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

February 9, 2024

[redacted], ADMINISTRATOR
WARWICK BRIDGES LLC
[redacted]

RE: THE BRIDGES AT WARWICK
1600 ALMSHOUSE ROAD
JAMISON, PA, 18929
LICENSE/COC#: 14316

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/27/2023, 11/28/2023 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 BRIDGES AT WARWICK* **License #**: *14316* **License Expiration**: *10/31/2024*

Address: *1600 ALMSHOUSE ROAD, JAMISON, PA 18929*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *WARWICK BRIDGES LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-1* **Date**: *12/08/2016* **Issued By**: *Warwick Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *113* **Waking Staff**: *85*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *11/28/2023*

Inspection Dates and Department Representative

11/27/2023 - On-Site: [redacted]

11/28/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *130* **Residents Served**: *72*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *30* **Residents Served**: *17*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *71*

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

Have Mobility Need: *41* **Have Physical Disability**: *0*

Inspections / Reviews

11/27/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/23/2023*

01/12/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/08/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/15/2024*

Inspections / Reviews *(continued)*

01/18/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/08/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/08/2024*

02/09/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/08/2024*

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

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

On 11/28/2023, Personal Care medication carts #1, #2, and Memory Care medication cart laptop monitors were unlocked, unattended, and accessible.

On top of the Personal Care Med Carts #1 and #2 were two books of the narcotics medication administration record's (MAR's) and one empty pack of medication with resident 1's information unlocked, unattended, and accessible.

On the memory care unit, the medication station was left unlocked, unattended, and accessible during the medication inspection.

Plan of Correction ***Accept ([redacted] - 01/08/2024)***

Correction: In Immediate response to this violation, a secondary medication technician was stationed with the state inspector and instructed to not leave the state inspector alone with the medication cart. Narcotic book was placed in bottom drawer of cart as is typical practice after each use. Empty pack of medication for resident 1 was immediately disposed of appropriately in shred box.
Door to medication station in memory care unit remains locked at all times, door is unable to be unlocked with the exception of key to enter.
Training: Director of Wellness has in-serviced Medication Technicians and Nurses on regulation 2600.17 adherence.
Action: The Director of Wellness and/or Designee will randomly check weekly, without warning, adherence to 2600.17, including ensuring laptop monitors are closed or minimized when not in use, narcotic log storage in medication cart when not in use and proper destruction of empty medication packs between November 29, 2023- February 28, 2024
Action: The results of audit will be reviewed monthly at Quality Assurance meeting November 29, 2023- February 28, 2024

Proposed Overall Completion Date: 03/30/2024

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] - 02/09/2024)

42s - Privacy

2. 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.

42s Privacy *(continued)*

Description of Violation

On 11/27/2023, there were video cameras pointing towards residents rooms throughout the facility.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Interpretive guideline states that video monitoring of the home's interior common areas is permitted. Video monitoring at Warwick is not recorded. Video monitoring feed is only accessible by the locked IT room.
Sign is posted at entrance that video monitoring is in place.
Corrective Action: Executive director and/or designee will contract to have camera video monitoring disabled. Will submit documentation and receipt once work has been completed.

Proposed Overall Completion Date: 03/30/2024

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] 02/09/2024)

51 - Criminal Background Check

3. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff member A's date of hire was [redacted]; however, staff member A's criminal background was completed on [redacted].
Staff member B's date of hire was [redacted]; however, staff member B's criminal background was completed on [redacted].

Plan of Correction ***Accept [redacted] - 01/18/2024)***

Training: ED in serviced BOD on necessity of background checks being completed before associate hire on 12/6/2023
Correction: Audit of all employee files for background check to be completed by 1/15/2024
Action: ED will audit all new associate chart for background check prior to hiring 12/1/23 3/30/24
Action: Offers of employment will be made contingent on results of background check. Potential new associate will not attend orientation until background check is received and appropriate.
Action: New hire process to be reviewed weekly during stand up, ED to verify that background has been received and is appropriate prior to approval to attend orientation. 12/1/2023 3/3/2024

Proposed Overall Completion Date: 03/30/2024

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] 02/09/2024)

65f - Training Topics

4. 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.
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 C did not receive training in medication self-administration, instructions on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation, or support plan. Care for residents with dementia and cognitive impairments, infection control, general principles of cleanliness and hygiene, and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition, and dehydration, personal care service needs of the resident, safe management techniques, and care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during the training year 2022.

Plan of Correction ***Accept ([redacted] - 01/08/2024)***

Direct care staff person C completed 2022 training in first half of 2023, after the 1/31/2023 deadline.
Correction: In-service - Executive Director in serviced direct care staff person C on importance of completing continuing education in a timely manner
Training: Wellness director included importance of continuing education for all associates in monthly all staff meeting. 12/15/23
Audit of all associate training to be completed by 12/31/2023
Associate continuing education will be audited monthly for compliance 1/1/2024 - 3/30/2024

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] - 02/09/2024)

65g - Annual Training Content

5. 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.

65g - Annual Training Content *(continued)*

Description of Violation

Staff person C did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations; resident rights; the Older Adult Protective Services Act; falls and accident prevention; and new population groups that are being served at the home that were not previously served, if applicable, during the training year 2022.

Plan of Correction ***Accept (- 01/18/2024)***

Staff person C did participate in fire drills conducted by fire expert in training year 2022. Participation log attached.
Correction: In-service - Executive Director in serviced direct care staff person C on importance of completing continuing education on fire safety in a timely manner
Correction: Staff person C completed fire training in the year 2023 on 6/21/2023.
Immediate action: Staff person C retrained on fire safety on 12/12/2023 by fire safety certified director.
Action: Audit of all staff required annual training completed by business office director on 1/10/2024.
Action: Monthly audit of staff training to be completed by BOD to review associates whose annual hire date is coming in the next 60 days to ensure that all annual training is completed prior to their annual anniversary date. Monthly audit to be reviewed by Quality Assurance committee monthly and recommendations to be made based on audit results. 1/1/2024 - 3/30/2024
Training: Wellness director included importance of continuing education for all associates in monthly all staff meeting. 12/15/23
Associate continuing education on fire safety will be audited monthly for compliance 1/1/2024 - 3/30/2024

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented - 02/09/2024)

81b - Resident Personal Equipment

6. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 11/28/2023, resident 2's bedside mobility device was loose, not securely attached to the bed.

Plan of Correction ***Accept - 01/08/2024)***

Correction: Mobility device was immediately removed on 11/28/23 [Document Z1]
Training: Resident and Family educated on safety measures including alerting DOW and/or ED when devices are added to apartment. [Document Z2]
Training: Director of Wellness educated appropriate staff on ensuring to check bed enablers and report all loose equipment. Furthermore, reporting all apartments that have a bed enabler in place as all such apparatuses must be checked for safety compliance. [Document Z3]
Action: Director of Wellness and/or Designee will audit current resident apartments for bed enablers, ensuring there is appropriate documentation and proper attachment of apparatus by 12/31/23. [Document Z4]
Action: Director of Wellness and/or Designee will audit occupied units from November 29, 2023 through March 30, 2024 to monitor for and ensure bed enablers are appropriately attached.

81b - Resident Personal Equipment (continued)

[Document Z5]
Action: Audit results shall be reviewed at Monthly Quality Assurance meeting to ensure adherence to regulation 2600.81B November 29, 2023 through March 30, 2024 [Document Z6]

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] - 02/09/2024)

101j3 - Bed/Linens/Pillows/Blankets

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 11/28/2023, at 10:15 am, there were no bed linens on resident 3's bed in [redacted] the soiled linens were thrown in the corner in the room.

Plan of Correction ***Accept [redacted]J - 01/08/2024)***

Correction: - in immediate response bed was made by housekeeper
Training: Director of Wellness and Memory care director have in-serviced associates on importance of making beds as soon as they are stripped.
Action: Directors will make rounds to ensure that beds are clean and made weekly. Audits will be done weekly by executive director and/or designee for compliance from 12/12/23 until 3/30/24

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] - 02/09/2024)

107b - Emergency Procedures

8. Requirements

2600.
107.b. The home shall have written emergency procedures that include the following:
1. Contact information for each resident's designated person.
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.
5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.
6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

The home's written emergency procedures do not include the contact information for each resident's designated person.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Correction: 11/27/23 – list of residents and designated person phone number and email was added to disaster binder
Training: in serviced all directors on requirement to update resident list with contact information weekly

107b - Emergency Procedures (continued)

Action: Business office director or designee will update contact list with admissions/discharges in emergency binder weekly 11/29/23 – 3/30/24

Action: Executive director or designee with audit contact list in emergency binder weekly through 3/30/2024 to verify contact information is updated with admissions/discharges.

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented ([redacted] - 02/09/2024)

141a 1-10 Medical Evaluation Information

9. 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 medical evaluation dated [redacted] did not include body positioning and movement stimulation for residents, if appropriate.

Resident 4 medical evaluation dated [redacted] did not include the medical information pertinent to diagnosis and treatment in case of an emergency.

Resident 5 medical evaluation dated [redacted], did not include the medication list.

Plan of Correction ***Accept ([redacted] - 01/08/2024)***

Correction: In immediate response to these violations, new DME's were secured signed by appropriate medical professionals, including reviewed medication lists.

Training: The Executive Director has in serviced the Director of Wellness and the Memory Care Director on adherence to regulation 2600.141 (A).

Training: The Director of Wellness has in-service staff qualified to assist in the review of information on a Documentation of Medical Evaluation for the adherence of regulation 2600.141 (A).

Action: The Director of Wellness and/or designee will audit all current resident DME's by 12/31/2023 to ensure compliance with regulation 2600.141 (A).

Action: The Director of Wellness and/or designee shall review all future move ins from November 29, 2023 –

141a 1 10 Medical Evaluation Information (continued)

February 28, 2024, to ensure compliance with regulation 2600.141

Action: The Executive Director and/or designee will review audits at monthly QA November 29, 2023 February 28, 2024, to ensure compliance with regulation 2600.141 (A).
See attached.

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented (- 02/09/2024)

171b5 - First Aid Kit

10. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in bus #1 used to transport residents does not include a breathing shield.
Van #1 used to transport residents does not have a first aid kit.

Plan of Correction ***Accept - 01/08/2024)***

Immediate Action Breathing shield was added to first aid kit in bus.
Correction first aid kit was ordered for van and installed on 12/10/2023
Training ED completed in service regarding importance of first aid kit in all community vehicles
Action: Lead driver will audit first aid kits monthly from 12/1/23 3/30/24

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented (- 02/09/2024)

183e - Storing Medications

11. 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 11/28/2023, there were two loose pills and a half pill on med carts 1 and 2 of the personal care unit. There were also two loose pills in the Memory Care medication cart.

On November 28, 2023, the tablet prescribed for resident 6 was in a blister card. The foil on the back of one of the pills had been torn and taped.

Plan of Correction ***Accept - 01/08/2024)***

Correction: In immediate response to 183 (E), all three Medication carts were inspected and cleaned of any loose medication.
Correction: tab with torn and taped back was immediately destroyed per policy.
Training: in serviced on regulation 183 adherence, including immediate removal and proper disposal of loose pills

183e - Storing Medications (continued)

in cart and immediate removal and proper disposal medication in blister pack if foil becomes damaged.
Training: Director of Wellness has in-serviced Medication Technicians and Nurses on regulation 183 (E) adherence.
Action: Director of Wellness and/or designee will inspect the medication carts on a weekly basis to ensure adherence to regulation 183 (E) from 11/29/23 until February 28, 2024.
Action: Results of audits will be reviewed at monthly QA by Executive director and/or designee and Director of Wellness and/or designee

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] 02/09/2024)

183f - Discontinued Medications

12. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

On 11/28/2023, bus #1 used to transport residents had expired [redacted] medications inside the first aid kit bag.

The following medication, [redacted] with an expiration date of [redacted] was in bus #2 first aid kit. This is not an approved method of destroying medications, according to the Department of Environmental Protection and federal and state regulations.

On 11/28/2023, there was one loose pill on med cart #1. Staff member D took the loose pill and threw it in the trash can. This is not an approved method of destroying medications, according to the Department of Environmental Protection and federal and state regulations.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Correction: [redacted] was removed from first aid kit and destroyed in med destroyer
Correction: In immediate response to this violation, the employee that disposed of the medication improperly was disciplined in writing.
Training: Director of Wellness has in-serviced this employee on adherence to 2600.17.
Training: In addition, this employee will assist the Director of Wellness in educating Medication Technicians and Nurses during In service on adherence to 2600.183(F)
Action: Driver to audit vehicle first aid kits, to include ensuring no oral medications are in kit and verifying any expiration dates of items in kits, 12/1/2023 - 3/30/2024
Action: All medications destroyed between November 29, 2023 – February 28, 2024 will be logged with the method of destruction.
Action: Results of medication destruction log will be reviewed monthly during Quality Assurance November 29, 2023- February 28, 2024.

183f Discontinued Medications *(continued)*

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented (- 02/09/2024)

185a - Implement Storage Procedures

13. 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 , resident 6 is prescribed tablet. The count on the book was 22, however, it was only 21 on the pack.

Plan of Correction ***Accept (- 01/08/2024)***

Immediate: Narcotic log signed appropriately to reflect administration of tab 22 to resident #6. was documented in MAR as given, but not signed on log at time of administration
Training: Executive Director completed in service training with director of wellness and director of memory care regarding procedures for storage, access and security of medications
Training: Director of Wellness completed in service with medication technicians and nurses regarding immediate documentation of controlled medications in both the MAR and narcotic log at the time of administration.
Action: Director of Wellness or designee to audit narcotic logs weekly 12/1/2023 3/30/23 to verify documentation of controlled medications in both the MAR and narcotic log appropriately. Audits to be reviewed monthly during QA meeting for further recommendations.

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented - 02/09/2024)

14. 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

Resident 2 is prescribed , ready to use, and ointment 20% as needed. On 11/28/23 these medications were not available in the home.

Resident 6 is prescribed and as needed. On 11/28/2023, these medications were not available in the home.

Resident 7 is prescribed , ready to use, glucose 4 gm, , and . On 11/28/2023, the medications were not available in the home.

Plan of Correction ***Accept (- 01/08/2024)***

Action: Director of Wellness obtained order to discontinue medications no longer needed by resident. Medications that were not discontinued were ordered and placed on medication cart.

185a - Implement Storage Procedures (continued)

Action: Director of Wellness conducted audit of med carts for resident prn medications.
Action: Director of Wellness and/or nursing associates will contact resident physicians to verify necessity of prn medications. If no longer necessary orders to discontinue will be requested.
Action: Director of Wellness or designee to audit medication carts weekly for medication availability 12/1/2023 - 3/30/23. Audits to be reviewed monthly during QA meeting for further recommendations.

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] - 02/09/2024)

224a - Preadmission Screen Form

16. 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 2 was admitted to the home on [redacted] however, the resident's preadmission screening form was missing the date of completion, admitting personal care home, level of supervision, and use and avoid poisonous materials.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

In immediate response to this violation, the prescreen form for resident 2 has been completed to the standard of the department.
Training: The Director of Wellness completed an in-service with staff qualified to complete a prescreen.
The Director of Wellness and/or designee will audit current residents prescreens. Audit will be completed by 12/31/2023
The Director of Wellness and/or designee will audit future prescreens prior to move in from 11/29/2023 - 3/3/2024
The results of the audit will be reviewed during monthly QA meetings from 12/1/23 - 3/30/24

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] - 02/09/2024)

17. 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 4 preadmission screening form, dated [redacted], does not include a level of care for the resident.

Plan of Correction ***Accept [redacted] 01/08/2024)***

In immediate response to this violation, the prescreen form for both residents have been completed and the standard of the department.
Training: The director of Wellness completed in-service for staff qualified to complete a prescreen.
Action: The Director of Wellness and/or designee will audit current residents prescreens. Audit will be completed by 12/31/2023.
The Director of Wellness and/or designee will audit future prescreens prior to move in from 11/29/2023 - 3/3/2024.

224a - Preadmission Screen Form (continued)

The results of the audit will be reviewed during monthly QA meetings from 12/1/23 - 3/30/24.

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] 02/09/2024)

225a - Assessment 15 Days

18. 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 [redacted]; however, the resident's assessment was not completed until [redacted]

Repeat violation - 7/13/2022.

Plan of Correction ***Accept ([redacted] - 01/08/2024)***

Correction: Assessment Modified 3/21/23. Original Completed assessment dated 3/2/2023 [Document Y1]
Action: Director of Wellness to in service appropriate staff on adherence to regulation 2600. 225 (A). [Document Y2]
Action: Director of wellness and/or Designee to audit current resident charts to ensure adherence to regulation 2600. 225 (A). [Document Y3]
Action: Director of Wellness and/or Designee to audit new admissions to ensure adherence to regulation 2600.225 (A) from December 1, 2023 through March 31, 2024. [Document Y4]
Action: Results of Audits will be reviewed monthly at Quality Assurance meeting from December 1, 2023 through March 30, 2024. [Document Y5]

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented ([redacted] - 02/09/2024)

227c - Support Plan Revision

19. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident 2 medical evaluation dated [redacted], has a no added sodium diet. However resident 2 assessment, dated [redacted], does not include an update for the non-added sodium diet.

Resident 4 assessment, dated [redacted], does not include an update for the puree diet change on 10/18/2023.

Resident 9 medical evaluation dated [redacted], has a no added sodium diet. However resident 9 assessment, dated 3/02/2023, does not include an update for the non-added sodium diet.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Correction: In immediate response to violation of 2600.227 (C), Resident C.L. and Resident B.S. diets were added to

227c - Support Plan Revision (continued)

current RASPs.
Training: The Executive Director in serviced the Director of Wellness and the Memory Care Director on adherence to regulation 2600.227.c on 12/11/2023
Training: The Director of Wellness in serviced the staff qualified to update, change and/or complete a RASP on the adherence to regulation 2600.227.c on 12/11/2023 and 12/13/2023.
Action: The Director of Wellness and/or Designee will audit current resident RASPs and ensure the diet is included by December 20, 2023.
Action: The Director of Wellness and/or Designee will audit new resident move in RASPs to ensure all diets are included from November 29, 2023 – March 30, 2024.
Action: The results of RASP audit shall be reviewed monthly during Quality Assurance meeting from November 29, 2023 – March 30, 2024.

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented ([redacted] - 02/09/2024)

227d - Support Plan Medical/Dental

20. 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 2, dated [redacted] did not include an update that the resident has a need for transferring. Resident 2 has a new order for a mechanical lift signed on [redacted].

Plan of Correction ***Accept ([redacted] - 01/08/2024)***

Immediate response to this violation:
Resident [redacted] RASP was updated and signed.
Resident [redacted] RASP was reprinted, signed and dated properly.
Resident [redacted] RASP was updated to include transfer status.

Training: The Director of Wellness in serviced staff qualified to complete and/or update RASP on the adherence to regulation 2600.277.d
Action: The Director of Wellness and/or designee shall audit resident RASP's to ensure dates, corrections and transfer status are properly documents by 12/31/23.
Action: The Director of Wellness and/or designee shall audit future RASPS weekly to ensure correct dates, corrections and transfer status are properly documented
11/29/23 - 3/30/24
Action:
The results of audits will be reviewed in monthly QA 12/1/23 - 3/30/24.

227d Support Plan Medical/Dental *(continued)*

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] - 02/09/2024)

227g -Support Plan Signatures

21. 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 his/her support plan on [redacted]. However, the resident did not sign the support plan.

Resident 9 participated in the development of his/her support plan on [redacted] However, the resident did not sign the support plan.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Correction: In an immediate response to this violation, both [redacted]. and [redacted] have signed their current RASPs.
Training: The Director of Wellness to in service nursing staff on the adherence of regulation 2600. 227 (G) by December 20, 2023.
Action: The Director of Wellness and/or Designee shall audit all current resident RASPs to ensure they have the proper signatures by December 20, 2023.
Action: The Director of Wellness and/or Designee shall audit future move in RASPs weekly to ensure proper signatures are included from November 29, 2023 March 30, 2024.
Action: The results of audits shall be reviewed at the monthly Quality Assurance meeting November 29, 2023 March 30, 2024.

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] - 02/09/2024)

231c - Preadmission Screening

22. 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 4 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, resident 4's doesn't have a written cognitive preadmission screening.

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Correction: In immediate response to this violation, the Director of Wellness has completed a preadmission screening form dated on day of discovery, 11/27/2023. [Document W1]

231c - Preadmission Screening (continued)

Training: The Executive Director has in-serviced the Director of Wellness, and the Memory Care Director on the adherence to regulation 2600.231 (C).
[Document W2]
Training: The Director of Wellness and/or the Memory Care Director will Inservice appropriate staff on the adherence to regulation 2600.231 (C). [Document W3]
Action: The Director of Wellness and/or Designee has audited current memory care resident charts to ensure preadmission screening was completed. [Document W4]
Action: The Director of Wellness and/or Designee will audit new and future memory care residents weekly to ensure that a preadmission screening was completed as needed for a move into the memory care unit ongoing from November 29. 2023 through March 31, 2024. [Document W5]
Action: The results of audits shall be reviewed at monthly Quality Assurance meetings from November 29, 2023 through March 30, 2024 [Document W6]

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] - 02/09/2024)

233c - Key-Locking Devices

23. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the staircase A and the gate outside the court yard from the Secure Dementia Care Unit (SDCU).

Plan of Correction ***Accept ([redacted] - 01/08/2024)***

Correction: 11/27/2023 – picture frame was immediately hung with exit code in sunroom. Weather resistant numbers were placed on back gate on top of a photo.
Training: Executive Director in serviced Memory care director and Maintenance director on importance of having conspicuously placed signs by all exits.
Action: ED or designee will check secure memory care egress from 11/29/23 to 3/30/24

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented ([redacted] - 02/09/2024)

234a - Admission Support Plan

24. 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 4 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's support plan was completed on [redacted], and it does not have an update on the resident's dementia status.

234a - Admission Support Plan (continued)

Plan of Correction ***Accept [redacted] - 01/08/2024)***

Correction: Immediate response to violation, support plan was updated with resident diagnosis of dementia. [Document V1]
Training: The Executive Director has in-serviced the Director of Wellness and the Memory Care Director on the strict adherence to regulation 2600.234 (A) [Document V2]
Training: The Director of Wellness and/or Memory Care Director will in-service appropriate staff on regulation 2600.234 (A). [Document V3]
Action: The Wellness Director and/or Designee audited all current memory care residents to ensure adherence to regulation 2600. 234 (A). [Document V4]
Action: The Memory Care Director and/or designee shall audit future/new admissions to the memory care unit to ensure adherence to regulation 2600.234 (A). November 29, 2023 through March 31, 2024. [Document V5]
Action: Results of audits shall be reviewed monthly at Quality Assurance meeting November 29, 2023 through March 30, 2024. [Document V6]

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented ([redacted] - 02/09/2024)

236 - Staff Training

25. 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 C, who works in the Secure Dementia Care Unit (SDCU), does not have any hours of training in dementia care during the 2022 training year.

Plan of Correction ***Accept ([redacted] - 01/08/2024)***

Direct care staff person C completed 2022 training in first half of 2023, after the 1/31/2023 deadline.
Correction: In-service - Executive Director in serviced direct care staff person C on importance of completing continuing education in a timely manner
Training: Wellness director included importance of continuing education for all associates in monthly all staff meeting. 12/15/23
Audit of all associate training to be completed by 12/31/2023
Associate continuing education will be audited monthly for compliance 1/1/2024 - 3/30/2024

Licensee's Proposed Overall Completion Date: *03/30/2024*

Implemented [redacted] - 02/09/2024)