

Department of Human Services
Bureau of Human Service Licensing

October 29, 2022

[REDACTED]
BROOKDALE SENIOR LIVING COMMUNITIES INC
6737 W. WASHINGTON ST, STE 2300
MILWAUKEE, WI, 53214

RE: BROOKDALE NORTHAMPTON
65 RICHBORO-NEWTOWN ROAD
RICHBORO, PA, 18954
LICENSE/COC#: 12714

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/14/2022, 09/15/2022 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

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

Facility Information

Name: *BROOKDALE NORTHAMPTON* License #: *12714* License Expiration: *07/16/2023*
Address: *65 RICHBORO-NEWTOWN ROAD, RICHBORO, PA 18954*
County: *BUCKS* Region: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *BROOKDALE SENIOR LIVING COMMUNITIES INC*
Address: *6737 W. WASHINGTON ST, STE 2300, MILWAUKEE, WI, 53214*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *02/19/1993* Issued By: *Commonwealth of PA L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *104* Waking Staff: *78*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint, Incident, Monitoring* Exit Conference Date: *09/15/2022*

Inspection Dates and Department Representative

09/14/2022 - On-Site: [REDACTED]
09/15/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* Residents Served: *65*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *120* Residents Served: *65*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *65*
Diagnosed with Mental Illness: *3* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *39* Have Physical Disability: *1*

Inspections / Reviews

09/14/2022 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *10/16/2022*

10/19/2022 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *10/27/2022*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *10/23/2022*

10/29/2022 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *10/27/2022*

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

3c - Post Current License

1. Requirements

2600.

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

Description of Violation

On 09/15/22, the home's copy of 55 Pa. Code Chapter 2600 was not posted in a conspicuous and public place in the home.

POC Submission

Accept [redacted] - 10/14/2022)

The following is the Plan of Correction for Brookdale Northampton in regard to the Statement of Deficiency dated October 16, 2022 for full renewal survey inspection on September 14, 2022 and September 15, 2022. The Plan of Correction report is not to be construed as an admission of or agreement with, the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.

Immediately- The copy of Pa Code Chapter 2600 was replaced back in the hallway outside of the main elevators. A plastic holder has now been hung to hold the document going forward in the common area of the first floor.

10/6/22- Appropriate management staff were re-educated on the regulation that the Pa Code, Chapter 2600 must be posted in a conspicuous and public place.

Going Forward- the Maintenance Director or designee will complete an audit monthly for 3 months to verify the Pa Code Chapter 2600 remains posted and available in a conspicuous and public place.

The Executive Director will review results of audits to determine if any further action is warranted.

Licensee's Plan Completion Date: 10/13/2022

Implemented [redacted] - 10/29/2022)

16c - Written Incident Report

2. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] resident 1 [redacted]. The home did not report this incident to the Department until 0 [redacted] 2.

On [redacted] resident 2 injured [redacted] and was sent to the hospital. The home did not report this incident to the Department until [redacted]

On [redacted] resident 3 fell to the floor. On [redacted], the resident complained of pain and was out to the hospital and admitted with a [redacted] The home did not report this incident to the Department until [redacted]

On [redacted], resident 4 report an incident of abuse. The home did not report this incident to the Department until [redacted]

16c - Written Incident Report (continued)

On [REDACTED] resident 5 had a unwitnessed fall and was sent to the hospital. The home did not report this incident to the Department until [REDACTED].

POC Submission

Accept [REDACTED] - 10/14/2022)

October 7, 2022 – Executive Director re-educated the appropriate management staff that reportable events need to be reported to the department within 24 hours.

Going Forward- Executive Director and/or designee will audit incident reports for 3 months for reportable events to verify they are reported within 24 hours.

The Executive Director will then determine if any further action is warranted.

Evidence: Attendance sheet for training.

Licensee's Plan Completion Date: 10/13/2022

Implemented [REDACTED] - 10/29/2022)

28e - Death of a Resident

3. Requirements

2600.

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

Description of Violation

Resident 6 passed away on [REDACTED] Resident 6’s personal belongings were removed from the room on [REDACTED] however, a refund check was not issued until [REDACTED]

POC Submission

Accept [REDACTED] - 10/14/2022)

The refund check was mailed initially within 30 days to [REDACTED] but the check should have been issued to [REDACTED] Clarification was sent that the [REDACTED] and the check should have been issued to [REDACTED]. Once clarification was received, proper documentation was secured, the check was then reissued [REDACTED].

October 7, 2022 – The Business Office Manager and appropriate manage staff were re-educated regarding the community policy on refund checks by the Executive Director.

October 7, 2022- Residents that were discharged in [REDACTED]s files were audited for receipt of the refund check. All were received within the 30 day window and no further action was necessary.

Going Forward- Business Office Manager or designee will complete an audit monthly for 3 months of identified residents to verify that the refund is issued within 30 days of clearing resident’s personal property out of the room.

The Executive Director will review the audit results and determine if any further action is warranted based on results of audits.

Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/13/2022

Implemented [REDACTED] - 10/29/2022)

42c - Treatment of Residents

4. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted] staff person A entered resident 4's bedroom and attempted to wake [redacted] up. Resident 4 is [redacted] medical condition, and [redacted]. Staff person A approached the resident and began telling [redacted] to get up, get up, hurry up, hurry up, and [redacted] up and said, "hurry up." Resident 4 told the staff person [redacted], but staff person was nasty and mean. [redacted] combative with the resident. [redacted] pulled on the resident and slapped [redacted] on the leg. The resident stated that [redacted] leg was swollen and in pain, and that the staff person smacked [redacted] like a horse. The resident told the staff person "Don't hit me".

POC Submission

Accept [redacted] - 10/14/2022)

Immediately- Upon notification of the allegation, staff person A was suspended pending investigation. The Investigation was initiated. Reportable event filed to BHSL and Bucks County Area of Aging. Bucks county Area Office of Aging completed investigation. Staff person A no longer works at the community.

10/ 6/2022- 10/22/2022 -Appropriate staff were re-educated on the community policy regarding treating the residents with dignity and respect by the Executive Director and Health and Wellness Director.

Going forward - Reportable incidents relating to resident dignity and respect concerns will continue to be investigated and reported in correlation with Pa code 2600. Incidents regarding residents will be reviewed by the Health and Wellness Director, Health and Wellness Coordinator, or Executive Director or designee for 3 months. The Executive Director will review the audit results and determine if any further action is warranted based on results of audits.

Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/22/2022

Implemented [redacted] - 10/29/2022)

85a - Sanitary Conditions

5. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 09/15/2022, the rugs in the dementia unit entrance had large brown stains that looked like liquid spills.

On 9/15/2022, the cans of fruit mix stored for emergency food were covered in a black substance that looked like mold.

POC Submission

Accept [redacted] - 10/14/2022)

Immediately- Rug in the dementia unit was cleaned. The cans of mixed fruit stored for emergency food was discarded by the Dining Director.

Immediately -Maintenance Director and/or designee completed an audit of rugs within the community to verify no visible stains were noted.

Immediately- Dietary Director completed an audit of emergency food supply and cans to verify their integrity was maintained. Any items identified as an expired were discarded.

10/6/22- 10/22/22S-Appropriate staff were re-educated regarding reporting, when a stain is noted on any rug, to report to maintenance or housekeeping to be cleaned. Dietary Director re-educated the appropriate staff that

85a - Sanitary Conditions (continued)

emergency food cans must maintain their integrity and if found to be damaged must be discarded immediately.
Going Forward- Maintenance Director and/or designee will complete audits/ rounds monthly for 3 months to verify
rugs within community have no visible stains noted.
Going Forward-Dietary Director and/or designee will audit appropriate emergency food supplies/cans monthly for 3
months to verify cans maintain their integrity.
The Executive Director will review the results of these audits to determine if any further action is warranted based on
results of audits.
Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/22/2022

Implemented [redacted] - 10/29/2022)

85e - Trash Outside Home

6. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and
rodents.

Description of Violation

On 09/15/2022, there were old wood pallets, salt bags and two carts outside the dumpsters.

POC Submission

Accept [redacted] - 10/19/2022)

Immediately- Items around dumpster (pallets, carts, & salt) were removed from area.
10/6/22-10/22/22- Executive Director and Maintenance Director re-trained the appropriate staff regarding the
community policy on storage of trash around the dumpster.
Going Forward- Maintenance Director and/or designee will complete monthly environmental rounds/audits for 3
months of the dumpster area to verify no items are stored outside of covered receptacles.
The Executive Director will review the results of the audits to determine if any further action is warranted.
Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/22/2022

Implemented [redacted] - 10/29/2022)

95 - Furniture and Equipment

7. Requirements

2600.

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

Description of Violation

On 09/15/2022, the drawers of the night stand in bedroom [redacted] in the [redacted] belonging to resident 7 were
broken and in disrepair.

POC Submission

Accept [redacted] - 10/19/2022)

Immediately- Nightstand in [redacted] was removed from the resident room and replaced with a different nightstand.
10/6/22-10/22/22- Appropriate staff were re-educated to report any furniture in disrepair or broken to the
maintenance department for replacement and/or repair by the Executive Director. Education also included noting

95 - Furniture and Equipment (continued)

the need for repair in our electronic TELS system as a reminder to maintenance as to the need for repair. Maintenance Director and designee completed community wide audit on resident rooms to verify night stands were in good condition. All night stands were in good condition and no further action was identified. Going Forward- Maintenance Director and/or designee will complete an audit monthly for 3 months of resident nightstands in the dementia unit. Any identified issues will be addressed or the nightstand will be replaced. The Executive Director or designee will determine if any further action is warranted based on results of audits. Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/22/2022

Implemented [redacted] - 10/29/2022)

101o - Walls, Floors, Ceilings

8. Requirements

2600.

101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On 09/15/2022, the walls in bedroom [redacted] in the [redacted] belonging to resident 7 were scratched and in disrepair.

POC Submission

Accept (MJ - 10/19/2022)

Immediately- Wall in [redacted] was repaired by the Maintenance Director. 10/6/22-10/22/22 -Appropriate staff were re-educated to report any walls needing repair to the maintenance department for follow-up by the Executive Director and Maintenance Director. Education also included noting the need for repair in our electronic TELS system as a reminder to maintenance for the need to repair. 10/6/22-Maintenance Director and designee completed an audit in the [redacted] of the walls to verify they were in good condition. All areas requiring repair were fixed. Going Forward- Maintenance Director and/or designee will complete an audit monthly for 3 months of walls in the dementia unit resident bedrooms to verify they are in good condition or identify areas needing repair. Staff were directed to report any issues noted with the walls in resident room requiring repair. The Executive Director will determine if any further action is warranted based on results of audits. Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/22/2022

Implemented [redacted] - 10/29/2022)

103d - Storing Food Off Floor

9. Requirements

2600.

103.d. Food shall be stored off the floor.

Description of Violation

On 09/15/2022, there were 102 five gallon jugs of water stored on the floor.

103d - Storing Food Off Floor (continued)

POC Submission

Accept (█ - 10/19/2022)

Immediately- the 102 five-gallon jugs of water were relocated from being stored on floor by the Maintenance Director and Dining Director.

10/6/22-10/22/22-Appropriate staff were re-educated that food or water cannot be stored on floor by the Executive Director.

Going Forward- Maintenance Director and/or designee will complete audits monthly for 3 months to verify water gallon jugs are stored according to community policy.

The Executive Director or designee will determine if any further action is warranted based on results of audits.

Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/22/2022

Implemented (█ - 10/29/2022)

103e - Left Overs

10. Requirements

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 09/15/2022, the main kitchen freezer contained two unlabeled, undated bags of chicken drumsticks; one bag of frozen peas; one bag of fish; two pizzas; one bag of meatballs; one bag of sliced peaches; one bag of carrots; and several bags of bread.

POC Submission

Accept (█ - 10/19/2022)

Immediately- Above noted unlabeled and undated food in the freezer were discarded. Dining Director and designee completed an audit of the freezer and discarded any undated/unlabeled food items.

10/6/22-10/22/22- Appropriate dining staff were re-educated on the community policy regarding storage of undated and labeled food by the Executive Director and Dining Director.

Going Forward- Dietary Director and/or designee will complete audits weekly for 4 weeks and then monthly for 2 months to verify food in the freezer is dated and labeled according to community policy.

The Executive Director or designee will determine if any further action is warranted based on results of audits.

Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/22/2022

Implemented (█ - 10/29/2022)

103f - Refrigerator/Freezer Temps

11. 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 09/15/2022, the temperature in the ice cream freezer was 10 degrees Fahrenheit.

103f - Refrigerator/Freezer Temps (continued)

POC Submission

Accept (█ - 10/19/2022)

Immediately- Ice cream freezer temp was checked by inspector after lunch meal in which ice cream was served. Ice cream freezer temperature rechecked at approximately 4 PM and ice cream freezer temperature was at -2 degrees, remaining at a temperature throughout rest of shift in accordance with the community policy.

10/6/22-10/22/22- Appropriate associates were re-educated by the Dining Director regarding the ice cream freezer temperature needing to be 0 degrees or less according to community policy and if the freezer is not maintaining temperature to notify maintenance .

Going Forward- Dining Director and/or designee will complete audits weekly for 4 weeks and then monthly for 2 months of ice cream freezers to ensure temperature is at 0 degrees or less.

Dietary Director and/or Executive Director will determine if any further action is warranted based on results of audits.

Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/22/2022

Implemented (█ - 10/29/2022)

103g - Storing Food

12. Requirements

2600.

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

Description of Violation

On 09/15/2022, several trays of pastries in the main kitchen freezer were opened, unsealed, unlabeled, and undated. In addition, four pies were opened, unsealed, unlabeled, and undated in the main kitchen.

POC Submission

Accept (█ - 10/19/2022)

Immediately- Uncovered food in the freezer was discarded by the Dining Director. The four pies had just been removed from the oven for cooling, however pies were covered with inspector present by the cook. Dietary Director and designee completed an audit of kitchen storage and discarded any uncovered items.

10/6/22-10/22/22-Appropriate associates were re-educated on the community policy regarding storage of food by the Dining Director.

Going Forward- Dietary Director, cook and/or designee will complete audits weekly for 4 weeks and then monthly for 3 months to verify all food is covered according to community policy.

The Dietary Director and/or ED will determine if any further action is warranted based on results of audits.

Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/22/2022

Implemented (█ - 10/29/2022)

105g - Lint Removal and Duct Cleaning

13. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

105g - Lint Removal and Duct Cleaning (*continued*)**Description of Violation**

On 09/15/2022, there was a large accumulation of lint in the lint trap of both dryer units. There were no clothes in the dryer at the time.

POC Submission

Accept [REDACTED] - 10/19/2022)

Immediately- Lint was removed from dryers by housekeeping staff member.

10/6/22-10/22/22-Appropriate associates were re-educated regarding the community policy that lint is to be removed from dryer after each cycle by the Executive director and Maintenance Director. Maintenance Director and designee completed an audit on other dryers within community to verify lint was removed after the previous cycle. Any lint found was removed. Reminder signage was placed near the dryers to remind staff to check for lint in between cycles.

Going Forward- Maintenance Director and/or designee will complete an audit of the community dryers monthly for 3 months to verify lint was removed after last cycle.

The Executive Director or Maintenance Director will determine if any further action is warranted based on results of audits.

Evidence: Attendance sheet for training, dryer signage

Licensee's Plan Completion Date: 10/22/2022

Implemented [REDACTED] - 10/29/2022)

109b - Rabies Vaccination

14. Requirements

2600.

109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On 09/14/2022, 1 dog was present at the home. The home does not have a current certificate of rabies vaccination. The last rabies vaccination certificate expired on 04/06/2022.

POC Submission

Accept [REDACTED] - 10/19/2022)

Immediately- Identified resident family was contacted by the Executive Director that the dog's vaccines were expired and to make an appointment for follow-up.

10/7/22- Appropriate management staff were re-educated that animals living within community require up to date vaccines by the Executive Director. Executive Director completed community audit of all pets living in the community to verify vaccines were up to date. There were no other pets in the community.

Going Forward- Business Office Manager or designee will complete audits monthly for 3 months of any pets living in community to verify vaccines are up to date. Business Office Manager will also make an annual calendar note reminder to check vaccine status on any pets.

The Executive Director will determine if any further action is warranted based on results of the audits.

Evidence: Attendance sheet for training, copy of current vaccine

Licensee's Plan Completion Date: 10/13/2022

Implemented [REDACTED] - 10/29/2022)

123b - Emergency Procedures Posted

15. Requirements

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

POC Submission

Accepted (█ - 10/19/2022)

Immediately- Emergency Preparedness Plan binder was previously located at main lobby desk. The binder has since been posted in a plastic wall file compartment by the Maintenance Director at the main lobby desk area which is more readily accessible.

10/7/22-Appropriate management staff were re-educated on the regulation that the Pa Code, Chapter 2600 must be posted in a conspicuous and public place.

Going Forward- the Executive Director or Business Office Manager or designee will complete an audit monthly for 3 months to verify the Emergency Procedure binder remains posted and available in a conspicuous and public place.

The Executive Director will review results of audits to determine if any further action is warranted.

Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/13/2022

Implemented (█ - 10/29/2022)

141a 1-10 Medical Evaluation Information

16. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

The resident 4's medical evaluation did not include section #4, the special health or dietary needs of the resident, or the medication list.

141a 1-10 Medical Evaluation Information (continued)

POC Submission

Accept (█ - 10/19/2022)

Immediately- Resident #4's medical evaluation was updated by the physician.

October 6, 2022-Health & Wellness Director and Clinical Specialist completed an audit of current resident medical evaluations to verify they are completed in entirety. Any identified issues were completed in conjunction with the physician.

10/06/22-10/22/22- Health and Wellness Director and Clinical Specialist re-educated the appropriate clinical staff regarding review for completion of submitted medical evaluation forms upon receipt.

Going Forward- Health & Wellness Director and/or designee will complete a review of medical evaluations when submitted by the physician for completion according to the community policy for 3 months. Review will be noted by initials in the upper right hand corner of the form.

The Health & Wellness Director or designee will determine if any further action is warranted based on results of audits.

Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/22/2022

Implemented (█ - 10/29/2022)

183e - Storing Medications

17. Requirements

2600.

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

Description of Violation

On 09/15/2022, one loose half pill was found in the first drawer of the first floor medication cart.

On 09/15/2022, █ tablet belonging to resident 8 had a piece of tape on the back of the blister card covering 1 pill.

POC Submission

Accept (█ - 10/19/2022)

Immediately- the half pill was removed from first floor medication cart and discarded; 1 pill of █ belonging to resident #8 was discarded.

10/6/22-10/22/22- Appropriate clinical staff were re-educated on the community policy regarding lose pills in medication cart and blister packs may not be taped at any time.

Health & Wellness Director and designee completed community wide audit of medication carts to verify no lose pills were identified as well as verifying no tape was on blister packs.

Going Forward- Health and Wellness Coordinator, Clinical Specialist or designee will complete weekly cart audits for 3 months of medication carts to verify no lose pills are identified and to verify no tape is evident on blister packs.

The Health & Wellness Director and/or designee will determine if any further action is warranted based on results of audits.

Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/22/2022

Implemented (█ - 10/29/2022)

185a - Implement Storage Procedures

18. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On the medication administration record (MAR) for resident 9, an [redacted] was documented. On [redacted] the [redacted] and the MAR was documented as [redacted]

Resident 10 is prescribed [redacted], the blister card had 50 pills in it however, the count in the [redacted] was 51.

POC Submission

Accept [redacted] - 10/19/2022)

Immediately- Resident #10's [redacted] medication was administered but not signed out by the LPN. LPN immediately educated on the community policy regarding [redacted] requiring documentation at the time when the [redacted] is administered.

10/6/22-10/22/22- Appropriate clinical staff were re-educated regarding the community policy on [redacted] book documentation on administration of [redacted]. Education from the Health and Wellness Director and or Clinical Specialist also included importance of the [redacted] accuracy being transcribed correctly from the glucometer into MAR in PCC.

Health & Wellness Director and/or designee completed an audit of [redacted] documentation and all other [redacted] were documented when administered. All other glucometer readings were also reviewed and matched the documentation in the MAR.

Going Forward- Health & Wellness Director, Health and Wellness Coordinator and/or designee will complete weekly audits for 3 months of [redacted] as they correspond to documentation in PCC to verify information from [redacted] was transcribed correctly to the MAR. During weekly medication cart audits, count sheet records will also be reviewed for signatures in the [redacted]

Going Forward- Health & Wellness Director and/or designee will review audit results to verify of any further action is warranted.

Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/22/2022

Implemented ([redacted] - 10/29/2022)

224a - Preadmission Screen Form

19. 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 4's preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home.

Resident 11's preadmission screening form, dated [redacted] 2, does not include a determination that the needs of the resident can be met by the services provided by the home.

POC Submission

Accept [redacted] - 10/19/2022)

Immediately – Preadmission screen form for Resident #11 was corrected.

224a - Preadmission Screen Form (continued)

10/6/22 – An audit was conducted by the Health and Wellness Coordinator and Clinical Specialist of current resident records to verify preadmission screening forms were completed according to community policy. No other issues were identified.

10/6/22-10/22/22 – Appropriate clinical management staff were retrained on this regulation regarding the need for complete preadmission screening form documentation by the Health and Wellness Director and Clinical Specialist. Ongoing – Preadmissions screening forms will be reviewed for 3 months by the Health and Wellness Director or designee prior to resident move-in. The reviewer will initial the screening documenting the review was completed. The Health and Wellness Director or designee will review results of audits to determine if any further action is warranted

Evidence – Record of Staff Training, Results of preadmission screening form audit, and last 2 new resident preadmission screening forms

Licensee's Plan Completion Date: 10/22/2022

Implemented ([redacted] - 10/29/2022)

225a - Assessment 15 Days

20. 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 11 was admitted to the [redacted]; however, the resident’s assessment was not completed until [redacted]

POC Submission

Accept [redacted] - 10/19/2022)

10/6/22 – An audit was conducted by the Health and Wellness Coordinator and Clinical Specialist of current resident records to verify resident assessments were completed and documented according to community policy. No other issues were identified.

10/6/22-10/22/22 – Appropriate clinical management staff were retrained on the need for timely completion of assessments in the [redacted] according to community policy by the Health and Wellness Director and Clinical Specialist.

Ongoing – Admission assessments in the [redacted] will be reviewed for 3 months by the Health and Wellness Director or designee for timely completion. The Health and Wellness Director or designee will review results of audits to determine if any further action is warranted

Evidence – Record of Staff Training

Licensee's Plan Completion Date: 10/22/2022

Implemented [redacted] - 10/29/2022)

227g -Support Plan Signatures

21. 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 11 participated in the development of her support plan on [redacted]

227g -Support Plan Signatures (continued)

. However, the resident did not sign the support plan.

Repeat Violation 06/03/2021.

POC Submission

Accept [redacted] 10/19/2022)

Immediately- Resident #11's support plan signed by resident.

10/6/22-10/22/22-Health and Wellness Director and/or designee re-educated appropriate clinical staff that support plans need to be reviewed and signed by resident and/ designee.

Health & Wellness director and/or designee completed audit of current residents support plans to verify they are signed by residents or designee according to community policy.

Going Forward- Health & Wellness Director, Health and Wellness Coordinator and/or designee will complete audits monthly for 3 months of current residents current support plans to verify signatures are present according to the community policy.

The Health & Wellness Director or designee will determine if any further action is warranted based on results of audits.

Evidence: Attendance sheet for training, resident #11's signed support plan

Licensee's Plan Completion Date: 10/22/2022

Implemented [redacted] 10/29/2022)

231c - Preadmission Screening

22. 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 11 was admitted to the [redacted]. However, resident 11's written cognitive preadmission screening was not dated.

POC Submission

Accept [redacted] 10/19/2022)

Immediately- Resident #11's cognitive screen was updated and completed in its entirety.

10/6/22-10/22/22-Health and Wellness Director re-educated appropriate clinical staff that cognitive screens need to be reviewed and verified that they are completely filled out according to community policy.

Health & Wellness Director and designee completed an audit of current resident's cognitive screens in the [redacted] to verify they were completely filled out according to community policy. All other screens were in compliance.

Going Forward- Health & Wellness Director, Health and Wellness Coordinator and/or designee will complete audits monthly for 3 months of new residents to the [redacted] prior to move-in for cognitive screen completion according to the community policy.

The Health & Wellness Director or designee will determine if any further action is warranted based on results of audits.

Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/22/2022

Implemented [redacted] - 10/29/2022)

252 - Record Content

23. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident 4's record does not include a copy of the abuse incident report.

Resident 4, 11 and 12 face sheets do not include religion and race.

Resident 13's record does not include a face sheet [REDACTED] personal information.

POC Submission

Accept [REDACTED] - 10/19/2022)

Immediately- Copy of incident report was placed in resident #4's record. Race and religion information was added to face sheets for residents #4, #11, and #12. A new face sheet from PCC was printed out and added to resident #13's record. Executive Director, Health & Wellness Director and Clinical Specialist completed audit of current resident records to verify face sheets were in the record as well as information was completed according to community policy. Any reportable incident reports were also placed in the medical record by the Executive Director.

252 - Record Content (continued)

10/6/22-10/22/22-Health and Wellness Director and/or designee re-educated appropriate clinical staff regarding face sheet information needing to be complete in PCC and placed on the medical record according to community policy.

Going Forward- Health & Wellness Director, Health and Wellness Coordinator and/or designee will complete audits monthly for 3 months of new resident face sheets for completion of necessary information according to community policy.

The Health & Wellness Director or designee will determine if any further action is warranted based on results of audits.

Evidence: Attendance sheet for training

Licensee's Plan Completion Date: 10/22/2022

Implemented [REDACTED] - 10/29/2022)