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

February 7, 2024

, MANAGING DIRECTOR
WATERMARK BELLINGHAM LLC

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

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/24/2023, 07/25/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

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

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

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

Administrator

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

Legal Entity

Name: *WATERMARK BELLINGHAM LLC*

Address:

Certificate(s) of Occupancy

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

Type: *I-2* **Date**: *01/06/2021* **Issued By**: *East Goshen Township*

Type: *C-2 LP* **Date**: *02/09/2001* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *45* **Waking Staff**: *34*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *07/25/2023*

Inspection Dates and Department Representative

07/24/2023 - On-Site:

07/25/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *28*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *The Gardens* **Capacity**: *24* **Residents Served**: *9*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *28*

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

Have Mobility Need: *17* **Have Physical Disability**: *0*

Inspections / Reviews

07/24/2023 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/24/2023*

Inspections / Reviews *(continued)*

08/28/2023 POC Submission

Submitted By: [redacted]
Date Submitted: *10/03/2023*
Reviewer: [redacted]
Follow Up Type: *POC Submission*
Follow Up Date: *09/02/2023*

09/08/2023 POC Submission

Submitted By: [redacted]
Date Submitted: *10/03/2023*
Reviewer: [redacted]
Follow Up Type: *Document Submission*
Follow Up Date: *10/02/2023*

02/07/2024 Document Submission

Submitted By: [redacted]
Date Submitted: *10/03/2023*
Reviewer: [redacted]
Follow Up Type: *Not Required*

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated , for resident #1 was not signed by the resident and by the administrator.

Repeat violation: 06/30/2022

Plan of Correction ***Accept (- 08/28/2023)***

**Resident was approached to sign contract on . was unable to sign due to cognitive decline. This was documented on the contract. Current Administrator signed reviewed and signed the contract on . Responsible Party, daughter, had signed the contract at time of move in.*
**All Memory Care and Personal Care resident contracts will be audited by the Sales Team, or designee, for compliance with signatures. This audit will be completed by 08/31/2023.*
**All new Personal Care and Memory Care resident contracts signatures will be obtained by the Move In Coordinator at time of Move In. All contracts will be reviewed upon receipt from the Sales Team upon Move In for completion by the Business Office Director, or designee. Results will be reviewed in Quality Assurance Meetings as scheduled facilitated by the Program Director.*

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

Implemented (- 11/01/2023)

28f - Resident's Funds and 30-day Refund

2. Requirements

2600.
28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident #2 was discharged on . The home did not issue the refund check until

Repeat Violation: 06/30/2022

Plan of Correction ***Accept (- 08/28/2023)***

**The Business Office Director, or designee, audited resident refunds from January 2023 through July 25, 2023 upon completion of the annual survey for compliance.*
**The Business Office Director, or designee, will audit all discharges and refunds on a monthly basis, submitting the report to the Administrator, or designee, for review.*
**The Business Office Director, or designee, will review the results of the monthly audits in Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/24/2023*

28f Resident's Funds and 30 day Refund *(continued)*

Implemented (- 11/01/2023)

41e Signed Statement

3. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Repeat Violation: 06/30/2022

Plan of Correction ***Accept (- 08/28/2023)***

**Resident was approached to sign the acknowledgement on . was unable to sign due to cognitive decline. This was documented on the form. Responsible Party, resident's daughter, had signed the acknowledgement at time of move in.*
**All Memory Care and Personal Care resident contracts will be audited by the Sales Team, or designee, for compliance with signatures. This audit will be completed by 08/31/2023.*
**All new Personal Care and Memory Care resident contracts signatures will be obtained by the Move In Coordinator at time of Move In. All contracts will be reviewed upon receipt from the Sales Team upon Move In for completion by the Business Office Director, or designee. Results will be reviewed in Quality Assurance Meetings as scheduled facilitated by the Program Director.*

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

Implemented (- 11/01/2023)

54a Direct Care Staff

4. Requirements

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

Description of Violation

The home does not have direct care staff person A's high school diploma on file.

Repeat violation: 06/30/2022

Plan of Correction ***Accept (- 09/08/2023)***

**Direct Care Staff Person A had submitted a transcript/diploma request and payment to Chester High School on March 8, 2023. A copy of receipt is in personnel file. has reached out to them for an update since then with no response. is contacting them again. has been removed from the direct care staffing schedule until is able to provide a copy of diploma or transcripts.*
**The Human Resource Associate utilizes a checklist during hiring process to ensure all required documentation is obtained. The HR Department is conducting an audit of all Personal Care and Memory Care staff to ensure*

54a Direct Care Staff (continued)

compliance with required documentation. This audit was completed by 08/31/2023.
**Human Resource Director, or designee, will audit new employee files on a monthly basis for compliance and review results in the Quality Assurance Meetings as scheduled facilitated by the Program Director.*

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

Implemented (- 11/01/2023)

60a - Staff/Support Plan

5. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home currently has no director of nursing. The last director of nursing left on 05/ 04/2023. There is only one medication technician (MT) each shift who passes meds to both the home's PC floor and MC floor each shift. There have been numerous medication errors (about 19) reported to the Department in May, June, and July 2023. These med errors are due to transcribing errors, pharmacy order/delivery issues, and only one MT passing meds each shift.

Repeat Violation: 06/30/2022

Plan of Correction ***Accept (- 08/28/2023)***

**The open position of Resident Care Director is posted on Indeed. The Community Recruiter is actively recruiting for this position.*
**The community is adding a new position of Lead Medication Technician to support the Medication Technicians administering the medications. This position will manage the nursing office, i.e. nursing calls, medication ordering, follow up with the pharmacy, transcribing medication orders to the MAR, physician contact and appointments, to allow the Medication Technician to focus on administering the medications.*
**The Program Director/Executive Director, or designee, will review all new orders and order changes transcriptions to the MAR as received, review the MARs for accurate documentation of medication administration and follow up with the pharmacy when a concern is identified by the Lead Medication Technician.*
** The Program Director/Executive, or designee, will review any ongoing concerns with medication errors in Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *09/30/2023*

Implemented (- 11/01/2023)

65e - 12 Hours Annual Training

6. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person A and B received only 4 hours and 23 minutes of annual training in training year 2022.

65e - 12 Hours Annual Training *(continued)*

Plan of Correction ***Accept (- 09/08/2023)***

**In reviewing the current community training plan and use of Trainings on Demand (TODs) within our Watermark Connect site, we learned that although the state required training topics were being covered, the required time frames were not being met. We are now utilizing Relias Trainings which have programmed times for their webinars that cannot be adjusted and live in house trainings.*
**The Program Director is creating a training checklist identifying the annual required state training topics. This checklist will be completed by 08/25/2023. All direct care staff training records will be audited for compliance for 2023 training utilizing this checklist by 09/15/2023 by HR.*
**Direct care staff persons A and B will complete the remaining hours of training required for 2022 by 09/30/2023.*
**Direct care staff will be scheduled time during their shifts to complete the required trainings for 2023 by 11/30/2023 by the Program Director, or designee.*
**The Program Director, with Human Resources, will review staff training reports monthly utilizing this checklist. The Human Resource Director, or designee, will review results of the monthly audit in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *09/30/2023*

Implemented (- 11/01/2023)

65f - Training Topics

7. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

Direct care staff person A and B did not receive training in following topics during training year 2022.
1. Medication self-administration training
6. Safe management techniques

Plan of Correction ***Accept (- 09/08/2023)***

**The Program Director is creating a training checklist identifying the annual required state training topics, to include Medication Self-Administration and Safe Management Techniques. This checklist will be completed by 08/25/2023. All direct care staff training records will be audited for compliance for 2023 training utilizing this checklist by 09/15/2023 by HR.*
**Direct care staff persons A and B will complete the identified trainings required for 2022 by 09/30/2023.*
**Direct care staff will be scheduled time during their shifts to complete the required trainings for 2023 by 11/30/2023 by the Program Director, or designee.*
**The Program Director, with Human Resources, will review staff training reports monthly utilizing this checklist. The Human Resource Director, or designee, will review results of the monthly audit in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *09/30/2023*

Implemented - 11/01/2023)

65g - Annual Training Content

8. Requirements

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

Description of Violation

Staff person A, B, and C did not receive training in following topics during training year 2022.

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.

3. Resident rights.

4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Repeat Violation: 03/28/2023

Plan of Correction ***Accept (- 09/08/2023)***

**The Plant Operations Director is scheduling the annual Fire Safety Training for 2023 with a Fire Safety Expert. Multiple training sessions will be provided to allow for all Personal Care staff, both direct care and ancillary, to attend.*

**The Program Director is creating a training checklist identifying the annual required state training topics, to include Fire Safety by a fire safety expert, Resident Rights and The Older Adult Protective Services Act. This checklist will be completed by 08/25/2023. All direct care staff training records will be audited for compliance for 2023 training utilizing this checklist by 09/15/2023 by HR.*

**Direct care staff persons A, B and C will complete the identified trainings required for 2022 by 09/30/2023.*

**Direct care staff will be scheduled time during their shifts to complete the required trainings for 2023 by 11/30/2023 by the Program Director, or designee.*

**The Program Director, with Human Resources, will review staff training reports monthly utilizing this checklist. The Human Resource Director, or designee, will review results of the monthly audit in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *09/30/2023*

Implemented (- 11/01/2023)

82c Locking Poisonous Materials

9. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 07/24/2023, personal hygiene items including Medline mouth wash, Crest toothpaste, and Dove antiperspirant deodorant, all with a manufacture's label indicating "if swallowed, get medical help or contact a poison control center right away", were unlocked, unattended, and accessible to residents in resident room #B2. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Repeat Violation: 06/30/2022

Plan of Correction ***Accept (- 08/28/2023)***

**The personal hygiene items were immediately secured on 07/24/2023.*

82c Locking Poisonous Materials (continued)

**All vanity cabinets in the secured dementia care unit have locking devices on the cabinet handles to secure all personal hygiene items.*
**Staff were provided with education regarding securing poisonous materials in the SDCU on 08/22/2023 and 08/23/2023. All new employees will be provided with education regarding securing poisonous materials in the SDCU within their initial 40 hours of training by the Program Director, or designee.*
**The Program Director, or designee, will complete daily rounds of the SDCU to ensure compliance with this regulation for 30 days, providing documentation of rounds on the 24 Hour Report. If compliance with this regulation is found at the 30 days, rounds will be then be documented quarterly. Results will be reviewed in the Quality Assurance Meetings as scheduled facilitated by the Program Director.*

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented (- 02/07/2024)

85a - Sanitary Conditions

10. Requirements

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

Description of Violation

On 07/24/2023, there was a strong smell of urine in resident room #B13. The carpet in front of this room was stained as well.

Repeat Violation: 09/19/2022

Plan of Correction ***Accept (- 08/28/2023)***

**The Housekeeping Director was contacted on 07/24/2023 regarding the carpet outside of B13 and the odor in the apartment. The carpet and apartment flooring were cleaned on 07/24/2023.*
**The Housekeeping Team provides daily cleaning to the resident apartment and are monitoring the carpet outside of the apartment. Direct care staff are reporting any immediate need for carpeting cleaning to housekeeping.*
**The Plant Operations Director is evaluating the need to replace the LVT flooring within the resident apartment.*
** The resident has been placed on a toileting schedule to assist in reducing incontinence episodes. This has been added to his RASP and Task Sheet. It will be monitored by the Program Director, or designee.*
**The Plant Operations Director, or designee, will provide updates on the flooring evaluation in the Quality Assurance Meetings as scheduled, as well as the Program Director, Resident Care Director, or designee, will report on the resident's progress with the toileting schedule.*

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented (- 11/01/2023)

89b - Hot Water Temperature

11. Requirements

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

89b Hot Water Temperature *(continued)*

Description of Violation

On 07/24/2023 at 02:50 PM, the hot water temperature at the bathroom sink at resident room #113 measured 127.7 degrees Fahrenheit.

Repeat Violation: 06/30/2022

Plan of Correction ***Accept (█ - 08/28/2023)***

**The Maintenance Department immediately adjusted the water temperature in Personal Care, bringing the water temperatures below 120 degrees when retested on 07/24/2023.*
**The Plant Operations Director, or designee, monitors the water temperatures of identified apartments/public rooms on a daily basis completing all rooms by the end of each month. The temperature log is maintained by the Maintenance Supervisor. Adjustments needed to the water temperature are made upon discovery.*
**The Plant Operations Director, or designee, will continue to monitor water temperatures ongoing and report results in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented (█ - 11/01/2023)

91 - Telephone Numbers

12. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in resident room #B2, #111, #212, and 1st floor/2nd floor common area.

Repeat Violation: 06/20/2022

Plan of Correction ***Accept (█ - 08/28/2023)***

**Several of the identified telephone number labels had become worn and fell off due to phone use and cleaning. Waterproof labels have been ordered with expected delivery of 08/22/2023. New waterproof labels will be printed and placed on all telephones in the common areas, offices and resident apartments by 08/28/2023 by the Program Director, or designee.*
**The Program Director/Executive Director, or designee, will inspect all new resident rooms for telephones and place emergency telephone number labels as needed within first week of move in.*
**The Program Director/Executive Director, or designee, will inspect all personal care/memory care telephones for emergency telephone numbers on a monthly basis for wear and tear and need for replacement during room inspections.*
**The Program Director/Executive Director, or designee, will review results in Quality Assurance Meetings as scheduled facilitated by the Program Director.*

Licensee's Proposed Overall Completion Date: *08/28/2023*

Implemented (█ - 02/07/2024)

91 Telephone Numbers *(continued)*

101j7 - Lighting/Operable Lamp

13. 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 #2 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept - 08/28/2023)***

**A bedside lamp was placed in resident #2's apartment on 07/24/2023.*
**The Program Director/Executive Director, or designee, will inspect the apartments of new move ins for the Department required items of furniture within the first week of move in to ensure compliance.*
**The Program Director/Executive Director, or designee, will inspect all resident apartments for the Department required items of furniture during monthly room inspections.*
**The Program Director/Executive Director, or designee, will review the results of the monthly room inspections in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented - 11/01/2023)

103e - Left Overs

14. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There was an unlabeled, undated container of macaroni and of hamburger in the lower level activity refrigerator.

Plan of Correction ***Accept (- 08/28/2023)***

**The unlabeled undated container was removed from the lower level activity refrigerator on 07/24/2023. All remaining items in the refrigerator were checked for labels and dates.*
**There is a notice posted on the exterior of the refrigerator instructing that all food items need to be labeled and date, as well as all prepared food items will be disposed of within three days of the labeled date if not consumed.*
**The Community Life Director notified all department directors of the regulations regarding food items stored in the refrigerators via email on 08/16/2023. The directors were instructed to provide their department staff with education regarding these regulations.*
**The Community Life Associates will be monitoring the refrigerator on a weekly basis and dispose of any unlabeled/undated or expired food.*
**The Community Life Director, or designee, will review any ongoing concerns with this regulation in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented - 11/01/2023)

103f - Refrigerator/Freezer Temps

15. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There was no thermometer in the ice-cream freezer in the main kitchen.

Plan of Correction ***Accept (- 08/28/2023)***

**The Dining Services Director installed a new thermometer in the ice cream freezer in the main kitchen on 07/25/2023.*
**The Dining Services Director implemented a temperature log for the ice cream freezer. The AM Cooks and Chef will document the temperature daily, reporting any concerns with the temperature to the Dining Services Director.*
**The Dining Services Director, or designee, will review the temperature log monthly for compliance and report the results in the Quality Assurance Meetings as scheduled facilitated by the Program Director.*

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented (CM - 11/01/2023)

103g - Storing Food

16. Requirements

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

Description of Violation

On 07/25/2023, one of the ice cream containers in the ice-cream freezer in the main kitchen was opened and unsealed.

Plan of Correction ***Accept (08/28/2023)***

**The ice creamer container was covered and sealed immediately on 07/25/2023. All other ice cream containers were checked for secured lids.*
**The Dining Services Director has assigned the AM Cook/Chef to check the ice cream containers daily in the AM and the Dining Room Managers to check in the PM before closing the kitchen. Any concerns with the securing the lids/containers will be reported to the Dining Services Director.*
**The Dining Services Director, or designee, will report any concerns in Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented - 11/01/2023)

105g - Lint Removal and Duct Cleaning

17. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer’s instructions.

105g - Lint Removal and Duct Cleaning *(continued)*

Description of Violation

On 07/24/2023, there were three dryers in the 1st floor laundry room. Two of the dryers had an approximate 1/4 inch accumulation of lint in the lint trap. There were no clothes in the dryers at the time.

Plan of Correction ***Accept (- 08/28/2023)***

**The lint was immediately removed by the Program Director upon discovery on 07/25/2023.*
**The Program Director has posted signs instructing the direct care staff to check the lint traps after each load of laundry. The housekeeping team will also check the lint traps on each dryer when cleaning the laundry rooms as scheduled.*
**The Program Director is providing education regarding the risks of fire hazards with the direct care staff. The education will be documented and completed by 08/28/2023.*
**The Program Director/Executive Director, or designee, will monitor the dryer lint traps for lint on a daily basis until compliance has been achieved and is consistent, at which time dryers will be monitored on a monthly basis. Results will be reviewed in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/28/2023*

Implemented - 11/01/2023)

107d - Procedure Emergency Management Agency Submission

18. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures were not submitted to the local emergency management agency in 2022.

Plan of Correction ***Accept (CM - 08/28/2023)***

**The Plant Operations Director reports that a copy of the community's emergency procedures had been submitted to the local emergency management agency in 2022; however, he did obtain a letter or email of receipt to document it. A notation has been added to the community's Survey Binder in the Emergency Procedures section identifying that the letter was not obtained in 2022 and was cited in the annual survey in 2023.*
**The Plant Operations Director is completing the review and updates on the emergency procedures for 2023. Upon completion, he will submit the emergency procedures to the local emergency management agency, obtain a letter of receipt for 2023 and file it in the community's Survey Binder. This will be completed by 09/30/2023.*
**The Plant Operations Director, or designee, will report of the progress of the updated procedures and the receipt of the letter of submission from the local agency in the Quality Assurance Meetings as scheduled facilitated by the Program Director.*

Licensee's Proposed Overall Completion Date: *09/30/2023*

Implemented (- 11/01/2023)

132a - Monthly Fire Drill

19. Requirements

2600.

132a - Monthly Fire Drill *(continued)*

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

Description of Violation

The home has personal care (PC) unit and secured dementia care unit (MC) in the same building. The home holds its monthly fire drills separately for the PC unit and the MC unit on the same day, about 30 minutes apart, which cannot be considered as unannounced for whichever unit the fire drill is held after the other unit's fire drill. For example, the fire drill was held
on 07/19/2023 at 06:00 PM on PC side, at 07:30 PM on MC unit
on 06/29/2023 at 02:45 PM on PC side, at01:15 PM on MC side
on 05/31/2023 at 03:15 AM on PC side, at 03:00 AM on MC side
on 04/23/2023 at 07:00 PM on PC side, at 06:30 PM on MC side
on 03/28/2023 at 01:45 PM on PC side, at 02:15 PM on MC side
on 02/24/2023 at 02:05 AM on PC side, at 01:45 AM on MC side

Repeat Violation: 06/30/2022

Plan of Correction ***Accept (- 09/08/2023)***

**Croker Fire Drill Corporation facilitates all monthly fire drills for the PC and MC units. They have been completing the fire drills for both PC and MC on the same day and shift each month as identified in the annual survey which may allow one of the programs to anticipate a fire drill.*
**The Plant Operations Director will contact Crocker Fire Drill Corporation by 09/05/2023 to schedule the fire drills for PC and MC on separate days of the month. This will ensure that the drills are not announced or anticipated by the other program. This will be effective for the drills beginning in September 2023.*
**The Plant Operations Director, or designee, will review all fire drill reports from Crocker on a monthly basis to confirm compliance with the drills occuring on separate days of the month. The Plant Operations Director, or designee, will review results in the Quality Assurance Meetings as scheduled.*

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented (- 11/01/2023)

141a 1-10 Medical Evaluation Information

20. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #4's medical evaluation completed does not include special health or dietary needs of the

141a 1-10 Medical Evaluation Information (continued)

resident, the ability to self-administer medications, and body positioning and movement stimulation.

Repeat Violation: 06/30/2022

Plan of Correction ***Accept (- 08/28/2023)***

**The medical evaluation for resident #4 was not able to be corrected due to the passing of the resident on*

**The Program Director, or designee, is completing an audit of all current resident medical evaluations for completion and compliance by the physician/CRNP. The audit will be completed by 08/25/2023. New medical evaluations will be obtained if any current medical evaluations are found to be incomplete during the audit by the Program Director or designee.*
**The Program Director/Executive Director, or designee, will audit all new move in medical evaluations prior to move in and ensure the form is completed in its entirety before move in.*
**The Program Director/Executive Director, or designee, will audit all annual and significant change medical evaluations for current residents upon receipt and monthly to ensure completion and compliance. Results will be reviewed in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/25/2023*

Implemented - 11/01/2023)

141b1 - Annual Medical Evaluation

21. Requirements

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

Description of Violation

Resident #5's most recent medical evaluation was completed on

Repeat Violation: 11/14/2022

Plan of Correction ***Accept - 08/28/2023)***

**Resident #5's medical evaluation for 2023 was obtained from physician on .*
**The Program Director, or designee, is completing an audit of all current resident medical evaluations for completion and compliance by the physician/CRNP. The audit will be completed by 08/25/2023. New medical evaluations will be obtained if any current medical evaluations are found to be out of time compliance.*
**The Program Director, or designee, is entering the dates of the current medical evaluations in each resident record in Point Click Care to enable a report to be pulled monthly to identify the annual medical evaluations that are due for completion in the next month to ensure compliance with regulatory time frames.*
**The Program Director/Executive Director, or designee, will review completion of medical evaluations in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/25/2023*

Implemented (- 11/01/2023)

183d Prescription Current

22. 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 07/25/2023, two blister packs of [redacted] (with an expiration date of [redacted] and [redacted]) and 7 blister packs of [redacted] (with an expiration date of [redacted]) prescribed for resident #6 were in the home's medication cart.

Plan of Correction ***Accept ([redacted] - 08/28/2023)***

**The identified expired medications were immediately removed from the medication cart.*
**Omnicare Pharmacy completed a 100% MAR to Cart audit on all three medication carts 07/31/2023. Any expired or discontinued medications found were removed from the carts. Any medications with 7 days supply or less were reordered. New scripts were requested for any medications with no remaining refills.*
**The Medication Technicians were provided training regarding medication storage by the Program Director and the Regional Director of Health Services on 08/02/2023. Review of medication storage will occur ongoing in Nursing Meetings as scheduled by the Program Director/Executive Director.*
**Medication Technicians are assigned to check all medications for compliance during their shifts. Medication Technicians are completing weekly medication cart audits.*
**The Program Director/Executive Director, or designee, will review the cart audits weekly and report results in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented ([redacted] - 11/01/2023)

183e Storing Medications

23. 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 [redacted] around [redacted] in the PC side medication cart, there was an unidentified cup half filled with yellow oval pills in the 1st floor medication cart. In the Memory Care side medication cart, a bottle of [redacted] was opened but without an open date. According to the manufacturer's instructions, the eye drop should be discarded 6 weeks after opening.

On [redacted], Resident #6's [redacted] pen was opened but was not dated. Another resident's Novolog insulin pen was opened but was not dated. According to the manufacturer's instructions, these pens should be discarded 28 days after opening.

On [redacted] an opened bottle of [redacted]% eye drop prescribed for resident #7 was in the medication cart without an open/discard after date. According to the manufacturer's instructions, the eye drop should be discarded 28 days after opening.

183e Storing Medications *(continued)*

Plan of Correction ***Accept (- 08/28/2023)***

**The half filled cup of yellow pills were immediately removed from the cart and destroyed in the drug disposal bottle. The eye drops and insulin pens were immediately reordered and removed from the cart.*
Pharmacy completed a 100% MAR to Cart audit on all three medication carts 07/31/2023. Any undated and opened eye drops and insulin pens were replaced with supply available in house and replaced in the cart with an open date or ordered from the pharmacy.
**The Medication Technicians were provided training regarding medication storage by the Program Director and the Regional Director of Health Services on 08/02/2023. Review of medication storage will occur ongoing in Nursing Meetings as scheduled by the Program Director/Executive Director.*
**Medication Technicians are assigned to check all medications for compliance during their shifts. Medication Technicians are completing weekly medication cart audits.*
**The Program Director/Executive Director, or designee, will review the cart audits weekly and report results in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented - 11/01/2023)

184a - Resident's Meds Labeled

24. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #4 is prescribed . The initial order on was every 3 hours as needed (PRN) and then a standing order of twice a day at was received on . Since there was a delay in pharmacy delivery, the staff signed out the standing order from the PRN card. There was no direction change sticker on the sign out sheet.

Resident #6 is prescribed . The order changed to once at bed time from 2 times a day on 07/14/2023. There was no direction change sticker on the blister pack.

Plan of Correction ***Accept - 08/28/2023)***

** completed a 100% MAR to Cart audit on all three medication carts 07/31/2023. Any discrepancies between the current order in the MAR and the blister card labels were addressed with Change of Direction stickers placed on the labels.*
**The Medication Technicians were provided training regarding medication transcriptions and order changes by the Omnicare RN on 07/31/2023. Review of medication transcriptions and order changes will occur ongoing in Nursing Meetings as scheduled by the Program Director/Executive Director.*
**Medication Technicians are assigned to check all medications for compliance during their shifts. Medication Technicians are completing weekly medication cart audits.*
**The Program Director/Executive Director, or designee, will review the cart audits weekly and report results in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

184a - Resident's Meds Labeled *(continued)*

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented (- 11/01/2023)

185a - Implement Storage Procedures

25. 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 #4's glucometer was not calibrated to correct time. On , the glucometer displayed The resident's glucometer has
no readings on at lunch but the resident's MAR read
no readings on at lunch but the resident's MAR read
no reading on at lunch but the resident's MAR read
On at bedtime, the glucometer displays but the resident's MAR read

Resident #8's glucometer was not calibrated to correct date and time. On at , the glucometer displayed The glucometer displayed on at but the resident's MAR read .
The glucometer displayed on at but the resident's MAR read

Repeat Violation: 06/30/2022

Plan of Correction ***Accept - 08/28/2023)***

All glucometers were calibrated to the correct date and time on 07/25/2023.
The Program Director and Regional Director of Health Services provided the Medication Technicians with education regarding the calibration of glucometers on 08/02/2023.
The Program Director/Executive Director, or designee, will audit the glucometer readings with the MAR on a daily basis until compliance with calibration and documentation is obtained consistently, at which time they will be audited weekly.
The Program Director/Executive Director, or designee, will review results of the audit in the Quality Assurance Meetings as scheduled facilitated by the Program Director.

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented (- 02/07/2024)

26. 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 #6 is prescribed and nasal spray as needed. On , these medications were not available in the home.

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept (08/28/2023)***

**The Medication Technician immediately reordered the Albuterol and Deep Sea Nasal Spray from the pharmacy.*
**Omnicare Pharmacy completed a 100% MAR to Cart audit on all three medication carts 07/31/2023. Any medications found to be unavailable in the carts were ordered from the pharmacy.*
**The Medication Technicians were provided training regarding medication ordering by the Program Director and Regional Director of Health Services on 08/02/2023. Review of medication ordering will occur ongoing in Nursing Meetings as scheduled by the Program Director, or designee.*
**Medication Technicians are assigned to check all medications for compliance during their shifts. Medication Technicians are completing weekly medication cart audits.*
**The Program Director/Executive Director, or designee, will review the cart audits weekly and report results in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented - 11/01/2023)

186c - Change in Medications

27. Requirements

2600.
186.c. Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by nurses in accordance with regulations of the Department of State. The resident's medication record shall be updated as soon as the home receives written notice of the change.

Description of Violation

Resident #9's order changed from 1 tab every 8 hours as needed to one tab three times a day on then to 1/2 tab three times a day on , and then back to one tab every 8 hours as needed on . However, the Medication Administration Record (MAR) did not reflect these changes correctly, resulting in the resident being administered the standing order of 1/2 tabs 3 times a day on , and on .

Plan of Correction ***Accept (- 08/28/2023)***

**The error in transcription with Resident #9's order was noted and corrected on 06/19/2023 by the Medication Technician. The resident received the correct dosage of the medication for the remainder of his respite stay at the community.*
**The Medication Technicians were provided training regarding medication transcriptions by the Omnicare RN on 07/31/2023. Review of medication transcriptions will occur ongoing in Nursing Meetings as scheduled.*
**The Program Director/Executive Director, or designee, is verifying all new medication order and medication change transcriptions on a daily basis for a two-step verification.*
**The Program Director/Executive Director, or designee, will report results of daily medication transcription audits in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented (11/01/2023)

187b - Date/Time of Medication Admin.

28. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #4 is prescribed [redacted] s 3 times a day. The checks were not performed at lunch time on [redacted], [redacted]. However, staff initials are present on these dates.

Plan of Correction ***Accept [redacted] - 08/28/2023)***

**The Program Director and Regional Director of Health Services provided the Medication Technicians with education regarding the proper insulin administration and documentation of glucometer readings on 08/02/2023.*
**The Program Director/Executive Director, or designee, will audit the glucometer readings with the MAR on a daily basis until compliance with documentation is obtained consistently, at which time they will be audited weekly.*
**The Program Director/Executive Director, or designee, will review results of the audit in the Quality Assurance Meetings as scheduled facilitated by the Program Director.*

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented ([redacted] 02/07/2024)

187d Follow Prescriber's Orders

29. Requirements

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

Description of Violation

Resident #4 is prescribed [redacted] 3 times a day. However, it was not performed at lunch time on [redacted] [redacted], and [redacted].

Resident #4 was prescribed [redacted] mg tab once a week. However, this medication was administered daily from [redacted].

Resident #9 is prescribed [redacted] 1 tab every 8 hours as needed. The resident received 1/2 tabs on [redacted] at [redacted] and at [redacted], and on [redacted]

Resident 10 is prescribed [redacted] [redacted] at bed time. On [redacted], these medications were not administered to the resident.

Plan of Correction ***Accept [redacted] - 08/28/2023)***

**The Medication Technicians were provided training regarding medication transcriptions by the [redacted] RN on 07/31/2023. Review of medication transcriptions will occur ongoing in Nursing Meetings as scheduled.*
**The Program Director and Regional Director of Health Services provided the Medication Technicians with education regarding proper medication administration and documentation on 08/02/2023.*
**The Program Director/Executive Director, or designee, will audit the glucometer readings with the MAR on a daily basis until compliance with calibration and documentation is obtained consistently in addition to auditing the MARs for proper medication administration documentation, at which time they will be audited weekly.*
**The Program Director/Executive Director, or designee, will review results of the audit in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

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

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented - 11/01/2023)

30. Requirements

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

Description of Violation

Resident #4 was prescribed 3 times a day. However, this medication was not administered to the resident from because the medication was not available in the home.

Plan of Correction ***Accept (- 08/28/2023)***

**The community has been experiencing difficulty with Omnicare Pharmacy with regards to timely deliveries and communication regarding medication refill unable to be filled at time of request. The Program Director and Regional Director of Health Services have been facilitating weekly virtual meetings with the management team of King of Prussia to address these concerns. The Program Director is also contacting the management team directly in the moment with any concerns to address them immediately. After investigating this violation, the Program Director found that the had been ordered prior to 06/28/2023. The community was notified on 06/28/2023 that it need a new script from resident #4's PCP, who was contacted for the new script that day. Pharmacy did not receive the new script until 07/01/2023 and it was delivered on 07/02/2023.*
**The Program Director and Regional Director of Health Services provided the Medication Technicians with education regarding the expectations with ordering medications in a timely manner and communicating any problems with medication refill and delivery immediately to the Program Director to address in the moment on 08/02/2023.*
**The Program Director/Executive Director, or designee, will review any medication needs and steps taken to obtain the medications daily with the Medication Technicians. The Program Director, or designee, will contact Omnicare directly if there are any issues.*
**The Program Director/Executive Director, or designee, will review any ongoing issues with medication orders and delivery in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented (- 11/01/2023)

191 - Resident Right to Refuse

31. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1, admitted , has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Repeat Violation: 06/30/2022

Plan of Correction ***Accept - 08/28/2023)***

**Resident was approached to sign contract on , which includes the acknowledgement of the*

191 - Resident Right to Refuse (continued)

Resident Rights. [redacted] was unable to sign due to cognitive decline. This was documented on the contract. Current Administrator signed reviewed and signed the contract on [redacted]. Responsible Party, resident's daughter, had signed the contract at the time of move in.
**All Memory Care and Personal Care resident contracts will be audited by the Sales Team, or designee, for compliance with signatures. This audit will be completed by 08/31/2023.*
**All new Personal Care and Memory Care resident contracts signatures will be obtained by the Move In Coordinator at time of Move In. All contracts will be reviewed upon receipt from the Sales Team upon Move In for completion by the Business Office Director, or designee. Results will be reviewed in Quality Assurance Meetings as scheduled facilitated by the Program Director.*

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

Implemented ([redacted] - 11/01/2023)

225c - Additional Assessment

32. Requirements

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

Description of Violation

Resident #4's annual assessment due in [redacted] was not completed.
Resident #11's annual assessment due in [redacted] was not completed.

Plan of Correction ***Accept [redacted] - 08/28/2023)***

**The annual assessment for Resident #4 is unable to be completed due to [redacted] passing in [redacted]. Resident #11's annual assessment will be completed by [redacted] and reviewed with the resident to bring her assessment in compliance.*
**The Program Director, or designee, is completing an audit of all current resident Resident Assessment and Support Plans (RASP) for completion and compliance. The audit will be completed by 08/25/2023. New RASPs will be completed if any current RASPs are found to be incomplete during the audit.*
**The Program Director/Executive Director, or designee, will audit all new move in RASPs within the first 15 days of move in and ensure the form is completed in its entirety.*
**The Program Director/Executive Director, or designee, will audit all annual and significant RASPs for current residents upon receipt and monthly to ensure completion and compliance. Results will be reviewed in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/25/2023*

Implemented [redacted] - 11/01/2023)

227g -Support Plan Signatures

33. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

227g -Support Plan Signatures *(continued)*

Description of Violation

The assessment/support plan (RASP) dated [redacted] for resident #11 was not signed by the assessor.

Repeat Violation: 11/14/2022

Plan of Correction ***Accept [redacted] - 08/28/2023)***

**The current Program Director has reviewed and signed the assessment/support plan for resident #11 in the absence of the assessor who is no longer with the community.*
**The Program Director, or designee, is completing an audit of all current resident Resident Assessment and Support Plans (RASP) for completion and compliance. The audit will be completed by 08/25/2023. New RASPs will be completed if any current RASPs are found to be incomplete during the audit.*
**The Program Director/Executive Director, or designee, will audit all new move in RASPs within the first 15 days of move in and ensure the form is completed in its entirety.*
**The Program Director/Executive Director, or designee, will audit all annual and significant RASPs for current residents upon receipt and monthly to ensure completion and compliance. Results will be reviewed in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/25/2023*

Implemented ([redacted] - 11/01/2023)

234d - Support Plan Revision

34. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

The support plan for resident #5 was completed on [redacted] however, the resident's support plan was not revised until [redacted]

Plan of Correction ***Accept [redacted] - 08/28/2023)***

**During the onsite survey on [redacted], the Program Director located the support plan for resident #5 for 2021. It had been started in Point Click Care (PCC), but had not been completed. This was provided to the licensing representative. It has been added to the resident's medical record with a notation that it was discovered to be out of compliance during the 2023 annual survey.*
**The Program Director, or designee, is completing an audit of all current resident Resident Assessment and Support Plans (RASP) for completion and compliance. The audit will be completed by [redacted]. New RASPs will be completed if any current RASPs are found to be incomplete during the audit.*
**The Program Director/Executive Director, or designee, will audit all new move in RASPs within the first 15 days of move in and ensure the form is completed in its entirety.*
**The Program Director/Executive Director, or designee, will audit all annual and significant RASPs for current residents upon receipt and monthly to ensure completion and compliance. Results will be reviewed in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *08/25/2023*

Implemented ([redacted] - 11/01/2023)

236 - Staff Training

35. Requirements

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

Description of Violation

Direct care staff person A and B, who works in the Secured Dementia Care Unit (SDCU), had only 2 hours of training in dementia care in 2022.

Repeat Violation: 03/28/2023

Plan of Correction ***Accept (- 09/08/2023)***

**In reviewing the current community training plan and use of Trainings on Demand (TODs) within our Watermark Connect site, we learned that although the state required dementia training topics were being covered, the required time frames were not being met. We are now utilizing Relias Trainings which have programmed times for their webinars that cannot be adjusted and live in house trainings.*
**The Program Director is creating a training checklist identifying the annual required state training topics, including dementia. This checklist will be completed by 08/25/2023. All direct care staff training records will be audited for compliance for 2023 training utilizing this checklist by 09/15/2023 by HR.*
**Direct care staff person A and B will completed the required Dementia training for the 2022 year by 09/30/2023.*
**Direct care staff will be scheduled time during their shifts to complete the required trainings for 2023 by 11/30/2023 by the Program Director, or designee.*
**The Program Director, with Human Resources, will review staff training reports monthly utilizing this checklist. The Human Resource Director, or designee, will review results of the monthly audit in the Quality Assurance Meetings as scheduled facilitated by the Program Director .*

Licensee's Proposed Overall Completion Date: *09/30/2023*

Implemented - 11/01/2023)