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

July 24, 2023

[redacted]T, ADMINISTRATOR
PARAMOUNT SENIOR LIVING AT MAYTOWN LLC
2760 MAYTOWN ROAD
MAYTOWN, PA, 17550

RE: PARAMOUNT SENIOR LIVING AT LANCASTER COUNTY
2760 MAYTOWN ROAD
MAYTOWN, PA, 17550
LICENSE/COC#: 33390

Dear Lori Prevost,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/14/2023, 03/21/2023, 03/24/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *PARAMOUNT SENIOR LIVING AT LANCASTER COUNTY* **Licen e #**: *33390* **Licen e Expiration**: *08/15/2023*

Address: *2760 MAYTOWN ROAD, MAYTOWN, PA 17550*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *PARAMOUNT SENIOR LIVING AT MAYTOWN LLC*

Address: *2760 MAYTOWN ROAD, MAYTOWN, PA, 17550*

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *11/17/1999* **I ued By**: *Department of Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *108* **Waking Staff**: *81*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *03/24/2023*

Inspection Dates and Department Representative

03/14/2023 On Site [redacted]
03/21/2023 On Site
03/24/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *116* **Residents Served**: *74*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *44* **Residents Served**: *28*

Hospice

Current Residents: *16*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *73*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *34* **Have Physical Disability**: *0*

Inspections / Reviews

03/14/2023 - Partial

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

Inspections / Reviews *(continued)*

04/13/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/25/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/21/2023*

04/25/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/25/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/25/2023*

07/24/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/25/2023*

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

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]/2023, Resident #1 was observed to rub his/her body in a sexual manner while standing over a staff member providing care to Resident #3. This incident was reported to Staff Member A on 1/29/2023. However, this allegation of abuse was was not reported to the local area agency on aging.

Plan of Correction ***Do Not Accept (CR - 04/10/2023)***

The report of suspected abuse concerning the above incident was completed and sent to DHS, Lancaster County Office of Aginng, and the PA. Department of Aging on April 3, 2023. Please see attached. The incident not being sent or reported to Protective Services within 24 hours was due to the fact that administration did not recognize this occurence" as abuse.

As has been our process since 12/15/22, there is a double check system that was put into place between the nursing department and administration. All falls or incidents of ANY kind will be directly called to the manager on call or reported immediately to administration to determine whether a report needs to be made to DHS. If there is a question of whether an occurence is reportable or not, administration will call DHS immediately for guidance. These reportable incidents will be reported timely within 24 hours of incident. This double check system was started on 12/7/22. The RCM and Executive Director will insure ongoing compliance which started on 12/15/22 by reading the 24 hour report and discussing all incidents that require reporting. (See attached checklist)

Licensee's Proposed Overall Completion Date: *04/05/2023*

Update: *04/10/2023*

- *A training will need to be provided to administration and direct care staff on recognizing abuse. Please reach out to the local Ombudsman applicable trainings to staff and/or residents in mandatory reporting and abuse. Please state the tentative date for the training by the Ombudsman and/or be prepared to submit staff sign-in sheets for the presentation.*
- *All incidents will need to be reviewed at the home's Quality Assurance meetings. Please provide the next scheduled QM meeting date.*

Plan of Correction ***Accept (CR - 04/21/2023)***

The report of suspected abuse concerning the above incident was completed and sent to DHS, Lancaster County Office of Aginng, and the PA. Department of Aging on April 3, 2023. Please see attached. The incident not being sent or reported to Protective Services within 24 hours was due to the fact that administration did not recognize this occurence" as abuse.

Lancaster County Office of Aging has been contacted to provide training on recognizing abuse and mandatory reporting for direct care staff and administration. It has been confirmed that the Director of Protective Services, Fred Niche will be providing this training on 5/9/23 at the staff meetings at 2 and 10pm. he inservice sign in sheets will be provided.

As has been our process since 12/15/22, there is a double check system that was put into place between the nursing department and administration. All falls or incidents of ANY kind will be directly called to the manager on call or reported immediately to administration to determine whether a report needs to be made to DHS. If there is a

15a - Resident Abuse Report (continued)

question of whether an occurence is reportable or not, administration will call DHS immediately for guidance. These reportable incidents will be reported timely within 24 hours of incident. This double check system was started on 12/7/22. The RCM and Executive Director will insure ongoing compliance which started on 12/15/22 by reading the 24 hour report and discussing all incidents that require reporting. (See attached checklist).
All incidents will be reviewed at all of the Quality Assurance meetings. The next quality assurance meetings are scheduled on July 11 and October 10, 2023.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Evidence of Completion ***Implemented (CR - 07/24/2023)***

See attached.

16c - Written Incident Report

2. Requirements

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

Description of Violation

On [redacted]/2023, Resident #1 was observed to rub his/her body in a sexual manner while standing over a staff member providing care to Resident #3. This incident was reported to Staff Member A on [redacted]/2023. The home did not report this incident to the Department.

Plan of Correction ***Do Not Accept ([redacted] - 04/10/2023)***

The report of suspected abuse concerning the above incident was completed and sent to DHS, Lancaster County Office of Aginng, and the PA. Department of Aging on April 3, 2023. Please see attached. The incident not being sent or reported to Protective Services within 24 hours was due to the fact that administration did not recognize this occurence" as abuse.
As has been our process since 12/15/22, there is a double check system that was put into place between the nursing department and administration. All falls or incidents of ANY kind will be directly called to the manager on call or reported immediately to administration to determine whether a report needs to be made to DHS. If there is a question of whether an occurance is reportable or not, administration will call DHS immediately for guidance. These reportable incidents will be reported timely within 24 hours of incident. This double check system was started on 12/7/22. The RCM and Executive Director will ensure ongoing compliance which started on 12/15/22 by reading the 24 hour report and discussing all incidents that require reporting. (See attached checklist)

Licensee's Proposed Overall Completion Date: *04/05/2023*

Update: *04/10/2023*

- *A training will need to be provided to administration and direct care staff on recognizing abuse. The local Ombudsman can be a great resource for applicable trainings to staff and/or residents. Please state the tentative date for the training by the Ombudsman and/or be prepared to submit staff sign-in sheets for the presentation.*
- *All incidents will need to be reviewed at the home's Quality Assurance meetings. Please provide the next scheduled QM meeting date.*

Plan of Correction ***Accept [redacted] 04/21/2023)***

The report of suspected abuse concerning the above incident was completed and sent to DHS, Lancaster County

16c - Written Incident Report (continued)

Office of Aginng, and the PA. Department of Aging on April 3, 2023. Please see attached. The incident not being sent or reported to Protective Services within 24 hours was due to the fact that administration did not recognize this "occurence" as abuse.

An inservice on mandatory abuse reporting and recognizing abuse has been scheduled with The Lancaster County Office of Aging Protective Services on 5/9/23 at the staff meetings at 2pm and 10pm. The Director of Protective Services, Fred Niche will do the presentations. A sign in sheet for the inservice will be sent to the Department after the meeting.

As has been our process since 12/15/22, there is a double check system that was put into place between the nursing department and administration. All falls or incidents of ANY kind will be directly called to the manager on call or reported immediately to administration to determine whether a report needs to be made to DHS. If there is a question of whether an occurance is reportable or not, administration will call DHS immediately for guidance. These reportable incidents will be reported timely within 24 hours of incident. This double check system was started on 12/7/22. The RCM and Executive Director will ensure ongoing compliance which started on 12/15/22 by reading the 24 hour report and discussing all incidents that require reporting. (See attached checklist)

All incidents will be reviewed at all of the Quality Assurance meetings. The next quality assurance meetings are scheduled on July 11 and October 10, 2023.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Evidence of Completion ***Implemented [redacted] - 07/24/2023)***

See attached.

23a - Activities of Daily Living Assistance

3. Requirements

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated [redacted]/2022, for Resident #3 indicates the resident requires assistance with oral hygiene twice daily. The assessment and support plan, dated [redacted] for Resident #4 indicates the resident requires assistance with oral hygiene at least twice daily. The assessment and support plan, dated [redacted], for Resident #5 indicates the resident requires assistance with oral hygiene twice daily. On [redacted], staff member interviews revealed residents in the Secured Dementia Care Unit (SDCU) do not receive daily oral hygiene care; Residents #3, #4 and #5 resident in the SDCU.

Plan of Correction ***Do Not Accept (CR - 04/06/2023)***

Staff education on proper oral hygiene for all residents that require assistance twice daily was completed on March 14, 2023 to all direct care staff. This education was presented in the monthly resident care staff meeting by the Resident Care Manager (RCM) and Assistant Resident Care Manager (ARCM). See attached education and staff sign in. Education will be reviewed again in the monthly staff meeting for direct care staff on April 11, 2023. This will be presented by the RCM and ARCM.

All residents who require twice daily oral hygiene assistance (according to their Resident Support Plan) were identified on April 3, 2023 by the Resident Care Manager and placed on the individual assignment sheet for each resident. Each direct care staff on their shift, uses a daily assignment sheet to complete all resident care needs. These assignment sheets are then handed in to the ARCM and reviewed for completeness the following day. This process was started on April 3, 2023. Any discrepancies that are identified by the ARCM on the daily assignment

23a - Activities of Daily Living Assistance (continued)

sheets will be discussed with the particular direct care staff and corrected. ARCM and RCM will ensure ongoing compliance with review of all of the assignment sheets daily and ongoing education.

Licensee's Proposed Overall Completion Date: *04/11/2023*

Update: *04/06/2023*

- *Please identify the date the ARCM and RCM will begin reviewing assignment sheets.*

Plan of Correction ***Accept (- 04/21/2023)***

Staff education on proper oral hygiene for all residents that require assistance twice daily was completed on March 14, 2023 to all direct care staff. This education was presented in the monthly resident care staff meeting by the Resident Care Manager (RCM) and Assistant Resident Care Manager (ARCM). See attached education and staff sign n. Education will be reviewed again in the monthly staff meeting for direct care staff on April 11, 2023. This will be presented by the RCM and ARCM.
All residents who require twice daily oral hygiene assistance (according to their Resident Support Plan) were dentified on April 3, 2023 by the Resident Care Manager and placed on the individual assignment sheet for each resident. Each direct care staff on their shift, uses a daily assignment sheet to complete all resident care needs. These assignment sheets are then handed in to the ARCM and reviewed for completeness the following day. This process was started on April 3, 2023. Any discrepancies that are identified by the ARCM on the daily assignment sheets will be discussed with the particular direct care staff and corrected. ARCM and RCM will ensure ongoing compliance with review of all of the assignment sheets daily and ongoing education. This process was started on April 3, 2023.

Licensee's Proposed Overall Completion Date: *04/18/2023*

Evidence of Completion ***Implemented - 07/24/2023)***

completed

42b - Abuse

4. 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

Per staff interviews and the home's documentation, on /2023 at approximately 12:00 AM, Resident #1 was observed to have feces covering his backside from "head to toe". The feces was hardened as a result of personal care services not being provided for an undetermined length of time, causing the brief to be stuck to the resident's body as well as the resident's pants to be stuck to the brief.

Resident #2 is incontinent of bowel and bladder. Per Resident #2's Support Plan dated /2022, Resident #2 requires assistance with hygienic practices and is placed on a toileting schedule. Per resident and staff interviews completed on /2023, Resident #2 receives personal care around 6:00 AM when a clean brief is provided and the resident is transferred via 2-person Hoyer lift to the resident's wheelchair. Resident #2 does not receive personal care again until 9:00 PM when the resident is transferred back to the resident's bed. Resident and direct care staff member's confirm that Resident #2 refuses personal care throughout the day and remains in a soiled brief until the resident is

42b - Abuse (continued)

positioned in bed for the overnight hours.

On [redacted]/2023, direct care staff reported to Staff Member A that Resident #1 has been having sexual behaviors by standing over the direct care staff and rubbing him/herself in a sexual manner while Resident #3 is receiving personal care. Direct Care staff members have been removing Resident #1 from the room to provide care for Resident #3.

Plan of Correction ***Do Not Accept ([redacted] 04/10/2023)***

Resident #1 has been very difficult in assisting with[redacted] personal care needs. [redacted]does have incontinence. Resident refused to get showered and was being very aggressive verbally and physically to the staff that tried to assist [redacted]. There were multiple attempts made to assist in the care of resident. The resident had been checked on frequently before the time of the incident. The resident is incontinent of bowel and bladder and is taken to the toilet frequently. All residents that need assistance with their continency are checked on and toileted at least every 2-2.5 hours. The last time that the resident was checked on was before the end of 2nd shift which was around 9:30pm. The resident was aggressive both verbally and physically at that point. When a resident is aggressive, the staff are nstructed to make sure that the resident is safe and to leave and reapproach in a few minutes. This was attempted several times to no avail by 2nd shift.
The resident care staff were educated in a 3/22/23 inservice on dementia behaviors, validation, and de-escalation of situations and how to reapproach. (See attached).
Going forward, the staff will continue to follow the same policies in frequent toileting for the residents that need assistance. They will also continue to be educated on redirection and de-escalation techniques that they can use with dementia care residents that exhibit behaviors.

Resident #2 continuously has had the behavior of refusing to be changed out of a soiled brief during the day when he is out of bed. The resident has stated and continues to only want to be changed when[redacted] wakes up in the morning with a.m care and when[redacted] is getting ready to go to bed in the p.m. [redacted] is on a frequent toileting program throughout the day and is being asked and spoken to throughout the day about changing[redacted] brief. Resident #2 does not want to be changed because[redacted] does not want to use the hoyer lift more than 2 times a day to get in or out of bed. There have been multiple conversations with the resident and with[redacted] POA,[redacted] son. The conversations have occurred between the resident,[redacted] son, the RCM, and the Executive Director on the following dates: 3/13, 3/17, 3/20, 3/21, 3/23, and 3/28. There has been no agreement by the resident to be toileted more than 2 times a day. Resident also refuses when[redacted] has a bowel movement during the day. ED and RCM have explained to resident about skin breakdown, etc.
Unfortunately, a 30 day notice to vacate the community will be issued to Resident #2 on 4/12/23 due to[redacted] refusal to allow the staff to care for[redacted] personal care and hygiene needs. The 30 day notice is attached. Since the resident is on hospice, the ED and the RCM will work with the social worker from the hospice to find suitable placement in a skilled facility so that the resident can be safely discharged.

Resident #1 was removed from the room with Resident #3 and given a private room on [redacted].

Licensee's Proposed Overall Completion Date: *04/05/2023*

Update: *04/10/2023*

- *Please identify the staff member's title providing education to staff on 3/22/22 on dementia behaviors, validation and de escalation.*

42b - Abuse (continued)

- *Please reach out to the Ombudsman and request training/education on caregiver neglect and mandatory reporting. Be prepared to submit a tentative scheduled date as well as a staff sign-in sheet for the presentation.*
- *Will there be a supervision plan in place for Resident #1 when Resident #1 is not in his/her private bedroom? If so, please update the residents Support Plan and provide the date this will be updated and by what staff member title.*

Plan of Correction ***Accept (- 04/21/2023)***

Resident #1 has been very difficult in assisting with personal care needs. does have incontinence. Resident refused to get showered and was being very aggressive verbally and physically to the staff that tried to assist . There were multiple attempts made to assist in the care of resident. The resident had been checked on frequently before the time of the incident. The resident is incontinent of bowel and bladder and is taken to the toilet frequently. All residents that need assistance with their continency are checked on and toileted at least every 2-2.5 hours. The last time that the resident was checked on was before the end of 2nd shift which was around 9:30pm. The resident was aggressive both verbally and physically at that point. When a resident is aggressive, the staff are nstructed to make sure that the resident is safe and to leave and reapproach in a few minutes. This was attempted several times to no avail by 2nd shift.
The resident care staff were educated in a 3/22/23 inservice on dementia behaviors, validation, and de-escalation of situations and how to reapproach. This inservice was done by a nurse from a home care agency that works with our residents. (See attached).
Going forward, the staff will continue to follow the same policies in frequent toileting for the residents that need assistance. They will also continue to be educated on redirection and de-escalation techniques that they can use with dementia care residents that exhibit behaviors.

Resident #2 continuously has had the behavior of refusing to be changed out of a soiled brief during the day when is out of bed. The resident has stated and continues to only want to be changed when wakes up in the morning with a.m care and when is getting ready to go to bed in the p.m. is on a frequent toileting program throughout the day and is being asked and spoken to throughout the day about changing brief. Resident #2 does not want to be changed because does not want to use the hoyer lift more than 2 times a day to get in or out of bed. There have been multiple conversations with the resident and with POA, son. The conversations have occurred between the resident, son, the RCM, and the Executive Director on the following dates: 3/13, 3/17, 3/20, 3/21, 3/23, and 3/28. There has been no agreement by the resident to be toileted more than 2 times a day. Resident also refuses when has a bowel movement during the day. ED and RCM have explained to resident about skin breakdown, etc.
Unfortunately, a 30 day notice to vacate the community will be issued to Resident #2 on 4/12/23 due to refusal to allow the staff to care for personal care and hygiene needs. The 30 day notice is attached. Since the resident s on hospice, the ED and the RCM will work with the social worker from the hospice to find suitable placement in a skilled facility so that the resident can be safely discharged.

Resident #1 was removed from the room with Resident #3 and given a private room on 3/27/23. Unfortunately, resident #1 has ceased to breathe on .

Lancaster County Office of Aging has been scheduled to do an inservice on caregiver neglect. The Director of Protective Services, Fred Nitche will be presenting this inservice. The inservice is scheduled on 5/9/23 at 2 and 10pm. A sign in sheet for the inservice will be provided.

42b - Abuse *(continued)*

Licensee's Proposed Overall Completion Date: *05/12/2023*

Evidence of Completion ***Implemented (- 07/24/2023)***

See attached.

42s - Privacy

5. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The home has, at minimum, two (2) facility-owned electronic communication devices that are located in the main lobby and dining rooms. On 3/21/2023, posted notification of the use of the device did not include notification that the device may be recording audio. Resident contracts and the home's policies and procedures were reviewed and they did not address the following:

- *Identification of staff who have access to administrative rights for the device*
- *The facility will delete the conversation history from any device used by the facility on a regular basis as determined by the facility*
- *Prevention of recorded conversations from being shared or disclosed in any way, unless required by law*
- *Knowing or intentional recording without the person's consent or the consent of their legal representative, is prohibited.*

Plan of Correction ***Do Not Accept (- 04/10/2023)***

All voice controlled electronic devices will be removed from the community by the Executive Director as of April 12, 2023. The community does not allow voice controlled electronic devices in resident rooms. There have not been any electronic voice controlled devices in any resident rooms in the past.

Licensee's Proposed Overall Completion Date: *04/12/2023*

Update: *04/10/2023*

- *Beginning (INSERT DATE), the (INSERT STAFF TITLE) will complete monthly inspections of the home and resident rooms to ensure electronic communication devices are not present. If any devices are found in the home, the home will remove the device immediately or update their current policy surrounding the use of such devices.*
- *Staff will receive training by the (INSERT STAFF TITLE) by (INSERT DATE) to routinely inspect resident rooms and common areas for the use of electronic communication devices. Any devices found in the home will be reported to the (INSERT STAFF TITLE).*

Plan of Correction ***Accept 04/21/2023)***

All voice controlled electronic devices that are in public areas will be removed from the community by the Executive Director as of April 21, 2023. The community does not allow voice controlled electronic devices in resident rooms. There have not been any electronic voice controlled devices in any resident rooms in the past. Beginning April 21, 2023, a designee appointed by the Executive Director will be responsible for completing monthly inspections of the home and resident rooms to ensure electronic communication devices are not present. If any devices are found, they will be removed immediately.

42s - Privacy (continued)

Staff will receive training by the Resident Care Manager and Executive Director on May 9, 2023 to routinely inspect resident rooms and common areas for the use of electronic communication devices. Any devices found in the home will be reported to the Assistant Resident Care Manager and removed from the home immediately.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Evidence of Completion ***Implemented [redacted] - 07/24/2023)***

completed

60a - Staff/Support Plan

6. 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's staffing during overnight hours is insufficient to meet the needs of the residents as specified in the resident's assessments, support plans and staff interviews. The home has a current census of 74 residents with 28 residents in the Secured Dementia Care Unit(SDCU). There are 34 residents in the home who are immobile, 9 residents who require a 2-person assist for transfers of wh ch a minimum of 4 residents require a 2-person lift/transfer via Hoyer-lift. Additionally, there are 2 residents that receive informal 1:1 supervision due to their behavioral needs per staff interviews. Staff interviews also report residents are not receiving personal care in a timely manner, such as with oral hygiene and toileting assistance. On 3/24/2023, the home had 6 staff members participating in a fire drill evacuation process which included the home's Administrator. As evidenced in violation 2600.132(d), the home was unable to evacuate the residents from the area of the simulated fire within the time specified by the fire safety expert.

Plan of Correction ***Do Not Accept ([redacted] - 04/13/2023)***

The community is staffed to meet the needs of our current resident population. In March, the 16th through the 31st, our hours were over regulated hours and more than 25% of the hours budgeted for any day are during the "sleeping hours". As a community, we strive to meet the needs of our residents by staffing above and beyond state required guidelines.

We are starting the pro ect to correct this issue of the evacuation time for our fire drills by identifying 3 rooms on memory care and 2 on personal care that we are going to be designated for residents requiring lifts. All current residents that require lifts and any new residents requiring a lift will be in these designated rooms. On 4/5/23, we are having a contractor come to the community to start the widening of the doorways of these 5 rooms, so we can evacuate the residents at night while they are sleeping in their beds. We can evacuate residents to the fire safe areas by wheeling the beds out of the rooms, which will save significant time. The designated rooms are 101 and 103 in traditional personal care since they are right next to the lobby and dining room which are designated fire safe areas. The 3 rooms in memory care will be 500, 501, and 502. These rooms are at the end of the 500 hall and are easily and quickly accessible to both fire safe areas in memory care.

The goal on night shift- 10:30p-6:30am is to have a minimum of 40 hours of resident care. As of 4/3/23, we hired and started 2 full time direct care staff for night shift. As of 4/10/23, we will have another full time care staff on night shift. This will be sufficient to meet the care needs of our residents. RCM, ARCM, and Executive Director will ensure compliance by having a minimum of 40 direct care hours are available during night shift as of 4/15/23.

Licensee's Proposed Overall Completion Date: *05/31/2023*

60a - Staff/Support Plan *(continued)*

Update: *04/13/2023*

- *An interim staffing plan will need to be implemented during the home's project to widen doorways.*
- *The home may need to reach out to Labor and Industry or the local building authority for appropriate permitting or to obtain a new certificate of occupancy, if needed.*
- *There should be an assessment of all residents with mobility needs including any residents with a Hoyer lift to determine if their needs can be met in personal care.*
- *An additional night time fire drill held in the SDCU will need to be held within 30 days of the approval of this plan to ensure staffing levels are sufficient to evacuate all residents within the safe evacuation time.*
- *After the project to widen doorways is complete, an additional fire drill will be held during the overnight hours in the SDCU-please include a projected completion date of the home's renovation.*

Plan of Correction ***Accept (CR - 04/25/2023)***

To ensure that the community is meeting the needs of all of our residents, the Resident Care Manager and Assistant Resident Care Manager have reassessed all residents with mobility needs which include any resident with a Hoyer lift to ensure that the community can meet their needs. This was completed on April 20, 2023 by reviewing their Resident and Support plan to make sure that their individual needs are being met. After this assessment, it was determined that 5 residents were inappropriate for personal care services because of their care needs. Resident #3 was discharged to a skilled facility on 4/17/23. Resident #2, along with 2 other residents were issued 30 day notices due to their care needs being too high for personal care services on 4/12 and 4/20/23. 1 other resident with a lift will be transferring to a skilled facility the week of 4/24/23 (Date TBD) This will leave 2 residents with mechanical ifts in the community. These residents will be moved to seperate hallways to redistribute the heavier care residents and to accomodate evacuation ease by April 28, 2023. As a community, we strive to meet the needs of our residents by staffing above and beyond state required guidelines.

We are starting the pro ect to correct this issue of the evacuation time for our fire drills by identifying 3 rooms on memory care and 2 on personal care that we are going to be designated for residents requiring lifts. All current residents that require lifts and any new residents requiring a lift will be in these designated rooms. These 5 rooms will have widened doorways, so we can evacuate the residents at night while they are sleeping in their beds. We can evacuate residents to the fire safe areas by wheeling the beds out of the rooms, which will save significant time. The designated rooms are 101 and 103 in traditional personal care since they are right next to the lobby and dining room which are designated fire safe areas. The 3 rooms in memory care will be 500, 501, and 502. These rooms are at the end of the 500 hall and are easily and quickly accessible to both fire safe areas in memory care. The projected completion date of the homes renovations to widen the 5 doors will be 8/2023.

The goal on night shift- 10:30p-6:30am is to have a minimum of 40 hours of resident care. As of 4/17/23, we hired and started 4 full time direct care staff for night shift. This will be sufficient to meet the care needs of our residents. RCM, ARCM, and Executive Director will ensure compliance by having a minimum of 40 direct care hours available during night shift as of 4/15/23.
An additional night time fire drill will be held in the SDCU within 30 days of the approval of this plan of correction to ensure staffing levels are sufficient to evacuate all residents in the fire safe zone within the safe evacuation time.
After the project to widen the doorways is complete, an additional fire drill will be held during the overnight hours in the SDCU.

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

60a - Staff/Support Plan *(continued)*

Evidence of Completion ***Implemented ([redacted] - 07/24/2023)***

completed

132d - Evacuation

7. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the fire drill on 3/24/2023 at 6:06 AM, the home exceeded the maximum safe evacuation time specified in writing by a fire safety expert of 7 minutes. The simulated fire was located in the Secured Dementia Care Unit's (SDCU) dining room area. The evacuation time to remove residents from the direct fire area and into a fire safe zone was 11 minutes and 50 seconds. The total time to ensure all residents in the SDCU were prepared for evacuation in the fire safe zone was 16 minutes and 50 seconds. During the fire drill, there were 6 staff members assisting the residents with the evacuation process. However, all 6 staff members were in the SDCU. Staff did not alert residents residing in the personal care units to be awake and ready to evacuate from the fire safe area if necessary or ensure the fire safe doors were closed and sealed.

Plan of Correction ***Do Not Accept ([redacted] - 04/13/2023)***

The evacuation time of 7 minutes is reasonable based on the fire safety expert with Keystone Management on our annual fire safety inspection on August 17, 2022. This is due to the construction and design of our community. There are 7 fire safe areas in our community. The monthly fire drills of our community have always been within the 7 minute timeline. See attached for 2022 and 2023.
The time was not met on the fire drill on 3/24/23 due to 4 residents that require the use of a hoyerlift. To correct this ssue, we have identified 3 rooms on memory care and 2 on personal care that we are going to designate for residents requiring lifts. All current residents that require lifts and any new residents requiring a lift will be in these designated rooms. On 4/5/23, we are having a contractor come to the community to start the widening of the doorways of these 5 rooms, so we can evacuate the residents at night while they are sleeping in their beds. We can evacuate residents to the fire safe areas by wheeling the beds out of the rooms, which will save significant time. The designated rooms are 101 and 103 in traditional personal care since they are right next to the lobby and dining room which are designated fire safe areas. The 3 rooms in memory care will be 500, 501, and 502. These rooms are at the end of the 500 hall and are easily and quickly accessible to both fire safe areas in memory care. (see attached floor plan).

Maintenance Manager and Executive Director will continue to train all staff upon hire and annually on fire drill procedures. Monthly drills on all 3 shifts will continue with training. When the doors are widened on the above rooms, a mandatory training for all care staff will be completed by Maintenance Manager and Executive Director to educate on new procedure of evacuating in beds at night, if the resident requires a lift, and correct drill procedures.

Licensee's Proposed Overall Completion Date: *05/31/2023*

Update: *04/13/2023*

- *What is going to be put in place until the home renovations are completed to ensure the home can safely evacuate all residents during a fire drill or in the event of an emergency?*

132d - Evacuation (continued)

- *Please provide a training to residents and staff members on their responsibilities during fire drill evacuations. Also include a training to all staff members on how to properly read the fire panel to notify staff where the fire is located in the home. Please include the date of the training and the person responsible for conducting the training.*
- *The home may need to reach out to Labor and Industry or the local building authority for appropriate permitting or to obtain a new certificate of occupancy, if needed.*
- *An additional night time fire drill held in the SDCU will need to be held within 30 days of the approval of this plan to ensure staffing levels are sufficient to evacuate all residents within the safe evacuation time.*
- *After the project to widen doorways is complete, an additional fire drill will be held during the overnight hours in the SDCU-please include a projected completion date of the home's renovation.*

Plan of Correction ***Directed ([redacted] - 04/25/2023)***

The evacuation time of 7 minutes is reasonable based on the fire safety expert with Keystone Management on our annual fire safety inspection on August 17, 2022. This is due to the construction and design of our community. There are 7 fire safe areas in our community. The monthly fire drills of our community have always been within the 7 minute timeline. See attached for 2022 and 2023.
The time was not met on the fire drill on 3/24/23 due to 4 residents that require the use of a hoyer lift. To correct this issue, we have identified 3 rooms on memory care and 2 on personal care that we are going to designate for residents requiring lifts. All current residents that require lifts and any new residents requiring a lift will be in these designated rooms. The project to widen the doorways of these 5 rooms is projeced to be done by 8/2023. We can then evacuate the residents at night while they are sleeping in their beds. We can evacuate residents to the fire safe areas by wheeling the beds out of the rooms, which will save significant time. The designated rooms are 101 and 103 in traditional personal care since they are right next to the lobby and dining room which are designated fire safe areas. The 3 rooms in memory care will be 500, 501, and 502. These rooms are at the end of the 500 hall and are easily and quickly accessible to both fire safe areas in memory care. (see attached floor plan).

n the interim, the community has discharged Resident #3 due to care needs. 4 more residents with hoyer lifts will be discharged by the end of May 2023. The 4 residents have all been issued 30 day notices by the Executive Director to move to a more appropriate level of care. Without the residents that require mechanical lifts, the safe evacuation time will be reached.

On May 9, 2023 at 2pm, our Maintenance Manager, who is a certified fire safety trainer, will train all of the staff at the staff meeting on their responsibilities during fire drill evacuations. This training will include how to properly read the fire panel to notify staff where the fire is located within the home.
The residents will be trained at 12pm on 5/9/23 on their responsibilities during fire drill evacuations.

Maintenance Manager and Executive Director will continue to train all staff upon hire and annually on fire drill procedures. Monthly drills on all 3 shifts will continue with training. When the doors are widened on the above rooms, a mandatory training for all care staff will be completed by Maintenance Manager and Executive Director to educate on new procedure of evacuating in beds at night, if the resident requires a lift, and correct drill procedures.

Directed)

- *An additional night time fire drill held in the SDCU will be held within 30 days of the approval of this plan to ensure staffing levels are sufficient to evacuate all residents within the safe evacuation time.*
- *After the project to widen doorways is complete, an additional fire drill will be held during the overnight*

132d - Evacuation (continued)

hours in the SDCU.

Directed Completion Date: *08/31/2023*

Evidence of Completion ***Implemented (- 07/24/2023)***

See attached.

202 - Prohibitions

8. Requirements

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

Description of Violation

The use of drugs for the specific and exclusive purpose of controlling acute or episodic aggressive behavior is prohibited. Resident #1 is prescribed which is administered once daily for increased sexual behaviors.

Plan of Correction ***Do Not Accept - 04/06/2023)***

The medication for Resident #1 has been discontinued. This resident is on hospice and all of by mouth medications have been discontinued per Hospice recommendation and doctor orders. See attached physician orders.

An audit will be completed of all resident's medications by RCM and ARCM to ensure that there are no medications prescribed for the sole purpose of controlling acute or episodic behaviors. This will be completed by April 21st. If there are any found, RCM will communicate with physician to seek alternative methods that are non pharmacological.

Licensee's Proposed Overall Completion Date: *04/21/2023*

Update: *04/06/2023*

On (INSERT DATE), the medication for Resident #1 was discontinued.

Plan of Correction ***Accept - 04/21/2023)***

On April 3,2023, the medication for Resident #1 has been discontinued. This resident is on hospice and all of his by mouth medications have been discontinued per Hospice recommendation and doctor orders. See attached physician orders.

An audit will be completed of all resident's medications by RCM and ARCM to ensure that there are no medications prescribed for the sole purpose of controlling acute or episodic behaviors. This will be completed by April 21st. If there are any found, RCM will communicate with physician to seek alternative methods that are non pharmacological.

202 - Prohibitions (continued)

Licensee's Proposed Overall Completion Date: *04/21/2023*

Evidence of Completion ***Implemented (- 07/24/2023)***

completed

234b - Support Plan Needs Elements

9. 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 , for Resident #6 does not address the resident's needs for staff assistance when transferring in/out of bed/chair, the use of an alarm on the resident's wheelchair and bed to alert staff when the resident is attempting to stand or ambulate or the resident's supervision needs. Staff interviews conducted on 3/14/2023 report Resident #6 requires the resident to be within visual field at all times as resident will fall if the resident attempts to stand or walk. Currently, the support plan states Resident #6 can ambulate independently with the use of a rolling walker, however the resident is unable to ambulate safely without the assistance of direct care staff members and utilizes a wheelchair for mobility needs. The support plan dated does not include Resident #6's aggression towards staff members or need for supervision during mealtime to prevent the resident from stealing other resident's food as reported by staff interviews.

The support plan, dated , for Resident #1 does not address the resident's sexual behaviors. On 1/29/2023, direct care staff member's observed Resident #1 sexually rubbing his/her body while standing over staff who were performing care on Resident #1's roommate. Direct Care staff member's currently provide support to Resident #1 by redirecting Resident #1 from his/her room in order to provide care for Resident #1's roommate.

Plan of Correction ***Do Not Accept (- 04/06/2023)***

The support plan for resident #6 was redone on as a significant change. (See attached). The new RASP ncludes the resident's need for assistance when transferring in and out of bed/chair. It also includes the use of the bed and chair alarm to alert the staff when the resident is attempting to stand or ambulate independently. The RASP also includes the resident's current supervision needs. The resident does not require the staff to be within isual field at all times, as his condition has declined to the point where he is not attempting to get out of his chair ndependently. The RASP also includes the resident's need for a wheelchair for his mobility needs. The support plan does address the resident's infrequent aggressive behavior when staff is attending to his personal care needs. The RASP also addresses need for supervision when in the dining room and encouragement to eat only own food.

Resident #1's RASP was updated on on the RASP addendum. (See attached) On , the RASP addressed the resident's increased sexual behaviors with self- masturbation. Resident was moved to a private room on when it became available, so that could have more privacy. On Resident #1's RASP was again updated to show his decline in condition and end of life need for only comfort measures at this time.

RASPs will be updated daily as resident care needs change. RCM and ARCM will read the daily report in Point Click Care that discusses all resident changes that have occurred in the past 24 hours and discuss all residents with the

234b - Support Plan Needs Elements (continued)

care staff during daily stand up meetings that are held on business days. Any change that needs to be added to the RASP for a resident will be done by the next business day and communicated to the staff. This double check has started as of 4/4/23. Executive Director will ensure compliance by also reading the daily communication on PCC and double check that changes were made on the RASP if necessary.

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

Update: *04/06/2023*

- *Please include the staff member's title who updated Resident #6's RASP on* [redacted]
- *Please include the staff member's title who updated Resident #1's RASP on* [redacted].
- *Please add a start date (day/month/year) that the RCM and ARCM will re view daily reports.*
- *Please identify the staff member's title that will add any changes to resident RASP's within the next business day.*
- *Please add a start date (day/month/year) that the ED will begin reviewing daily communication and checking the resident RASP's.*
- *An initial audit of all remaining resident RASP's will need to be completed to ensure their RASP's provide appropriate support for their physical, medical, social, cognitive and safety needs. Please identify when the audit will be completed by as well as the staff member's titles responsible; be prepared to submit documentation of the completed audit.*

Plan of Correction ***Accept ([redacted] - 04/21/2023)***

The support plan for resident #6 was redone by the Resident Care Manager, LPN [redacted] *as a significant change. See attached). The new RASP includes the resident's need for assistance when transferring in and out of bed/chair. t also includes the use of the bed and chair alarm to alert the staff when the resident is attempting to stand or ambulate independently. The RASP also includes the resident's current supervision needs. The resident does not require the staff to be within visual field at all times, as his condition has declined to the point where he is not attempting to get out of his chair independently. The RASP also includes the resident's need for a wheelchair for his mobility needs. The support plan does address the resident's infrequent aggressive behavior when staff is attending to his personal care needs. The RASP also addresses his need for supervision when in the dining room and encouragement to eat only his own food.*

Resident #1's RASP was updated on [redacted] *on the RASP addendum by the Resident Care Manager, LPN. (See attached) On* [redacted] *RASP addressed the resident's increased sexual behaviors with self-masturbation. Resident was moved to a private room on* [redacted] *when it became available, so that* [redacted] *could have more privacy. On 4/3/23, Resident #1's RASP was again updated to show his decline in condition and end of life need for only comfort measures at this time.*

RASPs will be updated daily starting April 4, 2023 as resident care needs change. RCM and ARCM will read the daily report in Point Click Care that discusses all resident changes that have occurred in the past 24 hours and discuss all residents with the care staff during daily stand up meetings that are held on business days. Any change that needs to be added to the RASP for a resident will be done by the next business day and communicated to the staff. The RCM or the ARCM will add these changes to the RASP and communicate tto the staff. This double check has started as of 4/4/23. Executive Director will ensure compliance by also reading the daily communication on PCC and double check that changes were made on the RASP if necessary. This was started on 4/4/23.
An initial audit of all resident's RASPs will be completed by 5/15/23 by the Resident Care Manager and the

234b - Support Plan Needs Elements (continued)

Assistant Resident Care Manager. This audit will be completed to ensure that the resident's RASPs provide appropriate support for their physical, medical, social, cognitive, and safety needs. Documentation of this initial audit will be submitted to the Department at completion.

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

Evidence of Completion ***Implemented (- 07/24/2023)***

completed