pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MAY 23, 2023

[redacted]
Rapps Senior Care, LLC
[redacted]

RE: Woodbridge Place
1191 Rapps Dam Road
Phoenixville, Pennsylvania 19460
License #: 143592

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection November 30, 2022, December 1, 2, and 6, 2022, and January 24 and 26, 2023 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from May 23, 2023 to November 23, 2023.

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

[redacted]

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
183d	2	58	$5	$290	5 calendar days from mailing date of this letter
187b	2	58	$5	$290	5 calendar days from mailing date of this letter
187d	2	58	$5	$290	5 calendar days from mailing date of this letter
188b	2	58	$5	$290	5 calendar days from mailing date of this letter
184a	2	58	$5	$290	5 calendar days from mailing date of this letter
85a	2	58	$5	$290	5 calendar days from mailing date of this letter

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

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

[redacted]

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

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

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

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

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *WOODBRIDGE PLACE* **License #**: *14359* **License Expiration**: *10/08/2022*

Addre : *1191 RAPPS DAM ROAD, PHOENIXVILLE, PA 19460*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *RAPPS SENIOR CARE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/28/1996* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *164* **Total Daily Staff**: *266* **Waking Staff**: *200*

Inspection Information

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

Reason: *Complaint, Provisional, Incident* **Exit Conference Date**: *12/06/2022*

Inspection Dates and Department Representative

11/30/2022 - On-Site: [redacted]
12/01/2022 - On-Site:
12/02/2022 - Off-Site:
12/06/2022 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served**: *60*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *21* **Residents Served**: *20*

Hospice

Current Residents: *18*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *58*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *42* **Have Physical Disability**: *0*

Inspections / Reviews

11/30/2022 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *12/26/2022*

12/28/2022 POC Submi ion

Submitted By: [redacted] **Date Submitted:** *01/26/2023*

Reviewer [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *01/05/2023*

01/13/2023 POC Submi ion

Submitted By: [redacted] **Date Submitted:** *01/26/2023*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *01/17/2023*

01/17/2023 POC Submi ion

Submitted By: [redacted] **Date Submitted:** *01/26/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *01/23/2023*

04/13/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/26/2023*

Reviewer: [redacted] **Follow Up Type:** *Enforcement*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 10/3/22, Resident 1 had an unwitnessed fall and was sent to the emergency room via ambulance. The resident sustained a head injury. The home did not report this incident to the department until 10/18/22.

Resident 1 is prescribed Lorazepam 0.5 MG Tablet, take 1/2 tablet(=0.25 MG) by mouth at bedtime. On 11/27/22, this medication was not available in the home and in its place Resident 1 was administered PRN Lorazepam 2 MG/ML Oral Concent, which has the instructions, take 0.5 ML(1MG/1 Syringe) orally every 4 hours as needed for agitation. The resident was not in need of PRN medication at the time. The home did not report this incident to the department.

Plan of Correction ***Accept [redacted] - 01/10/2023)***

Woodbridge Place reported the 10/3/22 incident when contacted by the Licensing Department regarding the fall. The Department noted that the fall should have been reported because EMS was on site, and the reportable was filed. Resident was diagnosed with a UTI and head injury, although CT scan and all other tests were clear. Resident had an abrasion/hematoma on [redacted] head not related to the fall. The reportable was completed by the Departments request on 10/18/22.

Resident #1's medication error was reported when it was found by during The Departments monitoring visit. All current orders for prn medications have been reviewed and discontinued, as able.

The Executive Director, or designee, will retrain the current Director of Wellness regarding completion of Reportable Incidents by 12/31/22. Training Attached. Managers on Duty will be trained by the Executive Director to support reporting per regulatory guidelines. This training will take place by 1/6/23. The new Director of Wellness will also be trained, upon hire on or about February 6th, 2023, as part of [redacted] onboarding to avoid additional citations related to this regulatory expectation. See Attached Training Documentation.

This Plan of Correction and Reportable Incidents will be reviewed at Quality Assurance meetings by the Executive Director and Department Managers. Results will be assessed and if this plan does not prove to be effective it will be immediately amended to ensure that this violation does not occur again.

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented [redacted] - 04/13/2023)

23a - Activities of Daily Living Assistance

2. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated [redacted]

23a - Activities of Daily Living Assistance (continued)

, for Resident 2 indicates the resident requires assistance with medication administration. The resident did not receive this assistance as required during the months of October 2022 and November 2022.

Plan of Correction ***Accept (01/10/2023)***

Resident #2 was reassessed by the Director of Wellness on 12/2/22 , and Care Plan was updated to reflect current ability. Woodbridge Place has assumed medication management for the resident on 12/2/22.

All residents who self-administer medication have been reassessed by The Director of Wellness between the dates of 12/2/22 and 12/13/22 and their RASP's reflect their current needs and abilities and person responsible for administration.

On 12/22/22 the Director of Nursing provided Med Tech training on self medication protocols per the 2600 regulations after she was retrained on 12/20/22. See Attached Training Documentation.

Residents will be continually reassessed every six months per Bridge standards.

This Plan of Correction and Reportable Incidents will be reviewed at Quality Assurance meetings by the Executive Director and Department Managers. Results will be assessed and if this plan does not prove to be effective it will be immediately amended to ensure that this violation does not occur again.

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented - 04/13/2023)

25b - Contract Signatures

3. 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 10/29/21, for Resident 3 was not signed by the resident.

Plan of Correction ***Accept - 01/10/2023)***

The contract was reviewed with Resident #3 on 12/7/22. was asked to sign the contract on that date, which declined. The Executive Director and Business Office Manager noted her declination and initialed and dated the contract to reflect this offer.

All resident contracts were comprehensively audited by the Regional Director of Operations on 12/20/22 for signature compliance. Each document requiring revision will be identified with the caveat statement of "In response to the Plan of Correction on the above dates" to avoid further citations on old records found to be out of compliance. Woodbridge Place will comply with this technical assistance clause provided during the 1/13/22 monitoring survey to avoid additional citations from years in the past.

The new Business Office Manager, once hired, will be trained by the Executive Director to the regulatory expectation regarding signing of the contracts as part of the onboarding process.

25b - Contract Signatures (continued)

This Plan of Correction and a random sampling of newly executed contracts will be reviewed by The Business Office Manager beginning in February of 2023. This random sampling audit will be presented to the Executive Director and The Department Managers, beginning February of 2023 at the Quality Assurance Meeting to ensure that progress is effective in maintaining our compliance with regulatory requirements. If it is determined that this method is no longer effective, it will be amended and a new POC will be implemented to ensure that the violation does not happen again.

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented ([redacted] - 04/13/2023)

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

Plan of Correction ***Accept ([redacted] - 01/10/2023)***

Resident Rights and Complaint Procedures are a part of the contract at Woodbridge Place. The contract was reviewed with Resident #3 on 12/7/22[redacted] was asked to sign the contract on that date, which [redacted] declined. The Executive Director and Business Office Manager noted her declination and initialed and dated the contract to reflect this offer.

All resident contracts were comprehensively audited by the Regional Director of Operations on 12/20/22 for signature compliance. Each document requiring revision will be identified with the caveat statement of "In response to the Plan of Correction on the above dates" to avoid further citations on old records found to be out of compliance. Woodbridge Place will comply with this technical assistance clause provided during the 1/13/22 monitoring survey to avoid additional citations from years in the past.

The new Business Office Manager, once hired, will be trained by the Executive Director to the regulatory expectation regarding signing of the contracts as part of the onboarding process.

This Plan of Correction and a random sampling of newly executed contracts reviewed by The Business Office Manager, or designee, will be audited by the Executive Director, or designee, and The Department Managers at the Quality Assurance Meeting to ensure that progress is effective in maintaining our compliance with regulatory requirements. If it is determined that this method is no longer effective, it will be amended and a new POC will be mplemented to ensure that the violation does not happen again.

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented [redacted] - 04/13/2023)

42v - Resident-Home Contract

5. Requirements

2600.
42.v. A resident has the right to receive services contracted for in the resident-home contract.

Description of Violation

For the months of October 2022 and November 2022, the home failed to provide medication administration to Resident 2, as contracted for in the resident-home contract.

Plan of Correction ***Accept [redacted] - 01/10/2023)***

Resident #2's [redacted] was preparing [redacted] medication, as they share a room. Resident was not paying for this service, as the conditions of the contract changed upon [redacted] request. Resident #2 was reassessed, on 12/2/22 by the Director of Wellness. The Care Plan was updated to reflect current ability. Woodbridge Place has assumed medication management for the resident.

All residents who self-administer medication have been reassessed between 12/2/22 and 12/23/22 and their RASP's reflect their current needs and abilities and person responsible for administration.

Residents will be continually reassessed every six months per Bridge standards.

This Plan of Correction will be reviewed at Quality Assurance meetings by the Executive Director and Department Managers. Results will be assessed and if this plan does not prove to be effective it will be immediately amended to ensure that this violation does not occur again.

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented [redacted] - 04/13/2023)

52 - Hiring Staff

6. Requirements

2600.
52. Staff Hiring, Retention and Utilization - Hiring, retention and utilization of staff persons shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults) and other applicable regulations.

Description of Violation

Staff person A was hired on [redacted] the staff person's criminal background check was not completed until 2/9/22.

Plan of Correction ***Accept [redacted] - 01/10/2023)***

All background checks are being comprehensively audited by the Business Office Manager, or designee, for signature compliance on 1/5/23. Each document found to be out of compliance will be identified with the caveat statement of "In response to the Plan of Correction on the above dates" to avoid further citations on old records found to be out of compliance. Woodbridge Place will comply with this technical assistance clause provided during the 1/13/22 monitoring survey to avoid additional citations from years in the past.

The new Business Office Manager, once hired, will be trained by the Executive Director, or designee, to the regulatory expectation regarding timeliness of background checks.

This Plan of Correction and a random sampling of newly hired staff will be reviewed by The Business Office

52 - Hiring Staff (continued)

Manager beginning in February of 2023. Results of this audit will be presented to the Executive Director and The Department Managers at the Quality Assurance Meeting to ensure that progress is effective in maintaining our compliance with regulatory requirements. If it is determined that this method is no longer effective, it will be amended and a new POC will be implemented to ensure that the violation does not happen again.

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented [redacted] - 04/13/2023)

54a - Direct Care Staff

7. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

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 [redacted] 01/17/2023)***

Direct Care Staff Person B was not an employee of the community. [redacted] worked one shift as an agency staff member at Woodbridge Place and the agency was not aware o[redacted] expired documents. Director of Nursing contacted all temporary staffing agencies utilized at the community on 12/1/2022 to make them aware, in writing of the licensure expectation or the diploma and GED expectation.

Effective 12/2/2022, all new agency staff will be required to provide a copy of their education prior to the start of their first shift.

Woodbridge Place's new Talent and Development Coordinator, or designee, will be responsible for auditing the training records, weekly, of all staff being scheduled from agency beginning 12/2/2022 and ending on 1/31/23.

The Talent and Development Coordinator, or designee, will provide a random audit of agency files to the Monthly QA committee for review beginning in February of 2023. Results will be assessed and if this plan does not prove to be effective it will be immediately amended to ensure that this violation does not occur again. QA meetings are held once per month.

See attached.

Licensee's Proposed Overall Completion Date: *01/31/2023*

Implemented ([redacted] 04/13/2023)

65a - FS Orientation 1st Day

8. 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:

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

Description of Violation

Staff person B, whose first day of work was 10/3/22, 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 ([redacted] 01/17/2023)***

Direct Care Staff Person B was not an employee of the community [redacted] worked one shift as an agency staff member at Woodbridge Place. Staff Person B has not returned to the community for additional shifts.

12/2/2022 - Woodbridge Place has implemented training documents to reflect the regulatory requirements and all staff working at the community from agency will be trained on the required content.

12/2/2022 - Woodbridge Place's new Talent and Development Coordinator, or designee, will be responsible for ensuring the training and credentials of all agency staff being scheduled moving forward.

The new Talent Acquisition Coordinator or designee will provide a random, weekly audits of agency files beginning 12/2/2022 through 2/28/2023. Result will be brought the Quality Assurance Team meeting to be assessed. If this plan does not prove to be effective it will be immediately amended to ensure that this violation does not occur again. QA meetings are held once a month.

See attached.

Licensee's Proposed Overall Completion Date: *01/31/2023*

Not Implemented [redacted] - 04/13/2023)

65d - Initial Direct Care Training

9. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person B, hired on [redacted], began providing unsupervised ADL services on 10/3/22. However, the

65d - Initial Direct Care Training (continued)

staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Accept [redacted] 01/17/2023)***

Direct Care Staff Person B was not an employee of the community. [redacted] worked one shift as an agency staff member at Woodbridge Place and the agency was not aware of [redacted] expired documents, which would negate the need for direct care test. The current Director of Nursing will contact all temporary staffing agencies utilized at the community to make them aware, in writing of the licensure expectation or the diploma, GED and Direct Care expectation. The agencies were contact on 12/1/2022.

Effective 12/2/2022, "the agencies" shall provide a copy of licensure or DCS training for all new agency staff member prior to the start of their first shift and moving forward.

Woodbridge Place's new Talent and Development Coordinator, or designee, will be responsible for auditing the credentials of all agency staff being scheduled on a weekly basis, beginning, 12/2/2023 and ending on 2/28/2023. The new Talent Acquisition Coordinator will provide a random audit of agency files to the QA committee for review. Results will be assessed and if this plan does not prove to be effective it will be immediately amended to ensure that this violation does not occur again. QA meetings are held once a month.

Licensee's Proposed Overall Completion Date: *01/31/2023*

Implemented [redacted] - 04/13/2023)

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

On 11/30/22, 2 tubes of Sensodyne toothpaste and 1 tube of Freshmint toothpaste, with a manufacture's label indicating "if swallowed, contact poison control immediately", was unlocked, unattended, and accessible to residents in room 154. Not all the residents of the home, including Resident 3, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] 01/05/2023)***

The materials deemed to be at risk were immediately removed from the unlocked medicine cabinet and stored in a locked area.

The Memory Care Director has initiated retraining of the staff beginning 12/19/22 and continuing until 1/9/22 regarding the importance of assuring that all chemicals or potentially poisonous materials are consistently secured in a locked area to prevent potential hazards. The Memory Care Director,or designee, will be responsible for change of shift rounds beginning in December to ensure compliance.

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

82c - Locking Poisonous Materials (continued)

as necessary to ensure that this violation does not occur again.

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented [redacted] - 04/13/2023)

89b - Hot Water Temperature

11. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 11/30/22 at 10:50 am, the hot water temperature at the bathroom sink in room 314 measured 124.8 degrees Fahrenheit.

On 11/30/22 at 11:04 am, the hot water temperature at the bathroom sink in room 214 measured 123.4 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 12/28/2022)***

Woodbridge Place Maintenance Director immediately adjusted the mixing valve to regulate the water temperature in the building. Testing on 12/1/22 as follow up continued to temp within regulatory expectations.

The Maintenance Director, or designee, will continue weekly water temperature audits to assure temps remain within range.

The Maintenance Director,or designee, will be responsible for reviewing the weekly audits at QA committee. Results will be assessed and if this plan does not prove to be effective it will be immediately amended to ensure that this violation does not occur again.

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented [redacted] - 04/13/2023)

103e - Left Overs

12. 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 11/30/22, there were an unlabeled, undated containers of cooked breakfast sausage, scrambled eggs, and breakfast potatoes, all leftover from the day's breakfast, in the walk-in refrigerator.

Plan of Correction ***Accept ([redacted] - 01/17/2023)***

Unlabeled items were disposed of on the day of survey, per the Executive Directors request.

103e - Left Overs (continued)

Chef Manager, or designee, to retrain all culinary team members regarding the need to label, date and seal all eftovers and food in dry storage or freezer and refrigerator beginning 12/28/22. This Training was completed on 12/31/2022.

Chef Manager, or designee, will complete random audits of the dry storage, refrigerator, and freezer beginning 12/15/22, twice per month, to assure that foods are always labeled and dated.

Chef Manager, or designee, will present to the Executive Director and Department Heads on the random audits as part of the Quality Assurance meeting. Results of these audits will be reviewed to ensure that this methodology is effective. Changes will be made as necessary to ensure that this violation does not occur again. QA meetings are held once a month.

See Attached Training and Audit

Licensee's Proposed Overall Completion Date: *01/31/2023*

Not Implemented ([redacted] - 04/13/2023)

103g - Storing Food

13. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 11/30/22, there was a bag of cocoa and a bag of macaroni in the dry storage area. Both were opened and unsealed.

Plan of Correction ***Accept ([redacted] - 01/17/2023)***

Unsealed items were disposed of on the day of survey, per the Executive Directors request.

Chef Manager, or designee, to retrain all culinary team members, beginning 12/28/22 regarding the need to label, date and seal all leftovers and food in dry storage or freezer and refrigerator. This training was completed on 12/31/2022

Chef Manager, or designee, will complete random audits beginning 12/15/22 of the dry storage,refrigerator and freezer to assure that foods are always labeled and dated. These audits will be conducted on the 1st and 15th of each month through 12/31/2023.
Chef Manager, or designee, will present to the Executive Director and Department Heads on the random audits as part of the Quality Assurance meeting. Results of these audits will be reviewed to ensure that this methodology is effective. Changes will be made as necessary to ensure that this violation does not occur again. QA meetings are held once a month.

See Attached

Licensee's Proposed Overall Completion Date: *01/31/2023*

Not Implemented [redacted] - 04/13/2023)

103i - Outdated Food

14. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 11/30/22, in the walk-in refrigerator, there were 2 slabs of deli turkey, 1 slab of deli ham, 1 bag of shredded cheese, and 1 block of feta cheese all were not labeled and not dated.

On 11/30/22, in the dry food storage area, there was 1 bag of rice, 1 bag of cocoa and 1 bag of macaroni, all were not labeled and not dated.

Plan of Correction ***Accept [redacted] - 01/17/2023)***

Unlabeled and unsealed items were disposed of on the day of survey, per the Executive Directors request.

Chef Manager, or designee, to retrain all culinary team members beginning 12/28/22 regarding the need to label, date and seal all leftovers and food in dry storage or freezer and refrigerator. Training was completed on 12/31/2022.

Chef Manager, or designee, will complete random audits of the dry storage, refrigerator and freezer to assure that foods are always labeled and dated beginning 12/15/22 and continuing on the 1st and 15th of each month until 12/31/2023.

Chef Manager, or designee, will present to the Executive Director and Department Heads on the random audits as part of the Quality Assurance meeting. Results of these audits will be reviewed to ensure that this methodology is effective. Changes will be made as necessary to ensure that this violation does not occur again. QA meetings are held once a month.

See Attached

Licensee's Proposed Overall Completion Date: *01/31/2023*

Not Implemented [redacted] - 04/13/2023)

132a - Monthly Fire Drill

15. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of January 2022.

Plan of Correction ***Accept [redacted] - 12/28/2022)***

Woodbridge Place currently utilizes a subcontracted service to conduct monthly fire drills. In January 2022, the service provider made the decision to refrain from conducting a drill secondary to COVID positive cases at the community.

The Maintenance Director will contact the current provider noting that future drills may not be postponed without

132a - Monthly Fire Drill (continued)

approval from the Executive Director and Maintenance Director. Should a COVID outbreak preclude the drill from occurring, the Department will be notified per regulatory protocols as expressed by the Licensing Representative. Another drill will be scheduled for the month to meet the regulatory expectation of an unannounced fire drill occurring monthly.

Monthly compliance with fire drill execution and fire drill outcomes shall be reviewed at Quality Assurance meetings and plans to correct issues will be implemented immediately.

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented [redacted] 13/2023)

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

Resident 4's medical evaluation dated 4/6/22, did not include immunization history.

Plan of Correction ***Accept [redacted] - 01/13/2023)***

Resident #4's immunization history was attached to the medical evaluation. However, the document failed to note a clause of "see attached." The Director of Wellness noted on the form "see attached" to create a comprehensive document.

See Attached Training conducted on 12.20.22

Executive Director to complete training with the current Director of Wellness regarding noting "see attached." The new Director of Wellness, once hired, will also be trained to this regulatory expectation.

Current Director of Wellness continues to maintain an active tickler regarding dates and requirements for the medical evaluations, per Bridge Senior Living standards.

The tickler file developed by Bridge Senior Living will be reviewed and monitored by The Directors of Wellness and Department Managers at the Quality Assurance Meeting to ensure that it is effective in maintaining Woodbridge Place's compliance with this regulatory standard. Should it be determined that the tickler is no longer effective, it will be amended or enhanced to ensure that this violation does not occur again, starting immediately.

141a 1-10 Medical Evaluation Information (continued)

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented [redacted] - 04/13/2023)

181c - Self-administration Assessment

17. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident 2 self-administers medications to include Dalfampridine ER 10 MG; however, resident 2 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction ***Accept [redacted] - 01/13/2023)***

Resident assessed to require assistance with medication administration by The Director of Wellness on 12/2/22. Residents [redacted] is no longer providing this assistance, per the regulations. Staff is now housing all medication and aiding with administration.

All residents self-administering medications have been reassessed by The Director of Wellness between 12/2/22 and 12/13/22 and safe storage and administration practices have been reviewed. Bridge self-administration assessment will occur at least biannually moving forward.

Residents choosing and passing the self-administration assessment will be reviewed at Quality Assurance meeting to guarantee that the assessments are timely and date compliant to maintain compliance with this regulatory standard. Should it be determined that this assessment is no longer effective, a significant change evaluation will be implemented for the resident and reviewed at the Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented [redacted] - 04/13/2023)

182b - Prescription Medication

18. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

Description of Violation

During the months of October 2022 and November 2022, Resident 5 was administering medications to Resident 2. Resident 5 is not one of the following:
(1) A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
(2) A graduate of an approved nursing program functioning under the direct supervision of a

182b - Prescription Medication (continued)

professional nurse who is present in the home.
(3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
(4) A staff person who has completed the medication administration training as specified in § 2600.190 for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Plan of Correction ***Accept [redacted] - 01/13/2023)***

Resident #2 was reassessed on 12/2/22 , and Care Plan was updated to reflect current ability. Woodbridge Place has assumed medication management for the resident on 12/2/22.

All residents who self-administer medication have been reassessed and their RASPs reflect their current needs and abilities and person responsible for administration.

This Plan of Correction and Reportable Incidents will be reviewed at Quality Assurance meetings by the Executive Director and Department Managers. Results will be assessed and if this plan does not prove to be effective it will be mmediately amended to ensure that this violation does not occur again.

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented [redacted] - 04/13/2023)

183b - Meds and Syringes Locked

19. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 12/1/22 at 3:00 pm, Dalfampridine ER 10 MG was unlocked, unattended, and accessible in an ottoman in the home's 3rd floor common hallway.

On 12/1/22, medications stored in Resident 2's room were being kept in a basket on the left side of the resident's dresser. The medications were unlocked and accessible.

Plan of Correction ***Accept [redacted] - 01/13/2023)***

Resident #2's medications were removed from [redacted] room the day after the survey on 12/2/22. Resident was reassessed to require assistance with medication administration on 12/2/22.

There are currently only two residents who continue to self-medicate in the community. Both residents have been re-educated between 12/2/22 and 12/23/22 on the storage of the medication in their room, by the Director of Wellness. The Executive Director also purchased locked containers to be utilized as the need arises.

Staff is being re-educated on the parameters of self-administration beginning 12/22/22 to assist in monitoring the safe storage of medications.

183b - Meds and Syringes Locked (continued)

All residents self-medicating will be reviewed at Quality Assurance meeting to guarantee that the medication self-administration assessments are timely and date compliant thereby enforcing this regulatory standard. Should it be determined that the self-administration assessment is no longer effective in maintaining cohesive compliance with this regulatory standard, a new plan will be immediately implemented.

See Attached

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented ([redacted] - 04/13/2023)

183d - Prescription Current

20. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 12/1/22, SM Gentle Laxative prescribed for Resident 2, was in the resident's room; however, the medication was discontinued.

Repeated violation: 1/13/22,

Plan of Correction ***Accept [redacted] - 01/13/2023)***

Resident #2's medications were removed from [redacted] room the day after the survey on 12/2/22. Resident was reassessed to require assistance with medication administration.

There are currently only two residents who continue to self-medicate in the community. Residents who self medicate have been re-educated between 12/2/22 and 12/13/22 on the storage of the medication in their room and the need for a comprehensive and timely medication list, by the Director of Wellness.

Staff is being re-educated on 12/22/22 regarding the parameters of self-administration to assist in monitoring the safe storage of medications by The Director of Wellness.

All residents self-medicating will be reviewed at Quality Assurance meeting to guarantee that the medication self-administration assessments are timely and date compliant thereby enforcing this regulatory standard. Should it be determined that the self-administration assessment is no longer effective in maintaining cohesive compliance with this regulatory standard, a new plan will be immediately implemented.

Licensee's Proposed Overall Completion Date: *01/09/2023*

Not Implemented [redacted] - 04/13/2023)

185a - Implement Storage Procedures

21. 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 11/26/22, Resident 4's am glucometer reading is 164. The resident's blood glucose is recorded as 136 on the

185a - Implement Storage Procedures (continued)

Medication Administration Record.

On 11/26/22, Resident 4's noon glucometer reading is 214. The resident's blood glucose is recorded as 241 on the Medication Administration Record.

Plan of Correction ***Accept [redacted] - 01/17/2023)***

The audits employed as part of the previous POC's were working and effective, as evidenced on several monitoring visits. This current citation was a result of wifi issues that prevented the transcription error from registering at time of printing of the MAR's. The Licensing Representative on site witnessed many of the connection issues during [redacted] visit.

Training will be conducted beginning 12/22/22 by the Director of Wellness with all the Medication Technicians and Wellness Nurses again regarding accurately recording glucose results and the negative impact of errors in recording.

Medication Technicians and Wellness Nurses will be responsible for weekly audits of the glucometers to ensure that they are properly calibrated, supplies are readily available and numeric accuracy is obtained. New weekly audits began on 12/27/2023 after the inservice.

The Director of Nursing will be responsible a random secondary audit of the glucometers and medication carts monthly beginning 12/31/2022. Results of the primary and secondary audits will be provided to the Executive Director and Managing Directors at the Quality Management Meeting. Results will be assessed and if this plan does not prove to be effective, it will be immediately amended to ensure that this violation does not occur again. QA meeting are held once a month.

Licensee's Proposed Overall Completion Date: *01/31/2023*

Not Implemented [redacted] 04/13/2023)

187b - Date/Time of Medication Admin.

22. 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

In the month of November 2022, staff did not administer medications to Resident 2. However the resident's Medication Administration Record has staff initials for Aripiprazole 2 MG rom 11/9/22 to 11/20/22 and Myrbetriq ER 50 MG from 11/2/22 to 11/27/22.

Plan of Correction ***Accept [redacted] - 01/17/2023)***

Resident #2's medication is now being administered by staff.

Current Director of Nursing has contacted our pharmacy to ensure that the eMAR system indicates self-administration for all medications for the two residents who continue to self-administer. The pharmacy was contracted on 12/1/2022.

Medication Technicians and Wellness Nurses will be re-educated by The Director of Nursing regarding the

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

parameter for self-administration, at a planned meeting on 12/22/22 which include contacting the pharmacy to ensure that all medications on electronic medication record indicate self-administration ensuring there are no blanks for signature.

The Director of Nursing will review the eMAR, weekly, for any resident's self-administering and will present findings at Quality Assurance Meeting to the Executive Director and The Department Managers. QA meeting are held once a month.

Repeated violation: 1/13/22 et al, 7/14/22

Licensee's Proposed Overall Completion Date: *01/31/2023*

Not Implemented [redacted] 04/13/2023)

187d - Follow Prescriber's Orders

23. Requirements

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

Description of Violation

Resident 1 is prescribed Lorazepam 0.5 MG Tablet, take 1/2 tablet(=0.25 MG) by mouth at bedtime. However, this medication was not administered to resident 1 on 11/27/22 because the medication was not available in the home.

Resident 2 is prescribed Myrbetriq ER 50 MG, take one tablet by mouth daily. However, this medication was not available in the home.

Resident 2 is prescribed Premarin [redacted] Cream, apply a pea sized amount [redacted] every Tuesday and Thursday at bedtime. However, this medication was not available in the home.

Repeat Violation: 1/13/22, 7/14/22

Plan of Correction ***Accept [redacted] - 01/13/2023)***

Resident #1's Lorazepam was filled on 11/27/22 and delivered on 11/28/22 for the dose prescribed. The eMAR has been updated for staff to assess the need to reorder controlled and counted substances every two days to request new prescriptions as needed, per pharmacy protocol. Residents PRN Lorazepam was discontinued with physicians' approval.

Resident #2's medications have been transitioned to staff administration, as the resident decided independently to stop the medications listed. Current medication list was verified when Woodbridge Place assumed medication responsibilities on 12/2/22.

Training will be conducted with all Medication Technicians and Wellness Nurses by The Director of Wellness on 12/22/22 regarding reordering protocols, pharmacy refill protocols and obtaining new prescriptions.

Medication cart audits continue weekly and by the Medication Techs and Wellness Nurses. These audits will continue to be reviewed at Quality Assurance Meeting. Should it be determined that cart audits are ineffective, a new plan will be implemented to ensure regulatory compliance.

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

Licensee's Proposed Overall Completion Date: *01/09/2023*

Not Implemented [redacted] - 04/13/2023)

24. Requirements

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

Description of Violation

Resident 1 is prescribed Lorazepam 0.5 MG Tablet, take 1/2 tablet(=0.25 MG) by mouth at bedtime. On 11/27/22, this medication was not available in the home and in its place Resident 1 was administered PRN Lorazepam 2 MG/ML Oral Concent, which has the instructions, take 0.5 ML(1MG/1 Syringe) orally every 4 hours as needed for agitation. The resident was not in need of PRN medication at the time.

Repeated Violation - 1/13/22, et al, 7/14/22

Plan of Correction ***Accept [redacted] - 01/17/2023)***

Resident #1's Lorazepam was filled and delivered to the community on 11/28/22. The eMAR has been updated for staff to assess the need to reorder controlled and counted substances every two days to request new prescriptions as needed, per pharmacy protocol. Residents PRN Lorazepam was discontinued with physicians' approval.

Training will be conducted with all Medication Technicians and Wellness Nurses regarding reordering protocols, pharmacy refill protocols and obtaining new prescriptions. This Training was conducted on 12/22/2023.

12/2/2022 - Medication cart audits continue to be audited weekly by the Wellness nurse or assigned Medication Technicians through 2/28/2023 and will be reviewed at Quality Assurance Meeting. Should it be determined that cart audits are ineffective, a new plan will be implemented to ensure regulatory compliance. QA meetings are held once a month.

Licensee's Proposed Overall Completion Date: *01/31/2023*

Not Implemented [redacted] - 04/13/2023)

188b Medication Error Reporting

25. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident s designated person and the prescriber.

Description of Violation

Resident 1 is prescribed Lorazepam 0.5 MG Tablet, take 1/2 tablet(=0.25 MG) by mouth at bedtime. On 11/27/22, this medication was not available in the home and in its place Resident 1 was administered PRN Lorazepam 2 MG/ML Oral Concent, which has the instructions, take 0.5 ML(1MG/1 Syringe) orally every 4 hours as needed for agitation. The resident was not in need of PRN medication at the time. The medication error was not reported to the resident, the resident's designated person and the prescriber.

188b - Medication Error Reporting *(continued)*

Plan of Correction ***Accept (MS 01/13/2023)***

Upon discovery, this medication error was reported to The Department, per regulatory protocol. PRN Lorazepam for Resident #1 has been discontinued. Routine dose of Lorazepam is present in the community.

Staff will be re-educated by The Director of Wellness on giving medications per the right route, dose, time, resident and medication as part of the upcoming staff meeting on 12/22/22. Staff will be educated regarding the need to self-report any errors for the safety and well-being of the resident.

Medication errors are reviewed at Quality Assurance meetings for prevention of further errors and opportunities to improve care. Repeated Violation - 1/13/22, et al

Licensee's Proposed Overall Completion Date: *01/09/2023*

Not Implemented [redacted] - 04/13/2023)

191 - Resident Right to Refuse

26. 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 3, admitted [redacted] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept ([redacted] - 01/13/2023)***

Resident Rights and the right to refuse medications are a part of the contract at Woodbridge Place. The contract was reviewed with Resident #3 on 12/7/22. [redacted] was asked to sign the contract on that date, which [redacted] declined. The Executive Director and Business Office Manager noted her declination and initialed and dated the contract to reflect this offer.

All resident contracts were comprehensively audited by the Regional Director of Operations on 12/20/22 for signature compliance. Each document requiring revision will be identified with the caveat statement of "In response to the Plan of Correction on the above dates" to avoid further citations on old records found to be out of compliance. Woodbridge Place will comply with this technical assistance clause provided during the 1/13/22 monitoring survey to avoid additional citations from years in the past.

The new Business Office Manager, once hired, will be trained by the Executive Director, or designee, to the regulatory expectation regarding signing of the contracts as part of the onboarding process.

This Plan of Correction and a random sampling of newly executed contracts reviewed by The Business Office Manager beginning in February of 2023, will be present to the Executive Director and The Department Managers at the Quality Assurance Meeting to ensure that progress is effective in maintaining our compliance with regulatory requirements. If it is determined that this method is no longer effective, it will be amended and a new POC will be mplemented to ensure that the violation does not happen again.

191 - Resident Right to Refuse *(continued)*

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented [redacted] 04/13/2023)

225a - Assessment 15 Days

27. 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 2's assessment, dated [redacted], does not include an assessment for making and keeping appointments, engaging in social and leisure activities, and obtaining clean, seasonal clothing.

Plan of Correction ***Accept ([redacted] - 01/13/2023)***

Resident #2's assessment and care plan has N/A written in the box associated with making and keeping appointments, and obtaining clean and seasonal clothing. However, the box associated with N/A either A or D was not checked as part of an oversight.

The documents cited were audited for additional blanks and updated appropriately.

The new Lifestyle Director, or designee, will audit all RASP's for completion of leisure and social activities beginning 12/20/22 through 1/6/23 and will update as needed. Updates to RASP's will be cited with the POC date to prevent further citations.

The Director of Nursing, or designee, will complete a secondary audit of the entire RASP/assessment prior to closing the document in Tabula Pro. The Director of Nursing, or designee, will also bring one assessment to Quality Assurance Meeting beginning in February of 2023 for a comprehensive secondary audit of box checking to correspond with written documentation in the box. Should this audit by the Executive Director and Department Directors prove ineffective, the plan will be immediately amended and a new POC initiated to ensure that this violation does not occur again.

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented [redacted] - 04/13/2023)

225c - Additional Assessment

28. Requirements

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

Description of Violation

Resident 4's assessment, dated [redacted], does not include an assessment for engaging in social and leisure activities .

Plan of Correction ***Accept ([redacted] - 01/13/2023)***

Resident #4's assessment has been updated to reflect the accurate assessment.

225c - Additional Assessment (continued)

The documents cited were audited for additional blanks and updated appropriately.

The new Lifestyle Director, or designee, will audit all RASP's for completion of leisure and social activities beginning 12/20/22 until completion by 1/6/22 and will update as needed. Updates to RASP's will be cited with the POC date to prevent further citations.

The Director of Nursing, or designee, will complete a secondary audit of the entire RASP/assessment prior to closing the document in Tabula Pro. The Director of Nursing will also bring one assessment to Quality Assurance Meeting beginning in February of 2023 for a comprehensive secondary audit of box checking to correspond with written documentation in the box. Should this audit by the Executive Director and Department Directors prove ineffective, the plan will be immediately amended and a new POC initiated to ensure that this violation does not occur again.

Licensee's Proposed Overall Completion Date: *01/09/2023*

Implemented [redacted] - 04/13/2023)