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

February 12, 2024

[redacted], REGULATORY DIRECTOR
ABINGTON SENIOR CARE LLC
[redacted]

RE: THE TERRACE AT CHESTNUT HILL
495 EAST ABINGTON AVENUE
PHILADELPHIA, PA, 19118
LICENSE/COC#: 14157

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/16/2023, 10/17/2023 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 TERRACE AT CHESTNUT HILL* **License #**: *14157* **License Expiration**: *08/16/2024*

Address: *495 EAST ABINGTON AVENUE, PHILADELPHIA, PA 19118*

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

Administrator

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

Legal Entity

Name: *ABINGTON SENIOR CARE LLC*

Address: *1000 LEGION PLACE, SUITE 1600, ATTN - BILL SNOW, ORLANDO, FL, 32801*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *09/17/1996* **Issued By**: *City of Phila L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *146* **Waking Staff**: *110*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *10/17/2023*

Inspection Dates and Department Representative

10/16/2023 - On-Site: [redacted]

10/17/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *122* **Residents Served**: *106*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *76* **Residents Served**: *32*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *106*

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

Have Mobility Need: *40* **Have Physical Disability**: *2*

Inspections / Reviews

10/16/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/09/2023*

11/16/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/13/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/15/2023*

Inspections / Reviews *(continued)*

02/12/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *12/13/2023*

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

15a - Resident Abuse Report

1. Requirements

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

Description of Violation

On [redacted], at [redacted], resident 1 cut resident 2 on the back of the right hand with a broken vase after a resident 2 called resident 1 a "crazy nut". This incident was reported to staff person A on 1[redacted] However, this allegation of abuse was was not reported to the local area agency on aging.

Plan of Correction ***Accept ([redacted] - 11/16/2023)***

Director of Wellness and all related clinical staff were in-serviced on 11/13/23 by the ED that whenever there is a reportable to be sent to DHS that is referenced as a suspected abuse of a resident in accordance with OAPSA 15.21 that additional reporting is required to Older Protective Services using the Act 13 form. A reportable was sent to Older Protective Services in regards to this situation on 10/16/23.
Moving forward all reportable's must be reviewed by the ED prior to submission to ensure that if additional reporting to Older Adult Protective Services it will be completed. In the absence of the ED, the Clinical VPO will review all reportables and instruct whether the reporting to OAPSA is warranted. See attached in-service and reportable.

Proposed Overall Completion Date: 11/14/2023

Licensee's Proposed Overall Completion Date: *11/14/2023*

Implemented ([redacted] - 02/12/2024)

16c - Written Incident Report

2. Requirements

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

Description of Violation

Resident 3 is prescribed [redacted] subcutaneously as per sliding scale: [redacted] However, resident 3 was administered [redacted] on [redacted] but the resident's blood sugar was [redacted] and the resident should have received [redacted]. The resident was administered [redacted] on [redacted] but the resident's blood sugar was [redacted] and the resident should have received [redacted]. The resident was administered [redacted] on [redacted] at [redacted] but the resident's blood sugar was [redacted] and the resident should have received [redacted]. The home did not report these incidents to the department.

Repeat Violation: 1/9/23 et al.

Plan of Correction ***Accept ([redacted] - 11/16/2023)***

The reportable was sent to DHS on [redacted] reporting the medication error as advised by DHS representative. See attached.

16c - Written Incident Report (continued)

Nursing and med. tech. staff in-serviced on 11/13/23 by ED on the proper way to read a glucometer, understand a sliding scale insulin order and how to properly document if insulin was administered. See attached in-service. Moving forward, weekly checks will be performed by Director of Wellness and/or ED of all glucometers compared to the EMAR to ensure that proper documentation and medication administration per the MD's order are being carried through correctly. Weekly audits to be completed for 12 weeks and reviewed monthly during quality assurance meeting for 3 months. Quality Assurance committee to make recommendations for further audits if necessary. This will be implemented until until 2/20/24.

Proposed Overall Completion Date: 11/10/2023

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented (- 02/12/2024)

42b - Abuse

3. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On , at resident 1 cut resident 2 on the back of the right hand with a broken vase after a resident 2 called resident 1 a "crazy nut". Resident 2 was sent to the hospital and diagnosed with a laceration of the right hand.

Resident 1 has been exhibiting aggressive behavior since according to progress notes. On it is noted that resident 1 had been "displaying behaviors that are harmful to staff and to residents" and to resident 1. On it is noted that resident 1 "has been very violent towards other residents", and bullying their way into other residents' rooms. On it is noted that resident 1 was observed threatening staff and residents with a butter knife. Resident 1's RASP dated does not have an assessment for agitation or aggression and there is no update to the RASP following the aggressive incidents. Resident 1 was not placed with a 1:1 until .

Repeat Violation: 1/9/23 et al; 2/22/23.

Plan of Correction ***Accept (- 11/16/2023)***

After the behavior exhibited by resident #1 was sent out to the ER for evaluation and treatment. Resident did not return to community per MD's order. The hospital and POA/son were all notified and a reportable was sent. In-service was completed with staff by ED on 11/13/23 regarding the process of responding to resident incidents related to regulation 2600.42b including notification to residents MD, family/POA and immediate interventions for residents involved. DOW and or designee to do random walk throughs of the home twice weekly to include interviews with staff regarding behaviors and to monitor if any concerning behaviors are being exhibited by residents for twelve weeks. Audits will be reviewed during monthly Quality assurance meeting and recommendations to be made if continued audits are required.

42b Abuse *(continued)*

Licensee's Proposed Overall Completion Date: *12/20/2023*

Implemented [redacted] - 02/12/2024)

42s - Privacy

4. Requirements

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

Description of Violation

On [redacted] at [redacted], resident 4 was administered [redacted], and [redacted] by staff person B while sitting at a table with of other residents present.

Plan of Correction ***Accept [redacted] - 11/16/2023)***

In Service completed with all clinical staff on 11/13/23 by ED to enforce regulation 2600.42s that no medication(s) are to be administered to residents in a common area. Privacy is to be promoted at all times when a resident is receiving any type of medication. Staff person B was in serviced on 10/17/23 so that going forward [redacted] is aware of this regulation. See attached in services. Director of Wellness and/or ED will observe medication passes three times weekly through 12/20/2023 to be sure that regulation 2600.42s is being followed.

Proposed Overall Completion Date: 12/20/2023

Licensee's Proposed Overall Completion Date: *12/20/2023*

Implemented [redacted] - 02/12/2024)

89a - Water Pressure

8. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 10/17/23, the hot water in room 302 had low water pressure.

Plan of Correction ***Accept [redacted] - 11/16/2023)***

Apartment 302's water pressure was corrected on 10/17/23 by the Maintenance Director. Maintenance Director completed audit of water pressure in all apartments, bathrooms, kitchens and laundry area was completed on 11/10/23 to ensure that the water pressure was acceptable in each to accommodate the needs of the residents in the home. Weekly water pressure audits of 10 apartments will be completed by the Maintenance Director through 12/31/23.
Staff training to be completed by 11/17/23 regarding reporting of water pressure concerns. Resident counsel meeting in December to include how to report water pressure concerns. See in service.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented [redacted] - 02/12/2024)

95 - Furniture and Equipment

9. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 10/16/23 at 2:50 pm, the toilet in the second-floor women's bathroom was clogged with toilet paper and would not flush.

Plan of Correction ***Accept (- 11/16/2023)***

Toilet was unclogged on 10/16/23 immediately by maintenance director. Housekeeping and maintenance team will monitor the common bathrooms three times during their shifts to ensure all toilets are in working order and that toilet paper and soap and paper towels are also well stocked. In-Service completed by ED on 11/13/23 with housekeeping and maintenance staff regarding the monitoring of bathrooms and adequate stock. Maintenance director will audit 2x weekly through 12/31/23.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented (- 02/12/2024)

102h - Toilet Paper

10. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 10/17/23 at 11:17 am, there was no toilet paper for the toilet in the women's bathroom on the first floor.

Repeat Violation: 8/15/22 et al.

Plan of Correction ***Accept - 11/16/2023)***

The toilet paper holder was stocked immediately on 10/17/23.
Housekeeping and maintenance team will monitor the common bathrooms three times during their shifts to ensure all toilets are in working order and that toilet paper and soap and paper towels are also well stocked.
In-Service completed by ED on 11/13/23 with housekeeping and maintenance staff regarding the monitoring of bathrooms and adequate stock. Maintenance director will audit 2x weekly through 12/31/23.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented - 02/12/2024)

103f - Refrigerator/Freezer Temps

11. Requirements

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

Description of Violation

On 10/17/23 at 11:08 am the temperature in the main freezer was 14 degrees Fahrenheit.

103f - Refrigerator/Freezer Temps (continued)

Repeat Violation: 8/15/22 et al.

Plan of Correction ***Accept (- 11/16/2023)***

The temperature of the main freezer was monitored on 10/17/23 for the next hour and it did show the correct temperature was being well maintained by that unit. (see attached photo of the freezer and temperature gauge). Temperature sheet on the freezer completed daily by the culinary team to ensure the correct temperature is being held. Culinary Director to audit temp. log daily to ensure appropriate temperatures until Feb. 7, 2023. (See attached in-service provided by ED to Culinary Director on 11/13/23).

Licensee's Proposed Overall Completion Date: *11/14/2023*

Implemented - 02/12/2024)

121a - Unobstructed Egress

12. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 10/16/23 at 10:10 am, a thick fuzzy mat prevented the door from opening all the way causing a blocked egress from the home's exit leading to the deck.

Plan of Correction ***Accept (- 11/16/2023)***

The mat was immediately removed on 10/16/23 which allowed the door to open freely. (see attached photo).

ED in-serviced Maintenance Director on 11/10/23 regarding unobstructed egress. Weekly checks will be done by Maintenance director on all stairways, hallways, doorways, passageways and egress routes from rooms and from the building to be sure they are unlocked and unobstructed will be completed until February 7, 2023. (see attached in-service).

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented (- 02/12/2024)

124 - Notice to Fire Department

13. 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 - 11/16/2023)***

On October 18, 2023 the notice to the Fire Department in writing of the address of the home, location of bedrooms and the assistance needed to evacuate in an emergency was re-sent to the Fire Department and notification that it was sent was printed and attached. This documentation is kept in the Survey Binder. (See attached documentation). Executive Director will ensure that the Fire Dept. is notified of the homes address, location of bedrooms and the

124 - Notice to Fire Department (continued)

assistance needed to evacuate in an emergency and verification will be kept in Survey binder. A reminder will be placed on EDs email of when to send.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented (- 02/12/2024)

141a 1-10 Medical Evaluation Information

14. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 2's medical evaluation dated [redacted] did not include a general physical examination by a physician, physician's assistant or nurse practitioner, immunization history, and mobility assessment.

Resident 5's medical evaluation dated [redacted] did not include allergy information.

Resident 6's medical evaluation dated [redacted] did not include allergy information.

Repeat Violation: 1/9/23 et al.

Plan of Correction ***Accept (- 11/16/2023)***

DME's for resident 2, 5 and 6 were updated on [redacted] to reflect missing information.
Clinical staff in-serviced on 11/13/23 by ED in regards to required information on DME as per regulation 141a.
Going forward Director of Wellness and or her designee will audit all DME's received to verify compliance. The Director of Wellness and/or her designee will audit DMEs due for annual, new admission or a change in condition twice weekly for 12 weeks. Audits to be reviewed during monthly Q&A.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented (- 02/12/2024)

141b1 - Annual Medical Evaluation

15. Requirements

2600.

141b1 Annual Medical Evaluation *(continued)*

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

Description of Violation

Resident 2's most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted]

Resident 6's most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted]

Resident 7's most recent medical evaluation was completed on [redacted] The resident's previous medical evaluation was completed on [redacted].

Plan of Correction ***Accept ([redacted] - 11/16/2023)***

Clinical staff in serviced on 11/13/23 by ED in regards to required information on DME as per regulation 141b1. Going forward Director of Wellness and or her designee will audit all DME's received to verify compliance. The Director of Wellness and/or her designee will audit DMEs due for annual, new admission or a change in condition twice weekly for 12 weeks. Audits to be reviewed during monthly Q&A.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented ([redacted] - 02/12/2024)

183e - Storing Medications

16. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On [redacted], an unopened [redacted] prescribed to resident 3 was on the home's medication cart. The pen had instructions which stated "refrigerate until opened". There was no date written on the pen to indicate how long it had been out of the refrigerator. According to the manufacturer's instructions a [redacted] that is not refrigerated must be discarded after 28 days.

Plan of Correction ***Accept [redacted] - 11/16/2023)***

[redacted] was discarded on 10/17/23. Med. techs and nurses were in serviced on 11/13/23 by ED to ensure they are aware to only take the insulin out of the refrigerator when it is needed to be used and only at that time is it to be taken out of the refrigerator. An audit was conducted by ED on 10/19/23, to ensure that there were no unopened insulin on the medication carts. Director of Wellness and or designee will do weekly cart audits of all med carts to include appropriate storage procedure until February 7, 2023. See attached in service.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented ([redacted] - 02/12/2024)

185a - Implement Storage Procedures

17. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

On [redacted] at [redacted], resident 3's glucometer reads [redacted] However this blood sugar reading is recorded as [redacted] on the resident's medication administration record.

On [redacted] at [redacted] resident 3's glucometer reads [redacted]. However this blood sugar reading is recorded as [redacted] on the resident's medication administration record.

On [redacted] at [redacted], resident 3's glucometer reads [redacted]. However this blood sugar reading is recorded as [redacted] on the resident's medication administration record.

Resident 3 is prescribed [redacted] as needed. On [redacted] this medication was not available in the home.

Repeat Violation: 8/15/22 et al, 1/9/23 et al.

Plan of Correction ***Accept ([redacted] - 11/16/2023)***

[redacted] was ordered from pharmacy on [redacted]. Medication is available on the medication cart for the resident as ordered.

Med. techs and nurses were in-serviced by ED on 11/13/23 on the importance of correct documentation of glucometer readings being entered into the EMAR system by staff.
Moving forward, Director of Wellness and or her designee weekly, will check that all glucometer readings for that day are documented correctly into the EMAR for each resident until February 6, 2023. If it is found that there is an incorrect documentation, that employee will receive remediation training by DOW and or [redacted] designee and they will sign off that they received the training. If an employee if found to have incorrect documentation of glucometer readings in the EMAR twice, that employee will be removed from the medication cart indefinitely.
Cart audits are completely weekly and checked that all medications are available for the residents per the MDs order. If a medication is not available, it will be ordered from pharmacy.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented [redacted] - 02/12/2024)

187d - Follow Prescriber's Orders

18. Requirements

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

Description of Violation

Resident 3 is prescribed [redacted] subcutaneously as per [redacted] call MD if [redacted]. However, resident 3 was administered [redacted] units on [redacted] but the resident's blood sugar was [redacted] and the resident should have received [redacted] units. The resident was administered [redacted] units on [redacted] but the resident's blood sugar was [redacted] and the resident should have received [redacted]. The resident was administered [redacted] on [redacted] am but the resident's blood sugar was [redacted] and the resident should have received [redacted] units.

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

Plan of Correction ***Accept [redacted] - 11/16/2023)***

Med. techs and nurses were in serviced by ED on 11/13/23 on the importance of correct documentation of glucometer readings being entered into the EMAR system by staff, and per the glucometer reading the proper dosage of insulin shall be administered per prescribers orders.
Moving forward, Director of Wellness and or [redacted] designee weekly, will check that all glucometer readings for that day are documented correctly into the EMAR for each resident and if a reading per MDs order noted a insulin amount ordered that that order was followed through and the resident received the correct dosage. If it is found that there is an incorrect documentation, that employee will receive remediation training by ED and they will sign off that they received the training. If an employee if found to have incorrect documentation of glucometer readings in the EMAR twice, that employee will be removed from the medication cart indefinitely.
Cart audits are completely weekly by clinical staff and checked that all medications are available for the residents per the MDs order.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented [redacted] - 02/12/2024)

188b - Medication Error Reporting

19. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident 3 is prescribed [redacted] However, resident 3 was administered [redacted] but the resident's blood sugar was [redacted] and the resident should have received [redacted] units. The resident was administered [redacted] but the resident's blood sugar was [redacted] and the resident should have received [redacted] units. The resident was administered [redacted] but the resident's blood sugar was [redacted] and the resident should have received [redacted] units. These medication errors were not reported to the resident, resident's designated person, and prescriber.

Plan of Correction ***Accept [redacted] - 11/16/2023)***

Medication error was reported to resident, PCP and family member and the reportable was sent to DHS, on [redacted], (see attached).
Med. techs and nurses were in serviced by ED on 11/13/23 on the importance of correct documentation of glucometer readings being entered into the EMAR system by staff, and per the glucometer reading the proper dosage of insulin shall be administered. If a residents glucometer reading resulted in insulin not being given per MDs order that staff member will receive remediation and a medication error reportable will be sent to DHS, along with contacting PCP, the resident and residents POA/family member.

Moving forward, Director of Wellness and or [redacted] designee weekly, will check that all glucometer readings for that day are documented correctly into the EMAR for each resident and if a reading per MDs order noted a insulin amount ordered that that order was followed through and the resident received the correct dosage until February 7, 2024.. If it is found that there is an incorrect documentation, that employee will receive remediation training by ED and

188b - Medication Error Reporting (continued)

they will sign off that they received the training. If an employee if found to have incorrect documentation of glucometer readings in the EMAR twice, that employee will be removed from the medication cart indefinitely. Any medication error that is found will be reported timely to DHS by Director of Wellness or ED.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented (- 02/12/2024)

224a - Preadmission Screen Form

20. Requirements

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

Description of Violation

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

Resident 9's preadmission screening form, dated does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept (- 11/16/2023)***

Pre-screens for resident 8 & 9 per updated, (see attached).
Clinical staff in-serviced on 11/13/23 on regulation 2600.224a by ED to ensure that staff is properly completing the pre-screen forms for each resident. Once Director of Nursing and or ED has verified the pre-screen is properly completed, that pre-screen can be filed into the residents record. (See in-service).
An audit of charts will be conducted and completed by clinical staff and or Director of Wellness and completed by 11/24/23 to ensure that all pre-screens are completed properly prior to being filed in the residents record.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented (- 02/12/2024)

225a - Assessment 15 Days

21. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident 8 was admitted on however, the resident's assessment was not completed until .

Resident 9's assessment, dated , does not include an assessment for eating and understanding instructions and resident's medical diagnoses are not listed.

225a - Assessment 15 Days (continued)

Resident 10 was admitted on [redacted]; however, the resident's assessment was not completed until [redacted] The resident's assessment does not include an assessment for eating.

Plan of Correction ***Accept [redacted] - 11/16/2023)***

Resident 9 & 10's assessments updated.
Clinical staff in-serviced on 11/13/23 by ED on regulation 2600.225a which states a resident shall have a written initial assessment documented on the dept.'s assessment form within 15 days of admission. The ED, DOW or designee may complete the assessment. Going forward DOW or designee will ensure that all new residents assessment is completed within 15 days of admission.
See attached in-service and updated assessments.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented ([redacted] - 02/12/2024)

225c - Additional Assessment

22. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 1's assessment, dated [redacted] does not include an assessment for eating and supervision. The assessment does not have an appropriate assessment for agitation and aggression. The resident's progress notes indicate the resident was frequently aggressive and easily agitated.

Resident 2's assessment, dated [redacted] does not include an assessment for eating. It does not list diagnoses and there is not an appropriate assessment for aggression and agitation. The resident's progress notes indicate episodes of aggression and agitation.

Resident 7's current assessment was completed on [redacted]. However, the resident's previous assessment was completed on [redacted].

Repeat Violation: 1/9/23 et al.

Plan of Correction ***Accept [redacted]S - 11/16/2023)***

Clinical staff in-serviced by ED on 11/13/23 on regulation 2600.225.c.-The resident shall have additional assessments as follows:
1.Annually.
2.If the condition of the resident significantly changes prior to the annual assessment.
3.At the request of the Department upon cause to believe that an update is required. See attached in-service.
Clinical staff was educated that when completing an assessment they must capture each topic and complete the

225c - Additional Assessment (continued)

assessment in its entirety and in a timely fashion. Residents assessments have been updated. Going forward, DOW and/or her designee will review the completed assessments monthly to assure proper timing completed as well as for accuracy. Clinical staff will refer to the spreadsheet as to when the assessments are due.

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

Implemented [redacted] - 02/12/2024)

227a - Support Plan 30 Days

23. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident 8 was admitted on [redacted] however, the resident's initial support plan was not completed until [redacted]

Plan of Correction ***Accept ([redacted] - 11/16/2023)***

Clinical staff in-serviced on 11/13/23 by ED on regulation 2600.227a, that a resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Dept.'s support plan form. (see attached in-service).
Moving forward clinical staff will follow the spreadsheet and Yardi to be aware when the DME's, Support Plans/Rasps are due for a resident so that all are completed timely. DOW or her designee will check monthly per Yardi to ensure that all support plans are completed timely per this regulation.

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

Implemented ([redacted] - 02/12/2024)

227d - Support Plan Medical/Dental

24. Requirements

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

Description of Violation

The assessment for resident 9, dated [redacted], indicates the resident has a need for for bladder management, securing healthcare, making and keeping appointments, and medications. The resident's support plan, dated [redacted] does not document how these needs will be met.

The assessment for resident 10, dated [redacted], indicates the resident has a need for transferring, toileting, bladder management, doing laundry, supervision, medications, and orientation to time, place, and person. The resident's support plan, dated [redacted] does not document how these needs will be met.

The assessment for resident 11, dated [redacted], indicates the resident has a need for transferring, doing laundry, diabetes. The resident's support plan, dated [redacted] does not document how these needs will be met.

227d Support Plan Medical/Dental (continued)

Plan of Correction ***Accept (- 11/16/2023)***

Residents 9, 10 and 11 assessments have been updated to ensure that all information is captured and documented as to how the home will meet the needs of each resident.
Clinical staff educated, with an in service on Nov. 13, 2023 by ED on regulation 2600.227d to be sure that when they are completing an assessment each need is documented as to how the home will meet the needs of the resident. The DOW and or her designee will check each assessment completed each month to ensure that the needs of the residents are captured on the assessments completed.

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

Implemented (- 02/12/2024)

227e - Self Administer Medication

25. Requirements

2600.
227.e. The resident's support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident 1's assessment, dated , does not address the resident's ability to self administer medications.

Repeat Violation: 1/9/23 et al.

Plan of Correction ***Accept (- 11/16/2023)***

Clinical staff in serviced on by ED on regulation 2600.227e. Educated staff on the importance of capturing and documenting each need for a resident on their assessment to ensure all needs are being supported. Resident 1 is no longer in the community.
Going forward, DOW and or designee will check for accuracy of each assessment completed monthly, (by checking the Yardi platform) to be sure each need of a resident is being captured on their support plan.

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

Implemented - 02/12/2024)

231c - Preadmission Screening

26. 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 11 was admitted to the Secure Dementia Care Unit (SDCU) on However, the resident's written cognitive preadmission screening was not completed.

Plan of Correction ***Accept (- 11/16/2023)***

Resident 1's pre screen in completed and in his medical record.
Clinical team in serviced by ED on 11/13/23 on regulation 2600.231c and the importance of completing a

231c Preadmission Screening (continued)

preadmission screening for a resident within 72 hours of admission to PC or SDU with collaboration of the MD or geriatric team and documented on the dept.'s preadmission screening form.
DOW and her designee will audit each medical record to ensure that all residents records have their prescreen form in their chart. This audit will be completed by end of the month by November 30, 2023.
To maintain compliance, DOW and or her designee will check monthly for all new residents that a prescreen form is in their chart.

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

Implemented [redacted] - 02/12/2024)

231g - Non-Dementia Admission

27. Requirements

2600.
231.g. An individual who does not have a primary diagnosis of Alzheimer's disease or other dementia may reside in the secured dementia care unit if desired by the resident.
1. The individual shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to residence or 30 days after residence.
2. If the medical evaluation shows that personal care services are needed, the requirements of this chapter apply.
3. The individual shall have access to and be able to follow directions for the operation of the key pads or other lock-releasing devices to exit the secured dementia care unit.

Description of Violation

Resident 6, who does not have a primary diagnosis of [redacted] or other [redacted], resides in the Secure Dementia Care Unit SDCU. The resident cannot independently operate the locking mechanism to exit the secure dementia unit .

Plan of Correction ***Accept [redacted]S - 11/16/2023)***

Clinical staff in serviced by ED on 11/13/23 on regulation 2600.231g. See attached in service.
Staff made aware of regulation and the need of the resident being admitted to SDU must be able to demonstrate they can operate the key pad to be able to come and go freely from the unit if that individual does not have a primary dx. of dementia but residing in the SDU. Going forward, any resident being considered to move into the SDU without a primary dx. of dementia, the ED will monitor whether the resident can operate the locking mechanism to exit the secured dementia unit. Other arrangements will be made if the resident can not operate the key pad by ED.

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

Implemented [redacted] - 02/12/2024)

234a - Admission Support Plan

28. 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 11 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was completed on [redacted]. There was no new support plan completed when the resident was admitted to the SDCU.

234a - Admission Support Plan *(continued)*

Plan of Correction ***Accept (- 11/16/2023)***

Clinical staff in-serviced on by ED on regulation 2600.234a-within 72 hours of admission or within 72 hours prior to the residents admission to the SDU a support plan shall be developed, implemented and documented in the residents record. See attached in-service. Resident 11 had an assessment completed since he did move from Personal Care to SDU. Audit completed by DOW and or her designee to ensure that all residents on the SDU has an assessment completed to capture the need for the SDU. Moving forward, any resident moving from PC to SDU ED and or DOW will ensure that an assessment is completed timely.

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

Implemented - 02/12/2024)

234b - Support Plan Needs Elements

29. Requirements

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

Description of Violation

The support plan, dated for resident 11 does not address a plan to meet the resident's needs for for transferring, doing laundry, and diabetes.

Plan of Correction ***Accept - 11/16/2023)***

Care plan for resident 11 was updated by clinical staff, and corrected to show the plan to meet all needs of the resident are captured and met. Clinical staff in-serviced on 11/13/23 by ED on regulation 2600.234b. Clinical staff educated on the importance of identifying on the support plan the residents physical, medical, social, cognitive and safety needs. See in-service. Going forward DOW and or designee to do monthly audits to ensure that the support plans for the residents have all needs identified are captured in the support plan. DOW will review all new support plans that are completed by clinical team to be sure that all needs are being captured and addressed on how need will be met by the home until Feb. 7, 2024.

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

Implemented (- 02/12/2024)