

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

December 4, 2023

[REDACTED], PRESIDENT AND CEO
ARTIS SENIOR LIVING OF LOWER MORELAND LLC
[REDACTED]

RE: ARTIS SENIOR LIVING OF
HUNTINGDON VALLEY
2085 LIEBERMAN DRIVE
HUNTINGDON VALLEY, PA, 19006
LICENSE/COC#: 14279

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/11/2023 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: ARTIS SENIOR LIVING OF HUNTINGDON VALLEY **License #:** 14279 **License Expiration:** 07/18/2023
Address: 2085 LIEBERMAN DRIVE, HUNTINGDON VALLEY, PA 19006
County: MONTGOMERY **Region:** SOUTHEAST

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: ARTIS SENIOR LIVING OF LOWER MORELAND LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I-2 **Date:** 10/13/2016 **Issued By:** Township of Lower Moreland

Staffing Hours

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

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 09/11/2023

Inspection Dates and Department Representative

09/11/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 72 **Residents Served:** 61

Secured Dementia Care Unit

In Home: Yes **Area:** Entire Community **Capacity:** 72 **Residents Served:** 61

Hospice

Current Residents: 17

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 60
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 61 **Have Physical Disability:** 0

Inspections / Reviews

09/11/2023 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 10/15/2023

10/30/2023 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 11/24/2023
Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 11/04/2023

Inspections / Reviews (*continued*)

11/03/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/24/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 11/24/2023

12/04/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/24/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

3c - Post Current License

1. Requirements

2600.

- 3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 9/11/23 the home's license, which expired July 8, 2023, was posted in a conspicuous and public place in the home. However, the home did not have a current license posted.

Plan of Correction

Accept ([REDACTED] - 11/03/2023)

In response to the violation on 09/11/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken by the Executive Director to obtain the current license. The home did not receive their new license in a timely manner. The home's license is current.

On 09/12/2023 the incident was reviewed with the Director of Business Services and education on the regulation was provided by the Executive Director. The Executive Director will ensure the licensing recertification process is timely, a calendar reminder has been set up for the Executive and the Director of Business Services. Effective 9/12/23, the Executive Director will monitor the posting board during daily rounds to ensure that required postings are in place and current. Any deficiency will be addressed immediately and discuss at the quarterly quality assurance meeting by the Executive Director. The monitoring is indefinite.

Proposed Overall Completion Date: 11/03/2023

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented ([REDACTED] - 12/04/2023)

25b - Contract Signatures

2. Requirements

2600.

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

Description of Violation

The resident-home contract, dated [REDACTED], for resident #1 was not signed by the resident.

The resident-home contract, dated [REDACTED], for resident #2 was not signed by the resident.

The resident-home contract, dated [REDACTED] for resident #3 was not signed by the resident.

Repeated Violation: 7/21/22 et al,

Plan of Correction

Accept ([REDACTED] 11/03/2023)

On 9/11/2023 Immediate action was taken by the Executive Director to obtain the signatures from the residents. On 9/12/23 and audit of all the business files for missing residents' signature was conducted by the Executive Director and the director of Sales and Marketing. on 9/12/23, the incident was also reviewed with the Director of Sales Marketing and education on the regulation was provided by the Executive Director. Effective 9/12/2023, The Executive Director or designee will review all move in paperwork and conduct monthly audit of the business files, any deficiencies will be corrected immediately, and findings will be documented and reviewed during quarterly quality

25b - Contract Signatures (continued)

assurance meeting for continuous improvement purposes. The Executive Director will report any abnormal finding at QAPI. These audits are ongoing and indefinite.

Proposed Overall Completion Date: 11/03/2023

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented (█) - 12/04/2023)

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.

Resident #2 's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Resident #3 's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Repeated Violation: 7/21/22 et al

Plan of Correction

Accept (█) - 11/03/2023)

In response to the violation on 09/11/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken to obtain signatures from the residents #1 #2 and #3. On 9/12/23 an audit of all the business files for the residents' rights and complaint procedure was conducted by the Executive Director and Director of Sales and Marketing. On 9/12/23 the incident was also reviewed with the Director of Sales Marketing and education on the regulation was provided by the Executive Director. Effective 9/12/23, the Executive Director or designee will review all move in paperwork and conduct quarterly audit for signed receipt resident rights and complaint procedures. Any deficiencies will be corrected immediately, and findings will be documented and reviewed during quarterly quality assurance meeting by the Executive Director for continuous improvement purposes. These audits are ongoing and indefinite.

Proposed Overall Completion Date: 11/03/2023

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented (█) - 12/04/2023)

81b - Resident Personal Equipment**4. Requirements**

81b Resident Personal Equipment (continued)

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 9-11-23, at 12:07pm, Staff person A, was observed pushing resident #5 in the wheelchair, without the proper foot pedals.

Plan of Correction

Accept () - 11/03/2023)

In response to the violation on 09/11/2023 by the Pennsylvania Bureau of Human Service and Licensing, immediate action was taken by the staff and the leg rest was added to wheelchair. The leg rest was not present because resident # 5 is able to propel himself in the wheelchair. On 9/18/23 and 10/12/23 all staff including, direct care, culinary, nursing and housekeeping staff were educated about the incident by the Health and Wellness Director and Assistant Health and Wellness Director. On 10/12/23 leg rest bags were also added to residents' wheelchairs to ensure the leg rests are available to staff when transporting residents who can propel themselves. Effective 9/12/23, the Director of Health and Wellness and the Assistant Director of Health and Wellness will monitor daily during rounds, any deficiency will be corrected immediately and reviewed at the quarterly quality assurance meeting by the Director of Health and Wellness effective 9/12/23. The monitoring for wheelchair leg rests is indefinite.

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented () - 12/04/2023)

82c Locking Poisonous Materials**5. 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

() with a manufacture's label indicating "If accidentally swallowed contact Poison Control", were unlocked, unattended, and accessible to resident in room #115. The residents in memory care, have not been assessed capable of recognizing and using poisons safely.

() with a manufacture's label indicating "If accidentally swallowed contact Poison Control ", were unlocked, unattended, and accessible to resident in room #205. The residents in memory care, have not been assessed capable of recognizing and using poisons safely.

() with a manufacture's label indicating "If accidentally swallowed contact Poison Control ", were unlocked, unattended, and accessible to resident in room #307. The residents in memory care, have not been assessed capable of recognizing and using poisons safely.

A bottle of () with a manufacture's label indicating "If accidentally swallowed contact Poison Control ", were unlocked, unattended, and accessible to resident in room # 416. The residents in memory care, have not been assessed capable of recognizing and using poisons safely.

Plan of Correction

Accept () - 11/03/2023)

On 9/11/23 Immediate action was taken to lock the medicine cabinet. The Director of Health and Wellness and his

82c Locking Poisonous Materials (continued)

assistant conducted a walkthrough of the rooms to ensure all poisonous materials were locked. On 9/12/23 the Executive Director and the Director of environmental services conducted an inspection of all the medicine cabinets to ensure they lock properly. On 9/18/23 the Director of Health and Wellness educated the Direct Care and Nursing staff on the regulation and instructed them to notify maintenance of any malfunction, immediately. Effective 9/12/23, the Director of Health and Wellness and his assistant will monitor weekly, any deficiency will be corrected immediately to ensure compliance. The weekly monitoring is indefinite.

Proposed Overall Completion Date: 11/03/2023

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented (█) - 12/04/2023)

85a - Sanitary Conditions**6. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 9 11 23, the following areas had concerns with sanitation:

- 11:42am, there was blood on the white bench in the common area of the home.
- 1:42pm, in room #318 the toilet seat and sink were stained with feces, the trash contained a paper towel with feces.

Plan of Correction

Accept (█) - 11/03/2023)

In response to the violation on 09/11/2023 by the Pennsylvania Bureau of Human Service and Licensing, immediate action was taken by the action was taken by the housekeeping staff to clean the bench and the toilet seat stained with feces. On 9/11 an inspection of all the other benches and residents' toilet seats was also conducted by the Executive and Maintenance Directors; blood or fecal stains were identified. On 9/12/23 an inspection of all the common area seating surfaces and residents' toilet seats was conducted by the Executive Director and the Director of environmental services, no blood or feces stains were identified. On 9/18/23 housekeeping staff was educated and informed by the Maintenance Director of the cleaning expectations were reviewed. Effective 9/12/23, Inspection of the common area seating and residents' bathrooms will be conducted daily by the housekeeping staff and the Director of environmental services effective 9/12/23. Any deficiency will be corrected immediately. The daily monitoring is indefinite.

Proposed Overall Completion Date: 11/03/2023

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented (█) - 12/04/2023)

95 Furniture and Equipment

7. Requirements

2600.

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

Description of Violation

The shower curtain in room #307 was on the floor in the corner of the shower, the curtain was not hung properly.

Plan of Correction

Accept (█ - 11/03/2023)

Immediate action was taken on 9/11 by the maintenance Director to hang the curtain in room #307. On 9/12 a walkthrough of all the rooms was conducted by the Executive and maintenance Directors, all other shower curtains were hung properly. On 9/18/22 training on reporting furniture and equipment malfunction was provided to the housekeeping and direct care staff by the Maintenance Director. Effective 9/12/23, Inspection of the shower curtains will be conducted daily by the housekeeping and direct care staff. Any deficiency will be reported in TELS, our maintenance request reporting tool and to the Director of environmental services. Effective 9/12/23, ongoing monitoring will be achieved through weekly inspection of the shower curtains by the Director of environmental services and the Executive Director. The weekly monitoring is indefinite.

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented (█ - 12/04/2023)

96a First Aid Kit

8. Requirements

2600.

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

Description of Violation

The first aid kit in neighborhood "one hundred" does not include antiseptic and gloves.

Plan of Correction

Accept (CM - 11/03/2023)

Immediate action was taken on 9/11 to add antiseptic and gloves to the first aid kit. On 9/18/23 the Health and Wellness Director educated the direct care and nursing staff on first aid kit content and replacing items from the kits when used. On 9/18/23, 4 new additional first aid kits were added, one for each neighborhood by the Executive Director. Effective 9/18/23, Charge nurses to inspect the first aid kits on Fridays after their cart audits, any deficiency will be corrected immediately. The Health and Wellness Director and Assistant Director of Health and wellness will monitor weekly to ensure ongoing compliance, effective 9/12/23. The weekly monitoring is indefinite.

Proposed Overall Completion Date: 11/03/2023

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented (█ - 12/04/2023)

101j2 Bedroom Chairs

9. Requirements

2600.

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

101j2 - Bedroom Chairs (continued)

Description of Violation

Bedroom # 318 is occupied by 1 resident; however, the chair was missing from the room.

Plan of Correction

Accept () - 11/03/2023)

Immediate action was taken on 9/11 by the Executive Director to replace the chair #318. On 9/12 a walkthrough of all the rooms was conducted by the Executive Director and the Maintenance Directors, a chair was present in all the other rooms. Effective 9/12/23, Inspection of the rooms for missing chairs will be conducted daily by the housekeeping and direct care staff and Assistant Director of Health. Any missing chair will be replaced immediately. On 9/18/23 the Maintenance Director educated the direct care and housekeeping staff on making daily rounds and looking for missing chairs. Effective 9/12/23, the executive Director and the Director of environmental services will monitor for ongoing compliance during weekly rounds. These rounds are indefinite.

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented () - 12/04/2023)

103g - Storing Food

10. Requirements

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

Description of Violation

The bread, cheese, and water bottles in the refrigerator located in neighborhood "one hundred" were not labeled and dated.

Plan of Correction

Accept () - 11/03/2023)

Immediate action was taken on 9/11 by the direct care staff to remove the bread, cheese and water bottles in the 100 neighborhoods. On 9/11/23, the Director of Culinary services conducted a walkthrough of all the neighborhoods refrigerators, no other items were found unlabeled and not dated. Effective 9/12/23, an inspection of all the neighborhood refrigerators will be conducted daily by the Director of Culinary Services or designee, any deficiency will be corrected immediately. Effective 9/12/23, ongoing monitoring will be maintained through weekly rounds by the Executive Director or designee. These rounds are indefinite.

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented () - 12/04/2023)

124 - Notice to Fire Department

11. Requirements

- 2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction

Accept () - 11/03/2023)

124 Notice to Fire Department (continued)

Immediate action was taken on 9/11 by the Executive Director to notify the local fire department. The local fire department was also notified via an email dated 1/3/23 sent to the local fire department with the emergency plan attached. Fire chief confirmed receipt. On 9/12/23 the Director of environmental services was educated on the regulation and documentation of notification to the local fire chief by the Executive Director. Effective 9/12/23, ongoing compliance will be maintained through quarterly review of the survey ready binder by the Executive Director at the quality assurance meeting. This quarterly review is indefinite.

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented (██████) - 12/04/2023)

132b - Safety Inspection/Fire Drill**12. Requirements**

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home did not have records of any of the past fire safety inspections or supervised drills.

Plan of Correction

Accept (██████) - 11/03/2023)

Immediate action was taken on 9/11 by the Executive Director to reach out the Fire safety expert ██████████. Root cause analysis of the incident indicated improper training of the Director of environmental Services. The fire safety expert, ██████████ conducted a successful fire drill at the home 9/13/23. The regulation was reviewed with the Director of environmental services and education was provided by the Executive Director. Effective 9/12/23, The Executive Director will review and monitor the maintenance record monthly for compliance any deficiency will be corrected and reviewed at quarterly quality assurance meeting by the Executive Director. Ongoing monitoring will be achieved through monthly audit of the maintenance record by the Executive Director effective 9/12 23. These audits are indefinite.

Proposed Overall Completion Date: 11/03/2023

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented (██████) /04/2023)

141a 1-10 Medical Evaluation Information**13. Requirements**

2600.

141a 1-10 Medical Evaluation Information (continued)

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

Description of Violation

The medical evaluation for resident #1 did not include allergies and medication.

Repeated Violation: 5/22/23

Plan of Correction

Accept (████ - 10/30/2023)

On 9/11/23 immediate action was taken by the Director Health and wellness to revise resident #1’s medical evaluation. On 9/12/23 and 9/13/23 and audit of the medical evaluation for all resident files was conducted by the Director of Health and Wellness Director and the assistant Director of Health and Wellness Director to ensure compliance. Effective 9/12/23, the Executive Director or designee will monitor by reviewing all medical evaluation forms prior to admission. The Director of Health and Wellness Director and the assistant Director of Health and wellness will also monitor through quarterly charts audits; these audits are indefinite.

Licensee's Proposed Overall Completion Date: 10/31/2023

Implemented (████ - 12/04/2023)

141b1 - Annual Medical Evaluation

14. Requirements

2600.

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

Description of Violation

Resident # 6’s most recent medical evaluation was completed on ██████████ The resident’s previous medical evaluation was completed on ██████████

Plan of Correction

Accept (████ - 10/30/2023)

On 9/12/23 and 9/13/23 and audit of the medical evaluation for all resident files was conducted by the Director of Health and Wellness Director and the assistant Director of Health and Wellness Director to ensure compliance, no deficiency was noted. Effective 9/12/23, The Director of Health and Wellness and the assistant Director of Health and wellness will monitor monthly through the annual medical evaluation tickler file and quarterly charts audits; these audits are indefinite.

Licensee's Proposed Overall Completion Date: 10/31/2023

Implemented (████ - 12/04/2023)

183b - Meds and Syringes Locked

15. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On [REDACTED], the following over the counter medications were unlocked, unattended, and accessible in the medication cabinet in the bathroom of room #205:

- [REDACTED]
- [REDACTED]
- [REDACTED]

Plan of Correction

Accept [REDACTED] - 11/03/2023)

Immediate action was taken on 9/11 to lock the medicine cabinet in #205. On 9/12/23 the Executive Director and Maintenance Director conducted an inspection of all the medicine cabinets to ensure they lock properly. On 9/18/23 and 10/12/23 the Director of Health and Wellness and his assistant educated the direct care and nursing staff on the regulation and instructed them to notify maintenance of any malfunction, immediately. Effective 9/12/23, the Director of Health and Wellness and Assistant Director of Health and Wellness will monitor weekly during rounds to ensure compliance. The weekly monitoring is indefinite.

Proposed Overall Completion Date: 11/03/2023

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented [REDACTED] - 12/04/2023)

185a - Implement Storage Procedures

16. 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

On 9-11-22, the glucometer for resident #5 was not calibrated to the correct time. The glucometer was reviewed at [REDACTED]; the screen display read [REDACTED].

Repeated Violation: 7/21/22 et al

Plan of Correction

Accept [REDACTED] - 11/03/2023)

Immediate action was taken on 9/11/23 by the Health and Wellness Nurse to calibrate the glucometer. The glucometer was calibrated to the correct time. On 9/11/23 and an audit of all other glucometers was also conducted by the Health and Wellness Nurse. All glucometers are calibrated to the correct time. On 9/18/23 Health and Wellness Nurses were educated on glucometer calibration by the Director of Health and Wellness. Effective 9/18/23, Health and Wellness Nurses will inspect the glucometers on Fridays during their weekly cart audits. The Director of Health and Wellness and assistant Director Health and wellness will monitor weekly to ensure ongoing compliance, effective 9/12/23. The weekly monitoring is indefinite.

185a - Implement Storage Procedures (continued)

Proposed Overall Completion Date: 11/03/2023

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented (████ - 12/04/2023)

191 - Resident Right to Refuse**17. 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

The following residents' did not have the resident right to refuse signed :

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.

Resident #2 , admitted ██████ has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident #4 , admitted ██████, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction

Accept (████ - 11/03/2023)

On 9/11/23 Immediate action was taken to obtain signatures from residents #1 #2 and #4. On 9/12/23 and audit of all the business files for the residents' rights to refuse medication if the resident believes that there may be a medication error was conducted by the Executive Director and Director of Sales and Marketing. On 9/12/23 the incident was also reviewed with the Director of Sales Marketing and education on the regulation was provided by the Executive Director. Effective 9/12/23, the Executive Director or designee will review all move in paperwork and conduct quarterly audit of the business files to ensure compliance. These audits will be indefinite.

Proposed Overall Completion Date: 11/03/2023

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented (████ - 12/04/2023)

227g -Support Plan Signatures**18. 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 following support plans were missing signatures:

Resident #1 participated in the development of his/her support plan on [REDACTED]. However, the resident did not sign the support plan.

Resident #2 participated in the development of his/her support plan on [REDACTED]. However, the resident did not sign the support plan.

Resident #3 participated in the development of his/her support plan on [REDACTED]. However, the resident did not sign the support plan.

Resident #4 participated in the development of his/her support plan on [REDACTED]. However, the resident did not sign the support plan.

Resident #5 participated in the development of his support plan on [REDACTED]. However, the resident did not sign the support plan.

Plan of Correction

Accept ([REDACTED] - 11/03/2023)

On 9/11/23 Immediate action was taken to obtain signatures from residents #1 #2 #3 and #4. On 9/12/23 the violation was reviewed with the Director of Health and Wellness and education on the regulation was provided by the Executive Director. On 9/12/23 and 9/13/23 an audit of all the residents' support plan for missing signature was conducted by the Director of Health and Wellness and assistant Director of Health and Wellness and the charts were updated. Effective 9/12/23, the Director of Health and Wellness or designee will monitor through quarterly audits of the support plans for missing signatures to ensure ongoing compliance. These quarterly audits will be ongoing.

Proposed Overall Completion Date: 11/03/2023

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented ([REDACTED] - 12/04/2023)

231c - Preadmission Screening

19. Requirements

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident # 1 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]. However, the resident # 1 's written cognitive preadmission screening was not completed the elements of the form were missing the following:

Name and signature of the assessor

Date assessment completed

Necessity for Secured Care Unit

231c Preadmission Screening (continued)

Plan of Correction

Accept [REDACTED] - 11/03/2023)

On 9/11/23 Immediate action was taken by the Director of Health and Wellness and the prescreening for resident #1 was revised. On 9/12/23 the regulation was reviewed with the Director of Health and Wellness and education on the regulation was provided by the Executive Director. On 9/12/23 and 9/13/23 an audit of all the residents' preadmission screening for missing information was conducted by the Director of Health and Wellness and assistant Director of Health and Wellness and the charts were updated. Effective 9/12/23, the Executive Director or designee will review all move in paperwork prior to admission to ensure compliance.

The Director of Health and Wellness or designee will monitor through quarterly audits of the preadmission screenings for missing signatures to ensure compliance. These quarterly audits will be ongoing.

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented [REDACTED] - 12/04/2023)

234a - Admission Support Plan

20. Requirements

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]. However, the resident's initial support plan was completed on [REDACTED].

Plan of Correction

Accept [REDACTED] - 11/03/2023)

On 9/11/23 immediate action was taken by the Director of Health and Wellness to review resident #1 's initial support plan. On 9/12/23 the regulation was reviewed with the Director of Health and Wellness and education on the regulation was provided by the Executive Director. On 9/12/23 and 9/13/23 and audit for all residents' initial support plans was conducted by the Director of Health and Wellness and the assistant Director of Health and Wellness. Ongoing monitoring will be achieved through monitoring of the tickler file and setting up outlook calendar reminders by the Director of Health and Wellness and the Assistant Director of Health and Wellness. Any deficiency will be reviewed at the quarterly quality assurance meeting. These audits are indefinite.

Proposed Overall Completion Date: 11/03/2023

Licensee's Proposed Overall Completion Date: 11/03/2023

Implemented [REDACTED] 12/04/2023)