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

February 28, 2024

[redacted], CORPORATE COMPLIANCE
[redacted]

RE: THE HEARTH AT DREXEL
238 BELMONT AVENUE
BALA CYNWYD, PA, 19004
LICENSE/COC#: 14062

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/11/2023, 10/12/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE HEARTH AT DREXEL* **License #**: *14062* **License Expiration**: *06/18/2024*

Address: *238 BELMONT AVENUE, BALA CYNWYD, PA 19004*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *MARY J DREXEL HOME*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *03/10/2014* **Issued By**: *Lower Merion Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *99* **Waking Staff**: *74*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *10/12/2023*

Inspection Dates and Department Representative

10/11/2023 - On-Site: [redacted]

10/12/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served**: *66*

Special Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *20* **Residents Served**: *17*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *66*

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

Have Mobility Need: *33* **Have Physical Disability**: *0*

Inspections / Reviews

10/11/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/18/2023*

12/15/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/20/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/18/2023*

Inspections / Reviews *(continued)*

01/22/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/20/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *01/25/2024*

02/28/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/20/2024*

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

3d Post license/VR/Regs

1. Requirements

2800.
3.d. The assisted living residence 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 assisted living residence.

Description of Violation

On 10/11/23, the residence's current violation reports, dated 07/06/23, 12/09/22, and 07/18/22, were not posted in a conspicuous and public place in the residence.

Plan of Correction ***Accept ([redacted] - 12/14/2023)***

All current licensing inspection summaries from the last annual licensing inspection have been posted in a conspicuous and public place on each of the residence's households. The Administrator will post licensing inspections surveys upon receipt. Completed on 10/13/23.

Licensee's Proposed Overall Completion Date: *12/07/2023*

Implemented ([redacted] - 02/28/2024)

15a Resident abuse report

2. Requirements

2800.
15.a. The residence 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], at approximately [redacted] a resident took off his/her shoe and struck another resident across the face. Both residents were sitting in a common area of the memory care unit. This incident was reported to the Department on [redacted]. However, this allegation of abuse was not reported to the local Area Agency on Aging.

Plan of Correction ***Accept ([redacted] - 01/19/2024)***

All staff in the community receive training annually on Recognizing and Reporting Abuse. All staff employed by the community are required to report abuse/suspected abuse by staff/resident/visitor to their immediate supervisor immediately. The Director of Nursing will report all incidents of abuse and/or suspected abuse to the Area Agency on Aging and The Department of Human Services upon discovery (immediately) in accordance with the required timeframe. Education on the reporting process completed on 10/13/23

Licensee's Proposed Overall Completion Date: *01/09/2024*

Implemented [redacted] 02/28/2024)

16c Incident reporting

3. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

16c Incident reporting (continued)

The residence is not reporting incidents in a timely manner:
On [redacted], a resident had a fall and sustained a fractured pubis. The residence did not report this incident to the Department until [redacted]
On [redacted], a resident's medication was administered outside the administration window resulting in a medication error. The residence did not report this incident to the Department until [redacted].
On [redacted] a resident took off his/her shoe and struck another resident across the face. Both residents were sitting in a common area of the memory care unit. This incident was not reported to the Department until [redacted]
On [redacted], a resident had a fall and sustained a closed fracture of shaft of right humerus. The residence did not report this incident to the Department until [redacted].
On [redacted] a resident was sent to the hospital for a change in mental status. The resident was admitted with [redacted]. The residence did not report this incident to the Department until [redacted]
On [redacted], the same resident listed immediately above had a fall in their room, was sent to the hospital and required surgery for left hip hemiarthroplasty. The residence did not report this incident to the Department until [redacted].

Plan of Correction ***Accept ([redacted] - 01/19/2024)***

The Director of Nursing or Nursing designee is responsible for reporting reportable incidents to the Department within 24 hours. The Director of Nursing or Assistant Director of Nursing will report all reportable incidents to the Department Monday-Friday. The LPN, Charge nurses will report all reportable incidents to the Department that occur on Saturday and Sunday.
Education on the reporting process completed on 10/13/23.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Implemented [redacted] - 02/28/2024)

17 Record confidentiality

4. Requirements

2800.
17. Confidentiality of Records - Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 10/11/23, at approximately 9:33 AM, the door to the medication room on the assisted living side was open leaving resident records unlocked and unattended.

Plan of Correction ***Accept [redacted] - 01/22/2024)***

All staff (Director of Nursing, Assistant Director of Nursing, LPN Charge Nurses, Medication Technicians, CNAs) will ensure the door to the Nursing Team Room where resident records are stored is closed and locked when unattended. Training is completed annually for all staff on HIPAA. Education on this violation was completed immediately upon discovery on 10/11/23.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Implemented ([redacted] 02/28/2024)

18 Other laws, regs, ordins.

5. Requirements

2800.
18. Applicable Health and Safety Laws A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Assisted Living Residences are considered "public places" under the Clean Indoor Air Act (35 P.S. § 637.1 – 637.11) and are subject to those regulations. According to the act, Assisted Living Residences must post a sign at each entrance that states "Smoking Permitted in Designated Areas Only" or "No Smoking." The international "No Smoking" symbol is also permitted. It is recommended that "Smoking Permitted" signs be posted at outdoor designated smoking areas. If the building is a multi-purpose building (such as a building that has independent living and/or skilled nursing as well as assisted living services), signs shall be posted at every entrance to the assisted living part of the building. Smoking is not permitted in independent apartments that are intermingled with assisted living residence apartments, as the building is being used to provide food or health care related services and is subject to the smoking ban. There was only one sign posted at the main entrance.

Plan of Correction ***Accept ([redacted] - 01/22/2024)***

The Director of Facilities has ordered "No Smoking" signs and will post on the exterior of the building on the property to notify staff, residents and visitors that we are a no-smoking property. The no smoking policy is reviewed in new hire orientation for staff and new resident orientation for new residents. The Director of Facilities will ensure the no-smoking signs are posted and visible at all times as part of his monthly inspection rounds. All staff and residents are required to adhere to this policy.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Implemented ([redacted] - 02/28/2024)

6. Requirements

2800.
18. Applicable Health and Safety Laws A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The PA Department of Agriculture Food Employee Certification Act, 3 Pa C.S.A. 6501 – 6510, effective January 22, 2011, requires one employee per licensed food facility to obtain a nationally recognized food manager certification. National exam programs are those that have been approved by ANSI using the Conference of Food Protection certified food protection manager standards. The Food Employee Certification Act requires one supervisory employee per food facility to obtain a food safety certification by taking an ANSI-CFP nationally recognized food safety class. The certified employee must be available during all hours of operation. The certified employee is the Person-in-Charge (PIC) when in the facility.
Currently the residence employs only two cooks who meet this requirement under ServSafe Certification. The current schedule shows several "holes" where neither are present during the residence's standard kitchen hours of 7:00 AM to 7:00 PM.

Plan of Correction ***Accept ([redacted] 01/22/2024)***

Administrator was educated by the Department of Human Services regarding the Department's position to not accept exemptions to the PA Department of Agriculture Food Employee Certification Act. The Director of Dining Services has certified one cook and is in the process of certifying two additional cooks to ensure coverage during all business hours. The Director of Dining will maintain the Serve Safe certifications for all of his cooks and ensure their certifications remain current. The Director of Dining will ensure coverage for all operating hours if any of the cooks fail to recertify in the required timeframe.

Licensee's Proposed Overall Completion Date: *01/09/2024*

18 Other laws, regs, ordins. *(continued)*

Implemented (/28/2024)

28e Refund death

7. Requirements

2800.
28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the residence shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101 10226.107). The residence shall keep documentation of the refund in the resident's record.

Description of Violation

Resident #1 passed away on . Resident #1's personal belongings were removed by 2. The resident's refund was issued on

The resident was 60 years of age or older and the residence did not provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107).

Plan of Correction ***Accept (- 01/22/2024)***

In the event of the death of a resident, the Billing Specialist is responsible for refunding the remainder of previously paid charges to the resident's estate within 30 days of the date of the removal of all personal property. The Director of Marketing will notify the Billing Specialist at the time of the apartment release and the refund will be processed and returned to the estate.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Implemented (- 02/28/2024)

42s Privacy self/possessions

8. Requirements

2800.
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 residence has cameras throughout the community. No signs are posted indicating these areas are under video surveillance or recording.

Plan of Correction ***Accept - 01/22/2024)***

Signs have been posted throughout the community where cameras are present to notify residents, visitors and staff the community is under surveillance. The Director of Facilities is responsible for ensuring the surveillance signs are maintained throughout the community. In addition, a sign has been installed on the exterior of the building to notify residents, visitors and staff the community is under surveillance. The Director of Facilities will ensure signs are posted and visible during building rounds. Temporary signs were installed on 10/13/23, permanent signs were installed on 12/4/23.

Licensee's Proposed Overall Completion Date: *01/11/2024*

Implemented - 02/28/2024)

65a Fire Safety 1st day

9. Requirements

2800.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was [redacted] did not receive orientation on the following topics: Evacuation procedures, Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, The designated meeting place outside the building or within the fire-safe area in the event of an actual fire, Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, The location and use of fire extinguishers, Smoke detectors and fire alarms, Telephone use and notification of emergency services.

Staff person B, whose first day of work was [redacted], did not receive orientation on the following topics: Evacuation procedures, Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, The designated meeting place outside the building or within the fire-safe area in the event of an actual fire, Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, The location and use of fire extinguishers, Smoke detectors and fire alarms, Telephone use and notification of emergency services.

Staff person C, whose first day of work was [redacted]. did not receive orientation on the following topics: Evacuation procedures, Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, The designated meeting place outside the building or within the fire-safe area in the event of an actual fire, Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, The location and use of fire extinguishers, Smoke detectors and fire alarms, Telephone use and notification of emergency services

Plan of Correction ***Accept [redacted] - 12/14/2023)***

Fire Safety and Emergency Preparedness training has been changed to an in-person training on the day of orientation from the previously used web based training required for completion prior to the first day. Human Resources is responsible for coordinating and ensuring required training for all new hires on the first day of work.

Licensee's Proposed Overall Completion Date: *12/07/2023*

Implemented ([redacted] - 02/28/2024)

65e Rights/Abuse 40 Hours

10. Requirements

2800.
65.e. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

65e Rights/Abuse 40 Hours *(continued)*

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.
5. Safe management techniques.
6. Core competency training that includes the following:
    i. Person-centered care.
    ii. Communication, problem solving and relationship skills.
    iii. Nutritional support according to resident preference.

Description of Violation

Staff person A has completed 40 work hours. However, this staff person did not complete training in the following topics: emergency medical plan, reporting of reportable incidents and conditions, safe management techniques, core competency training that includes the following: person-centered care, core competency training that includes the following: communication, problem solving and relationship skills, core competency training that includes the following: nutritional support according to resident preference.

Staff person B has completed 40 work hours. However, this staff person did not complete training in the following topics: emergency medical plan, reporting of reportable incidents and conditions, safe management techniques, core competency training that includes the following: person-centered care, core competency training that includes the following: communication, problem solving and relationship skills, core competency training that includes the following: nutritional support according to resident preference.

Staff person C has completed 40 work hours. However, this staff person did not complete training in the following topics: emergency medical plan, reporting of reportable incidents and conditions, safe management techniques, core competency training that includes the following: person-centered care, core competency training that includes the following: communication, problem solving and relationship skills, core competency training that includes the following: nutritional support according to resident preference.

Plan of Correction ***Accept ([redacted] - 01/22/2024)***

Administrator has developed an orientation training plan to ensure compliance with the Department's regulations. Administrator will monitor weekly, the completion of the orientation training plan for new hires. Any new hires who have not completed the mandatory trainings will be removed from the schedule until compliance is met. Human Resources will place the completed orientation training record in each employee's administrative file.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented ([redacted] - 02/28/2024)

65h 16 hrs annual training

11. Requirements

2800.
65.h. Direct care staff persons shall have at least 16 hours of annual training relating to their job duties. The training required in § 2800.69 (relating to additional dementia-specific training) shall be in addition to the 16 hour annual training.

Description of Violation

Direct care staff person D received only 11 hours of annual training relating to their job duties during training year 2022.

65h 16 hrs annual training *(continued)*

Plan of Correction ***Accept ([redacted] - 01/22/2024)***

The Administrator will ensure all staff meet the training requirements set forth by the Department. Administrator will monitor monthly, the training records for staff to ensure completion of the required training in accordance with the home's training plan. Human Resources will ensure a copy of the training record is stored in the employee's administrative file.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented ([redacted] - 02/28/2024)

65i Training topics

12. Requirements

2800.

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia, cognitive and neurological impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Assisted living service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the residence.

Description of Violation

Direct care staff person D did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, assisted living service needs of the resident, safe management techniques during the training year 2022.

Plan of Correction ***Accept [redacted] - 01/22/2024)***

The Administrator will ensure all staff meet the training requirements set forth by the Department. Administrator will monitor monthly, the training records for staff to ensure completion of the required training in accordance with the home's training plan. Human Resources will ensure a copy of the training record is stored in the employee's administrative file.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented ([redacted] - 02/28/2024)

65j Annual training content

13. Requirements

2800.

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

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708).

65j Annual training content *(continued)*

5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person D did not receive training in 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. during training year 2022.

Staff person E did not receive training in 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. during training year 2022.

Staff person F did not receive training in 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. during training year 2022.

Plan of Correction ***Accept ([redacted] - 01/22/2024)***

The Administrator, Director of Facilities and Human Resources Generalist have been trained by a Fire Safety Expert to train staff annually in person in addition to the training on our web based training system Relias. Completed training on 10/19/23.
The Director of Facilities will schedule the annual fire safety training annually at the same time as the recertification of the fire safe areas. The annual training has been added to our Outlook calendars with reminders set.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented [redacted] - 02/28/2024)

69 Dementia training

14. Requirements

2800.
69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Staff person A, date of hire [redacted], received only 1.25 hours of dementia-specific training within 30 days of hire.

Staff person B, date of hire [redacted] received only 1.25 hours of dementia-specific training within 30 days of hire.

Staff person C, date of hire [redacted], received only 1.25 hours of dementia-specific training within 30 days of hire.

Plan of Correction ***Accept ([redacted] - 01/22/2024)***

Administrator will ensure all staff receive at least 4 hours of dementia specific training within 30 days of hire and at minimum 2 additional hours of dementia specific training annually. Administrator will monitor for compliance with this regulation weekly for new hires and monthly according to the home's training plan. Human Resources will store a record of all training in the employee's file.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented ([redacted] - 02/28/2024)

82c Locked poisons

15. Requirements

2800.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

Description of Violation

Several Items, including [redacted] Adult Wascloths, [redacted] Toothpaste, [redacted] Spray, [redacted] Fluoride Toothpaste, [redacted] Ointment..., with a manufacture's warning labels indicating Keep out of reach of children..., danger of suffocation, contact a Poison Control Center...", were unlocked, unattended, and accessible to residents in memory care bedrooms W14, W16 and W18. Not all the residents of the residence, including residents of the memory care unit, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 12/14/2023)***

All staff will ensure that poisonous materials are in the locked cabinets in each resident's apartment. The residents do not have access to these cabinets. LPN Charge Nurses are responsible for ensuring all poisonous materials are locked away during rounds.

Licensee's Proposed Overall Completion Date: *12/11/2023*

Implemented [redacted] - 02/28/2024)

85a Sanitary conditions

16. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 10/12/23, the freezer door of the refrigerator/freezer in East 1's kitchenette had ice cream smeared on the door.

On 10/12/23, the ice maker on the refrigerator/freezer in East 2's kitchenette had a brown substance in and around the grate.

Plan of Correction ***Accept [redacted] - 12/14/2023)***

The Dining Coordinator is responsible for the daily cleaning of refrigerators. Monthly audits are conducted by the Dining Services Director. Dining Services Director reviewed training on refrigerator and temperature checks with all Dining Coordinators.

Licensee's Proposed Overall Completion Date: *12/11/2023*

Implemented [redacted] - 02/28/2024)

86b Bathroom ventilation

17. Requirements

2800.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathroom fan in rooms E73, W14, W16 and W18 were not in working order on 10/12/23.

Plan of Correction ***Accept [redacted] - 12/14/2023)***

We've contracted with Wilgro to repair the inoperable exhaust fans. The Director of Facilities will check for

86b Bathroom ventilation (continued)

operation of bathroom exhaust fans monthly and contract for repair as needed.

Proposed Overall Completion Date: 12/29/2023

Licensee's Proposed Overall Completion Date: *12/29/2023*

Implemented (- 02/28/2024)

101j7 Lighting/operable lamp

18. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
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 - 01/22/2024)***

Resident #2's bedside lamp has been replaced. Completed on 10/13/23. CNAs, Medication Technicians and LPNs are responsible for completing rounds daily to ensure all required furniture is present and in good condition in residents' rooms. Any issues noted will be reported to the Director of Nursing who will ensure compliance is met.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented - 02/28/2024)

103f Fridge/Freezer Temps

19. Requirements

2800.
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

On 10/12/23, at approximately 10:30 AM, the temperature in the East 2 freezer was 10 degrees Fahrenheit.

On 10/12/23, at approximately 11:30 AM, the temperature in the West 1 freezer was 12 degrees Fahrenheit.

Plan of Correction ***Accept (- 12/14/2023)***

The Dining Coordinator is responsible for taking daily temperatures on the refrigerators and freezers on each household kitchen to ensure appropriate temperatures are maintained. These logs are maintained in the main kitchen for review. Director of Dining Services reviewed training on refrigerator and temperature checks with all Dining Coordinators. The Director of Dining Services will ensure the daily checks are being documented.

Licensee's Proposed Overall Completion Date: *12/11/2023*

Implemented (- 02/28/2024)

103i Outdated food

20. Requirements

2800.
103.i. Outdated or spoiled food or dented cans may not be used.

103i Outdated food *(continued)*

Description of Violation

There was an unlabeled, undated carton of eggs, a pizza and a bag of pasta in the basement freezer.

In the west 2 kitchenette, there were three packs of pancakes in the freezer and several cups of poured orange juice and grape juice in the refrigerator. None of these items were dated.

In the East 1 refrigerator, there was a bag of salad and two and a half cartons of eggs without a date or a label.

Plan of Correction ***Accept [redacted] - 12/14/2023)***

The Dining Coordinators are responsible for labeling and dating all food items in the household kitchen. The Director of Dining Services is responsible for labeling and dating all food items in storage and freezer. Daily refrigerator checks are completed by Dining Coordinators. Monthly checks are completed by the Dining Services Director. Director of Dining Services reviewed training on refrigerator checks and temperature checks with all Dining Coordinators.

Licensee's Proposed Overall Completion Date: *12/11/2023*

Implemented [redacted] - 02/28/2024)

132b Safety inspection/fire drill

21. Requirements

2800.
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 last fire safety inspection observed by a fire safety expert was conducted on 03/23/22.

Plan of Correction ***Accept ([redacted] - 01/22/2024)***

Annual Fire Safety Inspection and fire drill conducted by a fire safety expert completed on 10/16/23. See attached. Director of Facilities will ensure the annual Fire Safety Inspection and Fire Drill are completed annually within the approved time frame. Administrator has added the annual inspection to her calendar with reminders set to ensure compliance.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented ([redacted] 02/28/2024)

132c Fire drill records

22. Requirements

2800.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the residence at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill records for the drills conducted between July 2022 to September 2023 do not include the exit route used.

Plan of Correction ***Directed ([redacted] - 01/22/2024)***

The fire drill records noted the evacuation route, listed on line 9 (h). Records attached.

132c Fire drill records (continued)

Proposed Overall Completion Date: 01/19/2024

Directed

The administrator will monitor all fire drills and the fire drill record monthly to ensure an unannounced fire drill is conducted at least once a month and is documented in the home's fire drill record which includes the date, time, amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was activated. [redacted]

Directed Completion Date: *01/19/2024*

Implemented ([redacted] - 02/28/2024)

132d Evacuation

23. Requirements

2800.
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 residence.

Description of Violation

The residence does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The residence exceeded an evacuation time of 2 minutes 30 seconds on all drills conducted between April through September 2023.

Plan of Correction ***Accept ([redacted] - 01/22/2024)***

Annual fire safety inspection and drill was completed on 10/16/23 to address this violation. Director of Facilities will ensure the annual Fire Safety Inspection and Fire Drill are completed annually within the approved time frame. Administrator has added the annual inspection to her calendar with reminders set to ensure compliance.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented [redacted] - 02/28/2024)

141b1 Annual medical evaluation

24. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

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

Resident #4's most recent medical evaluation was completed on [redacted].

Plan of Correction ***Accept ([redacted] - 12/14/2023)***

Director of Nursing manually entered a schedule for all medical evaluations into our electronic medical record system, PCC. All assessments are scheduled to trigger annually for review. Director of Nursing is responsible to

141b1 Annual medical evaluation (continued)

update the schedule to reflect changes in the evaluation date due to significant changes.

Licensee's Proposed Overall Completion Date: *12/11/2023*

Implemented (- 02/28/2024)

144d Smoking outside

25. Requirements

2800.
144.d. Smoking outside of the smoking room is prohibited.

Description of Violation

There is an area behind the concrete wall near the facility garage that is used for smoking by staff. This is not a designated smoking area.

Plan of Correction ***Accept (- 01/22/2024)***

Smoking is prohibited on site, we are a smoke free campus. This prohibition extends to staff as well. "No smoking" signs have been posted on the grounds. Director of Facilities will ensure compliance of staff to the policy. Grounds will be checked daily for any signs of smoking. Any staff found to be smoking on the grounds will be re educated on our no smoking policy.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented (- 02/28/2024)

162c Menus - posted

26. Requirements

2800.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 10/11/23, at approximately 9:31 AM, the menus posted in the assisted living residence were dated from 09/03/23 through 09/30/23.

The same menus dated 09/03/23 through 09/30/23 were posted outside of the memory care unit entrance. Weekly menus were not posted in a conspicuous and public place inside the memory care unit of the residence.

Plan of Correction ***Accept 01/22/2024)***

Director of Dining Services is responsible for ensuring the weekly menus are posted at least one week in advance. At all times, the current menu and the menu for the following week will be posted on each floor in the community in a common area. The Director of Dining Services (person responsible) will ensure the 5 week new cycle menu is posted at the beginning of week four (timeframe) to ensure compliance with regulations.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented (- 02/28/2024)

183b Medications and syringes locked

27. Requirements

183b Medications and syringes locked *(continued)*

2800.
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 living unit.

Description of Violation

On 10/12/23, at approximately 11:37 AM, prescription medications and OTC medications were unlocked, unattended, and accessible in the Secure Memory Care Unit room W18.

Plan of Correction ***Accept (- 01/22/2024)***

All staff will ensure that prescription medications, OTC medications, CAM and syringes are in the locked cabinets in each resident's apartment or stored in a locked medication cart. LPN Charge Nurses are responsible for ensuring all medication is stored appropriately. CNAs, Medication Technicians and LPNs will monitor for compliance on daily on each shift.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented (- 02/28/2024)

183d Current medications

28. Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

On [redacted] prescribed for resident #5, was in the residence's medication cart; however, the medication was discontinued and is not listed on the resident's current MAR.

Plan of Correction ***Accept (- 12/15/2023)***

The LPN Charge Nurses will audit the medication carts monthly at the end of the month. The monthly audit is being implemented to ensure accuracy of medication orders and medication supply. Audits will be documented and maintained for department review.

Licensee's Proposed Overall Completion Date: *12/11/2023*

Implemented - 02/28/2024)

184a Resident meds labeled

29. Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

The pharmacy packaged resident #6's [redacted] in with the resident's [redacted] medications. The resident's October MAR instructions for this medication state, "Give 1 tablet by mouth one time a day for [redacted]" and lists the administration time as [redacted]". The prescriber's order does not indicate a specific time for administration. The inconsistencies could cause a medication error and should be corrected.

Plan of Correction ***Accept - 01/22/2024)***

The Director of Nursing will work with prescribing doctors to ensure the administration orders provide more guidance to the time frame to ensure compliance with the Department's regulations. The LPNs will monitor for

184a Resident meds labeled (continued)

adherence to this requirement when completing Med Cart audits. The medication has been discontinued as it is no longer part of the resident's medical plan, no change is needed.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented (- 02/28/2024)

185a Storage procedures

30. Requirements

2800.
185.a. The residence 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 #7 is prescribed [redacted] Give 3 tablet by mouth as needed for lactose intolerance take with first bite of dairy food as needed. On 10/12/23, this medication was not available in the residence.

Plan of Correction ***Accept (- 12/15/2023)***

The LPN Charge Nurses will audit the medication carts monthly at the end of the month. The monthly audit is being implemented to ensure accuracy of medication orders and medication supply. Audits will be documented and maintained for department review.

Licensee's Proposed Overall Completion Date: *12/11/2023*

Implemented (- 02/28/2024)

190c Record of training

32. Requirements

2800.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The residence's medication administration training record for staff person F does not include documentation that the course was successfully completed. Two of the MAR Reviews are dated after the recertification date of 01/15/22, one of the MAR reviews are dated after the recertification date of 02/11/21, the 02/11/21 recertification date and Observation dates are written over a previous date, the initial certification form has blanks on the written documentation score portion and uses a score of 38.95 which is not a correct scoring number and was completed on 02/01/20 which makes the 2021 recertification late.

Plan of Correction ***Accept (- 12/15/2023)***

Director of Nursing will ensure all training records for Medication Technicians are complete. The DON will audit the records to ensure the initial training certification, the annual recertification, MAR reviews and observations are complete and up to date.

Licensee's Proposed Overall Completion Date: *12/13/2023*

Implemented (- 02/28/2024)

221c Post activity calendar

33. Requirements

2800.
221.c. The week's daily activity calendar shall be posted in advance in a conspicuous and public place in the residence. The residence shall provide verbal cueing and reminders of activities, their start times and locations within the residence.

Description of Violation

The residence does not have a current monthly activity calendar posted in a public and conspicuous place in the assisted living side of the residence or inside the special care unit.

Plan of Correction ***Accept [redacted] - 12/15/2023)***

Activity calendars are displayed in acrylic stands on all of the households. In addition, the Community Life staff delivers the weekly calendar to each resident's apartment. The Director of Community Life is responsible for ensuring the calendars are always displayed in the common areas on each household.

Licensee's Proposed Overall Completion Date: *12/11/2023*

Implemented ([redacted] - 02/28/2024)

224c1 Initial SP 30 days prior/adm

34. Requirements

2800.
224.c.1. An individual requiring services shall have a written preliminary support plan developed within 30 days prior to admission to the residence unless one of the conditions contained in paragraph (2) applies.

Description of Violation

Resident #3 was admitted on [redacted]; however, the resident's written preliminary support plan was not completed until [redacted]

Resident #6 was admitted on [redacted]; however, the resident's written preliminary support plan was not completed until [redacted].

Resident #7 was admitted on [redacted]; however, the resident's written preliminary support plan was not completed until [redacted]

Resident #8 was admitted on [redacted]; however, the resident's written preliminary support plan was not completed until [redacted].

Resident #9 was admitted on [redacted]; however, the resident's written preliminary support plan was not completed until [redacted]

Plan of Correction ***Accept [redacted] - 01/22/2024)***

Director of Nursing (RN) is responsible for developing the preliminary support plan 30 days prior to admission of a new resident. Going forward the DON will ensure all preliminary support plans are complete prior to admission as part of the admission process, to ensure compliance with this regulation. There is no corrective action that can be taken to correct previous late support plans.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented [redacted] - 02/28/2024)

225a1 Assessment – annually

35. Requirements

2800.
225.a.1. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: Annually.

Description of Violation

Resident #3's most recent assessment was completed on [redacted]

Resident #4's most recent assessment was completed on [redacted]

Resident #9's most recent assessment was completed on [redacted]

Plan of Correction ***Accept (- 12/15/2023)***

Director of Nursing manually entered a schedule for all assessments and support plans into our electronic medical record system, PCC. All assessments are scheduled to trigger annually for review. Director of Nursing is responsible to update the schedule to reflect changes in the evaluation date due to significant changes.

Licensee's Proposed Overall Completion Date: *12/11/2023*

Implemented (- 02/28/2024)

227a Final support plan – 30 days

36. Requirements

2800.
227.a. Each resident requiring services shall have a written final support plan developed and implemented within 30 days after admission to the residence. The final support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #3 was admitted on [redacted] *; however, the resident's final support plan was not completed until* [redacted]

Resident #4 was admitted on [redacted] *; however, the resident's final support plan was not completed until* [redacted].

Resident #9 was admitted on [redacted] *however, the resident's final support plan was not completed until* [redacted]

Plan of Correction ***Accept (- 01/22/2024)***

Director of Nursing (RN) is responsible for finalizing the support plan 30 days prior to admission of a new resident. The DON will enter the finalization date for the support plan into our medical records management system PCC which will trigger for the completion of the support plan to meet compliance.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented (02/28/2024)

227g Support plan signatures

37. Requirements

2800.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #5 participated in the development of their support plan on [redacted]*. However, the resident did not sign and date the support plan.*

227g Support plan signatures *(continued)*

Plan of Correction ***Accept (- 01/22/2024)***

Director of Nursing will ensure all participants in developing the support plan who have the ability to, sign the support plan. For residents who cannot sign, this will be noted on the support plan. DON has audited all of the resident records to ensure all support plans have the required signature. Audit was completed on 12/4/23

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented - 02/28/2024)

231e Additional assessments

38. Requirements

2800.
231.e.1. In addition to the requirements in § 2800.225 (relating to additional assessments), residents of a special care unit for Alzheimer's disease or dementia shall also be assessed quarterly for the continuing need for the special care unit for Alzheimer's disease or dementia.

Description of Violation

Resident #3 was last assessed for the need for special care unit on
Resident #9 was last assessed for the need for special care unit on .

Plan of Correction ***Accept - 01/22/2024)***

Director of Nursing has audited all resident records to determine which resident records are out of compliance and has brought those records current. DON has manually entered a schedule into our electronic medical record system, PCC, to trigger for quarterly reviews. Significant change and other updates will be added as needed. Audit completed on 12/4/23

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented - 02/28/2024)

233d Electronic/magnetic system

39. Requirements

2800.
233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

The gate door securing the special care unit's outdoor patio area does not have an electronic or magnetic locking system.

Plan of Correction ***Accept - 12/15/2023)***

The home has entered into a contract with NEPPS to install a magnetic lock on the gate enclosing the SDCU's outside area. Installation scheduled for 12/18/23.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented - 02/28/2024)

234a Admission – support plan

40. Requirements

2800.

234a Admission – support plan *(continued)*

234.a.1. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the special care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #6 was admitted to the special care unit on [redacted]. However, the resident's initial support plan was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 01/22/2024)***

Director of Nursing (RN) is responsible for developing the preliminary support plan within 72 hours prior to or after admission of a new resident to our secured unit as part of the admission process to ensure compliance. DON will ensure all preliminary support plans are developed, implemented and documented in the resident record in the required timeframe. A correction cannot be made to prior admissions that are out of compliance.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented ([redacted] - 02/28/2024)

236a Staff training

41. Requirements

2800.

236.a. Each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to dementia care and services, in addition to the 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

Description of Violation

Direct care staff person D, who works in the special care unit had only 6 hours of training related to dementia care during the 2022 training year.

Plan of Correction ***Accept ([redacted] - 01/22/2024)***

Administrator will ensure all staff who work in the SDCU receive 8 hours of dementia specific training within 30 days of hire and at minimum 8 additional hours of dementia specific training annually, in addition to the 16 hours of annual training. Administrator will monitor monthly the training records of all staff to ensure compliance with this regulation. Human Resources will store a record of all training in the employee's file.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented ([redacted] - 02/28/2024)

42. Requirements

2800.

236.a. Each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to dementia care and services, in addition to the 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

Description of Violation

Direct care staff person A, date of hire [redacted] works in the special care unit, but only completed 1.25 hours of initial training related to dementia care within the first 30 days of the date of hire.

Direct care staff person B, date of hire [redacted] works in the special care unit, but only completed 1.25 hours of initial training related to dementia care within the first 30 days of the date of hire.

236a Staff training *(continued)*

Plan of Correction ***Accept (- 01/22/2024)***

Administrator will ensure all staff who work in the SDCU receive 8 hours of dementia specific training within 30 days of hire and at minimum 8 additional hours of dementia specific training annually, in addition to the 16 hours of annual training. Administrator will monitor monthly the training records of all staff to ensure compliance with this regulation. Human Resources will store a record of all training in the employee's file.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented (- 02/28/2024)

236b Training topics

43. Requirements

2800.
236.b. The training for each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia at a minimum must include the following topics:

1. An overview of Alzheimer's disease and related dementias.
2. Managing challenging behaviors.
3. Effective communications.
4. Assistance with ADLs.
5. Creating a safe environment.

Description of Violation

Direct care staff person A, who works in the special care unit did not complete training in the following topics: an overview of Alzheimer's disease and related dementias, managing challenging behaviors, effective communications, assistance with ADLs, creating a safe environment.

Direct care staff person B, who works in the special care unit did not complete training in the following topics: an overview of Alzheimer's disease and related dementias, managing challenging behaviors, effective communications, assistance with ADLs, creating a safe environment.

Plan of Correction ***Accept (- 12/15/2023)***

The staff training plan has been audited to ensure compliance with the Dementia specific training requirements. Administrator will ensure all staff who work in the SDCU receive 8 hours of dementia specific training within 30 days of hire and at minimum 8 additional hours of dementia specific training annually, in addition to the 16 hours of annual training. Human Resources will store a record of all training in the employee's file.

Licensee's Proposed Overall Completion Date: *12/13/2023*

Implemented 02/28/2024)

252 Records – content

44. Requirements

2800.
252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.

252 Records – content *(continued)*

4. A language, speech, hearing or vision need which requires accommodation or awareness of during oral or written communication.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the residence, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the residence, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2800.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.
27. A record relating to any exception request under § 2800.229 (relating to excludable conditions; exceptions).
28. Ongoing resident progress notes.

Description of Violation

Resident #4's record does not include the resident's race.

Resident #8's record does not include the resident's hair color or eye color.

Plan of Correction ***Accept [redacted] - 01/22/2024)***

Director of Nursing updated Resident 4's and Resident 8's record with the missing information. The Director of Marketing will ensure all demographic information is added when creating the resident record. A review of the required contents of resident records will be audited by medical records monthly to ensure all required information is present in the resident's record.

Proposed Overall Completion Date: 01/19/2024

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented ([redacted] 02/28/2024)