to this process will be discussed at the weekly GM/RCD/GHD meeting for additional nterventions and solutions. Outcomes of the GM/RCD/GHD meeting will be reviewed at the Quality Assurance Meeting scheduled for 9/19/2022.*

## 190c - Record of Training

**1. Requirements**

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

**Description of Violation**

*The home's medication administration training record for staff person A does not include the training completion date.*

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

*The Training Date for Staff person A is now included on the Medication Administration Training Record.*

*All Medication Administration Training Records were reviewed and all necessary documentation is recorded on the Training Form.*

*Prior to the start date, the Medication Administration Training Records will be reviewed for completeness by the Resident Care Director/Designee. Any missing information will be investigated and obtained by the Resident Care Director/Designee prior to the staff person administering medications.*

## 190c - Record of Training (continued)

*Any issues identified with the process will be reviewed by the Resident Care Coordinator/Designee at the Quality Assurance Meeting scheduled for 9/19/2022*

**Completion Date:** *09/19/2022*

**Document Submission** ***Implemented***

*The Training Date for Staff person A is now included on the Medication Administration Training Record.*
*All Medication Administration Training Records were reviewed and all necessary documentation is recorded on the Training Form.*
*Prior to the start date, the Medication Administration Training Records will be reviewed for completeness by the Resident Care Director/Designee. Any missing information will be investigated and obtained by the Resident Care Director/Designee prior to the staff person administering medications.*
*Any issues identified with the process will be reviewed by the Resident Care Coordinator/Designee at the Quality Assurance Meeting scheduled for 9/19/2022*

## 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 #1's preadmission screening form, is not dated, not signed by the person completing the screening, and does not include a determination that the needs of the resident can be met by the services provided by the home.*

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

*Resident 1's preadmission screening form was signed, dated and the determination that the needs of the resident can be met at the community was completed. However, the date was not within the appropriate time frame. Moving forward, all resident's in SDCU will have their assessment completed within 72 hours of admission.*
*An audit was completed of all preadmission screening forms to review date of admission/date of assessment. There were no further issues identified upon completion of this audit.*
*To insure that the preadmission screening forms are completed and are within the appropriate time frame, all new admissions will have their preadmission screening forms discussed and reviewed at the Weekly GM/RCD/GHD meeting. Any issues identified will be corrected.*
*Outcomes of the Weekly GM/RCD/GHD meeting will be reviewed by the Resident Care Coordinator/Garden House DIrector at the Quality Assurance Meeting scheduled for 9/19/2022.*
**Completion Date:** *09/19/2022*

**Document Submission** ***Implemented***

*Resident 1's preadmission screening form was signed, dated and the determination that the needs of the resident can be met at the community was completed. However, the date was not within the appropriate time frame. Moving forward, all resident's in SDCU will have their assessment completed within 72 hours of admission.*
*An audit was completed of all preadmission screening forms to review date of admission/date of assessment. There were no further issues identified upon completion of this audit.*
*To insure that the preadmission screening forms are completed and are within the appropriate time frame, all new admissions will have their preadmission screening forms discussed and reviewed at the Weekly GM/RCD/GHD meeting. Any issues identified will be corrected.*

## *224a - Preadmission Screen Form (continued)*

*Outcomes of the Weekly GM/RCD/GHD meeting will be reviewed by the Resident Care Coordinator/Garden House DIrector at the Quality Assurance Meeting scheduled for 9/19/2022.*

**2. 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 #2 was admitted to the home on [redacted]/22; however, the resident's preadmission screening form was completed on [redacted]/22. Additionally, the resident's preadmission screening form was not signed by the assessor and does not include a determination that the needs of the resident can be met by the services provided by the home.*

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

*Resident #2 preadmission screening form is now signed with the current date and determination made that the needs of the resident could be met at this Community.*
*All Preadmission screening forms have been reviewed. All are signed and include a determination that needs can be met at this community.*
*To ensure that all Preadmission forms are completed, dated and signed, all new admission will have their Preadmissions forms discussed and reviewed at the GM/RCD/GHD weekly meeting. Issues identified at this meeting will be corrected .*
*Any concerns with this process will be discussed by the Resident Care Coordinator/Garden House Director at the Quality Assurance meeting scheduled for 9/19/2022.*

**Completion Date:** *09/19/2022*

**Document Submission** ***Implemented***

*Resident #2 preadmission screening form is now signed with the current date and determination made that the needs of the resident could be met at this Community.*
*All Preadmission screening forms have been reviewed. All are signed and include a determination that needs can be met at this community.*
*To ensure that all Preadmission forms are completed, dated and signed, all new admission will have their Preadmissions forms discussed and reviewed at the GM/RCD/GHD weekly meeting. Issues identified at this meeting will be corrected .*
*Any concerns with this process will be discussed by the Resident Care Coordinator/Garden House Director at the Quality Assurance meeting scheduled for 9/19/2022.*

## 225a - Assessment 15 Days

**1. Requirements**

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

**Description of Violation**

*Resident #1 was admitted on [redacted]/22; however, the resident's assessment was not dated for completion.*

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

*Resident 1 had their initial assessment signed and dated with the current date by the assessor.*

## *225a - Assessment 15 Days (continued)*

*An audit was completed of all initial assessments. Any initial assessment that was not signed or dated was corrected and signed with the current date.*
*All new admissions will have their Initial Assessment reviewed at the weekly GM/RCD/GHD meeting. Initial assessments will be reviewed for completeness and appropriate time frames. Any issue identified and will be corrected immediately by the staff person responsible.*
*Outcomes of the weekly GM/RCD/GHD review will be discussed at the Quality Assurance Meeting scheduled for 9/19/2022. Additional interventions will be provided as necessary.*

**Completion Date:** *09/19/2022*

**Document Submission** ***Implemented***

*Resident 1 had their initial assessment signed and dated with the current date by the assessor.*
*An audit was completed of all initial assessments. Any initial assessment that was not signed or dated was corrected and signed with the current date.*
*All new admissions will have their Initial Assessment reviewed at the weekly GM/RCD/GHD meeting. Initial assessments will be reviewed for completeness and appropriate time frames. Any issue identified and will be corrected immediately by the staff person responsible.*
*Outcomes of the weekly GM/RCD/GHD review will be discussed at the Quality Assurance Meeting scheduled for 9/19/2022. Additional interventions will be provided as necessary.*

## 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 #1's initial support plan is not signed and dated by the assessor and is not signed or marked unable to sign by the resident.*

*Resident #2's support plan dated 7/14/22 is not signed and dated by the assessor and is not signed or marked unable to sign by the resident.*

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

*Resident #1 support plan has been signed by the original assessor with the current date. Resident #1 support plan has been reviewed with the resident and signature obtained . Resident #2 assessor is no longer available to sign the support plan. Current Garden House Director (SDCU) reviewed the support plan with the resident, obtained signature and dated with the current date.*
*All support plans were reviewed for participant/assessor signatures/dates. No further issues were identified.*
*The Resident Care Director or Garden House Director (SDCU) will obtain signatures/dates of all individuals who participated in the development of support plan. All new admissions and scheduled support plans will have their support plan reviewed at the weekly GM/RCD/GHD meeting. Support plans will be reviewed for completeness and for participant signatures. Any issues identified will be corrected with the staff person responsible.*
*Any issues identified from the GM/RCD/GHD weekly meeting with obtaining signatures of participants on the support plan will be discussed at the Quality Assurance Meeting scheduled for 9/19/2022. Additional interventions will be applied as necessary.*

## *227g -Support Plan Signatures (continued)*

**Completion Date:** *09/19/2022*

**Document Submission** ***Implemented***

*Resident #1 support plan has been signed by the original assessor with the current date. Resident #1 support plan has been reviewed with the resident and signature obtained . Resident #2 assessor is no longer available to sign the support plan. Current Garden House Director (SDCU) reviewed the support plan with the resident, obtained signature and dated with the current date.*
*All support plans were reviewed for participant/assessor signatures/dates. No further issues were identified.*
*The Resident Care Director or Garden House Director (SDCU) will obtain signatures/dates of all individuals who participated in the development of support plan. All new admissions and scheduled support plans will have their support plan reviewed at the weekly GM/RCD/GHD meeting. Support plans will be reviewed for completeness and for participant signatures. Any issues identified will be corrected with the staff person responsible.*
*Any issues identified from the GM/RCD/GHD weekly meeting with obtaining signatures of participants on the support plan will be discussed at the Quality Assurance Meeting scheduled for 9/19/2022. Additional interventions will be applied as necessary.*

## 231c - Preadmission Screening

**1. 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]/22. However, the resident #1's written cognitive preadmission screening was completed on [redacted]/22.*

*Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/22. However, the resident #2's written cognitive preadmission screening was not signed by the person completing the form and was not dated for completion.*

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

*Resident #1 Preadmission cognitive screening was completed outside the regulatory time frame. Resident #2 written cognition preadmission screening was signed and current date documented on the form.*
*All Preadmission cognitive screenings were audited for signatures and dates. Outcome of audit revealed no further issues with timeliness of documentation, signatures and dates.*
*All new admissions will have their preadmission cognitive screening discussed and reviewed at the GM/RCD/GHD weekly meeting. Any issues identified will be corrected.*
*Outcomes of the weekly review will be discussed by the Garden House Director/Resident Care Director at the Quality Assurance Meeting scheduled for 9/19/2022.*

**Completion Date:** *09/19/2022*

## 231c - Preadmission Screening *(continued)*

**Document Submission** ***Implemented***

*Resident #1 Preadmission cognitive screening was completed outside the regulatory time frame. Resident #2 written cognition preadmission screening was signed and current date documented on the form.*
*All Preadmission cognitive screenings were audited for signatures and dates. Outcome of audit revealed no further ssues with timeliness of documentation, signatures and dates.*
*All new admissions will have their preadmission cognitive screening discussed and reviewed at the GM/RCD/GHD weekly meeting. Any issues identified will be corrected.*
*Outcomes of the weekly review will be discussed by the Garden House Director/Resident Care Director at the Quality Assurance Meeting scheduled for 9/19/2022.*

## 234a - Admission Support Plan

**1. Requirements**

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

**Description of Violation**

*Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]22. However, the resident's initial support plan was not dated for completion.*

*Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/22. However, the resident's initial support plan was completed on [redacted]/22.*

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

*Resident #1 initial support plan was dated for completion with the current date. Resident #2 support plan was completed. However the date is not within the regulatory time frame.*
*An audit was completed of all Garden House (SDCU) Support Plans. by the Garden House Director. No further issues were identified.*
*Support plans for new admissions to Garden House (SDCU) will be reviewed at the Weekly GM/RCD/GHD meeting. Support plan documentation will be reviewed for timeliness and completeness. Any issues identified at this meeting will be corrected immediately by the Garden House Director.*
*Outcomes of the weekly GM/RCD/GH will be reviewed by the Garden House Director at the Quality Assurance Meeting scheduled for 9/18/2022.*

**Completion Date:** *09/19/2022*

**Document Submission** ***Implemented***

*Resident #1 initial support plan was dated for completion with the current date. Resident #2 support plan was completed. However the date is not within the regulatory time frame.*
*An audit was completed of all Garden House (SDCU) Support Plans. by the Garden House Director. No further issues were identified.*
*Support plans for new admissions to Garden House (SDCU) will be reviewed at the Weekly GM/RCD/GHD meeting. Support plan documentation will be reviewed for timeliness and completeness. Any issues identified at this meeting will be corrected immediately by the Garden House Director.*

## *234a - Admission Support Plan (continued)*

*Outcomes of the weekly GM/RCD/GH will be reviewed by the Garden House Director at the Quality Assurance Meeting scheduled for 9/18/2022.*

## 234b - Support Plan Needs Elements

**1. Requirements**

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

**Description of Violation**

*The initial support plan, for resident #1 does not address cognitive needs.*

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

*Resident #1 support plan was reviewed and addresses cognitive needs.*
*All resident support plans in Garden House (SCDU) were reviewed by the Garden House Director. in order to insure the resident support plans identify the physical, medical, social, cognitive and safety needs of the resident. There were no further issues identified.*
*Following the completion of a support plan, the Garden House Director will review the written document to insure a resident's physical, medical, social, cognitive and safety needs have been identified and addressed,*
*Any issues identified during this review will be discussed by the Garden House Director at the Quality Assurance Meeting scheduled for 9/19/2022. If applicable, additional interventions will be provided.*

**Completion Date:** *09/19/2022*

**Document Submission** ***Implemented***

*Resident #1 support plan was reviewed and addresses cognitive needs.*
*All resident support plans in Garden House (SCDU) were reviewed by the Garden House Director. in order to insure the resident support plans identify the physical, medical, social, cognitive and safety needs of the resident. There were no further issues identified.*
*Following the completion of a support plan, the Garden House Director will review the written document to insure a resident's physical, medical, social, cognitive and safety needs have been identified and addressed,*
*Any issues identified during this review will be discussed by the Garden House Director at the Quality Assurance Meeting scheduled for 9/19/2022. If applicable, additional interventions will be provided.*

## 252 - Record Content

**1. Requirements**

2600.
252. Content of Resident Records - Each resident's record must include the following information:
1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.

## 252 - Record Content *(continued)*

10. A record of incident reports for the individual resident.

**Description of Violation**

*Resident #1's record does not include Incident report dated [redacted]22 .*

*Resident #2's record does not include Incident report dated [redacted]/22 .*

*Resident #3's record does not include Incident report dated [redacted]/22 .*

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

*Resident 1,2 and 3 now have their incident reports from [redacted]/2022 filed under the Miscellaneous Tab in the Residents Record.*
*The Resident Care Director/Designee reviewed the Resident Records for each Resident in the Community. Any ncident report not included is now filed in the Resident's Record.*
*The staff member writing the Incident Report will now include the Incident Report in the Resident Care Director's Incident Binder". The staff member will also file a copy of the Incident Report in the Resident's Record. The Resident Care Director/Designee will review the Resident's Record for inclusion of the Incident Report.*
*Any issues with this process will be discussed by the Resident Care Director at the Quality Assurance Meeting scheduled for 9/19/2022.*

**Completion Date:** *09/19/2022*

**Document Submission** ***Implemented***

*Resident 1,2 and 3 now have their incident reports from [redacted]2022 filed under the Miscellaneous Tab in the Residents Record.*
*The Resident Care Director/Designee reviewed the Resident Records for each Resident in the Community. Any ncident report not included is now filed in the Resident's Record.*
*The staff member writing the Incident Report will now include the Incident Report in the Resident Care Director's Incident Binder". The staff member will also file a copy of the Incident Report in the Resident's Record. The Resident Care Director/Designee will review the Resident's Record for inclusion of the Incident Report.*
*Any issues with this process will be discussed by the Resident Care Director at the Quality Assurance Meeting scheduled for 9/19/2022.*