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

May 17, 2023

[redacted], MANAGING DIRECTOR
WATERMARK BELLINGHAM LLC
[redacted]

RE: THE WATERMARK AT BELLINGHAM
1615 EAST BOOT ROAD
WEST CHESTER, PA, 19380
LICENSE/COC#: 14688

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/28/2023 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,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE WATERMARK AT BELLINGHAM* **License #**: *14688* **License Expiration**: *02/11/2024*

Address: *1615 EAST BOOT ROAD, WEST CHESTER, PA 19380*

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

Administrator

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

Legal Entity

Name: *WATERMARK BELLINGHAM LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I 1* **Date**: *01/23/2023* **Issued By**: *East Goshen Twp*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *28* **Waking Staff**: *21*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *03/28/2023*

Inspection Dates and Department Representative

03/28/2023 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *19*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Basement* **Capacity**: *24* **Residents Served**: *8*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *27*

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

Have Mobility Need: *9* **Have Physical Disability**: *1*

Inspections / Reviews

03/28/2023 - Partial

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *04/10/2023*

Inspections / Reviews *(continued)*

04/11/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/02/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/02/2023*

05/17/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/02/2023*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

15c - Supervision

1. Requirements

2600.
15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

Description of Violation

On [redacted], Resident #1 reported staff person A injured [redacted] right arm causing a skin tear on [redacted]. Staff A was immediately suspended but was brought back to duty on [redacted]. The home did not advise the Department of the staff's return to duty or advise the department of the staff's supervision plan.

Plan of Correction ***Accept ([redacted] - 04/11/2023)***

**On 03/28/2023, the Administrator acknowledged that staff person A had returned to duty on 03/20/2023 under supervision for additional training without the Department's approval. The Administrator had received approval from Chester County Area on Aging Office.*
**Staff Person A remains on supervision in the community, completing additional hands on care training with experienced care staff and additional training regarding Dementia. Staff Person A will remain on supervision with training until the supervision/training plan is approved by the Department.*
**The Administrator will ensure that the Department is provided with supervision plans for any staff persons involved in incidents resulting in suspension going forward. The Administrator will wait for approval from the Department before returning any suspended staff person to supervised duty.*
**The Administrator, or Resident Service Director, will review any incidents resulting in the suspension of any staff person and the status of the supervision plan in Quality Assurance Meetings as scheduled, starting immediately.*

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented ([redacted] - 05/03/2023)

25b - Contract Signatures

2. 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

Resident #1's home contract for the residents move into the SDCU, dated [redacted], was not signed by the resident or administrator.

Plan of Correction ***Accept ([redacted] - 04/11/2023)***

**The home contract for resident #1 was signed by the resident's Power of Attorney, the resident and the Administrator on [redacted].*
**The Sales Director, or designee, will complete an audit of all resident contracts for Personal Care and Memory Care to ensure that all contracts are signed by the resident, the resident's responsible party/POA as indicated and the administrator. The audit will be completed by 05/08/2023.*
**The Sales Director will review all contracts upon completion to ensure compliance with signatures.*
**The Sales Director will review results of home contract audits in Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: *05/08/2023*

25b Contract Signatures *(continued)*

Implemented (- 05/03/2023)

42c Treatment of Residents

3. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On , Resident #1 refused to give DCS A another residents food assessory bag. In an attempt to obtain the bag from the resident #1, staff A began pulling the bag from the resident causing increased agitation for the resident. The resident attempted to grab the staffs arm and the staff then let go of the bag causing the resident to lose balance hitting hand resulting in a skin tear. The resident said to staff "keep that fat bitch away from me" and staff A responded back by mocking the resident repeating the same inappropriate language.

Plan of Correction ***Accept (- 04/11/2023)***

**Staff Person A was suspended on as a result of the resident #1's allegation noted in 15c.*
**Staff Person A returned to duty under a supervision plan on . Staff Person A remains on the supervision plan, completing hands on care training with experienced care staff and additional training in Dementia. Staff Person A will remain on the supervision plan until all training is completed and determination is made that is appropriate to return to full duty.*
**The Administrator, Resident Care Director, or designee, will provide ongoing training to the Nursing staff regarding Dementia and managing challenging behaviors during Staff Meetings as scheduled and during "in the moment" coachings, starting immediatly for the next six months.*
**The Administrator, or training director, will review status of Department required Dementia training hours during Quality Assurance Meetings as scheduled, ensuring that all Nursing staff has received at minimum 6 hours of Dementia training a year, starting immediately.*

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented (- 05/03/2023)

51 Criminal Background Check

4. Requirements

2600.
51. Criminal History Checks Criminal history checks and hiring policies 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).

Description of Violation

Direct Care staff B, hired on , did not have a Criminial Background check.

Plan of Correction ***Accept (- 04/11/2023)***

**On , the Criminal Background Check for direct care person B could not be located in personnel file. Direct care person B had been initially employed by the previous management company for the community and it is believed that initial background check was misplaced in the transition.*

51 Criminal Background Check (continued)

**The Criminal Background check for direct care person B was received on [redacted] and placed in [redacted] personnel file.*
**The HR Director, or designee, will complete an audit of all background check forms. Personnel files of all those hired prior to Watermark assuming management of the community has been complete. Audit of all files for Watermark Associates will be completed by 5/1/23.*
**The HR Director will review results of the audit in Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: *05/01/2023*

Implemented [redacted] - 05/03/2023)

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:

Description of Violation

Staff person C did not receive training in Older Adult Protective Services, incident reporting, and resident rights during the 2022 training year .

Plan of Correction ***Accept [redacted] - 04/11/2023)***

**Staff person C will be scheduled to attend new hire orientation to receive the training on Older Adult Protective Services, incident reporting and resident rights. This training will be completed by 04/21/2023. The HR department will audit the files to make sure that training on Resident Rights, OAPSA and Abuse/Neglect Reporting is recorded in each personnel file. Audit will be completed by 5/1/23*
**The HR Department provides training on Older Adult Protective Services, incident reporting and resident rights during New Hire Orientation for all new employees as scheduled.*
**The Administrator, or training supervisor, will provide training on the listed topics annually during staff meetings and in services as scheduled, as well as online trainings through Relias and Watermark Connect.*
**The Administrative Assistant will assist the Administrator in tracking the completed trainings for the Nursing staff, scheduling each of them for training hours monthly to remain on course with the required trainings, to ensure completion annually.*
**The Administrator, or HR Director, will review status of Department required training topics during Quality Assurance Meetings as scheduled, ensuring that all Nursing staff has completed the Department required trainings annually.*

Licensee's Proposed Overall Completion Date: *05/01/2023*

Implemented [redacted] - 05/03/2023)

88a - Surfaces

6. Requirements

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

88a - Surfaces *(continued)*

Description of Violation

At 9:30am, there were two holes in the ceiling, measuring approximately 9inches by 9inches located near the nurses station.

Plan of Correction ***Accept (- 04/11/2023)***

**The two ceiling holes had been cut for work on the alarm system. The holes were sealed upon completion of the work on 04/04/2023. The openings were sealed with sheet rock which was primed and then painted.*
**The Plant Operations Director, or Administrator, will obtain estimated dates for completion of all repairs/renovations involving the structure of the community. Temporary coverings will be put into place in between actively working on the repair to provide for safety in the area the repair is located.*
**The Plant Operations Director, or Administrator will review any repairs/renovations requiring multiple working days and the plan for temporary coverings during Safety Committee Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: *04/10/2023*

Implemented (- 05/03/2023)

141a 1-10 Medical Evaluation Information

7. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

The resident's medical evaluation, dated , did not include body positioning.

Plan of Correction ***Accept (- 04/11/2023)***

**The medical evaluation form, dated , was corrected by the resident's PCP.*
**The Resident Care Director, or Administrative assistant, will complete an audit of all medical evaluations to ensure completion. This will be completed by 04/30/2023.*
**The Resident Care Director will review all medical evaluations upon receipt for completion of all fields. Physicians will be notified of any omissions, with medical evaluations being returned for completion.*
**The Resident Care Director will review and report on any medical evaluations received in the Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented (- 05/03/2023)

183c Refrigerated Meds Locked

8. Requirements

2600.
183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

Description of Violation

On [redacted] at [redacted] prescribed medications for residents #2, 3, 4, and 5 were unlocked and accessible in the refrigerator located in the nurses station.

Plan of Correction ***Accept ([redacted] - 04/11/2023)***

**On 03/28/2023, the padlock on the medication refrigerator was locked and secured in the presence of the DHS Licensing Representatives.*
**The Resident Care Director is providing the Nursing staff with education regarding the requirement for securing the medication refrigerator when it is not in use, identifying the risks of unsecured medication. This will be completed by 04/30/2023.*
**The Resident Care Director, or Administrator, will complete daily checks of the Nursing Office until compliance is met. Results of the daily checks will be reviewed in the Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented ([redacted] - 05/03/2023)

187a Medication Record

9. Requirements

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

Description of Violation

Resident #1 is prescribed [redacted] concentrate apply topically on skin for anxiety or agitaion or refusing oral medicaitons. However, resident's medication administration record does not indicate this prescription which was administered twice on 3/11/2023.

Plan of Correction ***Accept ([redacted] - 04/11/2023)***

**The Resident Care Director added the order for the Lorazepam Gel to the resident's MAR for ongoing administration documentation. The administration of the PRN medication had been documented on the Controlled Substance Administration Record.*
**The Resident Care Director is providing education to the Nursing staff regarding the proper documentation of medication administration for narcotics to include both the MAR and the Controlled Substance Administration Record. This education will be completed by 04/30/2023.*
**The Resident Care Director will review documentation of orders for narcotics on both the MAR and Controlled Substance Administration Record upon receipt of a new order and during monthly recaps. Omnicare Pharmacy will be informed of any orders omitted on the MARs. Results of the documentation review will be reported in Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented ([redacted] - 05/17/2023)

202 - Prohibitions

10. Requirements

2600.
202. The following procedures are prohibited:
4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

Description of Violation

Resident #1 is prescribed [redacted] for [redacted] or [redacted], and for refusing oral medications. According to the resident MAR, [redacted] gel was administered to resident #1 to control behaviors. The [redacted] gel was administered to the resident on [redacted] at [redacted] and [redacted] to control agressive statements towaard staff.

Plan of Correction ***Accept ([redacted] - 04/11/2023)***

**The Resident Care Director received a change to the order direction for the PRN [redacted] to indicate the use for anxiety from the resident's PCP.*
**The Resident Care Director is providing education to the Nursing staff on non-pharmacological interventions to attempt, prior to the use of PRN anti-anxiety medications. This education will be completed by 04/30/2023.*
**The Resident Care Director, or designee, will monitor the use of PRN anti-anxiety medications during MAR audits and review the results in the Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented ([redacted] - 05/17/2023)

231e - No Objection Statement

11. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept ([redacted] - 04/11/2023)***

**The Secured Dementia Care Unit Addendum to the home contract was signed by the resident's Power of Attorney and the resident on [redacted].*
**The Sales Director, or Administrative Assistant, will complete an audit of the Secured Dementia Care Unit Addendum for all residents residing in the Secured Dementia Care Unit to ensure compliance with signatures on the addendum. The audit will be completed by 05/08/2023.*
**The Sales Director will review all addendums upon resident admissions to the Secured Dementia Care Unit to ensure compliance. The Resident Care Director will also document on the resident's RASP the resident's and resident's responsible party's acknowledgement of residence in a Secured Dementia Care Unit to provide an additional acknowledgement.*
**The Sales Director will review the results of the SDCU addendum audit in Quality Assurance Meetings as scheduled.*

231e No Objection Statement *(continued)*

Licensee's Proposed Overall Completion Date: *05/08/2023*

Implemented [redacted] - 05/03/2023)

233c - Key-Locking Devices

12. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the door to enter the Secure Dementia Care Unit (SDCU).

Plan of Correction ***Accept ([redacted] - 04/11/2023)***

**The Administrator posted instructions for the home's locking mechanism above the keypad at the door to enter the Secured Dementia Care Unit. The Administrator checked all SDCU doors with the locking mechanism to ensure that all had instructions posted near them.*
**The Administrator, or Resident Service Director, will complete daily checks to ensure that the directions remain posted at each door. Directions will be reposted as needed.*
**The Administrator, or Resident Service Director, will complete the daily checks until compliance is met. The results of the daily checks will be reviewed during Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: *04/10/2023*

Implemented ([redacted] - 05/03/2023)

236 - Staff Training

13. 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 B, who works in the Secure Dementia Care Unit (SDCU) had only 26 minutes of training in dementia care during the 2022 training year.

Plan of Correction ***Directed [redacted] - 04/11/2023)***

**The Administrator, or designee, will schedule and provide Dementia training throughout 2023 during staff meetings and in services as scheduled, as well as online trainings through Relias and Watermark Connect.*
**The Administrative Assistant will assist the Administrator in tracking the completed trainings for the Nursing staff, scheduling each of them for training hours monthly to remain on course with the required trainings, to ensure that a minimum of 6 hours a year is completed.*
**The Administrator, or designee, will review status of Department required Dementia training hours during Quality Assurance Meetings as scheduled, ensuring that all Nursing staff has received at minimum 6 hours of Dementia training a year.*

Directed additional step to the submitted Plan of Correction [redacted] 4/11/23)

236 - Staff Training (continued)

1. Staff B will complete the additional training hours for 2022 on Dementia by 4/28/2023.
2. Staff B will also complete the required 6 hours of Dementia training for 2023 by 12/31/2023.
3. All training auditing will be completed by 4/28/23 and any staff that did not complete the 2022 Dementia training will complete the training for the additional hours by 4/28/23.

Directed Completion Date: *04/28/2023*

Implemented [redacted] - 05/17/2023)

254a - Records Discharge/Active

14. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On [redacted] at [redacted], the records for all PCH resident's were unlocked, unattended, and accessible to the Departments staff.

Plan of Correction ***Accept [redacted] - 04/11/2023)***

**On 03/28/2023, the door to the 1st floor Nursing Office was secured upon leaving the office with the DHS Licensing Representatives.*
**A self-locking doorknob has been ordered and will be installed once received.*
**The Resident Care Director is providing the Nursing staff with education regarding the requirement for closing and locking the door when the office is not in use, identifying the importance of securing the medical records. This will be completed by 04/30/2023.*
** The Resident Care Director, or designee, will complete daily checks of the Nursing Office until compliance is met. Results of the daily checks will be reviewed in the Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: *04/30/2023*

Implemented [redacted] - 05/03/2023)