pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **EAGLEVIEW LANDING LP**
LEGAL ENTITY

To operate **EAGLEVIEW LANDING**
NAME OF FACILITY OR AGENCY

Located at **650 STOCKTON DRIVE, EXTON, PA 19341**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **121** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 46**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **March 15, 2024** until **September 15, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **146982**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MARCH 15, 2024

Executive Vice President
Eagleview Landing, LP

RE: Eagleview Landing
650 Stockton Drive
Exton, Pennsylvania 19341
License #: 146982

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection October 11, 2023, November 28, 29, and December 6, 2023, and January 3, 4, and 8, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from March 15, 2024 to September 15, 2024.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
42s	3	80	$3	$240	15 calendar days from mailing date of this letter
183d	3	80	$3	$240	15 calendar days from mailing date of this letter
183e	2	80	$5	$400	5 calendar days from mailing date of this letter
185a	2	80	$5	$400	5 calendar days from mailing date of this letter
187d	2	80	$5	$400	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

Mr. Jason Childers

If you disagree with the decision to issue a SECOND PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

If you decide to appeal your SECOND PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *EAGLEVIEW LANDING* **License #**: *14698* **License Expiration**: *02/02/2024*

Address: *650 STOCKTON DRIVE, EXTON, PA 19341*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *EAGLEVIEW LANDING LP*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *08/03/2020* **Issued By**: *Uwchlan Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *135* **Waking Staff**: *101*

Inspection Information

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

Reason: *Complaint, Provisional, Monitoring* **Exit Conference Date**: *10/11/2023*

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *121* **Residents Served**: *94*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *46* **Residents Served**: *40*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *94*
Diagnosed with Mental Illness: *53* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *41* **Have Physical Disability**: *40*

Inspections / Reviews

10/11/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/02/2023*

Inspections / Reviews *(continued)*

11/09/2023 - POC Submission

Submitted By: [redacted]
Date Submitted: *12/14/2023*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *11/14/2023*

11/15/2023 - POC Submission

Submitted By: [redacted]
Date Submitted: *12/14/2023*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *12/15/2023*

02/27/2024 - Document Submission

Submitted By: [redacted]
Date Submitted: *12/14/2023*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

63a - First Aid/CPR Training

1. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 9/30/23 and 10/2/23, during the overnight shift, 94 residents were present in the home. During this time, no staff person certified in First Aid or CPR was present in the home.

Plan of Correction ***Accept (- 11/08/2023)***

We respectfully ask for this violation to be withdrawn. Of the staff members who were present on the overnight shift on 9/30/23, 4 of them are CPR certified and of the overnight staff present on 10/2/23 4 were certified in CPR. Documents uploaded.
All employee files will be audited by Business Office Director or Designee for updated First Aid/CPR Training by 11/30/23. Any employee with expired First Aid/CPR will be retrained.
CPR training is scheduled at the community on November 8, 2023 for all employees with expired First Aid/CPR training.
Heath Service Director, General Manager or Designee will verify that at least one staff person for every 50 residents will be always present in the community on each shift.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Implemented (- 02/27/2023)

82c - Locking Poisonous Materials

2. 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 10/11/23, two tubes of Calazime Zinc Oxide paste, with a manufacturer's label indicating, "If swallowed, get medical help or contact a Poison Control Center immediately," were unlocked, unattended, and accessible to Resident 1's bathroom cabinet in memory care. Not all the residents of the home, including Resident 1, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 11/08/2023)***

The tubes of Calamine Zinc Oxide paste were immediately removed was by Med Tech on duty on October 11, 2023.
All rooms were checked by Wellness Nurse on duty to ensure that all potentially poisonous materials were secured.
Health Service Director or Designee will provide education on this regulation to all staff by 11/30/23.
The General Manager and/or Guest Service Director of the home or the Memory Care Manager will conduct weekly rounds of the home to ensure all poisonous materials are locked, for the next six months, starting immediately.
The General Manager of the home will discuss the importance of locking poisonous materials in the Memory Care neighborhood at monthly staff meetings for the next six months, starting 11/5/23.
Copies of the agenda and sign in sheets will be maintained for the Departments review.
Weekly rounds in the Memory Care neighborhood will be made by General Manager or Designee for the next 30 days.

82c - Locking Poisonous Materials *(continued)*

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented (█ - 02/27/2023)

85a - Sanitary Conditions

3. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 10/11/23 at 10:25am, there was feces around the toilet bowl in Resident 1's bathroom.

On 10/11/23 at 10:18am, there was feces around the toilet bowl and toilet seat in Resident 2's bathroom.

Plan of Correction ***Accept (█ - 11/08/2023)***

The feces were immediately cleaned in both bathrooms by housekeeper on October 11, 2023.
A Full-Time housekeeper is now scheduled solely for SDCU. Housekeepers have been provided with a detailed schedule and list of duties.
General Manager, Health Service Director or Designee will provide education on this regulation to all staff by 11/30/23.
Weekly rounds will be made by General Manager or designee for the next 30 days.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented (█ - 02/27/2023)

103e - Left Overs

4. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 10/11/23 at 10:45am, there was an unlabeled, undated piece of cake in the second-floor memory care kitchen fridge.

Plan of Correction ***Accept (█ - 11/08/2023)***

The cake was immediately discarded by Active Living Assistant on October 11, 2023.
All staff will receive education on this regulation by Executive Chef or Designee by 11/30/23.
The General Manager, Executive Chef or designee will be responsible for checking all refrigerators for sealed and dated food daily for the next 3 months.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Implemented (█ - 02/27/2023)

141a - Medical Evaluation

5. 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 3 was admitted on [redacted] Resident 3's medical evaluation was completed on [redacted]

Resident 4 was admitted on [redacted]. Resident 4's medical evaluation was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 11/08/2023)***

General Manager, Health Service Director or Designee will complete a full audit of all resident records to ensure that every resident has a DME within the annual timeframe by 11/30/23.
Any resident that has not had a DME within the proper timeframe will be identified and a DME will immediately be obtained.
DME tracking will be done through the Yardi EHR system by Health Service Director and General Manager or designee. HSD and GM or designee will audit the DME tracking system to ensure that the DME's were obtained in the month that they were due for a period of three months, followed by spot checks.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Implemented ([redacted] - 02/27/2023)

183b - Meds and Syringes Locked

6. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 10/11/23 at 10:25am, a tube of Menthol and Zinc Oxide ointment was unlocked, unattended, and accessible in Resident 1's bathroom cabinet in memory care.

Repeat Violation Date: 6/29/23

Plan of Correction ***Accept ([redacted] - 11/08/2023)***

The tube of Menthol and Zinc Oxide was immediately removed by Med Tech on duty on October 11, 2023.
Health Service Director or Designee will provide education on this regulation to all staff by 11/30/23.
The General Manager and/or Guest Service Director of the home or the Memory Care Manager will conduct weekly rounds of the home to ensure all poisonous materials are locked, for the next six months, starting immediately.
The General Manager of the home will discuss the importance of locking poisonous materials in the Memory Care neighborhood at monthly staff meetings for the next six months, starting 11/5/23.
Copies of the agenda and sign in sheets will be maintained for the Departments review.
Weekly rounds in the Memory Care neighborhood will be made by General Manager or Designee for the next 30 days.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented ([redacted] - 02/27/2023)

183d - Prescription Current

7. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 10/11/23 at 10:25am, a tube of Menthol and Zinc Oxide ointment was accessible in Resident 1's bathroom cabinet in memory care. However, this medication is not in the current prescription order for Resident 1.

Repeat Violation Date: 6/29/23

Plan of Correction ***Accept (█ - 11/15/2023)***

The tube of Menthol Zinc Oxide was immediately removed by Med Tech on duty on October 11, 2023.
The Health Service Director or Designee will educate all medication staff on the proper removal of all medications that are expired or no longer current/discontinued by 11/30/23.
Weekly Medication cart audits began the week of October 23, 2023 and will continue through December 31, 2023.
Monthly Cart audits by the General Manager began the week of October 30, 2023 and will continue for 6 months- through April 30, 2024.
Weekly cart audits will be conducted by Health Service Director or designee for the next three months.
General Manager will conduct monthly Med Cart audits, on all three shifts, to ensure all required resident medications are available and accounted for in the cart for six months.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented (█ - 02/27/2023))

184a - Resident's Meds Labeled

8. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

The pharmacy label for Resident 3's Sodium Chloride Irrigation Solution does not include the prescribed dosage and instructions for administration, as medication administration record indicates:

- *Cleanse suspected deep tissue injury of left great toe every shift.*
- *Cleanse right hand every 5 days until healed.*
- *Cleanse right hand as needed for soiling.*

Repeat Violation Date: 6/29/23

Plan of Correction ***Accept (█ - 11/15/2023)***

A pharmacy label was obtained for the Sodium Chloride Irrigation Solution for Resident #3 by Wellness Nurse on October 11, 2023.
The Health Service Director or Designee will educate all medication staff on the proper labeling of all medications and to call the pharmacy if the original container does not include the prescribed dosage and instructions for

184a - Resident's Meds Labeled (continued)

administration, as medication administration record indicates by 11/30/23.
Weekly cart audits will be conducted by Health Service Director or designee for the next three months.
Weekly Medication cart audits began the week of October 23, 2023 and will continue through December 31, 2023.
Monthly Cart audits by the General Manager began the week of October 30, 2023 and will continue for 6 months-through April 30, 2024.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented (- 02/27/2023)

184b - Labeling OTC/CAM

9. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 10/11/23 at 10:25am, a tube of Menthol and Zinc Oxide ointment belonging to Resident 1 was in their bathroom cabinet and was not labeled with the resident's name.

Plan of Correction ***Accept (- 11/15/2023)***

The tube of Menthol and Zinc Oxide ointment was immediately removed by Med Tech on October 11, 2023.
All families of SCDU residents have been informed of items not to bring into the community, including any medications including over the counter medications in scheduled Family Meeting on October 11, 2023. Additional communication was sent via email to reinforce this communication on October 30, 2023.
Health Service Director or Designee will educate all nurses and med techs on regulation 184b to ensure that any OTC medication and CAM that belong to a resident, shall be identified with the resident's name.
Weekly cart audits will be conducted by Health Service Director or designee for the next three months and began the week of October 23, 2023.
General Manager will conduct monthly Med Cart audits, on all three shifts, to ensure all required resident medications are available and accounted for in the cart for six months beginning the week of October 30, 2024.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented (- 02/27/2023)

185a - Implement Storage Procedures

10. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident 3 is prescribed Systane Preservative Free Ophthalmic Solution 0.4-0.3%, instill 1 drop into both eyes four times daily as needed. On 10/11/23, the medication was not available in the home.

Resident 3 is prescribed Tegaderm Film, cover right hand after applying skin prep as needed for soilage. On 10/11/23, the medication was not available in the home.

Repeat Violation Date: 6/29/23, 4/26/23

Plan of Correction ***Accept (█ - 11/15/2023)***

Medication and Tegaderm were ordered from the pharmacy by MedTech on October 11, 2023.
All Med techs will be trained by Health Service Director or designee regarding safe storage, access, security, distribution, and use of medications by 11/30/23.
Weekly cart audits will be conducted by Health Service Director or designee beginning the week of October 23, 2023 and will continue for the next three months.
General Manger will conduct monthly med cart audits, on all three shifts, to ensure all required resident medications are available and accounted for in the cart, starting immediately, the week of October 30, 2023 for the next six months until April 30, 2024.
In the event medications are missing, the General Manager and or Health Service Director will initiate an investigation to the missing medications starting immediately, for the next six months.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented (█ - 02/27/2023)

187b - Date/Time of Medication Admin.

11. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident 2 is prescribed Lorazepam 0.5 mg, 1/2 tab every 8 hours as needed for anxiety. Resident 2's medication administration record does not include the initials of the staff person who administered medication on 10/8/23 at 4:10pm and 10/9/23 at 7:00am.

Plan of Correction ***Accept (█ - 11/15/2023)***

All Med techs will be trained by Health Service Director or designee regarding the requirement to document the administration of medication at the time the medication is administered by 10/31/23.
Weekly cart audits will be conducted by the Health Services Director or designee beginning the week of October 23, 2023 and continue for the next three months.

Weekly spot checks by Health Service Director or designee for 30 days.

187b - Date/Time of Medication Admin. *(continued)*

Licensee's Proposed Overall Completion Date: *11/30/23*

Not Implemented (█ - 12/22/2023)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident 4 was prescribed a urinalysis (UA) on 8/23/23 and 9/6/23. However, the home did not follow the prescriber's orders and collect a sample for testing.

Repeat Violation Date: 6/29/23

Plan of Correction ***Accept (█ - 11/15/2023)***

All Med techs will be trained by Health Service Director or designee regarding the requirement to document the administration of medication at the time the medication is administered by 11/30/23.

Weekly cart audits will be conducted by Health Service Director or designee beginning the week of October 23, 2023 and continue for the next three months.

General Manger will conduct monthly med cart audits, on all three shifts, to ensure all required resident medications are available and accounted for in the cart, starting immediately, the week of October 30, 2023 for the next six months until April 30, 2024.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented (█ - 02/27/2023)

13. Requirements

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

Description of Violation

Resident 3 is prescribed FeroSul Oral Tablet 325 mg, take one tablet by mouth once daily in the morning. However, on 10/11/23, the medication was not available in the home.

Resident 3 is prescribed Skin-Prep Protective Spray, apply to suspected deep tissue injury of left great toe every shift. However, on 10/11/23, the medication was not available in the home.

Repeat Violation Date: 6/29/23

Plan of Correction ***Accept (█ - 11/15/2023)***

All Med techs will be trained by Health Service Director or designee by 11/30/23.
Weekly cart audits will be conducted by the Health Service Director or designee for the next three months beginning the week of October 23, 2023.
Weekly spot checks by Health Service Director or designee for 30 days.

187d - Follow Prescriber's Orders (continued)

The General Manager will conduct monthly reviews of at least 10 resident records to ensure required documentation and medications are administered correctly, by auditing the MAR and the actual medications, starting immediately, for the next six months.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented (- 02/27/2023)

225a - Assessment 15 Days

14. 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 2 was admitted on ; however, the resident's initial assessment was not completed until

Plan of Correction ***Accept (- 11/09/2023)***

Resident #2 had an initial assessment completed on ; document attached. General Manager, Health Service Director or Designee will complete a full audit of all resident records to ensure that every resident has a written initial assessment within the 15 days of admission by 11/30/23.
General Manager, Health Service Director or designee will ensure ongoing compliance by reviewing all initial assessments upon admission to verify dates are within the required 15 days of admission.

Licensee's Proposed Overall Completion Date: *11/02/2023*

Implemented (- 02/27/2023)

234d - Support Plan Revision

15. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

A support plan for Resident 4 was completed on . However, on Resident 4 exhibited physical and verbal aggression against a resident. The resident's support plan has not been revised to reflect this change.

Plan of Correction ***Accept (- 11/09/2023)***

Resident #4's support plan was updated to reflect changes in care for resident on October 12, 2023 by General Manager.
General Manager, Health Service Director or Designee will complete a full audit of all resident records to ensure

234d - Support Plan Revision (continued)

that every resident has a support plan that is updated within the annual timeframe and/or with any changes in condition by 11/30/23.
Health Service Director or designee will educate all licensed nursing staff on this regulation to ensure that all support plans are updated with a change in condition and at least annually by 11/30/23.

Licensee's Proposed Overall Completion Date: ***11/02/2023***

Implemented (- 02/27/2023)

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

Facility Information

Name: *EAGLEVIEW LANDING* **License #**: *14698* **License Expiration**: *02/02/2024*

Address: *650 STOCKTON DRIVE, EXTON, PA 19341*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *EAGLEVIEW LANDING LP*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *08/03/2020* **Issued By**: *Uwchlan Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *134* **Waking Staff**: *101*

Inspection Information

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

Reason: *Incident, Monitoring* **Exit Conference Date**: *12/06/2023*

Inspection Dates and Department Representative

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

11/29/2023 - On-Site: [redacted]

12/06/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *121* **Residents Served**: *88*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *46* **Residents Served**: *35*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *88*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *46* **Have Physical Disability**: *41*

Inspections / Reviews

11/28/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/07/2024*

01/17/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/31/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/31/2024*

02/27/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *01/31/2024*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

16c - Written Incident Report

1. Requirements

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

Description of Violation

During the narcotic count on 11/23/23, it was discovered that Resident 1 was missing two vials of Lorazepam medication. Staff Member A, became aware of the drug diversion in the evening of 11/23/23; the facility did not report the missing medications until 11/27/23.

Plan of Correction ***Accept - 01/17/2024)***

The administrator received notice on 11/23/23 of a variance in the controlled substances count, indicating that 3 syringes of Lorazepam were not accounted for. An internal investigation was initiated within 24 hours. On 11/27/23, the results of the investigation were inconclusive, and a reportable incident was submitted to DHS.
During the site visit, education was provided to submit an initial report to the Department upon receipt of similar information and then submit a final report upon conclusion of investigation.
All staff responsible for reporting incidents and conditions to the Department will be re-educated regarding this by 1/31/24.
The administrator will conduct random reviews of all incident reports submitted to ensure they are submitted timely, starting immediately.

Licensee's Proposed Overall Completion Date: *01/31/2024*

Not Implemented (- 02/27/2023)

42b - Abuse

2. Requirements

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

Description of Violation

On , Resident 2, an SDCU resident, who is nonverbal and requires 24 hour supervision, was found lying outside of the home in the rain, in their pajamas at 6:04am. The temperature at the time the resident was outside in the rain, during the resident's elopement, was a low of 44 degrees Fahrenheit. The resident was last seen at am and staff was unaware the resident had eloped from the secure unit until 6:04am when found outside of the unit, soaking wet and cold. Staff member B reported hearing a low buzzing alarm at an unknown time, at a door in the SDCU but indicated that the alarm system did not report that an alarm had actually been triggered. Staff member B then reported that they did not initiate a resident head count because the system indicated no triggered alarm. The main door in the secure unit remains unlocked for approximately 45 seconds after it has been opened, and does not provide a secure environment for residents requiring 24 hour supervision.

42b - Abuse *(continued)*

Plan of Correction ***Directed (- 01/17/2024)***

Regarding the incident on , Resident 2 was immediately sent to the hospital via ambulance and returned later that day after a comprehensive medical workup, with no change in treatment plan. 1:1 companions were put into place and continue currently, 24/7.
Staff person B, as well as two other overnight staff persons assigned to the unit where Resident 2 resides, were placed on administrative leave pending investigation. Ultimately, those 3 team members were terminated from employment at the community.
The timing was adjusted to the main egress doors on 1st and 2nd floors from the SDCU was adjusted to engage the magnetic locks in less than 12 seconds. Auditory alarms were placed on the 1st and 2nd floor entry/exit doors to the stair tower adjacent to the 2nd floor SDCU main entrance. The community has plans in place to install a Wander Guard system in SDCU beginning the end of January 2024 . Additional security cameras are planned to be installed by the entrance to both the 1st and 2nd floors of SDCU.
Elopement drills were conducted on all 3 shifts the first week of December to re-educate staff on the process. Weekly elopement drills, alternating all 3 shifts will be held beginning January 7, 2024 until 2/15/24. Thereafter, monthly elopement drills will be conducted alternating all 3 shifts.
Directed Plan of Correction 1/16/24):
**The administrator or clinical supervisor will conduct a training, with all staff, on why not responding to alarms or follow up of potential elopements is considered the neglect/abuse of residents by 1/31/24.*
**Documentation of the neglect/abuse training will be maintained for the Departments review.*

Licensee's Proposed overall Completion Date: *01/31/2024*

Not Implemented (- 02/27/2023)

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

The staff record for Staff Member B, hire date of , did not include a completed criminal history check.

Plan of Correction ***Accept (- 01/17/2024)***

Staff Member B, hire date , did not have PA Patch background check, only FBI fingerprinting.
Business Office Director was re-educated on January 4, 2024 on the need for PA Patch test for all prospective employees prior to hire; fingerprinting for those prospective employees who have lived in Pennsylvania less than 2 years.
Business Office Director was re-educated on January 4, 2024 on the requirements for completion of the aforementioned trainings within the first 40 hours of employment.
Internal hiring process requirements, in accordance with state and local guidelines will be introduced to Business Office Director for implementation effective 1/8/24 and will remain in effect, with no expiration date. This will be incorporated for all hires moving forward, prepared by the Business Office Director and verified by the General Manager or designee for each new hire. All current employee files will be audited by 2/15/24.

51 - Criminal Background Check (continued)

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (- 02/27/2023)

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 C completed orientation on however, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

Plan of Correction ***Accept (- 01/17/2024)***

Staff person C was hired on and completed the training for Elder Abuse, Client's rights by but did not complete the training for Emergency Medical Plan within the designated 40 hours of employment.
Business Office Director was re-educated on January 4, 2024 on the requirements for completion of the aforementioned trainings within the first 40 hours of employment.
Internal hiring process requirements, in accordance with state and local guidelines will be introduced to Business Office Director for implementation effective 1/8/24 and will remain in effect, with no expiration date. This will be incorporated for all hires moving forward, prepared by the Business Office Director and verified by the General Manager or designee for each new hire. All current employee files will be audited by 2/15/24.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (- 02/27/2023)

82c - Locking Poisonous Materials

6. 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

Skintegrity Wound Cleaner , with a manufacture's label indicating "If swallowed get medical help or contact a poison control center immediately ", was unlocked, unattended, and accessible to Resident 3; it was observed on top of the bureau in resident's room # at 1:30 pm. Resident 3, has been assessed not capable of recognizing and using poisons safely.

Plan of Correction ***Directed (- 01/17/2024)***

The wound cleaner was immediately removed from the resident's room and secured.

82c - Locking Poisonous Materials (continued)

Staff will be re-educated on the necessity to secure all potentially poisonous materials by 2/15/24.
Garden House Director, date of hire, 1/2/24 was educated on regulation 2600.82.c on 1/4/24.
Garden House Director, or designee will institute room checks on each shift until 2/15/24.
Room checks will continue to be done weekly by Guest Services Director or designee for the next 3 months .

Directed Plan of Correction (■ 1/17/24):

** The dates of the training on poisonous materials will be completed by 1/31/24.*
**The room checks in the Secure Dementia Unit will be assigned, starting immediately, to review each room for unlocked poisonous materials by the Director.*

Licensees's Proposed overall Completion Date: *1/31/2024*

Not Implemented (■ - 02/27/2023)

85d - Trash Receptacles

7. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 11/29/23 at 1:12 pm there was a full, uncovered, unattended trash can in the MC1 kitchen.

Plan of Correction ***Directed (■ - 01/17/2024)***

During the site visit on 11/29/23, there was a full, uncovered trash can unattended in MC1 kitchen area.
Trash can was immediately covered, after trash was removed to dumpster.
Step on trash cans with attached lids will be purchased for both Memory Care kitchenettes and be in place by 2/15/24.
All staff will be re-educated regarding the regulation that trash in all kitchens and bathrooms shall be kept covered to prevent penetration of insects and rodents by 2/15/24. This training will be reinforced at monthly Town Hall for the next 3 months.

Directed Plan of Correction (■ 1/17/24):

** The purchase of step on trash cans must be completed by 1/31/24.*
**The staff training on the importance of covered trashcans will be completed by 1/31/24.*

Licensees's Proposed overall Completion Date: *1/31/2024*

Implemented (■ - 02/27/2023)

183e - Storing Medications

8. Requirements

183e - Storing Medications *(continued)*

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

Resident 3 is prescribed Timolol Maleate Ophthalmic Solution. On 11/28/23 the resident's opened bottle of medication had an opened on date of 10/4/23. The manufacturer's instructions indicate to discard any unused medication 4 weeks after opening.

Resident 4 is prescribed Potassium; the daily packet in which the medication was stored was partially open and a potassium pill fell out onto the floor.

Resident 5 is prescribed Dorsal Tomol Sol eye drops; package was open, but not dated. The manufacturer's directions indicate to write down the date the foil pouch is opened, and to throw away any unused, single use containers 15 days after opening of pouch.

Resident 6 is prescribed Latanoprost Ophthalmic Solution. On 11/28/23 the resident's opened bottle of medication had an opened on date of 10/4/23. The manufacturer's instructions indicate to discard any unused medication 6 weeks after opening.

Repeat Violation Date: 6/29/23, 4/13/23

Plan of Correction ***Directed (- 01/17/2024)***

Community nurses, Health Services Director, Wellness Nurse or designee will continue to do weekly cart audits on all medication carts, including checking for package integrity, manufacturer's directions regarding expiration dates for the next 3 months, beginning immediately.
This re-education will be reviewed with each med tech, LPN's and agency nurses who administers medications at the community beginning immediately.

Directed Plan of Correction (1/17/24):

** The training of all staff administering medications will be conducted by 1/31/24 on following manufacturer's instructions by the Director of Nursing.*

Licensee's Proposed Overall Completion Date: *01/31/2024*

Not Implemented (- 02/27/2023)

185a - Implement Storage Procedures

9. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

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 11/23/23 Staff Members C and D did not complete the narcotic counts correctly according to the home's medication policies during shift changes. Also on 11/23/23 at the 2:00pm shift change, staff members C and E completed a count but staff C member did not sign the count log. Later on the same day, Staff person E discovered that there were additional narcotic medications stored in the medication refrigerator and realized that the medication counts were not correct and there were missing Lorazepam medications belonging to resident 1.

Plan of Correction ***Accept (- 01/17/2024)***

Staff members C and D were placed on administrative leave pending investigation. Effective 12/1/2023, all Med Techs were removed from medication administration and at that time the community moved to utilizing all licensed professionals for Medication Administration.
Health Services Director or designee will provide training for all current and new agency staff on how to properly conduct controlled substances reconciliation at the change of each shift utilizing the bound controlled substances record by 1/31/24.

Repeat Violation Date: 6/29/23, 4/26/23

Licensee's Proposed Overall Completion Date: *01/31/2024*

Not Implemented (- 02/27/2023)

187b - Date/Time of Medication Admin.

10. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident 1 is prescribed Lorazepam Intensol 2mg/ml oral concentrate 2mg/ml with instructions to take one-half ML (1mg) by mouth or sublingually three times daily. Resident 1's medication administration record does not include the initials of the staff person who administered Lorazepam 2mg on 11/18/23, 9 am and 1 pm ; 11/23/23, 5 pm; 11/25/23, 9 am

Resident 1 is prescribed Citalopram Hydrobromide Oral Tablet 10mg. Resident 1's medication administration record does not include the initials of the staff person who administered Citalopram Hydrobromide Oral Tablet 10mg on 11/25/23 at 9:29 am.

Resident 7 is prescribed Calasoothe ointment , Cyclosporine Ophthalmic Eye emulsion .05%, Docusate Sodium Oral Capsule 100mg, Fluticasone Propionate Nasal Suspension 50mcg/act and Tamsulosin HCL Oral capsule 0.4mg. On 11/25/23 at 5 pm and evening medication administration the MAR notated with the generic code OTHER HW, indicating that the MAR was backdated. MAR does not include the actual initials of the staff person who administered the medication on this date.

Resident 8 is prescribed Carbidopa-Levodopa, 25 mg. Resident 8's medication administration record does not include the initials of the staff person who administered Carbidopa-Levodopa, 25 mg on 11/13/23 at 1 pm , 11/20/23 at 1

187b - Date/Time of Medication Admin. (continued)

pm, and 11/24/23 at 9 pm.

Resident 8 is prescribed Donepezil HCL Oral Tablet 10 mg, Senna-S Oral Tablet 8.6-50mg and Tamsulosin HL Oral Capsule 0.4 mg. Resident 8's medication administration record does not include the initials of the staff person who administered Donepezil HCL 10 mg, Senna Oral Tablet and Tamsulosin HL 0.4 mg on 11/24/23 at 9 pm.

Plan of Correction ***Accept (- 01/17/2024)***

Health Services Director or designee will provide training to all agency nursing staff on how to properly document exceptional charting using the community's current medication system beginning immediately. The General Manager, Resident Care Director or Designee will review the exceptional charting report at least weekly, beginning 1/8/24 for accuracy and follow-up with staff, if indicated, for the next 3 months.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Not Implemented (- 02/27/2023)

187c - Refusal of Medication

11. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident 1 is prescribed Cranberry Tablets 1500 ER, 2 by mouth daily. On 11/29/23 at 11:06 am , the resident refused to take the medication by spitting it out. The home did not contact the physician to report the refusal.

Resident 6 is prescribed Hydrocortisone External Cream 2.5% to be applied to hemorrhoid up to 4 times daily. On 11/9/23 at 1 pm, and on 11/15/23 at 1 pm, resident 6 refused to allow the scheduled application of Hydrocortisone Cream. The home did not contact the physician to report the refusal.

Resident 6 is prescribed Metoprolol Succinate 25mg ER Oral Tablet Extended release 24 hour 25mg , one-half tablet (12.5mg) to be taken by mouth once daily, Spironolactone Oral Tablet 25mg, one-half tablet (12.5mg) to be taken by mouth once daily and Vitamin D3 Oral Tablet 10mcg (400 unit), 2 tablets to be taken by mouth once daily. On 11/15/23 at 9 am , Resident 6 refused to take scheduled doses of Metoprolol Succinate 25mg ER Oral Tablet, Spironolactone Oral Tablet 25mg, and Vitamin D3 Oral Tablet 10mcg (400 unit). The home did not contact the physician to report the refusal.

Plan of Correction ***Accept (- 01/17/2024)***

Health Services Director or designee will provide training on exceptional charting, which includes refusals to all agency nurses. Staff will notify the prescriber within 24 hours, unless otherwise instructed by the prescriber. Refusals will be documented in the resident's medication record. At the time of notification, the community will request

187c - Refusal of Medication (continued)

additional instructions for any future refusal and notifications. This information will be added to the resident's chart and Medication Administration Record and followed as instructed.
The General Manager, Resident Care Director and/or designee will review the exceptional charting report at least weekly to ensure staff are following the regulatory guidelines beginning immediately and continue for the next 3 months.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Not Implemented (█ - 02/27/2023)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident 8's Seroquel oral tablet prescription was changed from 50 mg to 25 mg on 11/10/23. The MAR does not indicate a reduction in the Seroquel prescription on the MAR and the resident was administered 50 mg from 11/11/23 through 11/19/23.

Repeat Violation Date: 6/29/23

Plan of Correction ***Accept (█ - 01/17/2024)***

Resident 8 MAR was correct at the time of the site visit.
Community nurses, including Health Services Director, Wellness Nurse and Garden House Director will be educated on the community policy indicating that when there is a change in the resident's medications the community will review the written prescription, Medication Administration Record and instructions/directions label on the medication for accuracy, prior to administering the medication.
Following the initial verification, individual providing medication assistance will review the Medication Administration Record and Instruction/directions listed on the medication for accuracy, prior to administering a medication by 1/31/24.
The Health Services Director or Designee will review the process listed above with current and future agency nursing staff. New medication staff will be provided with this information during medication training and orientation.

Licensee's Proposed Overall Completion Date: *01/31/2024*

Not Implemented (█ - 02/27/2023)

188b - Medication Error Reporting

13. Requirements

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

Description of Violation

Resident 1 is prescribed Lorazepam Intensol 2mg/ml oral concentrate with instructions to take one-half ML (1mg) by mouth or sublingually three times daily. On 11/25/23 at 9 am, medication was not administered; on 11/29/23

188b - Medication Error Reporting (continued)

medication was administered at 11 am instead of at 1 pm. These medication errors were not reported to the resident, the resident's designated person and the prescriber.

Plan of Correction ***Accept (- 01/17/2024)***

Community nurses, including Health Services Director, Wellness Nurse and Garden House Director will be educated on the community policy indicating that when there is a medication error, by 1/31/24, this will be reported immediately to the resident, the resident's designated person and the prescriber. Staff will report medication errors to the General Manager, Health Services Director or Designee following the notification to the resident, designated person and prescriber by 1/31/24.
The General Manager, Health Services Director or Designee will complete an investigation to identify the root cause of the error. Based on the outcome of the investigation, additional training and support will be provided as indicated.

Licensee's Proposed Overall Completion Date: *01/31/2024*

Not Implemented (- 02/27/2023)

190c - Record of Training

14. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

Staff member C's original Med Tech training is not dated as to when the training was completed.

Staff member D's original Med Tech training was completed on The most recent annual practicum completed on does not include the completion date, student signature or the original qualification date noted. The annual practicum does not include a completion date, student signature, or any indication the Med Tech is requalified or failed to requalify. The MAR review and Medication Administration observations were all 4 completed on 6/20/23 with no supporting documentation

Staff Member F's original Med Tech training was completed on An Annual Practicum was conducted on to review MAR record review and Medication Administration observations; all 4 were completed on . The practicum document does not include a completion date, is not signed by the student and there is not an original date noted.

Staff Member G's original Med Tech training was completed on . An Annual Practicum was conducted on to review MAR record review and Medication Administration observations; all 4 were completed on ". No student signature and no date noted to indicate if the training was recertified or failed to qualify. Also, there is no documentation of the original observations or training documentation.

190c - Record of Training *(continued)*

Plan of Correction ***Accept (- 01/17/2024)***

As a result of this site inspection, all Med Techs were removed from administering medications effective 12/1/23, until such time that the new Health Services Director can obtain the Train the Trainer Certification and begin training anew for those team members ready to initiate Med Tech training. Health Services Director date of hire was and is not eligible to participate in the Train the Trainer certification until The community will submit an application for waiver to the Department to allow the Train the Trainer certification course to be initiated prior to this date.
Until that time, LPN's will be scheduled to administer all medications and will have training on the medication policies and regulations.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Not Implemented (- 02/27/2023)

227g -Support Plan Signatures

15. 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's support plan dated is not signed or dated by the assessor or anyone else who participated in the development of the support plan including the resident.

Plan of Correction ***Directed (- 01/17/2024)***

Resident charts are being audited to identify those without signatures of those who participated in the development of support plan. Chart audits will be completed by 1/31/24. Current support plans in place without signatures, will be submitted for appropriate signatures by 1/31/24.
Support plans developed and completed greater than 6 months prior will not be submitted for signatures since they have been updated.
Health Services Director and/ or designee have been educated as to how to develop a support plan and collaborating with both the resident and the family/significant others involved in the resident's care.
General Manager will continue to audit 10 resident charts/month for compliance until 4/30/24.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Not Implemented (- 02/27/2023)

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

Facility Information

Name: *EAGLEVIEW LANDING* **License #**: *14698* **License Expiration**: *02/02/2024*

Address: *650 STOCKTON DRIVE, EXTON, PA 19341*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *EAGLEVIEW LANDING LP*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *08/03/2020* **Issued By**: *Uwchlan Township*

Staffing Hours

Resident Support Staff: *22* **Total Daily Staff**: *139* **Waking Staff**: *104*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional, Incident* **Exit Conference Date**: *01/08/2024*

Inspection Dates and Department Representative

01/03/2024 - On-Site:

01/04/2024 - On-Site:

01/08/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *121* **Residents Served**: *80*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Garden House* **Capacity**: *46* **Residents Served**: *36*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *80*

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

Have Mobility Need: *37* **Have Physical Disability**: *1*

Inspections / Reviews

01/03/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/29/2024*

02/08/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/16/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/16/2024*

02/27/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *02/16/2024*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

15a - Resident Abuse Report

1. Requirements

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

Description of Violation

On [redacted], resident 1 struck resident 2 in the face, and bruised resident 2's upper lip. This incident was observed by staff person A. This incident was reported to staff person B on [redacted] However, this allegation of abuse was was not reported to the local area agency on aging.

On [redacted], resident 1 struck resident 2 twice in the chest. This incident was observed by staff person C. This incident was reported to staff person B on [redacted]. However, this allegation of abuse was was not reported to the local area agency on aging.

Plan of Correction ***Accept ([redacted] - 02/07/2024)***

Administrator or Designee provided education on reporting suspected abuse of a resident in accordance with the Older Adult Protective Services Act and 6 Pa. Code and comply with the requirements regarding restrictions to all staff persons by 1/31/24. This regulation will continue to be reinforced monthly at all staff Town Hall meetings for the next 3 months.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Not Implemented ([redacted] - 02/27/2024)

16c - Written Incident Report

2. Requirements

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

Description of Violation

On [redacted], resident 1 struck resident 2 in the face and bruised resident 2's upper lip. This incident was observed by staff person A. This incident was reported to staff person B on [redacted]. The home did not report this incident to the department until [redacted].

Resident 3 is prescribed Humalog Kwikpen 100 Unit/ML per sliding scale: 200-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units, greater than 401 notify MD. On 12/13/23 at 9:00 am, the resident's blood sugar was 250. The resident was administered 0 units. Per the resident's sliding scale, the resident should have been administered 2 units. The home did not report this medication error to the department.

Plan of Correction ***Accept ([redacted] - 02/07/2024)***

All staff responsible for reporting incidents and conditions to the Department were re-educated regarding this by 1/31/24. The administrator will conduct random reviews of all incident reports to ensure they are submitted timey, starting immediately, with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

16c - Written Incident Report *(continued)*

Not IImplemented (█ - 02/27/2024)

25b - Contract Signatures

3. 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 █ for resident 4 was not signed by the resident.

The resident-home contract, dated █ for resident 5 was not signed by the resident.

The resident-home contract, dated █ for resident 6 was not signed by the resident and the administrator.

Plan of Correction ***Directed (█ - 02/07/2024)***

Administrator or designee will complete an audit to ensure all contracts are signed by Administrator or designee as well as resident, payer, or resident's representative by 2/29/24.
All files will be audited by General Manager and designees as a dual process, upon move in with no expiration date.

Directed Plan of Correction (█ 2/7/24):

1. *In addition to the above stated steps the administrator or business office staff will attempt, at least twice, to explain the contract and obtain signatures of residents #4, #5, and #6 by 2/15/24.*
2. *The administrator or general manager will educate the business manager on the importance of explaining the contract to all residents and the multiple attempts necessary to obtain a signature for the contract to ensure the resident understands what is in the contract by 2/15/24.*
3. *Copies of the signed resident contracts noted in #1 and copies of the trainings will be maintained for the Departments review.*

Licensee's Proposed overall Completion Date: *02/15/2024*

Implemented (█ - 02/27/2024)

41e - Signed Statement

4. 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

Records for residents 4, 5, and 6 did not contain a statement signed by the residents acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Directed (█ - 02/07/2024)***

Administrator or designee will complete an audit to ensure all resident rights and complaint procedures statements

41e - Signed Statement (continued)

are signed by resident, payer, or resident's representative by 2/29/24.
All files will be audited by General Manager and designees as a dual process, upon move in with no expiration date.

Directed Plan of Correction (2/7/24):
In addition to the above stated steps the administrator or business office staff will attempt, at least twice, to explain the Resident Rights and obtain signatures of residents #4, #5, and #6 by 2/15/24.
The administrator or general manager will educate the business manager on the importance of explaining the contract to all residents and the multiple attempts necessary to obtain a signature for the Resident Rights by 2/15/24.
Copies of the signed resident rights noted in #1 and copies of the trainings will be maintained for the Departments review.

Licensee's Proposed overall Completion Date: 02/15/2024

Implemented (- 02/27/2024)

42b - Abuse

5. Requirements

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

Description of Violation

Resident 1 began displaying aggressive behavior towards other residents on The home did not complete a new Resident Assessment and Support Plan to address the resident's behavior. The most recent document at that time indicated that the resident was aggressive, but had no plan to address the resident's needs. The home then completed the annual assessment on and crossed out the assessment for aggression. On resident 1 struck resident 2 in the face, and bruised resident 2's upper lip. This incident was observed by staff person A. After this incident, there was no new assessment completed and no 1:1 supervision in place. Then on resident 1 struck resident 2 twice in the chest. This incident was observed by staff person C.

On resident 5 scratched resident 4 on the right hand after resident 4 told resident 5 to "shut up". Resident 5 is supposed to have a 1:1 24 hours per day, but the home's schedule indicates the resident does not consistently have a 1:1. On , resident 5 sustained a self-inflicted injury during a behavioral episode in which the resident was observed breaking glass and a stethoscope, flipping patio chairs, a patio table, and an umbrella. On resident 5 was observed hitting other residents. On resident 5 sustained a self-inflicted injury to the right thumb while striking a staff member with a cardboard box. On resident 5 threw utensils at the back of resident 7's head, and attempted to grab resident 4 by the back of the pants.

On 1/8/24, at 9:24 am, the main entrance on the first floor of the Secured Dementia Care Unit (SDCU) took 11 seconds to lock. The alarm to the door went off, and no staff responded to the alarm. On 1/8/24, at 9:27 am, the main entrance on the second floor of the SDCU took 15 seconds to lock. The alarm to the door went off, and no staff responded to the alarm. Both alarms were disabled by agents of the Department due to no response from staff.

42b - Abuse (continued)

Plan of Correction ***Directed (- 02/07/2024)***

Support plans for Residents #1 and #5 have been updated to reflect the resident's needs. Health Services Director and Garden House Director have been educated on the requirement to update resident's service plans in response to acts of aggression.
The community is in the process of shortening the time for mag lock engagement for the entrance doors to both floors for the SDCU units. The community is also in the process of installing a Wander Guard system for both floors. The completion of the installation of the new system will be completed by 2/15/24.
The community will continue weekly elopement drills, alternating on all shifts, until 3/31/24.

Directed Plan of Correction (2/7/24):

1. *In addition to the steps noted in the submitted Plan of Correction the General Manager will conduct a training to all direct care staff, licensed staff and any agency staff present on how resident to resident abuse and elopement is neglect of care in accordance with the OAPSA by 2/15/24.*
2. *Documentation of the training will be maintained for the Departments review.*
3. *The General Manager will discuss neglect and resident abuse at all monthly staff meetings for the next six months, starting immediately.*
4. *Documentation of the agenda for the staff meetings will be maintained for the Departments review.*

Licensee's Proposed overall Completion Date: *02/15/2024*

Not Implemented (- 02/27/2024)

42c - Treatment of Residents

6. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 1/8/24, at 10:10 am, staff person D tried to hand resident 8 a cup of chocolate pudding with medication mixed into it. The resident paused before taking the cup, and asked staff person D what was in the cup. Staff person D responded, " it's chocolate pudding" and did not disclose to the resident that medication was mixed in with the pudding. The resident did not ask any further questions, took the cup, and ate the contents of the cup.

Plan of Correction ***Accept (- 02/07/2024)***

All staff have been educated on Residents Rights effective 1/31/24. All nurses, including Agency Nurses have been educated, and all future agency nurses, will be educated on the adherence to resident's rights during medication administration including privacy and identifying medications being administered at time of administration with no expiration date.

Licensee's Proposed Overall Completion Date: *02/29/2024*

Not Implemented (- 02/27/2024)

42s - Privacy

7. Requirements

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

Description of Violation

On 1/8/24, at 10:10 am, staff person D administered medications to resident 8 in the dining room on the first floor of the Secured Dementia Care Unit. There were other residents present at the time.

Plan of Correction Repeat Violation Date: 6/29/23 ***Accept (- 02/07/2024)***

All staff have been educated on Residents Rights effective 1/31/24. All nurses, including Agency Nurses have been educated, and all future agency nurses, will be educated on the adherence to resident's rights during medication administration including privacy and identifying medications being administered at time of administration with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Not Implemented (- 02/27/2024)

51 - Criminal Background Check

8. 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 persons E, F, and G have not had criminal background checks 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).

Plan of Correction ***Directed (- 02/07/2024)***

Business Office Director was re-educated on 1/4/2024 regarding the requirements for completion of obtaining a criminal background check (PA Patch) prior to an employee beginning the first day of work. Internal Hiring process requirements, in accordance with state and local guidelines will be introduced to Business office Director for implementation effective 1/8/24 and will remain in effect, with no expiration date. This will be incorporated for all hires moving forward, prepared by the Business Office Director, and verified by the Administrator or Designee for each new hire. with no expiration date. All current employee files were audited by 1/31/24.

Directed Plan of Correction (2/7/24):

1. *The Business manager will obtain criminal background checks for staff E, F and G by 2/15/24.*
2. *Copies of the criminal background checks will be maintained in the staff's record and for the Departments review.*

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (- 02/27/2024)

60a - Staff/Support Plan

12. Requirements

60a - Staff/Support Plan *(continued)*

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

Resident 5 was not provided 1:1 supervision during the overnight shift in the entire month of December. The resident requires 1:1 supervision due to behaviors that endangers the resident and others.

On 1/8/24, residents 8, 9, and 10, did not receive assistance with morning care necessary for them to be ready to receive their morning medications. As a result, the residents received their morning medications late. According to staff interviews, these services could not be provided due to lack of available direct care staffing in the home.

Plan of Correction ***Directed (- 02/07/2024)***

Regarding Resident 5, it was determined after weeks of providing 24 hour 1:1 support that Resident 5 slept well at night and did not require 1:1 during the overnight shift. Resident 5 has never demonstrated unsafe behaviors overnight and sleeps well.
All staff and agency staff providers will be educated by 2/29/24 regarding the need to be on time for scheduled shifts and for outgoing staff to remain in place until the staff for the next scheduled shift has arrived.

Directed Plan of Correction (2/7/24):
In addition to the steps noted above, the home will implement the additional steps of this directed plan as indicated:

1. *The General Manager will review the staff schedule to ensure adequate staff are available to provide care to the residents, as well as sufficient staff to cover staffing breaks and the ancillary duties they perform (which are not included in the hour of care), at least weekly, starting immediately.*
2. *The Health Service Director will review the schedule daily to ensure adequate staff are available to provide care to the residents, as well as sufficient staff to cover staffing breaks and the ancillary duties they perform (which are not included in the hour of care), at least daily, starting immediately.*
3. *The Health Service Director will provide coverage for staff call outs to ensure the daily staffing requirements are met, starting immediately.*

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (- 02/27/2024)

62 - Contact List

13. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person the administrator, maintains a list of staff persons that does not include substitute personnel/agency staff that are working in the home.

Plan of Correction ***Accept (- 02/07/2024)***

Staffing list will be updated effective 2/15/24 to reflect a current list of all staff persons plus substitute

62 - Contact List (continued)

personnel/agency staff that working in the home. Business Office Director and Administrative Assistant or designee will be responsible for keeping this list current with the addition on any new providers with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (█ - 02/27/2024)

63a - First Aid/CPR Training

14. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 10/19/23, from 10 pm to 6 am, 80 residents were present in the home. During this time no staff person certified in First Aid or CPR was present in the home.

On 12/27/23, from 10 pm to 6 am, 80 residents were present in the home. During this time only one staff person certified in First Aid or CPR was present in the home.

Plan of Correction ***Accept (█ - 02/07/2024)***

All employee files will be audited by Business Office Director or Designee for updated First Aid/CPR Training by 2/15/24. Any employee with expired First Aid/CPR will be retrained.

Heath Service Director, Administrator or Designee will verify that at least one staff person for every 50 residents will be always present in the community on each shift, starting immediately.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (█ - 02/27/2024)

65a - FS Orientation 1st Day

15. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

65a - FS Orientation 1st Day *(continued)*

Description of Violation

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

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

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

Plan of Correction ***Accept ([redacted] - 02/07/2024)***

Staff person F no longer provides services at the community. Staff person G has received orientation on evacuation procedures, staff duties and responsibilities during fire drills and associated training as has Staff Person I. Business Office Director was re-educated on 1/4/24 on the requirements for completion of these trainings within the first 40 hours of employment. Internal Hiring process requirements, in accordance with state and local guidelines will be introduced to Business office Director for implementation effective 1/8/24 and will remain in effect, with no expiration date. This will be incorporated for all hires moving forward, prepared by the Business Office Director and verified by the Administrator or Designee for each new hire. All current employee files were audited by 1/31/24. Health Services Director or designee will be responsible for ensuring that all Agency personnel receive Fire Safety training on their first day of providing services in the community with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented ([redacted] - 02/27/2024)

65b - Rights/Abuse 40 Hours

16. 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.

65b - Rights/Abuse 40 Hours *(continued)*

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 F, whose first day of work was [redacted], and staff person G, whose first day of work was [redacted], did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Plan of Correction ***Accept ([redacted] - 02/07/2024)***

Staff person F no longer provides services at the community. Staff person G has received orientation on evacuation procedures, staff duties and responsibilities during fire drills and associated training as has Staff Person I.
Business Office Director was re-educated on 1/4/24 on the requirements for completion of these trainings within the first 40 hours of employment. Internal Hiring process requirements, in accordance with state and local guidelines will be introduced to Business office Director for implementation effective 1/8/24 and will remain in effect, with no expiration date. This will be incorporated for all hires moving forward, prepared by the Business Office Director, and verified by the Administrator or Designee for each new hire. All current employee files were audited by 1/31/24.
Health Services Director or designee will be responsible for ensuring that all Agency personnel receive training on Resident Rights, Emergency Medical Plan, OAPSA and reporting of reportable incident and conditions training on their first day of providing services in the community with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented ([redacted] - 02/27/2024)

65c - Ancillary Staff Orientation

17. Requirements

2600.
65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Ancillary staff person H, whose first day of work was [redacted] did not have a general orientation to [redacted] specific job functions.

Plan of Correction ***Accept ([redacted] - 02/07/2024)***

Staff person H has been working in [redacted] position for nearly 2 years now and is trained on the specific functions of their job. Documentation of the training on their position will be maintained by 2/15/24.
All Department Managers will be trained on orientation for ancillary staff for their specific job functions prior to working in that capacity and providing documentation of this orientation by 2/15/24.

Licensee's Proposed Overall Completion Date: *02/15/2024*

65c - Ancillary Staff Orientation *(continued)*

Implemented (█ - 02/27/2024)

65g - Annual Training Content

18. 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 H 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 (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, new population groups that are being served at the home that were not previously served, if applicable during training year January 1, 2023 to December 31, 2023.

Plan of Correction ***Accept (█ - 02/07/2024)***

Staff Person F is no longer providing services at the community.
Business Office Director was re-educated on 1/4/24 on the requirements for completion of the referenced trainings within the first 40 hours of employment. Internal Hiring process requirements, in accordance with state and local guidelines will be introduced to Business office Director for implementation effective 1/8/24 and will remain in effect, with no expiration date. This will be incorporated for all hires moving forward, prepared by the Business Office Director, and verified by the Administrator or Designee for each new hire. All current employee files were audited by 1/31/24.
Health Services Director or designee will be responsible for ensuring that all Agency personnel receive training on Fire Safety, Resident Rights, Emergency Medical Plan, OAPSA and reporting of reportable incident and conditions, falls and accident prevention and new population groups being served in the home on their first day of providing services in the community with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (█ - 02/27/2024)

81b - Resident Personal Equipment

19. Requirements

2600.

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

81b - Resident Personal Equipment *(continued)*

Description of Violation

On 1/4/24, a bedside mobility device was present on resident 11's bed, with openings measuring 12 inches wide by 33 inches long. The enabler was not covered.

Plan of Correction ***Accept (- 02/07/2024)***

Resident 11's bed mobility device has been covered. Resident was educated regarding the specific need for the device, the intended use and any risks associated with the use of the device, and the resident's ability to use the device safely for the purpose it was intended.
All residents with bed mobility devices have been assessed per the guidelines and associated documentation has been added to each resident's support plan.
Health Services Director and Garden House Director and Community nurses, will be educated on the regulations surrounding the use of Bed Mobility Devices by 2/15/24 and will be expected to maintain compliance moving forward with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (- 02/27/2024)

85a - Sanitary Conditions

20. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 1/3/24, on the second floor in Memory Care, there was a dried white substance on the bottom of the refrigerator, and there was a dried orange substance on the bottom of the freezer.

On 1/4/24, there was fecal matter around the toilet bowl and unflushed toilet paper in the bathroom in room MC108.

On 1/4/24, in room MC228, there was a strong odor of feces and there was toilet paper with feces in a clothing bin.

Plan of Correction ***Accept (- 02/07/2024)***

Dried white substance on the bottom of the refrigerator on the second floor of Memory Care was cleaned during the site visit as was the fecal matter on the toilet bowl of M108. Toilet was flushed. Clothing in clothing bin was washed. Executive Chef has been educated on the regulation regarding maintenance of sanitary conditions. Executive Chef or designee is responsible for ensuring sanitary conditions of all refrigerators and freezers during daily temp log checks. Verifying sanitary conditions are being maintained and is now incorporated into the daily MC room sweeps audit checklist and will be conducted daily beginning immediately by the Memory Care Director or designee for the next 4 weeks and then will resume as a weekly audit with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Not Implemented (- 02/27/2024)

85d - Trash Receptacles

21. Requirements

2600.

85d - Trash Receptacles *(continued)*

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 1/3/24 there was an uncovered, unattended trash can in the kitchen on the second floor of Memory Care.

Plan of Correction ***Accept (- 02/07/2024)***

Trash can on second floor of Memory care had lid reapplied immediately.
Step on trash cans with attached lids were purchased for both Memory Care kitchenettes and are in place by 1/31/24. All staff will be re-educated regarding the regulation that trash in all kitchen and bathrooms shall be kept covered to prevent penetration of insects and rodents by 1/31/24. This training will be reinforced at monthly Town Hall for the next 3 months.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (- 02/27/2024)

95 - Furniture and Equipment

22. Requirements

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

Description of Violation

The main exit doors to the Secured Dementia Care Unit on the first and second floors do not lock immediately. The door on the first floor takes 11 seconds to lock. The door on the second floor takes 15 seconds to lock.

Plan of Correction ***Accept (- 02/07/2024)***

The mag locks for the Memory Care doors are working properly. The timing was shortened in December 2023 from 20-25 seconds to 10-15 seconds. The community is in the process of installing a Wander Guard system on both floors in Memory Care. During the process of installing the Wander Guard system, the goal is to adjust the timing to the shortest period allowable without creating false alarms. The completion of the installation is scheduled to be prior to 2/15/24.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Not Implemented (- 02/27/2024)

101j7 - Lighting/Operable Lamp

23. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident 4 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept (- 02/07/2024)***

Operable lamp was placed at resident's bedside during site visit of 1/3/24.
Verifying access to a source of light is now incorporated into the daily MC room sweeps audit checklist and will be conducted daily beginning immediately by the Memory Care Director or designee for the next 4 weeks and then will resume as a weekly audit with no expiration date.

101j7 - Lighting/Operable Lamp (continued)

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (█ - 02/27/2024)

103f - Refrigerator/Freezer Temps

24. Requirements

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

Description of Violation

There was no thermometer in the freezer on the second floor of Memory Care.

Plan of Correction ***Accept (█ - 02/07/2024)***

Additional thermometers were purchased, and one was installed in the freezer of the second floor Memory Care refrigerator effective 2/2/24.
Executive Chef or designee is responsible to ensure that all refrigerators and freezers have thermometers installed and that daily temp logs are maintained effective immediately with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (█ - 02/27/2024)

105g - Lint Removal and Duct Cleaning

25. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 1/3/24, there was an approximate 1 inch accumulation of lint in the lint trap of each the two dryers in the laundry room on the second floor in Memory Care. There were no clothes in the dryers at the time.

Plan of Correction ***Accept (█ - 02/07/2024)***

Lint traps were cleaned in both dryers of 2nd floor Memory Care dryers during the site visit. Verifying that lint traps are cleaned is now incorporated into the daily MC room sweeps audit checklist and will be conducted daily beginning immediately by the Memory Care Director or designee for the next 4 weeks and then will resume as a weekly audit with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (█ - 02/27/2024)

107c - Food/Water 3 Day Supply

26. Requirements

107c - Food/Water 3 Day Supply *(continued)*

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 1/4/24, the home served 80 residents, requiring 240 gallons of emergency drinking water. However, the home had only 51 gallons.

On 1/4/24, the home served 80 residents, The only emergency food in the home was 6 beef stew cans (6.75 lb, 3.06 g), 6 fruit cocktail cans, 6 mixed vegetable cans, 2 chili con carne cans, and 6 beef ravioli in tomato sauce cans and a meal kit that only contains enough ready to eat meals for 25 people for one day.

Plan of Correction ***Accept (█ - 02/07/2024)***

Emergency food and water supplies were ordered and are now in place to provide a 3-day supply of nonperishable food and drinking water for residents by 2/15/24.
Executive Chef and sous Chef have been educated on this regulation and will be responsible for tracking the supply and reordering as needed based on occupancy and expiration dates by 2/15/24.
The General Manager will check emergency food and water at least monthly to ensure it is in place at all times, starting immediately.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (█ - 02/27/2024)

107d - Procedure Emergency Management Agency Submission

27. 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 have not been submitted to the local emergency management agency.

Plan of Correction ***Accept (█ - 02/07/2024)***

The home's written emergency procedures for 2024 will be submitted to the local emergency management agency by 2/15/24. General Manager or designee will be responsible for ensuring compliance with this regulation.

Licensee's Proposed Overall Completion Date: *02/14/2024*

Implemented (█ - 02/27/2024)

121a - Unobstructed Egress

28. Requirements

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

Description of Violation

On 1/3/24 the automatic door on the 1F back exit would not open. The photo eye (sensor) was inoperable.

121a - Unobstructed Egress *(continued)*

Plan of Correction ***Accept (- 02/07/2024)***

The automatic door on the first floor back exit switch was turned off and was corrected on site by the Maintenance Director. starting immediately. Maintenance Director or designee will be responsible for monitoring this door during their daily checks. Manager on Duty will be responsible for checking this on weekends with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (- 02/27/2024)

124 - Notice to Fire Department

29. Requirements

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

Description of Violation

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

Plan of Correction ***Accept (- 02/07/2024)***

The home's address, location of bedrooms and the assistance needed to evacuate in an emergency for 2024 will be submitted to the local fire department by 2/15/24. General Manager or designee will be responsible for ensuring compliance with this regulation and maintaining documentation of submission.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (- 02/27/2024)

141a - Medical Evaluation

30. 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

The medical evaluation for resident 12 was not complete within 60 days prior to admission or within 30 days after admission of the resident.

Plan of Correction ***Accept (- 02/07/2024)***

Administrator, Health Service Director or Designee will complete a full audit of all resident records to ensure that every resident has a DME within the annual timeframe by 02/29/24.
Any resident that has not had a DME within the proper timeframe will be identified and a DME will immediately be obtained.
DME tracking will be done through the Yardi EHR system by Health Service Director and Administrator, or designee will audit to ensure that the DME's were obtained in the month that they were due for a period of three months, followed by spot checks.

141a - Medical Evaluation *(continued)*

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (- 02/27/2024)

141a 1-10 Medical Evaluation Information

31. 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 1's medical evaluation dated did not include medication regimen.

Resident 4's medical evaluation dated did not include medication regimen.

Resident 12's medical evaluation dated did not include immunization history.

Plan of Correction ***Directed (- 02/07/2024)***

An audit of all resident current DME's will be conducted by 2/29/24 to ensure that all applicable documentation is included. If applicable documentation is not included, a signed correction will be obtained or a new DME will be obtained. Health Services Director, Garden House Director, and Wellness Nurses will be educated on regulation 2600. 141.a and the need for dual review of all DME's moving forward, to ensure all areas are addressed and documented appropriately by 2/29/24 with no expiration date for the dual review process.
'Directed Plan of Correction (2/7/24)

1. *Residents 1, 4 and 12 DME will be updated by 2/15/24 by the Health Service Director.*
2. *The Health Service Director and Wellness Nurses will review resident DME's upon the completion by the resident's physician to ensure the DME is correct, starting immediately.*

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (- 02/27/2024)

162c - Menus Posted

32. 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

The two-week menu was not posted on the first and second floors in Memory Care.

Plan of Correction ***Accept (█ - 02/07/2024)***

New menu boards were purchased and installed by 2/5/24 on first and second floor of Memory Care adjacent to the kitchenette. Executive Chef was educated on the regulation requiring the current week and following week needs to be always posted. Executive Chef or designee will be responsible for ensuring that the current week's menu is posted as well as the one week in advance with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (█ - 02/27/2024)

171b5 - First Aid Kit

33. 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 the white crossover used to transport residents does not include a breathing shield.

The first aid kit in the bus used to transport residents does not include an eye covering and a breathing shield.

Plan of Correction ***Accept (█ - 02/07/2024)***

All first aid kits for the community, including those for both vehicles, will be fully audited by 2/29/24 by Guest Services Director or designee to ensure that each kit contains nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers. First Aid kits will be audited monthly for the next 3 months beginning 3/15/24. All staff will be educated at Town Halls for the next 3 months regarding this regulation and the need to replenish any supplies utilized upon opening the kits. An inventory list will be maintained in each list.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (█ - 02/27/2024)

183d - Prescription Current

34. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 1/4/24, Ibuprofen 200 MG, was in the home's medication cart for resident 12; however, the medication was discontinued.

On 1/8/24, Levothyroxine 112 MCG, was in the home's medication cart for resident 11; however, the medication was

183d - Prescription Current (continued)

discontinued on 1/7/24.

Repeat Violation Date: 6/29/23

Plan of Correction ***Accept (█ - 02/07/2024)***

Ibuprofen for resident 12 was removed from the Medication Cart and destroyed.

The Health Service Director or Designee will educate all medication staff on the proper removal of all medications that are expired or no longer current/discontinued by 02/15/24. Weekly cart audits will be conducted by Health Service Director or designee for the next three months.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Not Implemented (█ - 02/27/2024)

183e - Storing Medications

35. 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 1/8/23, the blister pack of Alprazolam 0.5 MG prescribed to resident 13 was punctured in spot #25 and the pill was still in the spot, which does not maintain proper conditions of sanitation.

Repeat Violation Date: 6/29/23, 4/13/23

Plan of Correction ***Accept (█ - 02/07/2024)***

Alprazolam in spot 25 of blister pack for Resident 13 was destroyed following the community's policy for destruction of controlled substances during site visit.
Community nurses, Health Service Director, Wellness Nurse, or designee will continue to do weekly cart audits on all medication carts, including checking for package integrity, manufacturer's directions regarding expiration dates for the next 3 months, beginning immediately.
The training of all staff administering medications was conducted by 1/31/24 on following manufacturer's instructions by the Health Service Director. This same training will be provided to any new nurse to the community, agency or direct hires with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Not Implemented (█ - 02/27/2024)

185a - Implement Storage Procedures

36. 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 1 is prescribed Chest Congestion Relief as needed. On 1/8/24 this medication was not available in the home.

185a - Implement Storage Procedures (continued)

Resident 5 is prescribed Senna 8.6 MG as needed. On 1/8/24 this medication was not available in the home.

On 1/8/24, all of the Controlled Substance Count sheets for resident 3's Pregabalin were incorrect. There were 2 blister packs of Pregabalin that each had 12 pills remaining. The count sheets for those blister packs each read that there were 6 pills remaining. There was another blister pack of Pregabalin that had 20 pills left and the count sheet for that blister pack read 10 pills were remaining.

Repeat Violation Date: 6/29/23, 4/26/23

Plan of Correction ***Accept (█ - 02/07/2024)***

Medications for Residents 3 and 5 that were not available in the home were ordered during the site visit from the pharmacy and delivered that day.

All staff responsible for medication administration, including agency staff, will be trained by Health Service Director or designee regarding safe storage, access, security, distribution, and use of medications by 02/15/24.
Weekly cart audits will be conducted by Health Service Director or designee for the next three months.
In the event medications are missing, the General Manager and or Health Service Director will initiate an investigation to the missing medications starting immediately, for the next six months.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Not Implemented (█ - 02/27/2024)

187a - Medication Record

37. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident’s name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

The home's medication records do not include the name and initials of the staff person administering the medication.

187a - Medication Record (continued)

The home is using agency nursing staff to administer medications and using a generic code/initials for all agency staff who are administering the medications. This process does not identify the specific staff person who administered the medications.

Plan of Correction ***Accept (- 02/07/2024)***

User reports were obtained by IT support specialist dating back to 11/1/23 (historical data can be obtained if needed for prior to this date), for each account assigned to a specific user correlating with a daily agency nurse signature log, put into place on 1/17/24, identifying the specific fob used for Emar access so that the specific staff person administering medications can be identified. This format will remain in place as a protocol with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (- 02/27/2024)

187d - Follow Prescriber's Orders

38. Requirements

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

Description of Violation

Resident 3 is prescribed Humalog Kwikpen 100 Unit/ML per sliding scale: 200-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units, greater than 401 notify MD. On 12/13/23 at 9:00 am, the resident's blood sugar was 250. The resident was administered 0 units. Per the resident's sliding scale, the resident should have been administered 2 units.

Resident 11 is prescribed Levothyroxine 125 MG, take one tablet by mouth once daily in the morning on an empty stomach. However, resident 11 was administered Levothyroxine 112 MCG on 1/8/24 at 7:00 am.

On 1/8/24, at 10:04 am residents 8, 9, and 10 had not been administered their 8:00 am medications.

Repeat Violation Date: 6/29/23

Plan of Correction ***Accept (- 02/07/2024)***

Resident 11 Levothyroxine order was corrected.
Community nurses, including Health Service Director, Wellness nurse and Garden House Director will be educated on the community policy indicating that when there is a change in the residents' medications the community will review the written prescription, Medication Administration Record, and instructions/directions label on the medication for accuracy, prior to administering the medication.
Follow the initial verification, individual providing medication assistance will review the medication administration record and instruction/directions listed on the medication for accuracy, prior to administering a medication by 1/31/24.
This same training will be provided to all agency nurses on their first day at the community and additionally to all new nurses and Med Techs hired by the community with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Not Implemented (- 02/27/2024)

188b - Medication Error Reporting

39. Requirements

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

Description of Violation

Resident 3 is prescribed Humalog Kwikpen 100 Unit/ML per sliding scale: 200-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units, greater than 401 notify MD. On 12/13/23 at 9:00 am, the resident's blood sugar was 250. The resident was administered 0 units. Per the resident's sliding scale, the resident should have been administered 2 units. The home did not report this medication error to the resident, the resident's designated person and the prescriber.

Plan of Correction ***Accept (- 02/07/2024)***

Community nurses including Health Service Director, wellness Nurse and Garden House Director were educated on the community policy when a medication error occurs, by 1/31/24. This will be reported immediately to the resident, the residents designated person and the prescriber. Staff will report medication errors to the General Manager, Health Service Director or Designee following the notification to the resident, designated person, and prescriber as well as in a reportable incident to DHS.
The General Manager, Health Service Director or Designee will complete an investigation to identify the root cause of the error, based on the outcome of the investigation, additional training and support will be provided as indicated with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Not Implemented (- 02/27/2024)

191 - Resident Right to Refuse

40. 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 4, admitted has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident 5, admitted , has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident 6, admitted , has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept (- 02/07/2024)***

Residents 4 and 5 will be educated on their right to refuse medications by 2/15/24.
All resident administrative files will be audited General Manager or designee by 2/29/24 to ensure that all residents have been educated on resident rights, including the right to refuse medication. For all those for whom this documentation is not present, documentation will be obtained after the education is presented.

191 - Resident Right to Refuse (continued)

All files will be audited by General Manager and designees as a dual process, upon move in with no expiration date.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (- 02/27/2024)

225c - Additional Assessment

42. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 1's current assessment was completed on . However, the resident's previous assessment was completed on

Resident 4 was admitted on . On , progress notes indicate resident 4 began to exhibit aggressive behavior. The resident did not have a new assessment completed to address the change in behavior.

Resident 11 uses a bedside mobility device. The resident's assessment, dated does not include the specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Resident 14 uses 2 bedside mobility devices. The resident's assessment, dated , does not include the specific need for the devices, the intended use and any risks associated with the use, the resident's ability to use the devices safely for the purpose they were intended, identification of the specific devices to be used and whether covers are required to meet FDA guidelines.

Plan of Correction ***Accept (- 02/07/2024)***

Resident 1's current assessment date is within compliance with respect to dates.
Resident 4 has an updated assessment completed to address changes in behavior. Resident 4's service plan/RASP have been updated to address aggressive behaviors by 2/15/24.
All residents with bed mobility devices will have updated documentation to reflect their need for the specific devices, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, identification of the specific device to be used and whether a cover is required to meet the FDA guidelines by 2/15/24.
Health Services Director and Garden House Director and/or designee will be responsible for ensuring proper documentation as reflected above for all residents with a prescribed need for a mobility device and will audit all mobility devices and documentation monthly beginning 2/15/24 and continuing for 3 months.

225c - Additional Assessment (continued)

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (- 02/27/2024)

227g -Support Plan Signatures

43. 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 12 participated in the development of support plan on . However, the resident did not sign the support plan.

The support plans for resident 4, dated and resident 5, dated , were not signed by the assessor.

Plan of Correction ***Accept (- 02/07/2024)***

All Resident charts were audited to identify those without signatures of those who participated in the development of the support plan. Chart audits were completed by 1/31/24. Current support plans in place without signatures, will be submitted for appropriate signatures by 2/29/24.
Health Service Director and/or Designee have been educated as to how to develop a support plan and collaborating with both the resident and the family/significant others involved in the resident's care. General Manager will continue to audit 10 resident charts/month for compliance until 4/30/24.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Not Implemented (- 02/27/2024)

231b - Medical Evaluation

44. 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 4 was admitted to the Secure Dementia Care Unit (SDCU) on ; however, the resident's medical evaluation dated does not indicate a need for the SDCU.

Plan of Correction ***Accept (- 02/07/2024)***

An audit of all resident current DME's will be conducted by 2/15/24 to ensure that all applicable documentation, including documentation of a resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a SDCU, if applicable, is included. If applicable documentation is not included, a signed correction will be obtained or a new DME will be obtained. Health Services Director, Garden House Director, and Wellness Nurses will be educated on regulation 2600. 141.a and the need for dual review of all DME's moving forward, to ensure all areas are addressed and documented appropriately by 2/15/24 with no expiration date for

231b - Medical Evaluation (continued)

the dual review process.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (█ - 02/27/2024)

233b - Lock Manufacturer Statement

45. Requirements

2600.
233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:

1. Upon a signal from an activated fire alarm system, heat or smoke detector.
2. Power failure to the home.
3. Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

Description of Violation

The home does not have a statement from the manufacturer of the locks on the SDCU doors verifying that the locks will release when the fire alarm system is activated, the home's power fails, and when the lock releasing device is operated.

Plan of Correction ***Directed (█ - 02/07/2024)***

The home has the statement from the manufacturer and is attached.

Directed Plan of Correction (█ 2/7/24):

1. *The General Manager will maintain a copy of the manufacturer's statement regarding the mag locks throughout the home, starting immediately and available to the Department when requested.*

Licensee's Proposed overall Completion Date: *02/05/2024*

Implemented (█ - 02/27/2024)

233c - Key-Locking Devices

46. 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 door to the Secure Dementia Care Unit (SDCU) on the first and second floor. And the directions are not posted at stair tower C3 on the first floor.

233c - Key-Locking Devices *(continued)*

Plan of Correction ***Accept (- 02/07/2024)***

Directions for operating the home's locking mechanisms are now conspicuously posted near the door to the SDCU on the first and second floors as well as at stair tower C3 as of the 1/5/24. Memory Care Director and/or designee will be responsible for spot checks to ensure these directions remain in place. Regulation 2600.233.c will be reviewed with all staff at monthly Town Hall meetings for the next 3 months.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (- 02/27/2024)

234a - Admission Support Plan

47. 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 5 was admitted to the Secure Dementia Care Unit (SDCU) on . However, the resident's initial support plan was completed on

Plan of Correction ***Accept (- 02/07/2024)***

No correction could be made to Resident 5's initial support plan.
Health Services Director, Garden House Director and Wellness Nurses will be educated on regulation 2600.234.a regarding the requirement that 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 as well as the need for dual review of all support plans moving forward, to ensure all areas are addressed and documented appropriately by 2/29/24 with no expiration date for the dual review process.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (- 02/27/2024)

234b - Support Plan Needs Elements

48. Requirements

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

Description of Violation

The assessment for resident 1, dated , indicates the resident has a need for managing healthcare, securing healthcare, laundry, securing and using transportation, making and keeping appointments, aggression, short term, and long-term memory. The resident's support plan, dated does not document how these needs will be met.
The assessment for resident 5, dated , indicates the resident has a need for judgement and aggression. The resident's support plan, dated does not document how these needs will be met.

The assessment for resident 15, dated , indicates the resident has a need for bladder management, managing healthcare, securing healthcare, doing laundry, securing and using transportation, managing finances, making and keeping appointments, obtaining clean, seasonal clothing, irritability, agitation, aggression, short term memory, long term memory, ability to use and avoid poisonous materials, and medications. The resident's support plan, dated

234b - Support Plan Needs Elements (continued)

[redacted] does not document how these needs will be met.

Plan of Correction ***Accept ([redacted] - 02/07/2024)***

Support plans for Resident 1 and Resident 5 have been updated to reflect the omitted areas of focus. An audit of all current support plans will be conducted by 2/29/24 to ensure that all applicable documentation, including needs for managing healthcare, securing healthcare, laundry, securing and using transportation, judgment aggression, etc., if applicable, are included. Health Services Director, Garden House Director, and Wellness Nurses will be educated on regulation 2600.234.b and the need for dual review of all support plans moving forward, to ensure all areas are addressed and documented appropriately by 2/29/24 with no expiration date for the dual review process.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented ([redacted] - 02/27/2024)