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

November 21, 2023

[redacted]
HUMANGOOD PENNSYLVANIA
[redacted]

RE: RYDAL PARK PERSONAL CARE
1515 THE FAIRWAY
RYDAL, PA, 19046
LICENSE/COC#: 13812

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/10/2023, 08/11/2023, 08/18/2023 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: *RYDAL PARK PERSONAL CARE* **License #**: *13812* **License Expiration**: *02/19/2024*

Address: *1515 THE FAIRWAY, RYDAL, PA 19046*

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

Administrator

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

Legal Entity

Name: *HUMANGOOD PENNSYLVANIA*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *09/11/2012* **Issued By**: *Abington Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *72* **Waking Staff**: *54*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *08/11/2023*

Inspection Dates and Department Representative

08/10/2023 - On-Site: [redacted]

08/11/2023 - On-Site: [redacted]

08/18/2023 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *72* **Residents Served**: *51*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Support* **Capacity**: *23* **Residents Served**: *20*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *51*

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

Have Mobility Need: *21* **Have Physical Disability**: *0*

Inspections / Reviews

08/10/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/16/2023*

Inspections / Reviews *(continued)*

09/20/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/17/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/25/2023*

09/29/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/17/2023*

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

11/21/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/17/2023*

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

25b - Contract Signatures

1. Requirements

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

Description of Violation

The resident-home contract, dated 12/02/22, for resident #1 was not signed by the resident.

The resident-home contract, dated 11/12/21, for resident #2 was not signed by the resident.

Repeat Violation: 03/08/22

Plan of Correction ***Accept [redacted] - 09/20/2023)***

Preparation and execution of this Response and Plan of Correction does not constitute an admission or agreement by HumanGood/Rydal Park Personal Care Facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies and Plan of Correction. The Plan of Correction is being prepared and/or executed solely because it is required by State and Federal Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, the Response and Plan of Correction constitutes the facility's allegation of compliance in accordance with section 2600.3 (c) of the Regulatory Compliance Guide.

The contract for resident #1 was reviewed with the resident on 9/14/2023 and signed.

The contract for resident #2 was reviewed with the resident on 09/14/2023 and signed.

The Executive Director of the community is the current Administrator for the Personal Care home and has been educated on the contract signing requirement by Regulatory Compliance Guide.

Resident contracts for those residing in the home were reviewed on 09/07/2023. Any resident contract without a signature was reviewed with the resident and responsible party where applicable. Signatures were obtained by those residents willing to sign. If the resident refused to sign, documentation was obtained and placed with the contract.

Resident contracts will be audited by the Personal Care Administrator or designee the month after moving in for review of signature compliance for 12 months. A report will be generated and reviewed by the QA committee monthly. This process will begin in October 2023.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented [redacted] - 11/21/2023)

41e - Signed Statement

2. Requirements

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

Description of Violation

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

41e - Signed Statement (continued)

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

Repeat Violation: 03/08/22.

Plan of Correction ***Accept ([redacted] - 09/20/2023)***

The contract for resident #1 was reviewed with the resident on 9/14/2023 and signed.

The contract for resident #2 was reviewed with the resident on 09/14/2023 and signed.

The Executive Director of the community is the current Administrator for the Personal Care home and has been educated on the contract signing requirement via the Regulatory Compliance Guide.

The Resident contracts include the resident rights and complaint procedures. Resident contracts for those residing in the home were reviewed on 09/07/2023. Any resident contract without a signature was reviewed with the resident and responsible party where applicable. Signatures were obtained by those residents willing to sign. If the resident refused to sign, documentation was obtained and placed with the contract.

Resident contracts will be audited by the Personal Care Administrator or designee the month after move-in for review of signature compliance for 12 months. The report will be generated and reviewed by the QA committee monthly. The process will begin in October 2023.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented ([redacted] - 11/21/2023)

54a - Direct Care Staff

3. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person A does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept ([redacted] - 09/20/2023)***

Team member # A was placed on administrative leave immediately upon receiving the survey. It was determined they do not have a highschool diploma from the US and have been relocated to another department within the community.

Director of Human Resources and Human Resources team members was in-serviced on regulation 54a on 9/11/2023.

54a - Direct Care Staff (continued)

On 9/11/2023 the Director of Human Resources completed an audit on Direct Staff Requirements.

HR director or designee will complete a monthly audit related to all new hires and report findings monthly to QA for 12 months.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented ([redacted] - 11/21/2023)

65b - Rights/Abuse 40 Hours

4. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

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.

Description of Violation

Staff person B has completed their 40th scheduled work hour. However, this staff person did not complete training in the following topics: emergency medical plan and reporting of reportable incidents and conditions.

Staff person C has completed their 40th scheduled work hour. However, this staff person did not complete training in the following topics: reporting of reportable incidents and conditions.

Plan of Correction ***Accept [redacted] - 09/20/2023)***

Team Member B completed education on reporting of reportable incidents and conditions on 7/2/2023. Team member B will receive education on the community's emergency medical plan by 9/18/2023.

Team Member C was educated on reporting of reportable incidents and condition on 1/11/2023 under the abuse prevention, elder justice act and preventing, reporting and reporting abuse.

The Director of Human Resources, and Human Resources team was educated on 65b on 09/14/2023. See attached.

Moving forward The Human Resources Director will audit Personal Care Home new team member files monthly, and findings will be reported monthly to QA starting October 2023 for 12 months.

In addition to the above plan of correction: Administrator or designee will make available and provide requested documentation to the Department during inspections.[redacted]

Licensee's Proposed Overall Completion Date: *09/18/2023*

Implemented ([redacted] - 11/21/2023)

65e - 12 Hours Annual Training

5. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person A received an indeterminate amount of annual training in training year 2022.

Direct care staff person D received an indeterminate amount of annual training in training year 2022.

Plan of Correction ***Accept ([redacted] - 09/29/2023)***

Team member A received 17.5 hours of annual training in the the last 12 months. See attached transcript. Team member A is no longer employed with the personal care department.

Team Member D received?18.85 hours of annual training in the last 12 months. See Attached.

Human Resources Director was educated on regulation 65e on 9/11/2023.

Moving forward The Human Resources Director or Human Resources Assistant will be completing staff audits related to team members education completion monthly, and report findings monthly to QA starting October 2023 for 12 months.

In addition to the above plan of correction: The home will provide to the Department training documentation that includes name of staff, date of training, source, training topic, and training length. [redacted]

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented ([redacted] - 11/21/2023)

65f - Training Topics

6. Requirements

2600.
65.f. 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 and cognitive 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. Personal care service needs of the resident.
6. Safe management techniques.

65f - Training Topics *(continued)*

7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

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

Direct care staff person D did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2022.

Plan of Correction ***Accept [redacted] - 09/29/2023)***

Team Member A?is no longer employed in the Personal Care Home.

Team Member D received education instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan on 9/14/2023. see attached.

The director of Human Resources, and Human Resources team was educated on 65f on 09/11/2023, see attached.

The Director of Human Recourses and Human Resources assistants completed and audit on regulation. All Direct care team members will complete a training including the preadmission screening form, assessment tool, medical evaluation and support plan by 10/2/2023.

The director of Human Resources will complete monthly audits for the next 12 months starting October 2023 related to team members education completion, and report monthly to QA.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented [redacted] - 11/21/2023)

65g - Annual Training Content

7. Requirements

2600.

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

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—10225.5102).
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 A did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year 2022.

Staff person D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a

65g - Annual Training Content (continued)

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, emergency preparedness procedures and recognition and response to crises and emergency situations during training year 2022.

Plan of Correction ***Accept [redacted] - 09/29/2023)***

Team Member A?is no longer employed in the Personal Care Home

Team Member D completed the fire safety training on 9/22/2023 by trained fire safety expert. See attached.

The director of Human Resources, and Human Resources team was educated on 65g on 09/11/2023, see attached.

The Director of Human Recourses will hold fire safety training by a fire safety expert for all new hires. All Personal Care Home Team members go through the training by 09/30/2023.

Moving forward the Human Resources Director will audit Personal Care Home new team member files monthly for training including fire safety, and findings will be reported monthly to QA starting October 2023 for 12 months.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented [redacted] - 11/21/2023)

82c - Locking Poisonous Materials

8. Requirements

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

Description of Violation

On [redacted], at approximately [redacted], several items including [redacted], [redacted] and [redacted], with a manufacture's label indicating "... contact a Poison Control Center..."", were unlocked, unattended, and accessible to resident #1 in the resident's bathroom. Not all the residents of the home, including resident #1, have been assessed capable of recognizing and using poisons safely.

On [redacted] at approximately [redacted], several toiletry items were found on resident #3's bathroom sink counter. Some of the items: [redacted], [redacted], include a label stating "... contact a Poison Control Center ...". In addition, resident #3 has a medication cabinet in the bathroom which was unlocked and unattended. Resident #3 is assessed to safely use and avoid poisonous materials on [redacted] medical evaluation; however, resident #3 lives in "Memory Support" and not all the residents of the memory support unit are assessed to safely use and avoid poisonous materials. Resident #3 is also assessed as not being able to administer [redacted] own medications according to the homes assessment and support plan.

Plan of Correction ***Accept ([redacted] - 09/20/2023)***

The items in Resident 1's bathroom was secured once notified by the surveyor. New locking cabinets were hung in the resident's bathroom on 9/15/2023.

The items in Resident 3's bathroom was secured once notified by the surveyor.

82c - Locking Poisonous Materials (continued)

New locking cabinets were hung in the resident's bathroom on 9/15/2023.

Rounds were then completed for residents living in the home to secure any items that are poisonous materials. Locked cabinets are being installed in the bathrooms of those residents identified who cannot safely use poisonous materials.

Education was provided on 9/13/2023 to the team members to secure poisonous materials in the resident apartments.

Rounds are being completed weekly by a Personal Care nurse to ensure poisonous materials are secured in the resident apartments.

Report will be generated and reported to QA committee monthly beginning on September 13, 2023, and continuing for 12 months.

Licensee's Proposed Overall Completion Date: *09/29/2023*

Implemented [redacted] - 11/21/2023)

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

Resident #3 has a bedside mobility device that is uncovered and presents as a threat to the resident's safety.

Plan of Correction ***Accept ([redacted] - 09/20/2023)***

Resident #3 bedside mobility device was covered once notified by the surveyor it was uncovered.

Rounds were completed in the home on 9/5/2023 to review mobility devices.

Mobility devices were covered as appropriate.

Education was provided on 9/14/2023 to the team members on mobility devices to be covered as appropriate.

Rounds will be completed weekly by a Personal Care nurse to review mobility devices. A report will be generated and reported to the QA committee monthly beginning in October 2023 continuing for 12 months.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented [redacted] - 11/21/2023)

103c - Food Protected

10. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

103c - Food Protected *(continued)*

Description of Violation

On [redacted], at [redacted], there was an uncovered and undated tray of cooked meat patties stored in the home's refrigerator.

Plan of Correction ***Accept [redacted] - 09/20/2023)***

The food that was uncovered in the refrigerator was discarded once identified.

Rounds were completed in the other refrigerators to determine if other food was uncovered.

Education was provided on 9/14/2023 to the culinary team members on the proper food storage procedures.

Weekly audits will be completed by the designed culinary team member. A report will be generated and reported to the QA committee monthly beginning on September 9/15 continuing for 12 months.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented ([redacted] - 11/21/2023)

107a - Emergency Preparedness

11. Requirements

2600.
107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

Staff person E, the administrator does not have the emergency preparedness plan for the local municipality.

Plan of Correction ***Accept ([redacted] - 09/20/2023)***

The community maintains a copy of the local emergency preparedness plan and it is easily accessible in the PC Administrators office.

The Executive Director of the community is the current Administrator for the Personal Care home and has been educated on the emergency preparedness expectations via the Regulatory Compliance Guide 9/14/2023.

The emergency plan will be reviewed quarterly starting on September 14, 2023, by the Maintenance Manager. A report will be completed and reported to QA monthly continuing for 12 months.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented ([redacted] - 11/21/2023)

107d - Procedure Emergency Management Agency Submission

12. Requirements

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

Description of Violation

The home's written emergency procedures were last reviewed on 06/08/23. The previous review was completed on 04/26/22.

107d - Procedure Emergency Management Agency Submission (continued)

Repeat Violation: 03/08/22.

Plan of Correction ***Accept [redacted] - 09/20/2023)***

The community maintains an emergency preparedness plan. It is reviewed by the local municipality annually.

Executive Director of the community is current Administrator for the Personal Care home and has been educated on the emergency preparedness expectations via the Regulatory Compliance Guide. 9/14/2023.

The emergency plan will be reviewed quarterly starting on September 14, 2023, by the Maintenance Manager. A report will be completed and reported to QA monthly continuing for 12 months.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented [redacted] - 11/21/2023)

131f - Fire Extinguisher Inspection

13. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the home's van has not been inspected by a fire safety expert since 2018.

Plan of Correction ***Accept [redacted] - 09/20/2023)***

The fire extinguisher in the vehicle was replaced on 8/10/2023 and tagged by the Fire Experts on 9/15/2023.

An audit was completed on 9/14/2023 of the fire extinguisher in the vehicles.

Education was provided on 9/14/2023 to the Transportation Team on the requirements for the fire extinguishers.

An audit will be completed monthly on the fire extinguishers in the vehicles by the Lead Transportation team member is designee. A report will be generated and reported on at QA monthly starting September 14, 2023 and continuing for 12 months.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented [redacted] - 11/21/2023)

141a - Medical Evaluation

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.

Description of Violation

Resident #2 does not have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department. Resident #2 has been a resident since 11/12/21.

141a - Medical Evaluation (continued)

Resident #3's only DME, dated 05/31/23, does not indicate the need for a secure dementia care unit and does not include a Medical Professional License #, Signature or Date Signed. Resident #3 has been a resident since [redacted]

Resident #4 does not have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department. Resident #4 has been a resident since [redacted]

Plan of Correction ***Accept [redacted] - 09/20/2023)***

Resident 2 had an updated medical evaluation completed on 9/1/2023.

Resident 3 had an updated medical evaluation completed on 9/1/2023.

Resident 4 had an updated medical evolution completed on 9/7/2023.

An audit of the residents living in the home was completed on 8/30/2023 to determine if an updated medical evaluation was required. If appropriate the medical evaluation were completed by 9/15/2023 and placed in the resident record.

Education was provided to the clinical team in personal care as well as the CRNP's on staff at Rydal Park to the requirements of the medical evaluation on 8/28/2023.

A monthly audit will be completed on the residents residing in the home by the Person Care nurse or designee to review the medical evaluation date. This will begin in October 2023. The report was generated and reported on at QA monthly and continued for 12 months.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented ([redacted] - 11/21/2023)

141b1 - Annual Medical Evaluation

15. Requirements

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

Description of Violation

Resident #2 has not had an initial or annual medical evaluation completed by a physician since the resident's move in date of [redacted].

Plan of Correction ***Accept [redacted] - 09/20/2023)***

Resident 2 had an updated medical evaluation completed on 9/7/2023.

An audit of the residents living in the home was completed on 8/30/2023 to determine if an updated medical evaluation was required. If appropriate the medical evaluation was completed and placed in the resident record.

Education was provided to the clinical team in personal care as well as the CRNP's on staff at Rydal Park to the requirements of the medical evaluation on 8/28/2023.

A monthly audit will be completed on the residents residing in the home by the Person Care nurse or designee to

141b1 - Annual Medical Evaluation (continued)

review the medical evaluation date. This will begin in October 2023. The report was generated and reported on at QA monthly and continued for 12 months.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented [redacted] - 11/21/2023)

162c - Menus Posted

16. Requirements

2600.
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 [redacted], at [redacted] the home's menus for the weeks of 07/17/23 to 07/23/23 and 07/24/23 to 07/30/23 were the only menus posted.

Plan of Correction ***Accept ([redacted] - 09/20/2023)***

The menus for the week were updated on 8/10/2023 for the current and next week.
An audit of both dining rooms was completed on 8/10/2023 for the current and next week's menu.
Education was provided on 9/15/2023 to the food service team members on the requirement to have menus posted for the current week and next week.

A weekly audit will be completed by the Food Service Manager or designee on the current and next week's menus will begin on 9/15/2023.

A report will be generated and reported to the QA committee monthly continuing for 12 months.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented [redacted] - 11/21/2023)

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.

Description of Violation

On 08/11/23, an audit of resident #5's glucometer was compared to the documented blood sugar counts on the resident's medication administration record (MAR). The following errors were found:

- *On [redacted], at [redacted] MAR is documented as [redacted]; this reading is not on the glucometer,*
- *On [redacted] at [redacted] MAR is documented as [redacted]; the [redacted] reading for this date and time is [redacted].*
- *On [redacted], at [redacted] MAR is documented as [redacted]; the [redacted] reads [redacted] at [redacted]*
- *On [redacted], at [redacted] MAR is documented as [redacted]; the [redacted] reads [redacted] at [redacted]*
- *On [redacted], at [redacted] MAR is documented as [redacted]; the [redacted] r reads [redacted] at [redacted]*

The resident is prescribed [redacted]. The MAR lists the schedule as [redacted] and [redacted]

185a - Implement Storage Procedures (continued)

Repeat Violation: 03/08/22.

Plan of Correction ***Accept (- 09/20/2023)***

Resident #5 glucometer readings were reviewed against the MAR. It was determined there were transcription errors but no medication errors as a result of inaccuracies.

Nursing staff were educated on 9/14/2023 regarding the specific use of glucometers and accurate transcription to the MAR.

Beginning 9/15/23 Personal Care nurse or designed team member will complete weekly glucometer to MAR audits. An audit of the resident findings will be reported to monthly QA continued for 12 months.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented - 11/21/2023)

191 - Resident Right to Refuse

18. Requirements

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

Description of Violation

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

Resident #2, admitted has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error. The home does not have signed documentation.

Repeat Violation: 03/08/22.

Plan of Correction ***Accept - 09/20/2023)***

The contract for resident #1 was reviewed with the resident on 9/14/2023 and signed.

The contract for resident #2 was reviewed with the resident on 9/14/2023 and signed.

Executive Director of the community is current Administrator for the Personal Care home and has been educated on the contract signing requirement via the Regulator Compliance Guide.

Resident contracts for those residing in the home were reviewed on 09/07/2023. Any resident contract without a signature was reviewed with the resident and responsible party where applicable. Signatures were obtained by those resident willing to sign. If the resident refused to sign, documentation was obtained and placed with the contract.

Resident contracts will be audited by the Personal Care Administrator or designee the month after moving in for review of signature compliance for 12 months. A report will be generated and reviewed by the QA committee monthly. This process will begin in October 2023.

191 - Resident Right to Refuse *(continued)*

Licensee's Proposed Overall Completion Date: *09/29/2023*

Implemented [redacted] - 11/21/2023)

224a - Preadmission Screen Form

19. 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 #1 was admitted to the home on [redacted]; however, the resident's preadmission screening form was not completed.

Plan of Correction ***Accept ([redacted] - 09/20/2023)***

Resident 1 prescreen has not been located. The home is able to meet the resident needs based on the current RASP. There is a notation in the record that the prescreen was identified by survey.

Residents in the home prescreens have been reviewed for compliance. Anyone without a prescreen has been reviewed to ensure we can meet their needs based on the current RASP. A notation is in the record to reflect the survey findings.

Residents scheduled for move in will have a prescreen completed within 30 days prior to move in.

Executive Director of the community is current Administrator for the Personal Care home and has been educated on the prescreen requirement via the Regulator Compliance Guide on 9/11/2023.

An audit will be conducted by the Administrator or designee of the new move-ins' monthly for review of the pre-screen. A report will be generated and reported to the QA committee monthly for 12 months.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented [redacted] - 11/21/2023)

225a - Assessment 15 Days

20. 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

An assessment was not completed for resident #1, who was admitted to the home on [redacted].

An initial assessment was not completed for resident #3, who was admitted to the home on [redacted].

Plan of Correction ***Accept ([redacted] - 09/20/2023)***

Resident 1 initial assessment was not able to be located.

225a - Assessment 15 Days (continued)

Resident 1 had a department requested assessment drafted waiting for self and family review on 9/15/2023.

Resident 3 initial assessment was not able to be located.

Resident 3 had a department requested assessment drafted waiting for self and family review on 9/15/2023.

A review of the residents living in the home assessment review was completed during the survey and it was determined residents would receive new assessments. Residents who needed initial or annual assessments are being drafted and completed by 9/30/2023.

Executive Director of the community is current Administrator for the Personal Care home and has been educated on the RASP requirement via the Regulator Compliance Guide on 9/11/2023.

A monthly audit will be completed of the residents living in the home assessments by the Administrator or designee. A report will be generated and reported on to the QA committee monthly for 12 months.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented [redacted] - 11/21/2023)

225c - Additional Assessment

21. 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 #2's most recent assessment was completed on 11/18/21.

Plan of Correction ***Accept [redacted] - 09/20/2023)***

Resident 2 had a department requested assessment drafted waiting for self family review on 9/15/2023.

A review of the residents living in the home assessment review was completed during the survey and it was determined residents would receive new assessments. Residents who needed initial or annual assessments are being drafted and completed by 9/30/2023.

Executive Director of the community is current Administrator for the Personal Care home and has been educated on the RASP requirement via the Regulator Compliance Guide on 9/11/2023.

A monthly audit will be completed of the residents living in the home assessments by the Administrator or designee. A report will be generated and reported on to the QA committee monthly for 12 months.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented [redacted] - 11/21/2023)

225c - Additional Assessment *(continued)*

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 #3's current assessment was completed on 05/18/23. However, there are no previous assessments. The resident's date of admission is [redacted].

Plan of Correction ***Accept ([redacted] - 09/20/2023)***

Resident 3 initial assessment was not able to be located.

Resident 3 had a department requested assessment drafted waiting for self and family review on 9/15/2023.

A review of the residents living in the home assessment review was completed during the survey and it was determined residents would receive new assessments. Residents who needed initial or annual assessments are being drafted and completed by 9/30/2023.

Executive Director of the community is current Administrator for the Personal Care home and has been educated on the RASP requirement via the Regulator Compliance Guide on 9/11/2023.

A monthly audit will be completed of the residents living in the home assessments by the Administrator or designee. A report will be generated and reported on to the QA committee monthly for 12 months.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented [redacted] - 11/21/2023)

227g -Support Plan Signatures

23. Requirements

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

Description of Violation

Resident #2 participated in the development of their support plan on 11/18/21. However, the resident did not sign the support plan.

Resident #4 participated in the development of their support plan on 04/25/23. However, neither the resident nor staff person E, the Administrator, signed the support plan.

Plan of Correction ***Accept [redacted] - 09/20/2023)***

Resident 2 had a department requested assessment drafted waiting for self and family review on 9/15/2023.

Resident 4 had a department requested assessment drafted waiting for self and family review on 9/15/2023.

A review of the residents living in the home assessment review was completed during the survey and it was determined residents would receive new assessments. Residents who needed initial or annual assessments are

227g -Support Plan Signatures (continued)

being drafted and completed by 9/30/2023.

Executive Director of the community is current Administrator for the Personal Care home and has been educated on the RASP requirement via the Regulator Compliance Guide on 9/11/2023.

A monthly audit will be completed of the residents living in the home assessments by the Administrator or designee. A report will be generated and reported on to the QA committee monthly for 12 months.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented [redacted] - 11/21/2023)

227i - Support Plan Accessible

24. Requirements

2600.
227.i. The support plan shall be accessible by direct care staff persons at all times.

Description of Violation

On [redacted], at [redacted] resident support plans were locked in staff member F's office and were inaccessible to direct care staff.

During staff interviews staff person G, hired [redacted], stated [redacted] does not have access to support plans and staff person H, hired [redacted] stated [redacted] doesn't know what a RASP is, [redacted] has access to MAR's but that's it.

Plan of Correction ***Accept ([redacted] - 09/20/2023)***

The location of the Support plans is posted in the 4th Floor nurses station where team members have access to them.

Education was provided to the clinical team on what the support plan (RASP) is and where they are located on 9/14/2023.

A monthly audit will be completed by the Administrator to review the location and accessibility of the support plans. A report will be completed and reported to the QA committee monthly for 12 months.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented [redacted] - 11/21/2023)

231b - Medical Evaluation

25. Requirements

2600.
231.b. A resident 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 admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]; however, the resident's medical evaluation (DME) was completed on 05/31/23. Further, resident #3's DME does not indicate the need for a secure dementia care unit and does not include a Medical Professional License #, Signature or Date Signed.

231b - Medical Evaluation (continued)

Resident #6 is diagnosed with Alzheimer's Dementia on the medical evaluation dated 12/30/22 with an indication in part (4) that the resident should be in a secured dementia care unit. However, resident #6 was admitted to the personal care unit on [redacted].

Plan of Correction ***Accept [redacted] - 09/20/2023)***

Resident #3 had an updated medical evaluation (DME) completed on 9/1/2023. It was signed by the licensed practitioner. It was reviewed by the temporary Nurse Manager for clinical accuracy.

Resident #6 had an updated medical evaluation (DME) completed on 8/10/2023. It was signed by the licensed practitioner. It was reviewed by the temporary Nurse Manager for clinical accuracy. Resident #6 is not in need of a secure dementia unit.

An audit of the residents living in the home was completed on 8/30/2023 to determine if an updated medical evaluation was required. If appropriate the medical evaluation were completed by 9/15/2023 and placed in the resident record.

Education was provided to the clinical team in personal care as well as the CRNP's on staff at Rydal Park to the requirements of the medical evaluation on 8/28/2023.

A monthly audit will be completed on the residents residing in the home by the Person Care nurse or designee to review the medical evaluation date. This will begin in October 2023. The report was generated and reported on at QA monthly and continued for 12 months.

Education was provided on 8/28/2023 to the clinical team on the requirements for initial and ongoing DME's.

A monthly audit will be completed of the residents living in the home assessments by the Administrator or designee. A report will be generated and reported on to the QA committee monthly.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented [redacted] - 11/21/2023)

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 #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, a written cognitive preadmission screening was not completed.

Plan of Correction ***Accept [redacted] - 09/20/2023)***

Resident 1 prescreen has not been located. The home is able to meet the resident needs based on the current RASP. There is a notation in the record that the prescreen was identified by survey.

Residents in the home prescreens were reviewed during the survey. The home is able to meet the resident needs

231c - Preadmission Screening (continued)

based on the current RASP. There is a notation in the record that the prescreen was identified by survey.

Residents scheduled for move in will have a prescreen completed within 30 days prior to move in.

Executive Director of the community is current Administrator for the Personal Care home and has been educated on the prescreen requirement via the Regulatory Compliance Guide on 9/11/2023.

An audit will be conducted by the Administrator or designee of the new move-ins' monthly for review of the pre-screen. A report will be generated and reported to the QA committee monthly for 12 months.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented ([redacted] - 11/21/2023)

231e - No Objection Statement

27. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept [redacted] - 09/20/2023)***

The contract for resident #1 was reviewed with the resident on 9/14/2023 and signed with the no objection statement signed on the original contract date of 12/2/2022.

The contract for resident #2 was reviewed with the resident on 09/14/2023 and signed see attached.

The Executive Director of the community is the current Administrator for the Personal Care home and has been educated on the contract signing requirement by Regulatory Compliance Guide.

Resident contracts for those residing in the home were reviewed on 09/07/2023. Any resident contract without a signature was reviewed with the resident and responsible party where applicable. Signatures were obtained by those residents willing to sign. If the resident refused to sign, documentation was obtained and placed with the contract.

Resident contracts will be audited by the Personal Care Administrator or designee the month after moving in for review of signature compliance for 12 months. A report will be generated and reviewed by the QA committee monthly. This process will begin in October 2023.

Licensee's Proposed Overall Completion Date: *09/29/2023*

Implemented [redacted] - 11/21/2023)

231f - Assessed Annually

28. Requirements

2600.

231f - Assessed Annually *(continued)*

231.f. In addition to the requirements in § 2600.225 (relating to initial and annual assessment), the resident shall also be assessed annually for the continuing need for the secured dementia care unit.

Description of Violation

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. Resident #3 does not have an initial medical assessment (DME) or a DME for 2019, 2020, 2021, and 2022. Resident #3's current DME, dated 05/31/23 does not indicate the need for a secured dementia care unit, is not signed by a licensed medical professional with a license number or indicate the date signed by a licensed medical professional.

Plan of Correction ***Accept ([redacted] - 09/20/2023)***

Resident #3 had an updated medical evaluation (DME) completed on 9/1/2023. It was signed by the licensed practitioner. It was reviewed by the temporary Nurse Manager for clinical accuracy. This resident chooses to live in the secured dementia neighborhood and has a signed objection statement as part of the contract on 5/14/18.

A review of the residents DME's living in the home was completed during the survey. The decision was made to renew residents residing in the home. Moving forward anniversary of move-in date or change in condition will be used to trigger updated DME's.

Residents who needed initial or annual DME were completed by 9/15/2023.

Education was provided on 8/28/2023 to the clinical team on the requirements for initial and ongoing DME's.

A monthly audit will be completed of the residents living in the home assessments by the Administrator or designee. A report will be generated and reported on to the QA committee monthly for 12 months.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented [redacted] - 11/21/2023)

234a - Admission Support Plan

29. Requirements

2600.

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

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, resident #1 does not have a support plan.

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was not completed. The only support plan for resident #3 is dated 05/18/23.

Plan of Correction ***Accept [redacted] - 09/20/2023)***

Resident 1 had a department requested assessment drafted waiting for self and family review on 9/15/2023.

234a - Admission Support Plan (continued)

Resident 3 had a department requested assessment drafted waiting for self and family review on 9/15/2023.

A review of the residents living in the memory support unit review was completed during the survey. Residents who needed assessments were completed by 9/15/2023.

Education was provided on 9/14/2023 to the clinical team on the requirements for initial and ongoing assessments (RASP).

A monthly audit will be completed of the residents living in the home assessments by the Administrator or designee. A report will be generated and reported on to the QA committee monthly for 12 months.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented ([redacted] - 11/21/2023)

236 - Staff Training

30. Requirements

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

Description of Violation

Direct care staff person A, who works in the Secure Dementia Care Unit (SDCU) had an unmeasurable amount of training hours in dementia care during the 2022 training year.

Direct care staff person D, who works in the Secure Dementia Care Unit (SDCU) had an unmeasurable amount of training hours in dementia care during the 2022 training year.

Plan of Correction ***Accept [redacted] - 09/29/2023)***

Staff person A is no longer working in the Personal Care home.

Staff person D has completed 2 hours of training in Dementia Care in the past 12months. In addition, Staff person D received 5 hours of training titled Immerse Training by Kim Hill, Director of Resident Services on 09/21/2023. See attached.

Dementia Care Training is scheduled for all direct care team members by 09/30/2023. Moving forward, All Direct Care Staff working in the SDCU will be trained in dementia care yearly by the Director of Resident Services.

Moving forward the Human Resources Director will conduct quarterly audits about direct care team members completing dementia care training, findings will be reported monthly to QA for the next 12 months, starting October 2023.

In addition to the above plan of correction: The home will provide to the Department training documentation that includes name of staff, date of training, source, training topic, and training length. MJ

Licensee's Proposed Overall Completion Date: *10/02/2023*

236 - Staff Training *(continued)*

Implemented [redacted] - 11/21/2023)

251a - Record for Each Resident

31. Requirements

2600.
251.a. A separate record shall be kept for each resident.

Description of Violation

On 08/10/23, the home was not maintaining individual records for their residents.

Plan of Correction ***Accept [redacted] - 09/20/2023)***

The home maintains an electronic health record which keeps each resident record separate. The surveyor reviewed a grouping of paper records. A review the homes resident paper records was conducted during the survey. Induvial paper files are being created for the use of the care team members.

Education was provided on 9/13/2023 to the clinical team regarding keeping the paper files.

A monthly audit will be completed by the Administrator or designee regarding the paper files. A report will be generated and reported to the QA committee monthly for 12 months.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented ([redacted] - 11/21/2023)

252 - Record Content

32. Requirements

2600.
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.
4. Language or means of communication spoken or used by the resident.
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 home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.

252 - Record Content *(continued)*

Description of Violation

During the annual licensing inspection, the home was trying to put together files for review. None of the selected files were complete.

Resident #1's record does not include the preadmission screening, initial intake assessment and the most current version of the annual assessment or a support plan,

Resident #2's record does not include gender, Social Security number, height, weight, religious affiliation, if any, and identifying marks, address of a designated person to be contacted in case of an emergency, the address and telephone number of the resident's physician or source of health care, the current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms, a list of prescribed medications, OTC medications and CAM, dietary restrictions, a record of incident reports for the individual resident, a list of allergies, the documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies, the most current version of the annual assessment, a support plan, applicable court order, if any, and the resident's medical insurance information.

Resident #3's record does not include Social Security number, height, weight, religious affiliation, if any, the address of a designated person to be contacted in case of an emergency, the address of the resident's physician or source of health care, the current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms (current DME is not signed by a medical professional), dietary restrictions, a record of incident reports for the individual resident, a list of allergies, the documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies, initial intake assessment applicable court order, if any, and the resident's medical insurance information.

Resident #4's record does not include gender, Social Security number, race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks, a photograph of the resident that is no more than 2 years old, language or means of communication spoken or used by the resident, the name, address, telephone number and relationship of a designated person to be contacted in case of an emergency, the address of the resident's physician or source of health care, the current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms, a list of prescribed medications, OTC medications and CAM, dietary restrictions, a record of incident reports for the individual resident, a list of allergies, the documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies, applicable court order, if any, and the resident's medical insurance information.

Plan of Correction ***Accept [redacted] - 09/20/2023)***

Resident 1 prescreen has not been located. A department requested assessment is drafted waiting for self and family review on 9/15/2023.

Resident 2 records have been updated to include the gender, social security number, height, weight, religious affiliation and any identifying marks. The record has been updated to include and designated person or contacts for emergencies, the address and telephone number of the physician or healthcare provider. Resident 2 participated in the development of their support plan on 11/18/21. Resident 2 had a department requested assessment drafted on 9/15/2023 waiting for self and family review. Resident 2 previous medical evaluations were not able to be located. An updated DME, medical evaluation was completed on 8/25/23. The list of medications including the OTC medication is included with the evaluation. A record of incident reports is kept for each resident. Allergies are

252 - Record Content (continued)

included in the medical evaluation completed on 8/25/23. Orders for any visiting health agencies such as home health, rehab or hospice are included in the chart.
Resident #3, in the electronic health record the social security number, height, weight, religious affiliation are documented. They are also now in the paper chart. Emergency contacts and physician information are also documented in the electronic record along with any other applicable information listed as a requirement of the record.

Resident #4's record has been updated to include the required applicable information as listed. Current assessment and DME on hand. Initial RASP from April 2023 admission was not able to be located.
Education was completed for administration and associated support to review the required contents of resident records on 9/14/2023.

Moving forward the PC Administrator or designated PC team member to conduct sample audits of resident record content monthly and report compliance through the community QAPI process beginning with the month of September.

Licensee's Proposed Overall Completion Date: *10/02/2023*

Implemented [redacted] - 11/21/2023)