pennsylvania
DEPARTMENT OF HUMAN SERVICES

Mailing Date: October 11, 2023

[redacted]
Broadhead Senior Living LLC
115 Apple Blossom Way
Moon Township, Pennsylvania 15108

RE: Apple Blossom Senior Living
License #: 45073

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on March 16, 2023, March 17, 2023 and June 22, 2023, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

Facility Information

Name: *APPLE BLOSSOM SENIOR LIVING* **License #**: *45073* **License Expiration**: *05/15/2023*

Address: *115 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA 15108*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *BRODHEAD SENIOR LIVING LLC*

Address: *115 APPLE BLOSSOM WAY, MOON TOWNSHIP, PA, 15108*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *08/27/2019* **Issued By**: *Twp of Moon*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *48* **Waking Staff**: *36*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional* **Exit Conference Date**: *03/17/2023*

Inspection Dates and Department Representative

03/16/2023 - On-Site: [redacted]

03/17/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* **Residents Served**: *24*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire home* **Capacity**: *40* **Residents Served**: *24*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *24*

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

Have Mobility Need: *24* **Have Physical Disability**: *0*

Inspections / Reviews

03/16/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/16/2023*

04/28/2023 - POC Submission

Submitted By: [redacted] [redacted] **Submitted**: *05/10/2023*

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

Inspections / Reviews *(continued)*

05/05/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/10/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/12/2023*

06/28/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/10/2023*

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance.
On 3/16/23, at approximately 12:04 p.m., the carbon monoxide detector in the storage room was laying on the floor below the outlet, measuring approximately 1' from the furnace. The batteries were not dated. There were no other carbon monoxide detectors outside the storage room hall near bedrooms #107 and #109.

Plan of Correction ***Accept [redacted] - 04/28/2023)***

3/16/2023- Maintenance director placed the CO detector in the hall 15 ft. from the furnace and near bedrooms #107 & #109 and dated the batteries while inspector was present.
3/17/23 - Maintenance director inspected and measured the distance of all other CO detectors in the community to ensure compliance.
3/17/2023 - Maintenance director will change and date batteries in all CO detectors every 6 months and ensure detectors remain placed at proper distance for continued compliance. Executive Director will receive report of maintenance from Maintenance Director and spot check during walk throughs of community.

Licensee's Proposed Overall Completion Date: *04/16/2023*

Evidence of Completion ***Implemented ([redacted] - 06/28/2023)***

See attached.

65i - Training Record

2. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

On 3/16/23, there was no record verifying that direct care staff person B completed the required annual training in the 2022 training year, for the following:
**Infection control*
**Fire safety training conducted by a fire safety expert.*

On 3/16/23, there was no record verifying the date, length of course, trainer, etc. for the annual trainings for direct care staff person B and C in the 2022 training year, for the following:
**Medication self-administration.*
**Safe management techniques.*
**Resident rights.*
**OAPSA*

Plan of Correction ***Do Not Accept [redacted] - 04/28/2023)***

3/16/2023 - Digital training record was located that indicated training had been completed 1/19/2022, sign in sheet was not located for training for employees B & C.

65i - Training Record (continued)

3/16/2023 - Department recommended training sign in sheet is currently in place and being used for monthly staff training.
3/17/2023 - Executive Director will supervise all required annual staff training and ensure recommended sign in sheet indicating staff name, date, source, content and length id used for monthly staff training.

Licensee's Proposed Overall Completion Date: *04/16/2023*

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

5/2/2023 - Digital training record was located that indicated training had been completed 1/19/2022, Fire training by fire safe expert was completed on 6/17/2022. Sign in sheet with employee signatures that included employee B & C was located for training on Jan 19 & June 17 2022.
3/16/2023 - Department recommended training sign in sheet is currently in place and being used for monthly staff training.
3/17/2023 - Executive Director will supervise all required annual staff training and ensure recommended sign in sheet indicating staff name, date, source, content and length id used for monthly staff training. ED will be responsible for monitoring the compliance for 65i monthly.

Licensee's Proposed Overall Completion Date: *05/03/2023*

Evidence of Completion ***Implemented [redacted] - 06/28/2023)***

See attached.

85a - Sanitary Conditions

3. Requirements

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

Description of Violation

On 3/16/23, at approximately 11:10 a.m., the following unsanitary conditions were observed in bedroom #101 and the private bathroom of #101, to include:
** A very strong odor of urine was present in the bedroom, heaviest near the resident's bed.*
** There was a strong fecal odor in the private bathroom.*
** There was a brown substance that appeared to be feces, over multiple areas of the bathroom floor, on top of the toilet paper on the holder, on the edges of the two spare rolls of toilet paper standing on their sides in the wicker corner shelving unit, on the trash can lid and on the top lid to the toilet seat.*
** There were no paper towels, mechanical air blower, individual cloth towels or other means of safe hand drying in the private bathroom of bedroom #101.*

On 3/16/23 at approximately 11:16 a.m., there were the following unsanitary conditions observed in the private bathroom of bedroom #102, to include:
** There were no paper towels, mechanical air blower, individual cloth towels or other means of safe hand drying.*
** There was a heavy concentration of dried feces on the inside of the toilet bowl, with the heaviest concentration in the back of the bowl.*

On 3/16/23, at approximately 11:44 a.m., there were no paper towels, mechanical air blower, individual cloth towels or other means of safe hand drying in the private shared bathroom in bedroom #131.

Plan of Correction ***Do Not Accept [redacted] - 04/28/2023)***

3/18/2023 - Housekeeper and housekeeping supervisor were coached by Executive director on the importance of

85a - Sanitary Conditions (continued)

maintaining sanitary conditions for all residents. and checking daily the supply of paper towels in all bathrooms , private and public. All resident bathrooms were checked by Housekeeping Supervisor
3/18/2023 - A checklist was created for the housekeeper that lists the residents who are independent with toileting so their bathrooms can be checked each morning in addition to the weekly house cleaning provided to all residents.. The checklist details what needs to be checked to maintain sanitary conditions at all times.
3/18/2023 - Housekeeping supervisor and Memory Care Coordinator will be responsible to check bathrooms daily for any unsanitary conditions. Housekeeper will be notified immediately to remedy any issues found.

Licensee's Proposed Overall Completion Date: *04/16/2023*

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

3/16/23 - Housekeeper immediately replaced the paper towels in room #101 and checked other resident rooms for towels as well. Staff removed the soiled bedding and replaced it with clean linens. Housekeeping supervisor cleaned the feces out of the toilet bowl and cleaned the trash can lid. All of this was completed while the inspector was in the facility.
3/18/2023 - Housekeeper and housekeeping supervisor were coached by Executive director on the importance of maintaining sanitary conditions for all residents. and checking daily the supply of paper towels in all bathrooms , private and public. All resident bathrooms were checked by Housekeeping Supervisor
3/18/2023 - A checklist was created for the housekeeper that lists the residents who are independent with toileting so their bathrooms can be checked each morning in addition to the weekly house cleaning provided to all residents.. The checklist details what needs to be checked to maintain sanitary conditions at all times.
3/18/2023 - Housekeeping supervisor and Memory Care Coordinator will be responsible to check bathrooms daily for any unsanitary conditions. Housekeeper will be notified immediately to remedy any issues found.

Licensee's Proposed Overall Completion Date: *05/03/2023*

Evidence of Completion ***Implemented [redacted] - 06/28/2023)***

See attached.

88a - Surfaces

4. 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 fire safe doors, when closed have a gap, measuring approximately ½" in the following areas, to include:
** The hallway off the main common area.*
** The hallway past bedrooms #132 and #135.*

Plan of Correction ***Do Not Accept [redacted] - 04/28/2023)***

3/16/2023 - Maintenance Director contacted our fire safety expert to alert him of this violation since he had just inspected the community.
3/18/2023 - Recommended seals were purchased and installed on all fire doors.
3/18/2023 - Maintenance Director will inspect newly installed seals during his weekly community walk through to ensure they remain in proper placement.

Licensee's Proposed Overall Completion Date: *04/16/2023*

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

3/16/2023 - Maintenance Director contacted our fire safety expert to alert him of this violation since he had just

88a - Surfaces (continued)

inspected the community.
3/18/2023 - Recommended seals were purchased and installed on all fire doors.
3/18/2023 - Maintenance Director will inspect newly installed seals during his weekly community walk through to ensure they remain in proper placement.
5/2 - .

Licensee's Proposed Overall Completion Date: *05/03/2023*

Evidence of Completion ***Implemented (- 06/28/2023)***

See attached.

90b - Staff Communication

5. Requirements

2600.
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

Per the administrator, walkie talkies are utilized for staff communication during shifts, with one in the care stations and one in the med room. However, on 3/16/23 and 3/17/23, interviews indicated the staff do not utilize or carry the walkies on their person during their shifts. Staff reported many of the walkies are inoperable. Staff reported in the event of an emergency, they would have to yell out for assistance or seek another staff out for assistance. On 3/16/23 and 3/17/23, the home served 24 residents.

Plan of Correction ***Accept - 04/28/2023)***

3/18/2023 - Memory Care Coordinator was coached by Executive Director on the importance of staff being able to call for help without leaving the scene of need or emergency. Director care staff was coached on the same by the Memory Care Coordinator.
3/18/2023 - New walkie talkies were given to direct care staff to ensure operable devices were in place,
3/18/2023 - Memory Care Director will be responsible to verify that all direct care staff have their walkies on their possession at all times. Memory care director was instructed to use the disciplinary form if any staff member does not have the device on them during working hours. Executive Director will be notified of any staff that has been disciplined and will meet directly with the staff member.

Licensee's Proposed Overall Completion Date: *04/16/2023*

Evidence of Completion ***Implemented - 06/28/2023)***

See attached.

95 - Furniture and Equipment

6. Requirements

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

Description of Violation

On 3/16/23, at approximately 11:16 a.m., the soap dispenser set down in the sink counter was in disrepair. The pump use to get the soap out of the dispenser was broken off and missing. There was no other soap available on the sink counter in the private bathroom in bedroom #102.

95 - Furniture and Equipment *(continued)*

Plan of Correction ***Accept [redacted] - 04/28/2023)***

3/17/2023 - Maintenance Director replaced the broken soap dispenser in room #102.
3/18/2023 - Housekeeper and Housekeeping Supervisor were coached by the Executive Director on the negligence of the housekeeper not to report the broken soap dispenser to her supervisor or the maintenance director so it could have been replaced immediately.
3/18/2023 - Memory care director and housekeeping supervisor will verify daily that the checklist created for the housekeeper is being followed. Maintenance issues can be indicated on this form so they can be directed for immediate repair.

Licensee's Proposed Overall Completion Date: *04/16/2023*

Evidence of Completion ***Implemented [redacted] - 06/28/2023)***

See attached.

101j3 - Bed/Linens/Pillows/Blankets

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 3/16/23 at approximately 11:40 a.m., there were no bed sheets on the mattress belonging to resident #2.

Plan of Correction ***Accept [redacted] - 04/28/2023)***

3/16/2023 - Bed sheets were replaced on the bed in room belonging to resident #2. It was determined that the 11-7 shift had taken the sheets off the bed to be laundered but did not immediately replace them with clean sheets.
3/17/2023 - Memory care coordinator coached the staff about communicating with the on coming staff if they had removed something for laundering but did not immediately replace it.
3/18/2023 - During the daily room checks the housekeeper and/or housekeeping supervisor will immediately rectify any resident rooms issues that are found. Memory Care Coordinator will spot check resident rooms daily.

Licensee's Proposed Overall Completion Date: *04/16/2023*

Evidence of Completion ***Implemented [redacted] - 06/28/2023)***

See attached.

101j5 - Bedside Table/Shelf

8. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

Description of Violation

On 3/16/23 at approximately 11:16 a.m., the bed belonging to resident #1 does not have a bedside table or shelf within reach from the resident's bedside. The bedside table was approximately 9' from the resident's bedside.

Plan of Correction ***Accept [redacted] - 04/28/2023)***

3/16/2023 - Bedside table was moved back into position beside the bed. It was determined that the family of resident #1 had moved the bedside table while visiting the resident.
3/17/2023 - Memory care coordinator spoke to resident # 1's family member and explained the regulation of the

101j5 - Bedside Table/Shelf (continued)

bedside table remaining in place beside the bed.
3/18/2023 - Memory Care Coordinator will monitor daily all rooms to ensure bedside tale or shelf remain at bedside. If consistent moving of bedside tables are found in any resident room, community will install push puck lights on the wall within reach of the resident

Licensee's Proposed Overall Completion Date: *04/16/2023*

Evidence of Completion ***Implemented [redacted] - 06/28/2023)***

See attached.

101j7 - Lighting/Operable Lamp

9. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 3/16/23, at approximately 11:16 a.m., resident #1 does not have a source of light that can be turned on/off from bedside in bedroom #102.

Plan of Correction ***Accept ([redacted] 04/28/2023)***

3/16/2023 - Bedside table and lamp was moved back into position beside the bed. It was determined that the family of resident #1 had moved the bedside table and lamp while visiting the resident.
3/17/2023 - Memory care coordinator spoke to resident # 1's family member and explained the regulation of the bedside table and lamp remaining in place beside the bed.
3/18/2023 - Memory Care Coordinator will monitor daily all rooms to ensure bedside tale or shelf with an operable lamp remain at bedside. If consistent moving of bedside tables and lamps are found in any resident room, community will install push puck lights on the wall within reach of the resident

Licensee's Proposed Overall Completion Date: *04/16/2023*

Evidence of Completion ***Implemented [redacted] - 06/28/2023)***

See attached.

102i - Soap Dispenser

10. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 3/16/23 at approximately 11:16 a.m., the single use private bathroom, in bedroom #102, did not have a dispenser with soap.

Plan of Correction ***Accept [redacted] 04/28/2023)***

3/17/2023 - Maintenance Director replaced the broken soap dispenser in room #102 and filled with soap.
3/18/2023 - Housekeeper and Housekeeping Supervisor were coached by the Executive Director on the negligence of the housekeeper not to report the broken soap dispenser to her supervisor or the maintenance director so it could have been replaced immediately.
3/18/2023 - Memory care director and housekeeping supervisor will verify daily that the checklist created for the

102i - Soap Dispenser (continued)

housekeeper is being followed. Maintenance issues can be indicated on this form so they can be directed for immediate repair.

Licensee's Proposed Overall Completion Date: *04/16/2023*

Evidence of Completion ***Implemented [redacted] - 06/28/2023)***

See attached.

183e - Storing Medications

11. 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 3/16/23, the home's two first aid kits provided in the laundry room at 11:30 a.m. and the med room at 12:24 p.m., contained multiple expired OTC medications, to include:

** 9-individual packets Antiacid tablets expiration date: 2022-04.*

** 5 individual packets with two tablets Aspirin, with expiration date: 8/2021.*

** A bottle Medi First Purified Water 98.3% eye wash, expiration date:11/2021.*

** 3 individual packets with two tablets of non-aspirin, expiration date: 12/2021.*

** Multiple 0.5g individual packets of Triple Antibiotic Ointment, expiration date: 5/2022.*

** First aid Burn Cream packets, 0.9g*

Plan of Correction ***Do Not Accept [redacted] - 04/28/2023)***

3/16/2023 - Mfg.stock medication packets were removed from the first aid kit inside the medication room while the inspector was present. They were not replaced as they are not required in the home's first aid kit.
3/16/2023 - Memory care coordinator checked the homes other first aid kit to ensure no mfg. mediation packets were inside the kit.
3/18/2023 - Memory care coordinator and/or wellness director will ensure nothing is placed inside the first aid kits that are not required per regulation.

Licensee's Proposed Overall Completion Date: *04/16/2023*

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

3/16/2023 - Mfg.stock medication packets were removed from the first aid kit inside the medication room while the inspector was present. They were not replaced as they are not required in the home's first aid kit.
3/16/2023 - Memory care coordinator checked the homes other first aid kit to ensure no mfg. mediation packets were inside the kit.
5/2/2023- Memory Care director will be responsible for monthly monitoring of first aid kits.
5/2/2023 - Memory care coordinator and/or wellness director will ensure nothing is placed inside the first aid kits so they remain in compliance with 183e.

Licensee's Proposed Overall Completion Date: *05/03/2023*

Evidence of Completion ***Implemented [redacted] - 06/28/2023)***

See attached.

184a - Resident's Meds Labeled

12. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #3 is prescribed Novolog Flexpen syringe, sliding scale for coverage, three times daily with meals as follows: 70-130=0units; 131-180=2units; 181-240=4units; 241-300=6units301-350=8u; 351-400=10u; 400>=12u CALL MD. In addition to the sliding scale, inject 4 units subcutaneously three times daily with meals if BGM>180. However,
The pharmacy label does not include "In addition to SS, inject 4 units subcutaneously three times daily with meals if BGM>180.

Resident #3 is prescribed Basaglar 100unit/ML Kwikpen, inject 12 units subcutaneously twice daily. However, the pharmacy label indicates inject 10 units subcutaneously twice daily.

REPEAT VIOLATION: 3/21/22, et al.

Plan of Correction ***Accept[redacted] - 04/28/2023)***

3/16/2023 - A change of direction sticker was placed on resident #3 novalog pens and resident #3's kwikpens. Corrected medication/labels was ordered and received from the pharmacy.
3/17/2023 - Corrected medication with corrected labels were placed inside the med cart when received from the pharmacy.
3/17/2023 - Weekly med cart audits will be conducted by nurse and labels will be verified for correct instructions.
3/17/2023 - A copy of the med cart audit will be given to Executive Director when completed. If any issues are found during audit, the method used to correct them will be indicated on the audit sheet and nurse will verify that pharmacy has corrected all issues. Executive director will be notified of any pharmacy issues not corrected and will contact the pharmacy director for immediate resolution..

Licensee's Proposed Overall Completion Date: *04/16/2023*

Evidence of Completion ***Implemented[redacted] - 06/28/2023)***

See attached.

185a - Implement Storage Procedures

13. 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 # 3's glucometer is not calibrated to correct time indicating 9:21 a.m.; however, the actual time was 10:21 a.m.

Resident #3's March 2023 MAR indicates the resident is prescribed Hydroxyzine Pain Cap 25mg, take one capsule every 6 hours as needed for anxiety. However, the medication was not available in the home.

REPEAT VIOLATION: 5/19/22

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept [redacted] - 04/28/2023)***

3/16/2023 - Nurse corrected the time on the glucometer which had not been done when the time change to daylight savings time. Family of resident #3 was contacted and reminded that the PRN medication pain cap. still had not been supplied by family.
3/16/2023 - PRN medication was received from family.
3/17/2023 - Weekly med cart audits will be conducted by nurse and Executive Director will be notified via audit sheet for any medication issues. Nurse will verify all issues have been corrected immediately.

Licensee's Proposed Overall Completion Date: *04/16/2023*

Evidence of Completion ***Implemented [redacted] - 06/28/2023)***

See attached.

187a - Medication Record

14. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.

Description of Violation

Resident #3 is prescribed Novolog Flexpen syringe, sliding scale for coverage, three times daily with meals as follows: 70-130=0units; 131-180=2units; 181-240=4units; 241-300=6units;301-350=8u; 351-400=10u; 400>=12u CALL MD. In addition to the sliding scale, inject 4 units subcutaneously three times daily with meals if BGM>180. However, the amount of insulin administered, if any, is not documented in the residents March 2023 Medication Administration Record (MAR).

REPEAT VIOLATION: 12/1/22

Plan of Correction ***Accept [redacted] - 04/28/2023)***

3/17/2023 - Director of Wellness contacted eMAR developer for instructions on creating a place on the eMAR to document amount of insulin administered.
3/17/2023 - eMARS have been updated and now eMAR instructs staff to indicate amount of insulin given at time of injection.
3/17/2023 - During weekly med cart audits, nurse will ensure and audit insulin amounts are being indicated on eMAR.

Licensee's Proposed Overall Completion Date: *04/16/2023*

Evidence of Completion ***Implemented [redacted] 06/28/2023)***

See attached.

[redacted]

[redacted]

Resident #2 was admitted on [redacted] 2020; however, the residents preadmission screening was completed on 2/17/22.

REPEAT VIOLATION: 7/25/22

227c - Support Plan Revision

16. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #1 was admitted to gateway Hospice on [redacted]/22 and recently recertified on 12/26/22. Gateway Hospice provides assistance with ADL's including showering, shaving, transfer, and nail filing. However, the residents support plan, dated 1/25/23, does not indicate Gateway Hospice as a support provider, the services they provide, or the frequency of the services provided.

Plan of Correction ***Accept[redacted] - 04/28/2023)***

3/17/2023 - Memory care director corrected resident #1's support plan and added Gateway Hospice as the 3rd party provider and indicated what services they would provide when visiting the resident.
3/17/2023 - Memory care director reviewed the support plan of the other resident who is on hospice to ensure the information was indicated in that resident plan as well.
3/17/2023 - Memory care director and Executive Director will review and ensure all 3rd party information is listed on support plan when updated or resident has a change of condition.

Licensee's Proposed Overall Completion Date: *04/16/2023*

Evidence of Completion ***Implemented [redacted] - 06/28/2023)***

See attached.

[redacted]

Resident #2 was admitted to the Secured Dementia Care Unit (SDCU) on [redacted]/10/20; however, the residents cognitive screening was completed on 2/17/22.

Resident #4 was admitted to the SDCU, [redacted]/1/21; however, the residents cognitive preadmission screening was completed on 4/28/21.

REPEAT VIOLATION: 7/25/22; 5/19/22