pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SQR OPCO LLC**
LEGAL ENTITY

To operate **ATRIA LAFAYETTE HILL**
NAME OF FACILITY OR AGENCY

Located at **9303 RIDGE PIKE, LAFAYETTE HILL, PA 19444**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **170** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 34**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **December 1,** **2023** until **June 1,** **2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **146652**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 1, 2023

[redacted]
Regional Director
SQR OPCO, LLC
Attn: Atria Mgmt Co. – Legal Department
[redacted]

RE: Atria Lafayette Hill
9303 Ridge Pike
Philadelphia, Pennsylvania 19128
License #: 146652

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections March 14, 2023, April 20, 2023, June 1 and 2, 2023, July 3 and 20, 2023, and August 28, 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 hereby 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 December 1, 2023 to June 1, 2024.

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)
42b	2	79	$5	$395	5 calendar days from mailing date of this letter
96a	2	79	$3	$237	3 calendar days from mailing date of this letter
187a	2	79	$5	$395	5 calendar days from mailing date of this letter
187d	2	79	$5	$395	5 calendar days from mailing date of this letter
201	2	79	$5	$395	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], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

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: *ATRIA LAFAYETTE HILL* **License #:** *14665* **License Expiration:** *07/20/2023*

Address: *9303 RIDGE PIKE, LAFAYETTE HILL, PA 19444*

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

Administrator

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

Legal Entity

Name: *SQR OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *122* **Waking Staff:** *92*

Inspection Information

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

Reason: *Fine* **Exit Conference Date:** *03/14/2023*

Inspection Dates and Department Representative

03/14/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *170* **Residents Served:** *80*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Life Guidance* **Capacity:** *34* **Residents Served:** *23*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *80*

Diagnosed with Mental Illness: *3*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *42*

Have Physical Disability: *2*

Inspections / Reviews

03/14/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/26/2023*

03/28/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/01/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/24/2023*

04/27/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/01/2023*

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

08/08/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/01/2023*

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

183d - Prescription Current

1. 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 3/14/23, Multivitamins with minerals tablets prescribed for resident 1 were in the home's medication cart; however, the medication was discontinued on 3/2/23.

On 3/14/23, Atorvastatin Calcium F/C 40mg tablet prescribed for resident 2, was in the home's medication cart; however, the medication was discontinued on 2/10/23.

Plan of Correction ***Accept [redacted] - 03/28/2023)***

Resident Service Director/ designee will complete audit of all medication carts to ensure removal of all discontinued medication for release to resident/family or proper disposal according to state and federal laws by 4/2/2023.

The Regional Care Director will provide training to the Executive Director and Resident Services Director/designee on the med cart audit process, releasing of medications to responsible party or resident policy MED-0003-09, and medication destruction using and electronic medication administration record policy MED-0003-05 by 4/2/2023 to ensure understanding of policies and processes related to removal of discontinued medications from medication cart. The Resident Service Director/designee will conduct in-service on this training to medication staff by 4/7/2023.

Resident Service Director/designee will monitor med carts audits weekly for the next 90 days to ensure compliance. Executive Director will review medication cart audit monthly for the next 90 days to ensure compliance.

Licensee's Proposed Overall Completion Date: *04/07/2023*

Implemented [redacted] - 10/23/2023)

185a - Implement Storage Procedures

2. 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 is prescribed Nayzilam outer spray administer 5mg as a single dose in 1 nostril: may repeat same dose in 10 minutes in alternative nostril if needed. On 3/11/23, 3/12/23, 3/13/23, and 3/14/23 medication(s) were not available in the home.

Plan of Correction ***Accept ([redacted] - 03/28/2023)***

Community received discontinue order for medication for Resident #3 on 3/14/2023.

Resident Service Director will complete audit of all prescribed orders to ensure medication is available in medication carts by 4/2/2023. Any issues found will be corrected immediately.

185a - Implement Storage Procedures (continued)

The Regional Care Director will provide training to the Executive Director and Resident Services Director/designee on the med cart audit process, triple check process aka order verification, and ordering and receiving medication policy MED-0003-03 by 4/2/2023 to ensure understanding of policies and processes related to ordering and receiving medications. The Resident Service Director/designee will conduct in-service on this training to medication staff by 4/7/2023.

The Resident Services Director/designee will review triple checks aka order verification and med cart audits weekly to ensure proper medication reordering and timely receipt of medications for the next 90 days.

Licensee's Proposed Overall Completion Date: *04/07/2023*

Not Implemented [redacted] *10/23/2**023)***

187d - Follow Prescriber's Orders

3. Requirements

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

Description of Violation

Resident 1 is prescribed Aero chamber plus spacer inhaler use as directed. However, this medication was not administered to resident 1 on 2/11/23 because the medication was not available in the home.

Resident 1 is prescribed Losartan Potassium 25mg tablet take 1 tablet by mouth daily. However, this medication was not administered to resident 1 on 2/12/23 and 2/13/23 because the medication was not available in the home.

Resident 2 is prescribed aspirin 325mg 1 tab daily. However, this medication was not administered to resident 2 on 2/13/23 because the medication was not available in the home.

Resident 2 is prescribed daily-vite tab 400mcg tablet 1 tab by mouth in the morning. However, this medication was not administered to resident 2 on 2/13/23 because the medication was not available in the home.

Resident 2 is prescribed Preservision areds tablet 1 tab by mouth in the morning. However, this medication was not administered to resident 2 on 2/13/23 and 2/14/23 because the medication was not available in the home.

Resident 3 is prescribed Levetiracetam 750mg tablet 2 tabs by mouth twice daily. However, this medication was not administered to resident 3 on 2/12/23 and only administered once on 2/13/23 because the medication was not available in the home.

Resident 3 is prescribed Methenamine Hippurate 1gm 1 tab by mouth twice daily. However, this medication was not administered to resident 3 on 2/20/23 and 2/21/23, and only administered once on 2/19/23 and 2/22/23, because the medication was not available in the home.

187d - Follow Prescriber's Orders (continued)

Resident 6 is prescribed Vitamin D3 50mcg tablet 1 tab by mouth every day. However, this medication was not administered to resident 6 on 2/19/23 because the medication was not available in the home. [redacted] *4/26/23*

Plan of Correction ***Accept ([redacted] 03/28/2023)***

All medication were available in community for Residents #1, 2, 3, 4, 5, and 6 on 3/21/23. Community noted a configuration problem in the Electronic Medication Record causing medication to discontinue prior to new order. This was resolved on 3/14/2023.
Resident Service Director/Designee will complete audit of all prescribed orders to ensure medication is available in medication carts by 3/31/2023. Any issues found will be corrected immediately.
The Regional Care Director will provide training to the Executive Director and Resident Services Director/designee on the med cart audit process, triple check process aka order verification, and ordering and receiving medication policy MED-0003-03 by 4/2/2023 to ensure understanding of policies and processes related to ordering and receiving medications. The Resident Service Director/designee will conduct in-service on this training to medication staff by 4/7/2023.
The Resident Services Director/designee will review triple checks aka order verification and med cart audits weekly to ensure proper medication reordering and timely receipt of medications for the next 90 days.

Licensee's Proposed Overall Completion Date: *04/07/2023*

Not Implemented [redacted] - 10/23/2023)

4. Requirements

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

Description of Violation

Resident 1 was prescribed calcium 500mg tab chew 2 tbs by mouth every day and it was discontinued on 3/8/23. However, resident 1 was administered this medication on 3/9/23, 3/10/23, 3/11/23, 3/12/23 and 3/13/23.

Resident 2 is prescribed Amlodipine Besylate 5mg tablet 1 tab by mouth daily. However, resident 2 was not administered this medication on 2/20/23.

Resident 3 is prescribed Ammonium Lactate lotion apply to back twice daily. However, resident 3 was not administered this medication on 3/1/23 and only administered once on 3/2/23.

Resident 3 is prescribed Escitalopram 10mg tablet 1 tab by mouth daily. However, resident 3 was not administered this medication on 3/1/23.

Resident 4 is prescribed Gabapentin 100mg Capsule take 1 cap by mouth at bedtime for anxiety . However, resident 4 was not administered this medication on 2/23/23, 2/24/23, 2/25/23, and 2/26/23.

Resident 4 is prescribed Vitamin D3 400iu take 1 tab my mouth twice daily. However, resident 4 was not administered this medication on 2/24/23, 2/25/23, and 2/26/23, and was only administered this medication once on 2/23/23 and 2/27/23.

187d - Follow Prescriber's Orders (continued)

Resident 4 is prescribed Carbidopa-Levodopa 25mg-100mg tablet take 1 tablet by mouth three times a day. However, this was only administered twice on 3/1/23.

Resident 5 is prescribed Donepezil HCL 10/mg tablet 1 tablet by mouth at bedtime. However, resident 5 was not administered this medication on 2/27/23

Resident 5 is prescribed Memantine HCL ER 28 mg cap 1 cap by mouth every day. However, resident 5 was not administered this medication on 2/24/23 and 2/25/23.

Plan of Correction ***Accept [redacted] - 03/28/2023)***

All medication were available in community for Residents #1, 2, 3, 4, 5, and 6 on 3/21/23. Community noted a configuration problem in the Electronic Medication Record causing medication to discontinue prior to new order. This was resolved on 3/14/2023.
Resident Service Director/Designee will complete audit of all prescribed orders to ensure medication is available in medication carts by 3/31/2023. Any issues found will be corrected immediately.
The Regional Care Director will provide training to the Executive Director and Resident Services Director/designee on the med cart audit process, triple check process aka order verification, and ordering and receiving medication policy MED-0003-03 by 4/2/2023 to ensure understanding of policies and processes related to ordering and receiving medications. The Resident Service Director/designee will conduct in-service on this training to medication staff by 4/7/2023.
The Resident Services Director/designee will review triple checks aka order verification and med cart audits weekly to ensure proper medication reordering and timely receipt of medications for the next 90 days.

Licensee's Proposed Overall Completion Date: *04/07/2023*

Not Implemented [redacted] - 10/23/2023)

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

Facility Information

Name: *ATRIA LAFAYETTE HILL* **License #**: *14665* **License Expiration**: *07/20/2023*

Address: *9303 RIDGE PIKE, LAFAYETTE HILL, PA 19444*

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

Administrator

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

Legal Entity

Name: *SQR OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *115* **Waking Staff**: *86*

Inspection Information

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

Reason: *Fine* **Exit Conference Date**: *04/20/2023*

Inspection Dates and Department Representative

04/20/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *170* **Residents Served**: *76*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Life Guidance* **Capacity**: *34* **Residents Served**: *20*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *76*

Diagnosed with Mental Illness: *1*

Diagnosed with Intellectual Disability: *2*

Have Mobility Need: *39*

Have Physical Disability: *1*

Inspections / Reviews

04/20/2023 - Partial

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

05/09/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/07/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/08/2023*

08/08/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/07/2023*

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

185a - Implement Storage Procedures

1. 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 1 is prescribed Robafen 100mg/5ml take 20ml by mouth every 6 hours as needed. On 4/20/23 this medication was not available in the home.

Resident 2 is prescribed Polyethylene Glycol 3350 give 17 in 8oz of water daily as needed. However on 4/20/23 this medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 05/09/2023)***

Resident Services Director/ Designee ordered and received medication for Resident #1 and Resident #2 by 4/22/2023.

Resident Service Director will complete audit of all prescribed orders to ensure medication is available in medication carts by 5/2/2023. Any issues found will be corrected immediately.

The Regional Care Director will provide training to the Executive Director and Resident Services Director/designee on the med cart audit process, triple check process aka order verification, and ordering and receiving medication policy MED-0003-03 by 5/5/2023 to ensure understanding of policies and processes related to ordering and receiving medications. The Resident Services Director/designee will conduct in-service on this training to medication staff to include all new medication staff by 5/15/2023.

The Resident Services Director/designee will review triple checks aka order verification and med cart audits weekly beginning 5/8/2023 and continuing for the next 90 days to ensure proper medication reordering and timely receipt of medications.

Licensee's Proposed Overall Completion Date: *05/15/2023*

Not Implemented ([redacted] - 10/23/2023)

187d - Follow Prescriber's Orders

2. Requirements

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

Description of Violation

Resident 1 is prescribed Clopidogrel 75mg tablet 1 tab by mouth every day. However this was not administered on 3/29/23.

Resident 1 is prescribed Amiodarone HCL 200mg tablet 1 tab by mouth every day. However, this was not administered on 4/18/23.

187d - Follow Prescriber's Orders (continued)

Resident 1 is prescribed Eliquis 5mg tablet 1 tab by mouth every 12 hours. However, this was administered 4/3/23 at 9AM then was not administered on 4/3/23 at 9PM or 4/4/23 at 9AM.

Resident 2 is prescribed Oyster Shell Calcium 500mg 1 tab by mouth twice daily. However, this was only administered once on 3/7/23.

Resident 3 is prescribed Acetaminophen 500MG take 2 tablets by mouth twice a day. However, on 4/3/23 this was only administered once.

Resident 4 is prescribed Fesoterodine Fumarate 8mg take 1 tablet by mouth daily and Omeprazole 20g take 1 capsule by mouth daily. However, these were not administered on 3/7/23. Repeated Violation- 4/26/22

Plan of Correction ***Accept [redacted] - 05/09/2023)***

Resident Services Director/ Designee ordered all unavailable medication and it has been received in community for Residents #1, Resident #2, and Resident #3 by 4/22/23.

Resident Service Director/Designee will complete audit of all prescribed orders to ensure medication is available in medication carts by 5/1/2023. Any issues found will be corrected immediately.

The Regional Care Director will provide training to the Executive Director and Resident Services Director/designee on the med cart audit process, triple check process aka order verification, ordering and receiving medication policy MED-0003-03, and order approval process in the EMAR system by 5/5/2023 to ensure understanding of policies and processes related to ordering and receiving medications and to ensure timely approval of medications. The Resident Service Director/designee will conduct in-service on this training to medication staff to include all new medication staff by 5/15/2023.

The Resident Services Director/designee will review triple checks aka order verification, med cart audits, and monitor order approval in EMAR system weekly beginning 5/8/2023 and continuing for the next 90 days to ensure proper medication reordering and timely receipt and approval of medications.

Licensee's Proposed Overall Completion Date: *05/15/2023*

Not Implemented ([redacted] - 10/23/2023)

3. Requirements

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

Description of Violation

Resident 1 is prescribed Metoprolol Succ 25mg tab .5 tab orally once a day for 90 days. However, this medication was not administered to resident 1 on 3/24/23 or 3/25/23 because the medication was not available in the home.

Resident 2 is prescribed Oyster Shell Calcium 500mg 1 tab by mouth twice daily. However, this was only

187d - Follow Prescriber's Orders (continued)

administered once on 3/19/23 because the medication was not available in the home.

Resident 3 is prescribed Atorvastatin Calcium F/C 20mg take 1 tab orally at bedtime. However, this medication was not administered to resident 3 on 4/9/23 because the medication was unavailable in the home.

Repeated Violation- 4/26/22

Plan of Correction ***Accept ([redacted] - 05/09/2023)***

Resident Services Director/ Designee ordered all unavailable medication and it has been received in community for Residents #1, Resident #2, and Resident #3 by 4/22/23.

Resident Service Director/Designee will complete audit of all prescribed orders to ensure medication is available in medication carts by 5/1/2023. Any issues found will be corrected immediately.

The Regional Care Director will provide training to the Executive Director and Resident Services Director/designee on the med cart audit process, triple check process aka order verification, ordering and receiving medication policy MED-0003-03, and order approval process in the EMAR system by 5/5/2023 to ensure understanding of policies and processes related to ordering and receiving medications and to ensure timely approval of medications. The Resident Service Director/designee will conduct in-service on this training to medication staff to include all new medication staff by 5/15/2023.

The Resident Services Director/designee will review triple checks aka order verification, med cart audits, and monitor order approval in EMAR system weekly beginning 5/8/2023 and continuing for the next 90 days to ensure proper medication reordering and timely receipt and approval of medications.

Licensee's Proposed Overall Completion Date: *05/15/2023*

Not Implemented ([redacted] - 10/23/2023)

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

Facility Information

Name: *ATRIA LAFAYETTE HILL* **License #:** *14665* **License Expiration:** *07/20/2023*

Address: *9303 RIDGE PIKE, LAFAYETTE HILL, PA 19444*

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

Administrator

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

Legal Entity

Name: *SQR OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date:** *04/20/2020* **Issued By:** *Township of Springfield*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *134* **Waking Staff:** *101*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date:** *06/02/2023*

Inspection Dates and Department Representative

06/01/2023 - On-Site: [redacted]

06/02/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *170* **Residents Served:** *78*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Life Guidance* **Capacity:** *29* **Residents Served:** *22*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *78*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *56* **Have Physical Disability:** *1*

Inspections / Reviews

06/01/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/17/2023*

06/22/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/19/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/20/2023*

08/16/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/19/2023*

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

63a - First Aid/CPR Training

1. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 5/21/23 from 3:00 pm to 7:00 am there were 76 residents in the home. There was only 1 staff person present in the home certified in CPR and obstructed airway techniques.

On 5/27/23, for the entire day, there were no staff persons present in the home certified in CPR and obstructed airway techniques.

On 5/28/23, for the entire day, there were no staff persons present in the home certified in CPR and obstructed airway techniques.

Plan of Correction ***Accept ([redacted] 06/22/2023)***

- *Resident Service Director scheduled First Aid/CPR Training was scheduled for 7/1 at the community for all direct care staff who did not have such training*
- *Effective 6/20/23, Resident Service Director will ensure that there is 1 First Aid/CPR certified direct care employee per 50 residents on each shift. Such employee(s) will be clearly identified on the schedule posted at the community*
- *Executive Director, starting 6/20/23, will inspect direct care staff schedules weekly to ensure compliance with regulation 2600.63.a*

Licensee's Proposed Overall Completion Date: *06/21/2023*

Not Implemented [redacted] 10/23/2023)

65d - Initial Direct Care Training

2. 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 A, hired on [redacted]/22, did not complete and pass the Department-approved direct care training course and pass the competency test until [redacted]/23.

Repeat Violation: 4/26/22

Plan of Correction ***Accept ([redacted] - 06/22/2023)***

- *On 6/5/23, CBD/ED (Community Business Director/ Executive Director) started an audit of all direct care employee files to ensure compliance with regulation 2600.65.d. Audit was completed on 6/16/23 resulting*

65d - Initial Direct Care Training (continued)

on full compliance.

- *Effective 6/19/23, CBD/ED will meet weekly to review new employee files ensuring compliance with regulation 2600.65.d. No new direct care employee will be permitted to start work without being compliant with regulation 2600.65.d.*

- *Effective 6/19/23, Regional Vice President (RVP) will conduct random monthly audits of new direct care employee files for the next 6 months ensuring compliance with regulation 2600.65.d*

Licensee's Proposed Overall Completion Date: *06/21/2023*

Implemented ([redacted] - 10/23/2023)

3. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
3. Initial direct care staff person training to include the following:
i. Safe management techniques.
ii. ADLs and IADLs
iii. Personal hygiene.
iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
vi. Implementation of the initial assessment, annual assessment and support plan.
vii. Nutrition, food handling and sanitation.
viii. Recreation, socialization, community resources, social services and activities in the community.
ix. Gerontology.
x. Staff person supervision, if applicable.
xi. Care and needs of residents with special emphasis on the residents being served in the home.
xii. Safety management and hazard prevention.
xiii. Universal precautions.
xiv. The requirements of this chapter.
xv. Infection control.
xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, hired on [redacted]/22, began providing unsupervised ADL services did not complete the following initial direct care staff person training until [redacted]/23:
(i) Safe management techniques.
(ii) ADLs and IADLs.
(iii) Personal hygiene.
(iv) Care of residents with dementia, mental illness, cognitive impairments, mental retardation and other mental disabilities.
(v) The normal aging-cognitive, psychological and functional abilities of individuals who are older.
(vi) Implementation of the initial assessment, annual assessment and support plan.
(vii) Nutrition, food handling and sanitation.

65d - Initial Direct Care Training (continued)

(viii) Recreation, socialization, community resources, social services and activities in the community.
(ix) Gerontology.
(x) Staff person supervision, if applicable.
(xi) Care and needs of residents with special emphasis on the residents being served in the home.
(xii) Safety management and hazard prevention.
(xiii) Universal precautions.
(xiv) The requirements of this chapter.
(xv) Infection control.
(xvi) Care for individuals with mobility needs, such as prevention of decubitus ulcers (bed sores), incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Repeat Violation: 4/26/22

Plan of Correction ***Accept [redacted] - 06/22/2023)***

• On 6/5/23, CBD/ED (Community Business Director/ Executive Director) started an audit of all direct care employee files to ensure compliance with regulation 2600.65.d. Audit was completed on 6/16/23 resulting on full compliance.

• Effective 6/19/23, CBD/ED will meet weekly to review new employee files ensuring compliance with regulation 2600.65.d. No new direct care employee will be permitted to start work without being compliant with regulation 2600.65.d.

• Effective 6/19/23, Regional Vice President (RVP) will conduct random monthly audits of new direct care employee files for the next 6 months ensuring compliance with regulation 2600.65.d

Licensee's Proposed Overall Completion Date: *06/21/2023*

Implemented [redacted] - 10/23/2023)

65g - Annual Training Content

4. 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.

Description of Violation

Staff person B did not receive training in the following during training year 2022:

65g - Annual Training Content (continued)

(1) Fire safety completed by a fire safety expert or by a 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.

Plan of Correction ***Accept [redacted] - 06/22/2023)***

- *On 6/11/23, CBD/ED (Community Business Director/Executive Director) started an audit of all employee files ensuring up to date annual training compliance in accordance with regulation 2600.65.g. Audit will be completed by 6/30/23*

- *Effective 6/19/23, Executive Director or designee will conduct weekly audits for 90 days to ensure employees stay current with their annual training required by regulation 2600.65.g.*

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented ([redacted] - 10/23/2023)

85d - Trash Receptacles

5. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 6/2/23 there were 2 full, uncovered, unattended trash cans in the main kitchen.

Plan of Correction ***Accept [redacted] - 06/22/2023)***

- *Culinary Director installed the 2 missing trash receptacle lids on 6/2/23*

- *Divisional Culinary Director and Culinary Director will in-service all food service staff on regulation 2600.85.d. by 6/21/23*

- *Starting 6/19/23 the Executive Director/RVP will conduct weekly inspections of the kitchen and common areas to ensure compliance with regulation 2600.85.d.*

Licensee's Proposed Overall Completion Date: *06/21/2023*

Not Implemented [redacted] - 10/23/2023)

96a - First Aid Kit

6. Requirements

2600.

96a - First Aid Kit *(continued)*

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in wellness office is missing a breathing shield, eye covering, and thermometer.

The first aid kit in Life Guidance is missing an eye covering and breathing shield.

Repeat Violation: 4/26/22

Plan of Correction ***Accept (- 06/22/2023)***

- *Maintenance Director replaced all First Aid Kits and audited them for compliance with regulation 2600.96.a on 6/7/23*
- *Maintenance Director/Resident Services Director will in-service all community staff on regulation 2600.96.a. by 6/30/23*
- *Executive Director/RVP will inspect each First Aid Kit weekly for the next 90 days to ensure compliance with regulation 2600.96.a.*

Licensee's Proposed Overall Completion Date: *06/30/2023*

Not Implemented (10/23/2023)

101j7 - Lighting/Operable Lamp

7. 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

Resident 1 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept (- 06/22/2023)***

- *Maintenance Director provided Resident #1 with access to a source of light (flashlight) that can be turned on/off at the bedside on 6/2/23*
- *Maintenance Director ordered additional wall mounted light fixtures that will always allow residents access to a source of light at the bedside. All fixtures will be installed in resident apartments by 6/21/23*
- *Maintenance Director will in-service all direct care and housekeeping/maintenance employees on regulation 2600.101.j.7 by 6/25/26*
- *Effective 6/21/23, Maintenance Director/Executive Director will inspect weekly for the next 90 days random apartments to ensure compliance with regulation 2600.101.j.7*

101j7 - Lighting/Operable Lamp *(continued)*

Licensee's Proposed Overall Completion Date: *06/30/2023*

Not Implemented [redacted] - 10/23/2023)

141a 1-10 Medical Evaluation Information

8. 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 2's medical evaluation did not include body positioning.

Resident 3's medical evaluation dated [redacted]/22 did not include special health needs, allergies, general physical examination, body positioning, health status, and cognitive functioning.

Repeat Violation: 1/12/23 et al.

Plan of Correction ***Accept ([redacted] - 06/22/2023)***

- *Resident #2 is no longer a resident. Resident #3 Medical evaluation from 2022 with physician approval by 6/23/2023*

- *The Resident Service Director/ Designee will complete an audit of all current resident DMEs by 7/7/2023, to ensure compliance with regulation 2600 141a. Any issues found during the audit will be addressed immediately if able to be corrected by getting a new or completed DME, or if not able to be corrected (due to for example, resident no longer being a resident, DME prior to more current DME, etc.) by utilizing a POC tool to document what was found but could not be corrected and attaching it in the resident record.*

- *Regional Care Director will provide additional education on 6/23/2023 to the Executive Director and Resident Services Director/ designee to ensure compliance with regulation 2600 141a to make sure DMEs are completed within the required timeframe according to regulation and Atria expectations. Regional Care Director will provide additional training to Executive Director and Resident Service Director/designee on move in process to ensure understanding of requirements for obtaining DME and DME completeness prior to move in by 6/23/2023.*

141a 1-10 Medical Evaluation Information (continued)

- *Executive Director/designee will be meeting with the Resident Services Director/designee weekly starting 6/26/2023 for 90 days to review all new resident DMEs to ensure compliance with regulation 2600 141a. Resident Services Director will be responsible to ensure continue compliance with regulation.*

Licensee's Proposed Overall Completion Date: *07/07/2023*

Implemented [redacted] - 10/23/2023)

141b1 - Annual Medical Evaluation

9. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident 3's most recent medical evaluation was completed on [redacted]22.

Plan of Correction ***Accept ([redacted] - 06/22/2023)***

- *Resident Services Director/ designee will ensure completion of resident # 3DME per regulation by 6/23/2023.*

- *The Resident Service Director (RSD)/ designee will complete an audit of all current resident DMEs by 7/7/2023, to ensure compliance with regulation 2600 141b. Any issues found during the audit will be addressed immediately if able to be corrected by getting a new or completed DME, or if not able to be corrected (due to for example, resident no longer being a resident, DME prior to more current DME, etc.) by utilizing a POC tool to document what was found but could not be corrected and attaching it in the resident record.*

- *Regional Care Director will provide additional education on 6/23/2023 to the Executive Director/designee and Resident Services Director/designee to ensure compliance with regulation 2600 141b to make sure DMEs are completed within the required timeframe (annually) according to regulation and Atria expectations.*

- *Executive Director will be meeting with the Resident Services Director/designee weekly starting 6/26/2023 to review new DMEs for next 90 days to ensure compliance with regulation 2600 141b. Resident Services Director will be responsible to ensure continue compliance with regulation.*

Licensee's Proposed Overall Completion Date: *07/07/2023*

Implemented ([redacted] - 10/23/2023)

171b5 - First Aid Kit

10. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the bus used to transport residents does not include tweezers, eye covering, and thermometer.

171b5 - First Aid Kit *(continued)*

Plan of Correction ***Accept [redacted] - 06/22/2023)***

- *Maintenance Director re[placed the First Aid Kit on the bus and inspected it for compliance with regulation 2600.171.b.5 on 6/7/23*
- *Maintenance Director will in-service the Bus Driver on regulation 2600.171.b.5 by 6/30/23*
- *Executive Director/RVP will inspect First Aid Kit on the bus weekly for the next 90 days to ensure compliance with regulation 2600.171.b.5.*

Licensee's Proposed Overall Completion Date: *06/30/2023*

Not Implemented [redacted] - 10/23/2023)

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 6/2/23, Alphagen eye drops opened on 4/20/23, Brimonide eye drops opened on 4/14/23, and Travoprost eye drops opened on 3/26/23, all prescribed to resident 4, were on the medication cart. According to the manufacturers' instructions, all of these eye drops must be discarded 4 weeks after opening.

Plan of Correction ***Accept [redacted] - 06/22/2023)***

- *Resident Service Director/ Designee will obtain new eye drops and will destroy current eye drops per regulation and Atria guidelines by 6/16/2023 for Resident #4.*
- *Resident Service Director/designee will audit all opened eye drops in carts by 6/30/2023. Any eye drops in carts greater than 4 weeks will be ordered and obtained from pharmacy and current eye drops will be destroyed immediately per regulations and Atria guidelines.*
- *The Regional Care Director will provide training to the Executive Director and Resident Services Director on work instruction MED-0003-07 Medication Controls- Access, Storage, and Labeling by 6/23/2023. Regional Care Director will train to process of adding discard eye drops 4 weeks after date of opening into the electronic MAR in the notes section for all resident with eye drops. The Resident Service Director/designee will conduct in-service on this training to all medication staff by 7/7/2023.*
- *The Resident Services Director/designee will audit medication carts weekly starting 6/26/2023 for dates on all eye drops to ensure proper storage/ destruction for the next 90 days.*

Licensee's Proposed Overall Completion Date: *07/07/2023*

Not Implemented [redacted] - 10/23/2023)

187a - Medication Record

12. 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 5 is prescribed Lorazepam 0.5 mg, take 1 tablet every 6 hours as needed. However, resident's 5 medication administration record does not indicate a diagnosis or purpose for the medication.

Resident 5 stated the Lorazepam 0.5 mg is always requested for anxiety attacks. Staff are noting on the medication administration record that the medication is being administered for various different reasons such as agitation, sleep, and shortness of breath.

Repeat Violation: 12/13/22 et al

Plan of Correction ***Accept ([redacted] - 06/22/2023)***

- *Resident Service Director/ designee corrected Resident #5's medication record to reflect the diagnosis/purpose for medication immediately on 6/3/2023.*

- *Resident Service Director/designee will complete audit of all prescribed orders to ensure diagnosis/ purpose for each medication is documented on the EMAR per the physician order by 7/7/2023. Any issues found will be corrected immediately.*

- *The Regional Care Director will provide training on 6/23/2023 to the Executive Director/designee and Resident Services Director/designee on the med cart audit process, triple check process aka order verification to ensure understanding of policies and processes related to physician orders and medication ordering and clarification for all medication to have diagnosis or purpose. Regional Care Director will also provide training on proper documentation for as needed medication to be given for ordered purpose/diagnosis. The Resident Service Director/designee will conduct in-service on these trainings to all medication staff by 7/7/2023.*

- *The Resident Services Director/designee will review triple checks aka order verification and med cart audits weekly starting 6/26/2023 ensure proper medication reordering, clarification of orders, and proper documentation of PRN medications for the next 90 days.*

Licensee's Proposed Overall Completion Date: *07/07/2023*

Not Implemented [redacted] - 10/23/2023)

187c - Refusal of Medication

13. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

187c - Refusal of Medication *(continued)*

Description of Violation

On a regular basis, resident 6 refuses to take a scheduled dose of Sodium Bicarbonate 10 GR 650 MG at 10:00 pm. The home does not report the refusals to the prescriber.

Plan of Correction ***Accept [redacted] - 06/22/2023)***

- *Resident Service Director/ designee will ensure physician notification of Resident #6 medication refusal to the physician by 6/16/2023.*

- *Resident Service Director/designee will complete audit of June Electronic Medication Administration Record and to ensure physician notification of all residents refused medications by 6/23/2023.*

- *The Regional Care Director will provide training by 6/26/2023 to the Executive Director/designee and Resident Services Director/designee on the reporting process for medication refusals and verification of notification by nurse daily to ensure understanding of the process related to physician notification of medication refusal. The Resident Service Director/designee will conduct in-service on this training to all medication staff by 7/7/2023.*

- *The Executive Director and Resident Services Director/designee will review the EMAR weekly starting 6/26/2023 to ensure proper physician notification of medication refusals for the next 90 days.*

Licensee's Proposed Overall Completion Date: *07/07/2023*

*Not **Implemented** [redacted] - 10/23/023)*

187d - Follow Prescriber's Orders

14. Requirements

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

Description of Violation

Resident 5 is prescribed Cephalexin 250 MG, 1 cap by mouth every 6 hours for 5 days. However, this medication was not administered to resident 5 on 6/1/23 at 12:00 am and 6:00 am because the medication was not available in the home.

Resident 7 is prescribed Risperidone 0.25, 1 tab by mouth at bedtime. This medication was not available in the home on 6/2/23.

Repeat Violation: 4/26/22.

Plan of Correction ***Accept [redacted] - 06/22/2023)***

The Administrator is requesting the Department to review this citation do to the fact that Resident #5 medication was ordered on 5/31/2023 and was started within 24 hours of receiving medication, and Resident #7 medication was received prior to administration time and resident never missed dose of medication.

- *Resident Service Director/ designee will complete audit of all prescribed orders to ensure medication is*

187d - Follow Prescriber's Orders (continued)

available in medication carts by 6/23/2023. Any issues found will be corrected immediately if able to be corrected, and if not able to be corrected, documented by utilizing a POC tool to document what was found but could not be corrected and attach it in the resident record.

- *The Regional Care Director will provide training to the Executive Director/designee and Resident Services Director/designee on the med cart audit process, triple check process, and ordering and receiving medication policy MED-0003-03 by 6/26/2023 to ensure understanding of policies and processes related to ordering and receiving medications.*

- *The Resident Service Director/designee will conduct in-service on this training to medication staff by 7/7/2023.*

- *The Resident Services Director/designee will review triple checks daily and med cart audits weekly starting 6/26/2023 to ensure proper medication reordering and timely receipt of medications for the next 90 days.*

Licensee's Proposed Overall Completion Date: *07/07/2023*

Not Implemented ([redacted] - 10/23/2023)

224a - Preadmission Screen Form

15. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 8's preadmission screening form, dated [redacted]/23, does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept [redacted] - 06/22/2023)***

- *Resident Service Director will update Resident #8 Preadmission screening form to ensure determination of needs is completed by 6/16/2023.*

- *The Resident Service Director/ Designee will complete an audit of all current resident Preadmission screenings by 7/7/2023, to ensure compliance with regulation 2600 224a. Any issues found during the audit will be addressed immediately if able to be corrected by the Resident Service Director, otherwise (due to for example, resident no longer being a resident, outside of regulated time frame, etc.) by utilizing a POC tool to document what was found but could not be corrected and attaching it in the resident record*

- *Regional Care Director will provide education to the Executive Director/designee and Resident Services Director/designee to ensure compliance with regulation 224.a to make sure Preadmission Screening is completed within the required timeframe according to regulation and Atria expectations. Regional Care Director will provide additional training to Executive Director/designee and Resident Service Director/ designee on move in process to ensure understanding of requirements for obtaining a completed Preadmission Screening within 30 days prior to admission to ensure that the needs of the resident can be*

224a - Preadmission Screen Form (continued)

met by the services provided by the community by 6/23/2023.

- *Executive Director/designee will be meeting with the Resident Services Director/ designee weekly starting 6/26/2023 to review preadmission screening for all new admissions for next 90 days to ensure compliance with regulation 224.a. Resident Services Director will be responsible to ensure continue compliance with regulation.*

Licensee's Proposed Overall Completion Date: *07/07/2023*

Implemented [redacted] - 10/23/2023)

227d - Support Plan Medical/Dental

16. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident 5, dated [redacted]/23, indicates the resident has a need for anxiety. The resident's support plan, dated [redacted]/23 does not document how this need will be met and does not document how staff can identify an anxiety attack.

Plan of Correction ***Accept ([redacted] - 06/22/2023)***

- *Executive Director/Resident Services Director will complete new service plan/support plan for Resident #5 by 6/23/2023 to ensure the residents anxiety is captured on the support plan.*

- *Resident Service Director/designee will complete an audit of the current residents' service plans by 7/7/2023, to ensure all diagnosis are addressed including how they are managed have been captured. Any issues found during the audit will be addressed immediately if able to be corrected by updating the support plan, or if not able to be corrected (due to for example, resident no longer being a resident , etc.) by utilizing a POC tool to document what was found but could not be corrected and attaching it in the resident record*

- *Regional Care Director will provide additional training to the Executive Director and Resident Services Director/designee by 6/23/2023 to ensure all service plans/support plans are capturing the medical diagnosis and plan for management.*

- *Executive Director will meet with Resident Services Director/designee weekly starting 6/26/2023 for the next 90 days to review all new support plans to ensure compliance with capturing diagnosis and plan for management. Resident Services Director will be responsible for compliance with regulation.*

Licensee's Proposed Overall Completion Date: *07/07/2023*

Not Implemented [redacted] - 10/23/2023)

227g -Support Plan Signatures

17. 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 9 participated in the development of [redacted] support plan on [redacted]/2022. However, the resident did not sign the support plan.

Resident 10 participated in the development of [redacted] support plan on [redacted]/22. However, the resident did not sign the support plan.

Plan of Correction ***Accept ([redacted] - 06/22/2023)***

- *Resident Services Director will review completed service plan with resident # 9 ([redacted]/22) and resident # 10 ([redacted]/22) and have the support plans signed by 6/16/2023.*

- *An audit of the current residents' service plans will be completed by the Resident Services Director by 7/7/2023, to ensure compliance with regulation 2600 227g. Any issues found during the audit will be addressed immediately if able to be corrected by getting service plans signed or noted why the resident cannot sign, or if not able to be corrected (due to for example, resident no longer being a resident) by utilizing a POC tool to document what was found but could not be corrected and attaching it in the resident record.*

- *Regional Care Director will provide training to the Executive Director and Resident Service Director/Designee on assessment process to ensure understanding of requirements for obtaining signatures for assessments/service plans per regulation 2600.227g by 6/23/2023.*

- *Executive Director will meet with Resident Services Director weekly starting 6/26/2023 for the next 90 days to review all new support plans to ensure compliance with regulation 2600 227g. Resident Services Director will be responsible for compliance with regulation.*

Licensee's Proposed Overall Completion Date: *07/07/2023*

Not Implemented ([redacted] - 10/23/2023)

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

Facility Information

Name: *ATRIA LAFAYETTE HILL* **License #:** *14665* **License Expiration:** *07/20/2023*

Address: *9303 RIDGE PIKE, LAFAYETTE HILL, PA 19444*

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

Administrator

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

Legal Entity

Name: *SQR OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date:** *04/20/2020* **Issued By:** *Township of Springfield*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *110* **Waking Staff:** *83*

Inspection Information

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

Reason: *Incident* **Exit Conference Date:** *07/20/2023*

Inspection Dates and Department Representative

07/03/2023 - On-Site: [redacted]

07/20/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *170* **Residents Served:** *78*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Life Guidance* **Capacity:** *34* **Residents Served:** *23*

Hospice

Current Residents: *NM*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *78*

Diagnosed with Mental Illness: *2*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *32*

Have Physical Disability: *1*

Inspections / Reviews

07/03/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/12/2023*

08/24/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/31/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/01/2023*

11/09/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/31/2023*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted]-23, at [redacted]am , Staff person A, heard resident #3 say, "Help, help me, I'm being abused." This incident was observed by staff person A and reported to the Resident Services Director on [redacted]-23 at [redacted] am. But not reported to local AAA. Staff person B, reports [redacted] walked in the room, the resident declined personal care assistance and told staff person B, [redacted] was abused. Staff person B, left the room and told staff person A, the resident is reporting abuse.

Plan of Correction ***Accept ([redacted] - 08/24/2023)***

Regional Vice President will in service the community leadership team on regulation 2600 – 15.a. Resident Abuse Report by 8/31/23.

Executive Director/Designee will in service all community staff/agency personnel on regulation 2600 – 15.a. Resident Abuse Report by 8/31/23.

Resident Service Director/Resident Service Supervisor, starting 8/14/23, will ensure that shift hand over meetings take place 3 times per day (am, pm, overnight) to ensure any information pertaining to regulation 2600 – 15.a. are captured and reported if needed. Executive Director/designee, starting 8/15/23, and for 90 days, will complete daily audits of the hand over meetings shift logs to ensure compliance with regulation 2600 – 15.a.

Licensee's Proposed Overall Completion Date: *08/31/2023*

Implemented ([redacted] - 10/23//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

Resident #4 entered the community on [redacted]-21. The following events have occurred:
[redacted]-21, resident # 4 was referred to psychiatric consult for aggressive concerns when sleeping in the rooms of other residents.
[redacted]-23 psychiatric consultation documents resident #4 has aggressive tendencies towards other residents.
[redacted]-23 the support plan for resident documents that [redacted] has know aggression but suitable for the memory care community.
[redacted]-23 return discharge back to memory care from [redacted] Hospital, directives to increase antipsychotics and pro re nata medication. The home was not able to met the needs of pro re nata medication and failed to acknowledge a higher level of care for the more aggressive behaviors.

42b - Abuse (continued)

On [redacted]-23- emergency services had to be called to the home for the following aggressive actions:
Resident #3 - pushed by resident #4
Resident #5 - physically hit while sleeping by resident #4.
Resident #6- physically hit in the head with a closed fist by resident #4
Resident #7- physically poked in the forehead without being provoked by resident #4
Resident #8 -Resident #4 attempted to take the walker from the resident. Resident#5, stated the following: " Oh no! I need my walker!"
Resident #4 continued the victimizing of other residents in the community. Upon the arrival of the responding police officer, resident # 4 attempted to grab the gun of the responding officer. The resident displayed poor judgement and aggression, the home failed to initiate an assessment for a higher level of care.

On [redacted]-23 the following events occurred :
Resident #7- poked in the face by resident #4
Resident #8 -poked in the forehead by resident #4

Assessment for a higher level of care was deemed on [redacted]-23, when the pro re nata medication could not be implemented. The administration did not appropriately address the aggressive behaviors of resident #4, while neglectfully jeopardizing the safety of the other 21 residents, in the memory care community.
Repeat violation Date: 6/14/22 et al, 12/13/22 et al.

Plan of Correction ***Accept ([redacted] - 08/24/2023)***

Resident #4 had given notice of move out at the time of the inspection and no longer resides at the community.

Regional Care Director will provide additional education to the Executive Director, Resident Services Director, and Resident Services Supervisor to ensure compliance with regulation 2600 – 42.b, and the Community's Admission, Retention and Discharge Policy by 8/15/2023.

Executive Director/Resident Service Director will in service all community staff on regulation 2600 – 42.b. as well as on safe management and de-escalation techniques related to residents' aggressive behaviors by 8/31/2023.

Effective 8/14/23 and continuing for the next 90 days, Executive Director/Designee, will audit daily shift logs identifying residents with behavioral incidents. Where applicable, Resident Support Plan will be updated and/or additional steps will be taken (including resident's discharge) to ensure resident's needs are met and in the interest of that resident's and other residents' safety.

Licensee's Proposed Overall Completion Date: *08/31/2023*

Not Implemented [redacted] - 10/23/2023)

65b - Rights/Abuse 40 Hours

3. Requirements

2600.

65b - Rights/Abuse 40 Hours *(continued)*

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Staff person B, completed [redacted] 40th scheduled work hour on [redacted]-23. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory abuse reporting, and report of reportable incidents

Plan of Correction ***Accept [redacted] - 08/24/2023)***

Executive Director/Resident Service Director began in servicing of all staff on 7/12/2023 on regulation 2600 – 65.b. and will complete the in service of all staff by 8/31/2023.

Effective 7/31/23, Executive Director/Resident Services Director ensured no community staff, agency employees, substitute personnel or volunteers who have not completed the trainings on resident rights, emergency medical plan, mandatory abuse reporting, and report of reportable incidents will be on the schedule until such trainings are completed.

Effective 7/12/2023, Executive Director or designee started to review planned staffing schedule and calendar daily for new agency, substitute personnel or volunteers to ensure orientation to resident rights, emergency medical plan, mandatory abuse reporting and reportable incidents occurs for the next 90 days and weekly thereafter.

Effective 7/31/23, Executive Director will audit all new employee files, as well as new agency, substitute personnel and volunteers files prior to them starting work at the community. No one will be allowed to work without having completed orientation to resident rights, emergency medical plan, mandatory abuse reporting and reportable incidents.

Licensee's Proposed Overall Completion Date: *08/31/2023*

Implemented ([redacted] - 10/23/2023)

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

On 7-20-23 at 3:15pm, a strong malodorous smell of urine was in the shared entrance of the room of resident #3 and resident #4

Plan of Correction ***Accept [redacted] - 08/24/2023)***

Maintenance Director thoroughly cleaned carpet of resident #4 apartment immediately on 7/20/23.

Memory Care Director/Maintenance Director will in service all SDU employees and Housekeeping/Maintenance Employees on behavior driven incontinence management by 8/31/23.

Executive Director/Designee will audit all SDU residents starting 8/1/23 for incontinence and where applicable, support plan will be updated with related behaviors by 8/31/23.

85a - Sanitary Conditions (continued)

Licensee's Proposed Overall Completion Date: *08/31/2023*

Implemented [redacted] - 10/23/2023)

201 - Positive Interventions

6. Requirements

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident #4 has displayed aggression against other residents since [redacted]-23. The home has not implemented positive interventions to modify or eliminate the aggressive behaviors of resident #4. Resident #4 demonstrated aggressive on the following dates:

[redacted]-23- Became physically aggressive with residents residing in memory care. Emergency services called and attempted to grab the gun of a police officer

[redacted]-23- Three residents were aggressively attacked by resident #4 without provocation. Staff were unable to redirect the resident.
The home failed to put safety measures in place to assist with reducing the negative behaviors when the first aggressive episodes began on [redacted]-23. Safety precautions to include but not limited to relocation to higher level of care, private living space , and/or more training to assist with the aggressive behaviors.

Repeat Violation Date: 1/31/23

Plan of Correction ***Accept [redacted] 08/24/2023)***

Resident #4 had given notice of move out at the time of the inspection and no longer resides at the community.

Regional Care Director will in service community leadership team on safe management and de-escalation techniques related to aggressive behaviors as well as Admission/Retention/Discharge Policy by 8/31/23.

Executive Director/Resident Service Director will in service all community staff/agency personnel on safety management and de-escalation techniques by 8/31/23.

Effective 8/14/23 and continuing for the next 90 days, Executive Director/Designee will audit daily shift logs isolating residents with behavioral incidents. Where applicable, Resident Support Plan will be updated and/or additional steps will be taken (including resident's discharge) to ensure resident's needs and residents' safety are met. Executive Director/Designee will also evaluate if proper intervention took place.

Licensee's Proposed Overall Completion Date: *08/31/2023*

Not Implemented [redacted] - 10/23/2023)

201 - Positive Interventions *(continued)*

221a - Program Activities

7. Requirements

2600.
221.a. The administrator shall develop a program of activities designed to promote each resident's active involvement with other residents, the resident's family and the community.

Description of Violation

The home does not have a program of activities designed to promote the active involvement of residents with families and the community.

Plan of Correction ***Accept ([redacted] 08/24/2023)***

Activities calendar will be updated by 7/31/23 to ensure back-up delivery of activities if responsible staff member is out.

Regional Memory Care Director will in service the Executive Director and Memory Care Director on regulation 2600 – 221.a. by reviewing expectations regarding monthly activities calendar adherence, staffing appropriately to provide scheduled activities, and reviewing substitution process, when necessary, by 8/31/23.

Executive Director/Memory Care Director will in service all Memory Care staff/agency personnel on regulation 2600 – 221.a. on providing program of activities designed to promote each resident's active involvement with other residents, the resident's family, and the community by 8/31/23.

Effective 8/7/23 and continuing for the next 90 days, Executive Director and Memory Care Director will meet weekly to review current's week activities and accurate staffing to ensure compliance with regulation 2600 – 221.a.

Licensee's Proposed Overall Completion Date: *08/31/2023*

Implemented [redacted] - 10/23/2023)

223a - Description of Service

8. Requirements

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

Description of Violation

The home failed to follow the admission and discharge criteria for resident #4 who requires nontraditional modes of medication management. Resident #4, has become physically aggressive by attacking the residents in memory care. The home's current written description of services and activities at the home state the following in the Atria Policy:

- *Mental Health Conditions must be manageable through traditional interventions*
- *Residents must not be a threat of harm to [redacted] or others*

223a - Description of Service (continued)

Plan of Correction ***Accept (- 08/24/2023)***

Resident #4 had given notice of move out at the time of the inspection and has moved out of the community.

The Executive Director and Resident Service Director (RSD)/ designee will ensure all current residents meet the criteria in the AL-001-PA-Acceptance, Retention, and Discharge Policy by 8/31/2023. Any issues found during the audit will be addressed immediately.

Regional Care Director will provide additional education to the Executive Director and Resident Services Director/ designee on AL-001-PA Acceptance, Retention, and Discharge Policy to ensure understanding of the criteria for acceptance, retention, and discharge by 8/15/2023.

Executive Director will be meeting with the Resident Services Director/designee weekly starting 8/21/2023 to review new resident moving in, residents returning, and current residents with change of condition for next 90 days to ensure compliance with regulation 2600 - 223.a.

Licensee's Proposed Overall Completion Date: *08/31/2023*

Implemented - 10/23/2023)

225d - Higher Level of Care

9. Requirements

2600.
225.d. If the resident's physician or appropriate assessment agency determines that the resident requires a higher level of care, a plan for placement shall be made as soon as possible by the administrator in conjunction with the resident or designated person, or both.

Description of Violation

On -23, resident #4 was determined to need more assistance with the medication management in utilizing pro re nata medication as communicated in the discharge summary. The home does not utilize pro re nata medications. The home failed to develop a placement plan for resident #4, due to the home no longer being able to meet the resident's needs.

Plan of Correction ***Accept (- 08/24/2023)***

Resident #4 has moved out of the community.

Executive Director and Resident Service Director will consider all memory care residents for appropriateness under the AL-001-PA Acceptance, Retention, and Discharge Policy by 8/31/2023.

Regional Care Director will provide additional education to the Executive Director and Resident Services Director/ designee to ensure compliance with regulation 225d, by making sure to review all memory care resident's appropriateness and all new residents and returning resident's DME and/or discharge paperwork to confirm the ability to meet the residents needs per the physician orders by 8/15/2023.

Executive Director will be meeting with the Resident Services Director/designee weekly starting 8/21/2023 to review all DMEs and/or discharge paperwork for next 90 days to ensure compliance with regulation 2600 - 225d.

Licensee's Proposed Overall Completion Date: *08/31/2023*

225d - Higher Level of Care *(continued)*

Implemented (10/23/2023)

234b - Support Plan Needs Elements

10. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated 23, for resident #3, does not address the resident's tendency to cry out for help, because allegedly they are being abused.

Plan of Correction ***Accept - 08/24/2023)***

Resident Service Director/ designee will complete a new Support Plan for Resident #3 to include any behaviors and interventions by 8/15/2023.

Regional Care Director will provide education to the Executive Director and Resident Service Director/ designee by 8/15/2023 on the importance of ensuring service plans/support plans are completed to include all elements including behaviors and interventions in accordance with regulation 2600 - 234.b.

Executive Director will meet with Resident Services Director/ designee weekly starting 8/21/2023 for the next 90 days to review all residents service plan/support plans with change in condition to ensure they are updated per regulation 2600 - 234.b.

Licensee's Proposed Overall Completion Date: *08/31/2023*

Implemented (- 10/23/2023)

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

Facility Information

Name: *ATRIA LAFAYETTE HILL* **License #:** *14665* **License Expiration:** *07/20/2023*

Address: *9303 RIDGE PIKE, LAFAYETTE HILL, PA 19444*

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

Administrator

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

Legal Entity

Name: *SQR OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date:** *04/20/2020* **Issued By:** *Township of Springfield*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *105* **Waking Staff:** *79*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *08/28/2023*

Inspection Dates and Department Representative

08/28/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *170* **Residents Served:** *79*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Life Guidance* **Capacity:** *34* **Residents Served:** *24*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *79*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *26*

Have Physical Disability: *1*

Inspections / Reviews

08/28/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/16/2023*

Inspections / Reviews *(continued)*

09/28/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/18/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/03/2023*

10/04/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/18/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/18/2023*

10/23/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/18/2023*

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

65a - FS Orientation 1st Day

1. 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:
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.

Description of Violation

Staff person A, whose first day of work was [redacted]/23, 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.

Repeat Violation Date: 01/31/23.

Plan of Correction ***Accept [redacted] - 10/04/2023)***

Staff #A completed all required trainings as per regulation 2600 – 65.a. by 9/19/23

Regional Vice President will in-service all community leadership team (including Executive Director) on required new employee orientation expectations, including if the employee has transferred from another PCH managed by the company, in compliance with regulation 2600 – 65.a. by 9/14/23.

Effective 9/18/23, Executive Director will perform weekly audits of new employee files for duration of 90 days to ensure compliance with regulation 2600 – 65.a. No employees, including those transferred from another Atria PCH, will be scheduled to work unless Orientation 1st Day trainings are completed.

Licensee's Proposed Overall Completion Date: *10/03/2023*

Implemented [redacted] - 10/23/2023)

65b - Rights/Abuse 40 Hours

2. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

65b - Rights/Abuse 40 Hours *(continued)*

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A completed [redacted]r 40th scheduled work hour on [redacted]/23. However, this staff person did not complete training in the following topics:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Plan of Correction ***Accept ([redacted] - 10/04/2023)***

Staff #A completed all required trainings as per regulation 2600 – 65.b. by [redacted]/23.

Regional Vice President will in-service all community leadership team (including Executive Director) on required new employee orientation expectations, including if the employee has transferred from another PCH managed by the company, in compliance with regulation 2600 – 65.a. by 9/14/23.

Effective 9/18/23, Executive Director will perform weekly audits of new employee files for duration of 90 days to ensure compliance with regulation 2600 – 65.a. No employees, including those transferred from another Atria PCH, will be scheduled to work unless Rights/Abuse – 40 hours trainings are completed.

Licensee's Proposed Overall Completion Date: *10/03/2023*

Implemented [redacted] - 10/23/2023)

96a - First Aid Kit

3. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the Life Guidance nurses' station does not include eye coverings.

The first aid kit in the wellness office does not include nonporous disposable gloves and eye coverings.

Repeat Violation Date: 04/26/22.

Plan of Correction ***Accept [redacted] - 09/27/2023)***

Maintenance Director replaced all First Aid Kits and audited them for compliance with regulation 2600.96.a on 9/14/23

96a - First Aid Kit (continued)

Maintenance Director/Resident Services Director will in-service all community staff on regulation 2600.96.a. by 9/24/23 to ensure all First Aid Kits are fully equipped at all times.

Executive Director/RVP will inspect each First Aid Kit weekly starting 9/18/23 for the next 90 days to ensure compliance with regulation 2600.96.a.

Licensee's Proposed Overall Completion Date: *09/24/2023*

Not Implemented ([redacted] - 10/23/2023)

101j2 - Bedroom Chairs

4. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

Room 21 is occupied by one resident; however, there is no chair in this room.

Plan of Correction ***Accept [redacted] - 09/27/2023)***

Maintenance Director replaced missing chair in apartment #21

Regional Vice President will in-service all community leadership team on regulation 2600 – 101.j.2 by 9/14/23.

Executive Director/Designee will in-service all community staff on regulation 2600 – 101.j.2 by 9/24/23

Executive Director/Maintenance Director starting 9/18/23 will perform weekly and random apartment audits for the next 90 days to ensure compliance with the regulation 2600 – 101.j.2

Licensee's Proposed Overall Completion Date: *09/24/2023*

Implemented [redacted] - 10/20/2023)

101j7 - Lighting/Operable Lamp

5. 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

Resident 1 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept [redacted] - 09/27/2023)***

Maintenance Director provided Resident #1 with access to a source of light (flashlight) that can be turned on/off at the bedside on 9/1/23

Maintenance Director ordered additional wall mounted light fixtures that will always allow residents access to a source of light at the bedside. All fixtures will be installed in resident apartments by 9/24/23

Maintenance Director will in-service all direct care and housekeeping/maintenance employees on regulation

101j7 - Lighting/Operable Lamp (continued)

2600.101.j.7 by 9/24/23

Effective 9/18/23 Maintenance Director/Executive Director will inspect weekly for the next 90 days random apartments to ensure compliance with regulation 2600.101.j.7

Licensee's Proposed Overall Completion Date: *09/24/2023*

Implemented [redacted] - 10/23/2023)

171b5 - First Aid Kit

6. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the bus used to transport residents does not include eye coverings.

Plan of Correction ***Directed ([redacted] - 10/04/2023)***

Once again, Atria Lafayette Hill respectfully requests reconsideration of this violation and that it be withdrawn. The First Aid Kit was located on the bus and had all items required by the regulation 2600 – 96.a: "The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers." Eye coverings (eye patches) were in the First Aid Kit during the time of the inspection. Eye coverings are a part of the provision of first aid like bandages and gauze pads. First aid response for an eye injury is to cover the eye with a shield of some sort like a patch. The Community does have, and had at that time, appropriate PPE, including goggles - which were located in the glove compartment on the bus, but the regulation does not specifically define eye coverings as goggles instead of an eye patch. Therefore, it should be withdrawn.

Directed Plan of Correction:
Executive Director/RVP will inspect each First Aid Kit in vehicles weekly starting within 5 calendar days of the receipt of this plan of correction and continuing for the next 90 days to ensure compliance with regulation. Documentation of the audits shall be kept for Department review.

Directed Completion Date: *10/03/2023*

Not Implemented ([redacted] - 10/23/2023)

183e - Storing Medications

7. 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

Resident 2 is prescribed Fluticasone Propionate 50 mcg spray, instill one spray in each nostril daily for allergies. On

183e - Storing Medications (continued)

8/28/23, the medication was not protected with a cap, and it was leaking inside a zipper bag.

Plan of Correction ***Accept ([redacted] 10/04/2023)***

Resident Service Director ensured Resident #2 received new nasal spray with lid by 8/30/2023 and destroyed unprotected nasal spray per regulation and Atria guidelines immediately.

Resident Service Director will check all carts to ensure all medications are stored correctly by 9/30/2023. Any issues found will be corrected immediately.

The Regional Care Director will provide training to the Executive Director and Resident Services Director on work instruction MED-0003-07 Medication Controls- Access, Storage, and Labeling by 9/20/2023. The Resident Service Director/designee will conduct in-service on this training to all medication staff by 9/30/2023.

The Resident Services Director/designee starting 9/1/23 will audit medication carts weekly for any improperly stored medication to ensure proper storage for the next 90 days.

Licensee's Proposed Overall Completion Date: *10/03/2023*

Not Implemented ([redacted] - 10/23/2023)

187d - Follow Prescriber's Orders

8. Requirements

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

Description of Violation

Resident 3 is prescribed Rosuvastatin Calcium 10 mg tablet, take one tablet by mouth nightly for hyperlipidemia. However, this medication was not administered to Resident 3 on 8/26/23 and 8/27/23 because the medication was not available in the home.

Repeat Violation Date: 04/26/22.

Plan of Correction ***Accept ([redacted] - 10/04/2023)***

Resident Service Director ensured Resident #3 medication was available in the community for administration on 8/29/2023.

Resident Service Director/Designee will complete audit of all prescribed orders to ensure medication is available in medication carts by 9/30/2023. Any issues found will be corrected immediately.

The Regional Care Director will provide training to the Executive Director and Resident Services Director/designee on the med cart audit process, triple check process aka order verification, and ordering and receiving medication policy MED-0003-03 by 9/20/2023 to ensure understanding of policies and processes related to ordering and receiving medications. The Resident Service Director/designee will conduct in-service on this training to medication staff by 9/30/2023.

The Resident Services Director/designee starting 9/1/23 will review triple checks aka order verification and med cart audits weekly to ensure proper medication reordering and timely receipt of medications for the next 90 days.

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

Licensee's Proposed Overall Completion Date: *10/03/2023*

Not Implemented ([redacted] - 10/23/2023)

225a - Assessment 15 Days

9. 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 4's assessment, dated [redacted]/23, does not include their allergies to penicillin, seafood, and Losartan. Additionally, it does not include that the resident requires a walker for ambulation and a wheelchair for longer distance.

Plan of Correction ***Directed[redacted] - 10/04/2023)***

This is the second request from Atria Lafayette Hill for reconsideration of this violation and that it be withdrawn. The violation is for not including required information on the assessment, but that information was in fact on the assessment and provided to the surveyor. On the top of page 1 of that assessment it lists: Drug Allergies: losartan, Penicillin. Food Allergies: Shellfish, Shrimp. On page 7 of 13, under 33. Assistive /Adaptive Devices, it states: Uses a rolling walker for ambulation and will require a wheelchair for distance. Because Resident #4's assessment on 8/23/23 does in fact include allergies to penicillin, seafood and losartan and requires a walker for ambulation and a wheelchair for longer distance, this violation should be withdrawn. Attached, please find the assessment for Resident #4 that was provided to the surveyor at the time of the visit where the above stated citations are captured.

Directed Plan of Correction:
Within 10 calendar days of the receipt of this plan of correction, the administrator or designee shall audit all current resident assessments to ensure they are complete and include the required information.
Administrator or designee shall audit all new admission assessments and support plans for the next 90 days to monitor for compliance. Documentation of the audits shall be kept for Department review.

Directed Completion Date: *10/03/2023*

Implemented [redacted] - 10/23/2023)