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

March 20, 2024

[redacted], ADMINISTRATOR
THE ATRIUM OF ALLENTOWN LLC
[redacted]

RE: THE ATRIUM OF ALLENTOWN
5767 CETRONIA ROAD
ALLENTOWN, PA, 18106
LICENSE/COC#: 23050

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/06/2023, 12/12/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE ATRIUM OF ALLENTOWN* **License #**: *23050* **License Expiration**: *12/09/2023*

Address: *5767 CETRONIA ROAD, ALLENTOWN, PA 18106*

County: *LEHIGH* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *THE ATRIUM OF ALLENTOWN LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *10/02/2020* **Issued By**: *Upper Macungie Twp*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *70* **Waking Staff**: *53*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *12/12/2023*

Inspection Dates and Department Representative

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

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *52*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDU* **Capacity**: *30* **Residents Served**: *13*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *52*

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

Have Mobility Need: *18* **Have Physical Disability**: *1*

Inspections / Reviews

12/06/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/13/2024*

01/19/2024 - POC Submission

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

Reviewer: [redacted] [redacted] **Type**: *POC Submission* **Follow-Up Date**: *01/26/2024*

Inspections / Reviews *(continued)*

01/31/2024 POC Submission

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

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/05/2024*

03/20/2024 Document Submission

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

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

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

On 12/12/23 at approx. 9:05am, the door to the facility's Wellness Office which contains residents' records and private medical information was unlocked and unattended, leaving access to this confidential information accessible to the public.

Plan of Correction ***Accept [redacted] - 01/31/2024)***

On 12/06/23 while inspector on site the door to the wellness office was closed and all records were secured. On 1/12/24 the facility administrator hosted a mandatory training and in-serviced all staff on regulation 2600.17, residents rights to privacy and expectations that the wellness office shall be secured at all times when not occupied staff member providing oversight to records and a sign was posted on the wellness office door that door must be kept closed. (See attached) The Wellness Director and Manager on duty will be responsible to ensure the wellness door is kept closed when not occupied by an authorized staff person on an ongoing basis. The facility Executive Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented [redacted] - 02/23/2024)

18 - Compliance With Laws

2. Requirements

2600.

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

Description of Violation

The batteries in the carbon monoxide detector in the kitchen were last changed 10/20/22. As per The Care Facilities Carbon Monoxide Standards Act the batteries need to be changed annually.

18 Compliance With Laws (continued)

The home's boiler inspection is expired. The certificate contains a signature from March 2023, however the home has not obtained an updated inspection certificate.

Repeat Violation: 9/22/22

Plan of Correction ***Accept (- 01/31/2024)***

On 12/06/23 immediately following the inspection the administrator changed the battery on the carbon monoxide detector. (see attached) The facility Administrator and Maintenance Director will be responsible to change the battery annually or as needed. On 1/19/24 the Executive Director created a log and on 01/22/24 implemented a procedure to check on a monthly basis and this procedure will coincide with the monthly fire drills to ensure compliance on an ongoing basis. (see attached)

The homes boiler has a recorded inspection of March 2023. The new facility Administrator has reached out the Department of Labor on 01/18/24 and requested the a copy of the inspection certificate. On 01/25/24 the boiler certificate was received. (see attached) The facility Maintenance Director and Executive Director will be responsible to ensure that the boiler is inspected annually and that an updated certificate is received. This process will be reviewed annually in our quality plan meeting to ensure ongoing compliance. The Executive Director and Maintenance Director will be responsible to ensure this ongoing compliance.

Licensee's Proposed Overall Completion Date: *02/16/2024*

Implemented - 02/23/2024)

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

Resident #3's contract dated and Resident #6's contract dated were not signed by the residents.

Plan of Correction ***Accept (- 01/31/2024)***

On immediately following the inspection, the Marketing Director presented the contracts to resident #3 and resident #6. Resident #3 and resident #6 reviewed and signed their contracts. See attached. On 1/12/24 the facility administrator retrained the Admissions/Marketing Director to ensure that all resident contracts are presented to and signed by each resident. The facility administrator will audit all residents' files by 01/31/24 to ensure all incumbent residents have signed their contracts and any errors or corrections are addressed. (see attached) Going forward the facility Executive Director has created a procedure and checklist for the Marketing Director and Executive Director to sign all files ensure all items are checked for completeness and accuracy. The new procedure and checklist will be implemented and utilized by 01/31/24. The facility Executive Director will be responsible on an ongoing basis to ensure compliance. This will be reviewed during the facilities annual quality plan review. See attached.

25b - Contract Signatures *(continued)*

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

Implemented ([redacted] - 02/23/2024)

25c2 - Fee Schedule

4. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
2. A fee schedule that lists the specify the following: actual amount of allowable resident charges for each of the home's available services.

Description of Violation

Resident #7's contract dated [redacted] and Resident #8's contract dated [redacted] doesn't include a fee schedule.

Plan of Correction ***Accept ([redacted] - 01/31/2024)***

On 12/06/23 immediately following the inspection resident # 7 and resident #8 were presented a fee schedule to review and sign. (see attached)
on 01/11/23 the admissions director was re-educated that all contracts must contain a fee schedule. By 01/31/24 the facility Executive Director will audit all incumbent resident records to ensure that all contracts contain a fee schedule. If any are missing the executive director will ensure all affected residents receive a copy and copy is added to the resident record. On 01/22/24 the facility Executive Director created a procedure and checklist for the Marketing Director and Executive Director to sign all files ensure all items are checked for completeness and accuracy. (see attached) The new procedure and checklist will be implemented and utilized by 01/31/24. The facility Executive Director will be responsible on an ongoing basis to ensure compliance. This will be reviewed in as part of the facilities annual quality plan.

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

Implemented [redacted] - 02/23/2024)

41e - Signed Statement

5. Requirements

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

Description of Violation

Resident #3 and Resident #6 did not sign a statement acknowledging receipt of the residents' rights and complaint procedures.

Plan of Correction ***Accept ([redacted] - 01/31/2024)***

On 01/08/23 both residents were presented a statement of residents' rights by the admissions director. Both had signed copies in their files but it was not directly in the contract. The statement of residents' rights was then added to resident #3 and resident #6's records in the correct order of the resident lease. (see attached) 01/11/24 the admissions director was re-educated that all contracts must contain a fee schedule. By 01/31/24 the facility Executive Director will audit all incumbent resident records to ensure that all contracts contain a statement of residents' rights. (see attached) If any are missing the executive director will ensure all affected residents receive a copy and signed copy is added to the resident record. On 01/22/24 the facility Executive Director created a procedure and checklist

41e - Signed Statement (continued)

for the Marketing Director and Executive Director to sign all files ensure all items are checked for completeness and accuracy. (see attached) The new procedure and checklist will be implemented and utilized by 01/31/24. The facility Executive Director will be responsible on an ongoing basis to ensure compliance. This will be reviewed as part of the facilities annual quality plan. (see attached)

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

Implemented (- 02/23/2024)

42s - Privacy

6. 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

The home utilizes voice controlled listening devices throughout the home for music. The home does not have a policy regarding the use of these devices and how privacy will be maintained.

Plan of Correction ***Accept (- 01/31/2024)***

On 12/12/24 the facility discontinued use of voice listening devices temporarily in order to protect the privacy of residents. On 01/22/24 an electronic devices policy was created by the facility Executive Director. (see attached) The Executive Director will send a notice to all residents by 01/29 of this new policy to be implemented in 30 days and an addendum to all current leases will be added to each resident contract. On 02/29/24 this new policy will be in effect. All leases dated 01/29/24 and thereafter will include the voice controlled listening devices policy (see attached). As of 1/26/24 a notice is displayed in the facility common areas notify residents of the potential use of voice listening devices. (see attached) Executive Director and Director of Life Enrichment will be responsible for ongoing compliance of the adherence of this policy and to ensure compliance.

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

Implemented - 02/23/2024)

51 - Criminal Background Check

7. 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

Direct care staff person A, date of hire , did not have a criminal background check completed until , more than 30 days after hire.

Dietary staff person B, date of hire , did not have a criminal background check completed until more than 30 days after hire.

51 - Criminal Background Check *(continued)*

Plan of Correction ***Accept [redacted] - 01/31/2024)***

By 1/31/24 The Executive Director will audit all employee files to ensure all employees have criminal background checks that are in compliance with regulation 2600.51 and the older adult protective services act. The Executive Director will be responsible to train the facility Business Office Manager on regulation 2600.51. Effective 1/12/24 the Business office manager is responsible to run all criminal background checks prior to the employees first day of onboarding. on 1/22/24 the Executive Director implemented a new file checklist and procedure for checking files. (see attached) Going forward the facility Executive Director will be responsible to ensure ongoing compliance.

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

Implemented [redacted] - 02/23/2024)

63a - First Aid/CPR Training

8. 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 [redacted], the facility had 51 residents in house, which requires 2 staff trained in First Aid and CPR be present in the building at all times. There was only 1 staff person trained in First Aid and CPR present in the building from the hours of 12pm through 12am. There was no staff present trained in First Aid and CPR before 12pm.

On [redacted] there were 49 residents in the facility, which requires 1 staff trained in First Aid and CPR be present in the building at all times. On [redacted], there was no staff present trained in First Aid and CPR from [redacted] until [redacted]. On [redacted] there was no staff present trained in First Aid and CPR from [redacted]

Plan of Correction ***Accept ([redacted] - 01/31/2024)***

On 1/8/24 a new facility administrator took over the facility. Upon review of the inspection survey report the Executive Director immediately, on 1/12/24 audited the staffing schedules and determined that additional trained staff will be required to maintain compliance. The Executive Director scheduled a CPR and First Aid training to be held on 1/29/24 to ensure that compliance can be met long term. The Director of Nursing and Memory Care Coordinator will be responsible to ensure that an adequate number of trained staff are on each shift. The process scheduling classes will be reviewed as part of the annual quality plan to ensure that there is a long term plan to maintain adequately trained staff on each shift at all times. The new quality plan review will be expedited and held no later than 2/26/24. The Executive Director will be responsible for ensuring ongoing compliance.

Licensee's Proposed Overall Completion Date: *02/26/2024*

Implemented [redacted] - 02/23/2024)

87 - Lighting

9. Requirements

2600.

87 - Lighting *(continued)*

87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

2 of the 4 ceiling lights in the 2nd floor laundry room did not work and one light was flickering at time of inspection.

Plan of Correction ***Accept (- 01/31/2024)***

On 1/11/23 all staff were trained on reporting of all faulty lights and equipment immediately to the manager on duty in addition to submitting a work order. (see attached) Immediately, following the inspection on 12/12/23 and for the safety of residents any residents wishing to do their own laundry, the facility offered the use of the laundry room on the first floor in lieu of the 2nd floor laundry room until repairs were completed. 1/15//24 the lights were repaired. (see attached) The facility Maintenance Director also acquired additional lighting materials to ensure supplies are on hand for future use as to avoid future repair delays. The facility Executive Director and maintenance Director will be responsible for ensuring ongoing compliance. The Facility team will review this process during the annual quality plan by 2/26/24

Licensee's Proposed Overall Completion Date: *02/26/2024*

Implemented (- 02/23/2024)

88a - Surfaces

10. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The light covering in the kitchen located closest to the stove and reach in refrigerator had a 2 foot by 1 foot area that was black and brown. An interview with ancillary staff person C indicated that it has been there 3-4 months and it couldn't be determined where the water came from.

Plan of Correction ***Accept (- 01/31/2024)***

on 12/06/23, immediately following the inspection, the executive director scheduled repair. This repair has been completed on 12/15/23 (see attached)

All staff were trained on 01/11/23 to submit work orders and repair any faulty equipment or maintenance repairs needed immediately to the MOD. (see attached) This will be reviewed as part of the annual quality plan process. The facility Maintenance Director will be responsible to address any such repairs immediately and will be required to review all work orders with the Executive Director. This process will be reviewed during our annual quality plan by 2/26/24. The facility Executive Director will be responsible to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *02/26/2024*

Implemented (- 02/23/2024)

95 - Furniture and Equipment

11. Requirements

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

95 Furniture and Equipment *(continued)*

Description of Violation

The fire door next to Room #217 is propped open with a tree stump. The magnet that keeps the door open is broken.

The door in the hallway in the basement leading to the stair tower from the kitchen was propped open at time of inspection. The handle of the door is broken.

Plan of Correction ***Accept [redacted] - 01/31/2024)***

On 12/06/23, Immediately following the inspection the side table designed to look like a tree stump was removed. The door was still operable to open and close. On 1/15/24 the door was repaired and the magnetic lock was replaced. (see attached) on 1/11/24 all staff were trained to complete work orders and report safety issues to the Director and Maintenance and the Executive Director promptly. (see attached) Discussing furniture and equipment safety will be added to the annual quality plan. The Executive Director will be responsible to oversee ongoing compliance.

On 12/12/24, immediately following the inspection the door handle was replaced to the door in the basement leading to the stairwell. All staff was trained on 01/11/23 to submit work orders to the Maintenance Director and Manager on duty immediately of any faulty equipment or maintenance repairs needed immediately. (see attached) The maintenance Director and Manager on duty will be responsible to ensure any faulty furniture is removed and any broken equipment is fixed immediately. Going Forward, the Maintenance Director and Executive Director will be responsible to ensure that all doors are in safe and working order and repairs are made timely. This will be reviewed as part of the annual quality plan by 2/26/24

Licensee's Proposed Overall Completion Date: *02/26/2024*

Implemented [redacted] - 02/23/2024)

102h - Toilet Paper

12. Requirements

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

Description of Violation

On 12/6/23 at approximately 1pm, there was no toilet paper in either of the 2 bathroom stalls of the women's restroom in the home's lobby area.

Plan of Correction ***Accept [redacted] - 01/31/2024)***

On 12/06/23 while inspector on site toilet paper was placed in both bathroom stalls.
1/11/23 Housekeeping and Direct care staff trained to check stalls twice per shift to ensure an adequate supply of toilet paper is in the bathroom at all times. (see attached)
on 1/16/24 new toilet paper dispensers with locks added to the bathroom stalls to eliminate the issue of loose toilet paper rolls being taken. (see attached)
Beginning on 01/11/23 the facility housekeepers will be responsible to check the bathrooms twice per shift during wake hours and the facility PCA's will be responsible to check the bathrooms in the evenings and overnight to ensure and adequate supply is maintained. The facility will review this during the facility's annual quality plan by 2/26/24
The facility Executive Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *02/26/2024*

102h Toilet Paper *(continued)*

Implemented ([redacted] - 02/23/2024)

103e Left Overs

13. 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

A container of leftover red/green pepper and a red onion were in the reach-in refrigerator of the kitchen without a label or date.

Plan of Correction ***Accept ([redacted] - 01/31/2024)***

On 12/06/23 immediately after the container of food without a label was disposed of. Additionally, on 12/06/23 the dining director checked the entire reach-in refrigerator to ensure that no other food was stored without a proper. On 1/11/24 all staff were trained on food labeling and storage guidelines (see attached) The facility Dining Director and Executive Director will be responsible to ensure ongoing compliance. During the annual quality planning the facility will review the process for ongoing compliance by 2/26/24.

Licensee's Proposed Overall Completion Date: *02/26/2024*

Implemented ([redacted] - 02/23/2024)

103f Refrigerator/Freezer Temps

14. 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

The freezer section of the split refrigerator freezer located in the back of the dining room did not contain a thermometer.

Plan of Correction ***Accept ([redacted] - 01/31/2024)***

On 12/06/23 immediately after the inspection the Dining Director replaced the missing thermometer in the refrigerator freezer. (see attached)
On 1/11/24 The Executive Director held a training with all staff to include reporting of missing equipment and thermometer guidelines (see attached)
The dining director and/or cook on duty will be responsible to ensure all refrigeration has a working thermometer and this this is checked daily by default as temperatures are checked. The Dining Director and Executive Director will be responsible for ongoing compliance. This will be reviewed in the annual quality plan by 2/26/24.

Proposed Overall Completion Date: 01/12/2024

Licensee's Proposed Overall Completion Date: *02/26/2024*

103f - Refrigerator/Freezer Temps *(continued)*

Implemented ([redacted] - 02/23/2024)

105g - Lint Removal and Duct Cleaning

15. 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

The facility was unable to verify that lint has been cleaned from the internal and external ductwork of clothes dryers according to manufacturer's instructions.

Plan of Correction ***Accept [redacted] - 01/31/2024)***

Immediately, on hire the new facility director hired on 1/8/24 scheduled a cleaning of the dryer ducts. The ducts' cleaning was completed on 01/13/23. (see attached)
The Maintenance Director and Executive Director will be responsible to ensure that the dryer duct cleaning is scheduled annually to ensure compliance. This will be reviewed in the annual quality plan by 2/26/24.

Licensee's Proposed Overall Completion Date: *02/26/2024*

Implemented [redacted] - 03/20/2024)

125a - Combustible Storage

16. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

A sock, washcloth, dryer sheet and an accumulation of lint was located behind the dryer in the homes SDCU, posing a possible fire hazard.

Plan of Correction ***Accept [redacted] - 01/31/2024)***

On 12/06/23 immediately following the inspection the facility executive director had all the lint/debris, sock, washcloth and dryer sheet removed and cleaned in and around this dryer. On 12/12/24 A sign was posted on all dryers with instructions to all users to remove all lint and debris after each use. (see attached)
On 01/11/23 all staff were re-trained by the Executive Director on proper use and cleanup of lint and debris of the dryers. (see attached) This will be reviewed on our annual quality training plan no later than 02/26/24. Going forward, the Executive Director will be responsible to ensure compliance.

Licensee's Proposed Overall Completion Date: *02/26/2024*

Implemented ([redacted] - 02/23/2024)

132c - Fire Drill Records

17. Requirements

2600.

132c Fire Drill Records *(continued)*

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

Description of Violation

The fire drill record for the drill conducted on 7/18/23 does not include the number of staff who participated in the drill.

Plan of Correction ***Accept (- 01/31/2024)***

On 12/12/23 immediately following the inspection the Executive Director researched which staff participated in the fire drill and updated the fire drill record. (see attached)
Going forward and as of 01/08/24 the new facility Executive director or Maintenance Director will be responsible to record accurate and complete information onto the fire drill record monthly. This record will be kept in the survey binder and the Executive Director will audit this record monthly commencing with the current month fire drill to ensure all information is captured. This will be reviewed as part of our quality plan by 02/26/24.
The Executive Director is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented - 02/23/2024)

132e - Fire Drill Sleeping Hours

18. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The home's most recent overnight fire drill conducted 8/3/23 at 10pm. The home did not have an additional overnight fire drill within 6 months previous to this date.

Plan of Correction ***Accept (- 01/31/2024)***

The Executive Director conducted an unscheduled fire drill on 1/26/21 at 12:04am. The nightvshift staff participated in this fire drill. (see attached). The facility Executive Director and Maintenance director will be responsible to ensure that an overnight drill occurs on an ongoing basis as per the the regulation requirements by reviewing the fire record log on a monthly basis. The Executive Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented (- 02/23/2024)

132g - Fire Drills Days/Times

19. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The drill that occurred 8/3/23 at 10pm includes participating staff from the shift ending at 10pm. The home has not conducted a fire drill with only 3rd shift staff, and no additional staff, participating.

Plan of Correction ***Accept (- 01/31/2024)***

The Executive Director conducted an unscheduled fire drill on 1/26/21 at 12:04am. The night shift staff

132g - Fire Drills Days/Times (continued)

participated in this fire drill. (see attached). The facility Executive Director and Maintenance director will be responsible to ensure that an overnight drill occurs on the night shift with the 3rd shift staff as per guidelines on an ongoing basis. The Executive Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented (- 02/23/2024)

181c - Self-administration Assessment

20. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #1, Resident #2, and Resident #3 are not assessed to be able to self-administer medications per their most recent medical evaluations. At time of inspection, the following medications for each resident were found in the residents' bedrooms:
Resident #1 found in resident's bathroom and drops found on resident's end table. Resident #2 found in resident's bathroom. Resident #3: protectant and found in resident's bathroom

Plan of Correction ***Accept - 01/31/2024)***

On 12/06/23 immediately while inspector on site all all medications were removed from resident #1, #2 and #3's rooms. Additionally, all other rooms were checked and items were removed.
On 01/11/24 and 01/12/24 the Executive Director scheduled a training for all medication associates on proper medication administration procedures including not leaving medication in rooms. (see attached) . On 01/11/24 Executive Director facilitated a training with all staff so they understand their role in reporting medications found in rooms. (see attached) in order to ensure vigilance of all staff. This topic will be reviewed in the annual quality plan by 02/26/24

Licensee's Proposed Overall Completion Date: *02/26/2024*

Implemented (- 03/20/2024)

182c - Medication Administration

21. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:

Description of Violation

Per resident interviews, Med Techs will on occasion leave residents' medications in the residents' bedrooms and leave without further verifying that residents have taken their medications.

Plan of Correction ***Accept (- 01/31/2024)***

On 12/06/23 immediately while inspector on site all rooms were checked for Prescription medications, OTC

182c - Medication Administration (continued)

medications, CAM and syringes. Any items of concern were removed from rooms. On 1/13/24 The Executive Director reviewed residents rights and concerns surrounding medications with a council meeting. On 1/11/24 and 1/12/24 The Executive Director and Memory Care Coordinator held training for all medication associates on proper medication administration procedures. (see attached). The Executive Director will conduct a random room audit on 10% of occupied resident rooms each week which include interviewing residents for three weeks beginning on 01/15/24 to ensure processes are being followed and adhered to. (see attached) This will be reviewed as part of the annual quality plan by 2/26/24.The Executive Director and Director of Nursing will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *02/26/2024*

Implemented [redacted] - 02/23/2024)

183b - Meds and Syringes Locked

22. 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

At time of inspection, the following medications for each resident were found unlocked and accessible in the residents' bedrooms: Resident #1: [redacted] found on resident's end table. Resident #2: [redacted] found in resident's bathroom. Resident #3: [redacted] skin protectant and [redacted] paste found in resident's bathroom

Plan of Correction ***Accept ([redacted] - 01/31/2024)***

12/06/23 immediately while the inspector on site all medications were removed from resident #1, #2 and #3's rooms. Additionally, all other rooms were checked and items removed following the inspection.
On 1/11/24 and 1/12/24, the Executive Director and Memory Coordinator held training for all medication associates on proper medication administration procedures. (see attached) The Director of Nursing will facilitate a training to all staff that includes safety topics in regards to medications left in resident rooms. The Executive Director will conduct random room audits for three weeks beginning on 01/15/24 to ensure processes are being followed and adhered to. Audits are anticipated to be completed on 1/29/24. See attached. This will be reviewed in our annual quality planning process by 2/26/24. The Executive Director is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *02/26/2024*

Implemented ([redacted] - 03/20/2024)

187a - Medication Record

23. Requirements

2600.

187a - Medication Record *(continued)*

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

13. Date and time of medication administration.

Description of Violation

Resident #1 is prescribed [redacted] with parameters to hold for SBP less than [redacted]. On [redacted] at [redacted] the resident's SBP was [redacted] The medication record was erroneously documented to indicate medication was administered when it was held.

Repeat Violation: 9/22/22

Plan of Correction ***Accept ([redacted] - 01/31/2024)***

On 1/11/24 and 1/12/24 The Executive Director and Memory Care Coordinator facilitated trainings to all Medication Associates to review parameter guidelines and documentation guidelines and overall proper medication administration procedures. (see attached) The Director of Nursing will be responsible to ensure that each medication receives observations and ongoing training to ensure resident safety. Documentation and proper medication administration procedures will be reviewed during the annual quality process by 2/26/24. The Executive Director is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *02/26/2024*

Implemented [redacted] - 02/23/2024)

187d - Follow Prescriber's Orders

24. Requirements

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

Description of Violation

Resident #4 is prescribed [redacted], with parameters to hold for SBP under [redacted] The medication was erroneously held on [redacted] at [redacted] with the resident's [redacted]

Resident #5 is prescribed [redacted], to administer for SBP greater than [redacted] On [redacted] at [redacted] the resident's SBP was [redacted] and the medication was not administered when it should have been.

Plan of Correction ***Accept ([redacted] - 01/31/2024)***

Immediately following the inspection on 12/12/23 the Director of Nursing reviewed with the medication associates proper documentation and holding for parameters. On 1/11/12 and 1/12/23 The Executive Director and the Assistant to the Director of Nursing/Memory Care Coordinator held training for all medication . (see attached) The Director of Nursing will be responsible to ensure that each medication associate receives observations and ongoing training to ensure resident safety. This process will be reviewed during the quality plan by 2/26/24. The Director of Nursing and Executive Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *02/26/2024*

Implemented ([redacted] - 03/20/2024)

191 - Resident Right to Refuse

25. 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 #3 and Resident #6 did not receive education on the residents' right to question or refuse a medication if the resident believes there may be a medication error.

Plan of Correction ***Accept [redacted] - 01/31/2024)***

on [redacted] resident #3 and resident #6 received a copy of the residents rights to review. (see attached exhibit D of the resident contract)

On 01/11/24 at the resident council meeting the Executive Director informed all residents that they have the right to question or refuse a medication if the resident believes there may be a medication error for any reasons. (see attached)

On 01/11/23 the executive director reviewed all residents rights with all staff at a staff training. (see attached) On 1/11/24 and 1/12/24 medication associates received training that included the right of residents to refuse and question medications. (see attached) . The process of training Medication Associates will be reviewed during the annual quality process plan by 2/26/24. A new procedure was implemented in which the Executive Director will check all incoming resident files and sign-off to ensure each resident received a statement of residents rights. (see attached) . The Marketing Director and Executive Director will both be responsible for this process. The Executive Director is responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *02/26/2024*

Implemented ([redacted] - 02/23/2024)

227d Support Plan Medical/Dental

26. Requirements

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

Description of Violation

Resident #1 utilizes an enabler bar attached to his/her bedside. The assessment for Resident #1 dated [redacted] does not contain required verbiage regarding the resident's use of an enabler bar, including:

- *The specific need for the device*
- *The intended use*
- *Any risks associated with the device*
- *The resident's ability to use the device safely for the intended purpose*
- *Identification of the specific device to be used*
- *If a cover is required to meet FDA guidelines*

Plan of Correction ***Accept ([redacted] - 01/31/2024)***

On 1/9/24 the new facility executive director checked all rooms for enablers. The only room with a current bed enabler is not Resident #1, it is Resident #9. As of [redacted] there is only one resident in the facility with a bed

227d - Support Plan Medical/Dental (continued)

enabler and the care plan marked updated as of 12/07/23 immediately following the inspection. (see attached). On 1/21/24 the Executive Director re-checked all rooms for bed enablers and compliance. (see attached). On 1/11/24 The Executive Director educated the Memory Care Coordinator on how to properly document on the resident support when a bed enabler is being issued to a resident. The Director of Nursing and the Executive Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented [redacted] - 02/23/2024)

231b - Medical Evaluation

27. 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 #9 resides in the home's Secured Dementia Care Unit. Resident #9's Documentation of Medical Evaluation dated [redacted] does not list a diagnosis of [redacted] disease or another dementia.

Plan of Correction ***Accept ([redacted] - 01/31/2024)***

On 12/07/23 immediately following the inspection the Director of Nursing contacted the physician and received a corrected Medical Evaluation (DME) from the physician. (see attached) on 1/17/24 All SCDU residents records were checked and to ensure all evaluations contain a diagnosis of Alzheimer's or Dementia. At this time the new Executive Director did not find any additional missed. The Executive Director implemented a new procedure to check all resident admission records. (see attached) Going forward the Executive Director and Marketing Director will sign off all resident files within 30 days of admission to ensure all medical evaluations meet regulation 231b. The Executive Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented [redacted] - 02/23/2024)

233c - Key-Locking Devices

28. 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 following keypads to operate the key locking devices did not have a code posted to operate the locks: the exits near the laundry room, near room 101, 113 and 117.

Plan of Correction ***Accept ([redacted] - 01/31/2024)***

On 01/12/23 a sign was posted near exits near Laundry room 101, 113 and 117 with the code posted to operate the locks. (see attached)

01/11/23 staff informed to report if the key code posting gets removed that another must be immediately created and posted. (see attached)

The Memory Care Coordinator and Manager on Duty will be responsible on an ongoing basis to check to ensure

233c Key Locking Devices (continued)

the key codes are kept posted in a conspicuous area by rounding the neighborhood daily. The Executive Director will be responsible to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented [redacted] 02/23/2024)