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

March 23, 2023

ABINGTON SENIOR CARE LLC

RE: THE TERRACE AT CHESTNUT HILL
495 EAST ABINGTON AVENUE
PHILADELPHIA, PA, 19118
LICENSE/COC#: 14157

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/09/2023, 01/09/2023, 01/11/2023, 01/17/2023, 01/18/2023 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE TERRACE AT CHESTNUT HILL* **License #**: *14157* **License Expiration**: *08/16/2023*

Address: *495 EAST ABINGTON AVENUE, PHILADELPHIA, PA 19118*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *ABINGTON SENIOR CARE LLC*

Address: *1000 LEGION PLACE, SUITE 1600, ATTN - BILL SNOW, ORLANDO, FL, 32801*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *09/17/1996* **Issued By**: *City of Philadelphia*

Type: *Other* **Date**: *09/17/1996* **Issued By**: *City of Philadelphia*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *109* **Waking Staff**: *82*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *01/18/2023*

Inspection Dates and Department Representative

01/09/2023 - On-Site:
01/09/2023 - On-Site:
01/11/2023 - Off-Site:
01/17/2023 - Off-Site:
01/18/2023 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *122* **Residents Served**: *88*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care Unit* **Capacity**: *45* **Residents Served**: *34*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *86*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *21* **Have Physical Disability**: *1*

Inspections / Reviews

01/09/2023 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/19/2023*

03/01/2023 - POC Submission

Submitted By: [redacted]
Date Submitted: *03/20/2023*
Reviewer: [redacted]
Follow-Up Type: *POC Submission* **Follow-Up Date:** *03/06/2023*

03/07/2023 - POC Submission

Submitted By: [redacted]
Date Submitted: *03/20/2023*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date:** *03/22/2023*

03/23/2023 - Document Submission

Submitted By: [redacted]
Date Submitted: *03/20/2023*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

16c - Written Incident Report

1. Requirements

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

Description of Violation

On [redacted], resident #1 had an unwitnessed fall, and incurred a bruise to his eye. Emergency services were called to the home; resident #1 was transferred to the hospital. The home did not report this incident to the Department until 1/10/23.

Plan of Correction ***Accept (MJ - 03/01/2023)***

Med-Techs and Nurses to be educated on the the 2600.16.c regulation that anytime an incident involving a resident requires emergency service to the hospital will be reported to the Bureau of Human Licensing within 24 hours. Training to be completed by 3/1/2023

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented (MJ - 03/23/2023)

42b - Abuse

2. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 1/10/23, resident #2 was interviewed by the Department in regards to [redacted] personal care needs not being met during the overnight shift. Resident #2 who is wheelchair bound and has a catheter reports that during the overnight shift [redacted] toileting needs are not being addressed and has been forced to sleep in [redacted] wheelchair. Overnight staff do not change [redacted] personal care product and they do not transfer resident #2 from the wheelchair to [redacted] bed. Resident #2 communicates that [redacted] needs assistance with [redacted] urinary catheter being drained, this care is not being provided. Resident #2 reports when seeking assistance of the overnight direct care staff they are sleeping. Resident #2, reports many nights [redacted] sleeps upright in [redacted] wheelchair due to these personal care not being addressed on the overnight shift. The Department representative, interviewed the overnight medication technician, staff person A, who confirmed the overnight staff are sleep and the direct care staff are failing to provide care for resident #2 on the overnight shift. The staff in the home are not providing the care required for resident #2.

Plan of Correction ***Directed (MJ - 03/07/2023)***

Resident #2 uses the wheelchair as a preference but is not wheel chair bound and has the ability to walk with a walker and empty [redacted] foley bag but chooses not to. Staff to be educated on accommodating residents right to have needs met according to the residents preference. Training to be completed with all staff by 3/1/2023.
Current staff have been educated on the importance of protecting residents from abuse and neglect, by Executive Director, per regulation 2600.42b. (see attached in-service)
Going forward, the Director of Nursing and Executive Director will also provide education to present staff ad any new hires on the importance of protecting residents from abuse and neglect.

42b - Abuse (continued)

Directed

In addition to the above plan of correction: The administrator or designee shall ensure overnight staff are awake and available to provide direct care to residents per the resident support plan. The administrator or designee shall conduct weekly checks of overnight staff. Documentation of checks shall be kept for Department review.

Directed Completion Date: *03/03/2023*

Implemented (MJ - 03/23/2023)

58a - Awake Staff 16 or More

3. Requirements

2600.
58.a. If a home serves 16 or more residents, all direct care staff persons on duty in the home shall be awake at all times one or more residents are present in the home.

Description of Violation

On 1/10/23, 88 residents were present in the home. It was identified by residents and confirmed by staff person A and B, the overnight staff are sleeping in the home.

Plan of Correction ***Accept (MJ - 03/07/2023)***

It was identified that the staff person who was reported to have been sleeping was on ███ 30 minute break period. Staff person was counseled on 1/9/23, (see attached counseling form).. All staff are entitled to a 30 minute meal break in which they should be able to utilize their 30 minute break period to rest. Staff will be educated on taking their 30 minute break period in a staff break area and that only one staff member is to be on break and remaining staff to be awake.
An In-service was conducted by the Executive Director and/or Director of Nursing to educate staff that no one is allowed to sleep while on duty. When a staff person has a break, they are to take their break in the provided employee break area. Going forward, any staff member observed sleeping and not in the employee break area will be terminated immediately by the Executive Director and/or Director of Nursing. (See attached in-service to staff on 2/28/23 by the ED).

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented (MJ - 03/23/2023)

65g - Annual Training Content

5. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

The home's staff training plan does not include Mechanical Hoyer Lift, Ostomy Care, and Urinary Catheter Care. The

65g - Annual Training Content (continued)

home serves residents with these needs.

Plan of Correction ***Accept (MJ - 03/01/2023)***

Training is provided for Mechanical Hoyer Lift, Ostomy Care and Urinary Catheter Care as part of new hire Orientation with refreshers provided throughout the year as part of the annual training plan and when specific training per specific residents is needed. Annual training plan was updated to specify training. A refresher for all staff will completed by 3/8/2023 by Director of Wellness.

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented (MJ - 03/23/2023)

82c - Locking Poisonous Materials

6. 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

The following poisons were unattended and unlocked on the 2nd floor memory care unit:

- *A& D Ointment, with a manufacture's label indicating "may be harmful if swallowed, call a poison control center right away", was unlocked, unattended, and accessible to residents on the 2nd floor memory care unit. Not all the residents of the home, in memory care have been assessed capable of recognizing and using poisons safely.*

- *Prang Paint, with a manufacture's label indicating "may be harmful if swallowed, call a poison control center right away", was unlocked, unattended, and accessible to residents on the 2nd floor memory care unit. Not all the residents of the home, in memory care, have been assessed capable of recognizing and using poisons safely.*

Plan of Correction ***Accept (MJ - 03/01/2023)***

All items deemed harmful were removed and locked up on date of inspection. New locks were installed on Memory care cabinets to ensure safety of all residents. Staff to be educated on proper way to store items that could be a hazard to a resident and instructed to do routine sweeps of memory care neighborhoods to ensure compliance with regulation.

Licensee's Proposed Overall Completion Date: *02/21/2023*

Implemented (MJ - 03/23/2023)

85a - Sanitary Conditions

7. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 1/9/23, at 3:04 pm, resident #4 resides in a shared living space to include the bathroom. The towels were used and hanging on the shower bar. The towels and wash clothes were not identified by resident creating an unsanitary condition.

Plan of Correction ***Accept (MJ - 03/01/2023)***

Upon exit of the inspection Memory Care director completed an Audit of all resident rooms that occupied more than one residents and labeled and installed appropriate bars/hooks to clearly identify which items belonged to resident A and resident B. Memory Care directly will do weekly walkthrough to ensure compliance.

Licensee's Proposed Overall Completion Date: *02/20/2023*

Implemented (MJ - 03/23/2023)

88a - Surfaces

8. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The following surfaces were observed as unclean or in need of repair :

- *The ceilings in the wellness office were not in good repair.*
- *The floors leading to lower first floor dining room had spots and grime markings.*

Plan of Correction ***Accept (MJ - 03/01/2023)***

Items that were observed as being in disrepair or potential hazards were corrected at time of inspection. Issue with floor had just occurred during the inspection and was in the process of being cleaned. Maintenance Director was educated on the timeliness of correcting any issues that could be a potential hazard for residents and/or staff.
ED and/or Maintenance Director or other designee in their absence will conduct daily walkthrough of the community and place any repair orders in TELS. Any issues requiring immediate remedy will be reported to appropriate person to be corrected timely.

Licensee's Proposed Overall Completion Date: *02/21/2023*

Implemented (MJ - 03/23/2023)

90b - Staff Communication

9. Requirements

2600.

90b - Staff Communication *(continued)*

90.b. For a home serving 9 or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

The home does not have a system that allows staff in different parts of the home to communicate with each other in an emergency.

- *On 1/9/23, the home served 88 residents. Staff person D, did not utilize the home's communication when leaving the 2nd floor memory care unit, with 6 unattended residents in memory care.*
- *On 1/10/23, the home served 88 residents. Staff person E, did not utilize the home's communication while working with the Department during the medication audit in the personal care section of the home.*

Plan of Correction ***Accept (MJ - 03/01/2023)***

The community does have a system that allows staff in different parts of the home to communicated with each other in an emergency. Each nursing staff personnel is provided with a walkie upon hire and are responsible for bringing the walkie to work with them each day. Nursing department will maintain extra walkies in the nursing office and med techs will be instructed to do walkie checks to ensure each staff member has a walkie for communication. Director of Wellness and Memory Care Director will check in with care staff routinely to ensure compliance.
Instruction on walkie usage is reviewed with each employee upon hire.
Training on walkie checks and protocol will be reviewed with Med Tech, Nurse supervisors, Memory Care Director and Director of Wellness to be complete by 3/1/2023

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented (MJ - 03/23/2023)

95 - Furniture and Equipment

10. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The cabinets located in the kitchen of the 2nd floor memory care unit, had broken locks and some locks were missing from the cabinet.

Plan of Correction ***Accept (MJ - 03/01/2023)***

Items that were observed as being in disrepair or potential hazards were corrected at time of inspection.
Maintenance Director was educated on the timeliness of correcting any issues that could be a potential hazard for residents and/or staff.
ED and/or Maintenance Director or other designee in their absence will conduct daily walkthrough of the community and place any repair orders in TELS. Any issues requiring immediate remedy will be reported to appropriate person to be corrected timely.

Licensee's Proposed Overall Completion Date: *02/21/2023*

Implemented (MJ - 03/23/2023)

141a 1-10 Medical Evaluation Information

11. 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 medical evaluation for resident #2 did not include the following:

- *Blood pressure*
- *Pulse rate*
- *Temperature*
- *Immunization History*

The medical evaluation for resident #5 did not include the following:

- *Blood pressure*
- *Height*
- *Weight*
- *Pulse Rate*
- *Temperature*

Plan of Correction ***Accept (MJ - 03/01/2023)***

Director of Wellness, Memory Care Director and those that support the wellness office were educated on the requirements for the Document of Medical Evaluation (DME) Director of Wellness and or designee will audit all DME forms for completion.

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented (MJ - 03/23/2023)

162c - Menus Posted

12. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menu for the week of 12/25/22 was posted. However, the menu for 1/8/23 to 1/13/23 was not posted on 1/9/23 at 12:32 pm.

162c - Menus Posted *(continued)*

Plan of Correction ***Accept (MJ - 03/07/2023)***

Director of Dining services was educated on 2/21/23, (see attached), on the importance of ensuring menus are posted for current week and following week. Executive Director will audit menu postings weekly to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented (MJ - 03/23/2023)

162e - Menu Changes

13. Requirements

2600.
162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On 1/10/23, yams were listed on the menu for the dinner meal. There was a substitute served instead. No notice was provided to the residents in advance of the meal change.

Plan of Correction ***Accept (MJ - 03/07/2023)***

Director of Dining services and cooks were educated on 2/21/23, on the importance of notifying residents when there is a substitution on the menu and log the substitution on the substitution log as well as post notice for residents. Executive Director will audit menu postings weekly to ensure compliance. See Attached.

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented (MJ - 03/23/2023)

181c - Self-administration Assessment

14. 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 #5 self-administers medications to include giving insulin; however, resident #5 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 (MJ - 03/07/2023)***

Director of Wellness as well as the Wellness nurse, Director of Memory and nursing support personnel were educated on the regulation and procedure of having physician assess residents who prefer to administer their own medication. on 3/1/23 by the ED. (Please see attached in-service).
Resident #5 was assessed by medical professional and was identified as being able to self-administer their medication. Director of Wellness and/or Executive Director will ensure going forward that residents have physician assessment prior to self-administration. DME's of residents who self administer will be audited quarterly to ensure compliance by Wellness Dept. and/or ED.

Licensee's Proposed Overall Completion Date: *03/01/2023*

181c - Self-administration Assessment *(continued)*

Implemented (MJ - 03/23/2023)

183f - Discontinued Medications

15. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

The following medications Acetaminophen Suppositories belonging to resident #6 were discontinued and stored on the medication administration cart. This is not an approved method of destroying medications according to the Department of Environmental Protection and Federal and State regulation.

Plan of Correction ***Accept (MJ - 03/07/2023)***

Director of Wellness and med techs were educated on 3/1/23 by the ED, on the regulation and reminded to utilize their med-cart audit form and the removal of medications that should not remain on the med-cart along with process of medication destruction. See attached in-service, dated 3/1/23.

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented (MJ - 03/23/2023)

185a - Implement Storage Procedures

16. 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

Resident #7 is prescribed Glucagon Kit 1 mg as needed. On 1/10/23, at 9:48 am, the Glucagon Kit 1 mg medication was not available in the home.

Plan of Correction ***Accept (MJ - 03/07/2023)***

Glucagon Kit for Resident #7 is not being utilized and will be Discontinued by physician on 2/22. Director of Wellness, Nurses and med-techs were educated on 3/1/23 in regards to the policy that all medication listed on the MAR must be in house and available.
Med-techs to conduct weekly med cart audit and Director of Wellness to oversee that audits are being completed. Pharmacy will also assist in cart audits per their contract.

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented (MJ - 03/23/2023)

223a - Description of Service

17. Requirements

2600.
223.a. The home shall have a current written description of services and activities that the home provides including the following:

223a - Description of Service *(continued)*

1. The scope and general description of the services and activities that the home provides.
2. The criteria for admission and discharge.
3. Specific services that the home does not provide, but will arrange or coordinate.

Description of Violation

The home's current written description of services and activities at the home does not include the specific components for the following:

- *The scope and general description of services*
- *The criteria for admission and discharge*

Plan of Correction ***Directed (MJ - 03/07/2023)***

Description of services were presented to surveyor. Attached please review the Residency Agreement, ie. contract that lists the description of services as well as the criteria for admission and discharge and the process. Contract will be reviewed with Marketing Director and/or Executive Director upon move in so they are aware of services and criteria for admission and discharge.

Directed

Within 15 calendar days of receipt of the accepted plan of correction: The administrator shall update the homes written description of services and activities. The description will include:
1. A list of all the services and activities that the home provides, and a short description of what each service and activity entails.
2. The criteria for admission and discharge, including any resident treatments or conditions that the home is unable to safely address and the reasons for discharge described in 2600.228
3. A list of services that the home does not provide, and how it will arrange for those services to be provided.

Directed Completion Date: *03/03/2023*

Implemented (MJ - 03/23/2023)

223b - Service Procedures

18. Requirements

2600.
223.b. The home shall develop written procedures for the delivery and management of services from admission to discharge.

Description of Violation

The home does not have written procedures for the delivery and management of services from admission to discharge. Per the homes Acuity and Resident Retention Philosophy the following services are to be provided for Ostomy and Urinary Catheter care are not being followed. The policy communicates the following recommendations:

- *Ostomy care requires that a home agency be involved in care. The Home Health agency is not identified in the care plans.*
- *Urinary catheter care a Home Health Agency, must provide monthly visits to change monthly, and the service*

223b - Service Procedures (continued)

must be documented in the care plan.

- *Mechanical Hoyer Lifts, trained caregiver will provide the service, the home does not have record of training for Mechanical Hoyer Lift, in the annual training calendar or record of training.*

Plan of Correction ***Accept (MJ - 03/01/2023)***

Care plan for resident #3 with Ostomy will be updated to identify the home health agency for ostomy care.
Urinary Catheter care for Resident #2 and #3 are provided by Urologist monthly. Care plan will be updated to reflect this service.
Mechanical Hoyer lift training is part of new hire orientation and performed as part of our annual training plan. Listed as transfer training will update plan to specifically state that Hoyer training is included.

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented (MJ - 03/23/2023)

225c - Additional Assessment

19. Requirements

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

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #2's most recent assessment was completed on [redacted].
Resident #5's most recent assessment was completed on [redacted]

Plan of Correction ***Accept (MJ - 03/07/2023)***

Resident #2 and #5 have updated assessments completed by Director of Wellness and signed by residents on [redacted] Wellness Team educated on assessment policy and that assessments are to be done annually and upon significant change. Director of Wellness will utilize audit tool to ensure timely completion of all assessments. (see in-service for Wellness Team held by ED on 3/3/23).

Licensee's Proposed Overall Completion Date: *03/03/2023*

225c - Additional Assessment *(continued)*

Implemented (MJ - 03/23/2023)

227e - Self Administer Medication

20. Requirements

2600.
227.e. The resident’s support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident #5's assessment, dated [redacted] does not address the resident's ability to self-administer [redacted] insulin.

Plan of Correction ***Accept (MJ - 03/07/2023)***

Resident #5 was assessed and approved for self administration, support plan was updated to reflect the ability to self-administration and new DME was obtained from physician to reflect ability to self-administer medication. (see provided documentation:.
Director of Wellness and those that support the wellness office were educated on process on 3/1/23.

Licensee's Proposed Overall Completion Date: *03/03/2023*

Implemented (MJ - 03/23/2023)

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

Plan of Correction ***Accept (MJ - 03/07/2023)***

Nursing staff were educated by ED on regulation 2600.227G and are aware that at time of support plan meeting the resident is to sign their support plan. See attached in-service. Support plans are being auditied by Wellness Director, Memory Care Director and Wellness nurse, and audit should be completed by 6/1/23 to ensure all care plans are signed by residents and or families if necessary. Wellness nurse staff to review care plans, (RASP) quarterly to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/02/2023*

Implemented (MJ - 03/23/2023)

236 - Staff Training

22. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person D, did not receive the annual dementia training during the 2022 training year.

236 - Staff Training (continued)

Plan of Correction ***Accept (MJ - 03/01/2023)***

Director of Wellness and Memory care director instructed to document training as related to the requirements of the regulation and to ensure each staff person is meeting the requirement. Staff person D will complete the 6 hours of required training to be in compliance.

Licensee's Proposed Overall Completion Date: *03/01/2023*

Implemented (MJ - 03/23/2023)

237a - Activities

23. Requirements

2600.
237.a. The following types of activities shall be offered at least weekly:

1. Gross motor activities, such as dancing, stretching and other exercise.
2. Self-care activities, such as personal hygiene.
3. Social activities, such as games, music and holiday and seasonal celebrations.
4. Crafts, such as sewing, decorations and pictures.
5. Sensory and memory enhancement activities, such as review of current events, movies, story telling, picture albums, cooking, pet therapy and reminiscing.
6. Outdoor activities, as weather permits, such as walking, gardening and field trips.

Description of Violation

On 1/9/23 and 1/10/23, the activities were not offered on the memory care units. Due to limited staff. Staff person C, was unable to complete the activity, "Guided Meditation" on 1/9/23 at 9:30 am.

Plan of Correction ***Directed (MJ - 03/07/2023)***

Moving forward the Memory Care Director will ensure that the scheduled activity will proceed on time on the units. If ███ is unable to, ███ will notifiy ED who will do the activity or ███ designee. See attached in-service.

Directed

Within 15 calendar days of receipt of the accepted plan of correction: The administrator shall ensure the home has sufficient staff to ensure activities are conducted timely and residents receive direct care per the resident support plan.

Directed Completion Date: *03/03/2023*

Implemented (MJ - 03/23/2023)