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

February 5, 2024

[redacted], EXECUTIVE DIRECTOR
SIMPSON HOUSE INC
[redacted]

RE: SIMPSON HOUSE
BELMONT AVENUE & MONUMENT ROAD
PHILADELPHIA, PA, 19131
LICENSE/COC#: 18921

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/07/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SIMPSON HOUSE* **License #**: *18921* **License Expiration**: *06/14/2024*

Address: *BELMONT AVENUE & MONUMENT ROAD, PHILADELPHIA, PA 19131*

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

Administrator

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

Legal Entity

Name: *SIMPSON HOUSE INC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *06/17/1996* **Issued By**: *Philadelphia L&I*

Staffing Hours

Resident Support Staff: *22* **Total Daily Staff**: *46* **Waking Staff**: *35*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *12/07/2023*

Inspection Dates and Department Representative

12/07/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* **Residents Served**: *19*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Comfort Haven* **Capacity**: *9* **Residents Served**: *1*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *19*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *5*

Have Physical Disability: *0*

Inspections / Reviews

12/07/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/22/2023*

12/26/2023 - POC Submission

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

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

Inspections / Reviews *(continued)*

02/05/2024 Document Submission

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

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

65a - FS Orientation 1st Day

1. 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.

Description of Violation

Staff person A, 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.

Repeat Violation: 5/3/22 .

Plan of Correction ***Accept [redacted] - 12/26/2023)***

• Attached you will find the completed Orientation paper that covers the topics of general fire safety and emergency orientation, as outlined in 2600.65a. (Exhibit A1)
• On 12/20/2023, the PCHA audited the homes currently employed direct care staff personnel records to validate that the general fire safety and emergency orientation topics were covered on the employees first day of employment. For instances identified where this orientation was not fully or partially provided, employees will attend the next available orientation class. (Exhibit A2 – Comprehensive Audit Tool)
• Beginning January 2024, the PCHA or designee will audit newly hired direct care staff personnel records weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month to validate sustained compliance. (Exhibit A3 – Tapering Audit Tool)
• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

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

Implemented ([redacted] - 02/05/2024)

65b - Rights/Abuse 40 Hours

2. 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.

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

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 A completed his/her 40th scheduled work hour on or about [redacted]. 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), reporting of reportable incidents and conditions.

Repeat Violation: 5/3/22 .

Plan of Correction ***Accept ([redacted] - 12/26/2023)***

• Attached you will find the completed Orientation paper that covers the topics of Rights/Abuse, as outlined in 2600.65b. (Exhibit B1)
• On 12/20/2023, the PCHA audited the homes currently employed direct care staff personnel records to validate that Rights/Abuse 40 hours orientation topics were covered within the employees scheduled first 40 hours of employment. For instances identified where this orientation was not fully or partially provided, employees will attend the next available orientation class. (Exhibit B2 Comprehensive Audit Tool)
• Beginning January 2024, the PCHA or designee will audit newly hired direct care staff personnel records weekly x 4 weeks, then bi weekly x 4 weeks, then monthly x 1 month to validate sustained compliance. (Exhibit B3 Tapering Audit Tool)
• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

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

Implemented (MS - 02/05/2024)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

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

Plan of Correction ***Accept ([redacted] 12/26/2023)***

• On 9/232023, 11/13/2023,11/15/2023, 11/16/2023, 11/19/2023, 11/20/2023, 11/21/2023, and 11/22/2023,

65f - Training Topics (continued)

Staff Person B received training as outlined in 2600.65f. (Exhibit C1 – Training Record)

• On 12/20/2023, the PCHA audited the homes currently employed direct care staff personnel records to validate that they received training as outlined in 2600.65f for calendar year 2023. For instances identified where this training was not provided, the PCHA educated the employee accordingly. (Exhibit C2 – Comprehensive Audit Tool)

• The PCHA scheduled the annual training topics as outlined in 2600.65f for calendar year 2024. (Exhibit C3/E2 – 2024 Annual Training Schedule)

• Beginning January 2024, the PCHA or designee will audit 5 actively employed direct care staff personnel records monthly x 3 months to validate sustained compliance. (Exhibit C4 – Monthly Audit Tool)

• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented ([redacted] - 02/05/2024)

65g - Annual Training Content

4. 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 B did not receive training in 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 during training year January 2022 to December 2022.

Plan of Correction ***Accept ([redacted] - 12/26/2023)***

• On 12/21/2023, the Campus Executive Director (CED) educated the PCHA on the requirements within 2600.65g (Exhibit D1 – In-service)

• At the time of the 2024 on-site training, the PCHA will record staff attendance and identify staff members that were not present, if applicable. The PCHA, in conjunction with the fire safety expert, will identify a subsequent training date for these individuals, if needed.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented ([redacted] - 02/05/2024)

66a - Staff Training Plan

5. Requirements

2600.
66.a. A staff training plan shall be developed annually.

66a - Staff Training Plan *(continued)*

Description of Violation

The home does not have a staff training plan for 2023.

Plan of Correction ***Accept ([redacted] - 12/26/2023)***

• On 12/18/2023, the PCHA drafted a comprehensive training plan comprised of the regulated annual training topics and held an all-staff meeting on 12/20/2023, 12/21/2023 and 12/22/2023 to cover the required training topics for calendar year 2023. (Exhibit E1 – In-service)

• On 12/15/2023, the PCHA scheduled the annual training topics as outlined in 2600.66a for calendar year 2024. (Exhibit C3/E2 – 2024 Annual Training Schedule)

• Beginning January 2024, the PCHA or designee will audit 5 actively employed direct care staff personnel records monthly x 3 months to validate sustained compliance. (Exhibit E3 – Monthly Audit Tool)

• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented ([redacted] - 02/05/2024)

81b - Resident Personal Equipment

6. Requirements

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

Description of Violation

On 12/7/23, 2 bedside mobility devices were present on resident 1's bed. The devices are attached to the resident's bed frame, however device closest to the resident's bedside table was loose.

Plan of Correction ***Accept ([redacted] - 12/26/2023)***

• On 12/7/2023, the PCHA reaffixed resident #1's bedside mobility device.

• Currently, no additional residents reside in the home that utilize a bedside mobility device.

• On 12/20/2023, 12/21/2023 and 12/22/2023, the PCHA educated the homes currently employed direct care staff on the requirements within 2600.81b. (Exhibit F1 – In-service)

• Beginning January 2024, the PCHA or designee will audit the bedside mobility devices belonging to current residents weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month to validate sustained compliance (Exhibit F2 – Tapering Audit Tool)

• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented [redacted] - 02/05/2024)

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.

85d - Trash Receptacles *(continued)*

Description of Violation

On 12/7/23, there were 2 uncovered, unattended trash cans in the main kitchen.

Plan of Correction ***Accept [redacted] - 12/26/2023)***

• On 12/8/2023, the PCHA replaced the two uncovered trash receptacles located within the home's kitchen with receptacles with covers.
• On 12/15/2023, the PCHA audited the homes trash receptacles located in the kitchens and bathrooms to ensure receptacle covers were present. For instances identified where a trash receptacle was not covered, the PCHA replaced the receptacle with a covered receptacle. (Exhibit G1 – Comprehensive Audit Tool)
• On 12/20/2023, 12/21/2023 and 12/22/2023, the PCHA educated the homes currently employed staff on the requirements within 2600.85d. (Exhibit G2 – In-service)
• Beginning January 2024, the PCHA or designee will audit the homes kitchens and bathrooms weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit G3 – Tapering Audit Tool)
• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented [redacted] - 02/05/2024)

96a - First Aid Kit

8. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the personal care kitchenette does not include eye coverings.

Plan of Correction ***Accept [redacted] - 12/26/2023)***

• On 12/08/2023, the PCHA placed goggles i n the personal care kitchenette's first aid kit.
• On 12/08/2023, the PCHA audited the homes first aid kits to validate that they contained the required items as outlined in 2600.96a. For instances identified where an item was omitted from the kit, the ED replaced the item accordingly. (Exhibit H1 – Audit Tool)
• On 12/20/2023, 12/21/2023 and 12/22/2023, the PCHA educated the homes direct care staff on the requirements within 2600.96a. (Exhibit H2 - In-service)
• Beginning January 2024, the PCHA or designee will audit the homes first aid kits weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month to validate sustained compliance. (Exhibit H3 – Tapering Audit Tool)
• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented [redacted] - 02/05/2024)

103c - Food Protected

9. Requirements

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

103c - Food Protected *(continued)*

Description of Violation

In the freezer, there was a bag with a soft pretzel that was not sealed and a tub of orange sherbert that was uncovered.

Plan of Correction ***Accept (- 12/26/2023)***

• On 12/07/2023, the PCHA discarded the unsealed, unlabeled bag of soft pretzels and orange sherbet.
• On 12/08/2023, the PCHA audited the homes refrigerators and freezers for uncovered or unlabeled foods. No additional instances of noncompliance were identified.
• On 12/20/2023, 12/21/2023 and 12/22/2023, the PCHA educated the homes staff on the requirements set within 2600.103c. (Exhibit I1 – In-service)
• Beginning January 2024, the PCHA or designee will audit the homes refrigerators and freezers weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month to validate sustained compliance. (Exhibit I1 – Tapering Audit Tool)
• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented - 02/05/2024)

103i - Outdated Food

10. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There were unlabeled, undated bags of biscuit in the freezer and an unlabeled, undated bag of shredded mozzarella cheese in the refrigerator.

Plan of Correction ***Accept (- 12/26/2023)***

• On 12/07/2023, the PCHA discarded the unlabeled bags of biscuits in the freezer and unlabeled, undated, bag of shredded mozzarella cheese.
• On 12/08/2023, the PCHA audited the homes refrigerators and freezers for unlabeled foods. No additional instances of noncompliance were identified.
• On 12/20/2023, 12/21/2023 and 12/22/2023, the PCHA educated the homes staff on the requirements set within 2600.103i. (Exhibit J1 – In-service)
• Beginning January 2024, the PCHA or designee will audit the homes refrigerators and freezers weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month to validate sustained compliance. (Exhibit J2 – Tapering Audit Tool)
• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented (- 02/05/2024)

141a 1-10 Medical Evaluation Information

11. Requirements

2600.

141a 1 10 Medical Evaluation Information *(continued)*

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

Description of Violation

Resident 2's medical evaluation dated [redacted], did not include a general physical examination by a physician, physician's assistant or nurse practitioner, special health or dietary needs of the resident, allergy information, medication regimen, contraindicated medications, medication side effects and the ability to self administer medications, body positioning and movement stimulation for residents, if appropriate.

Plan of Correction ***Accept [redacted] - 12/26/2023)***

• On [redacted], Resident #2's licensed medical provider completed a new Documentation of Medical Evaluation (DME). (Exhibit K1 New DME)

• On [redacted], the PCHA audited the most recent Documentation of Medical Evaluation's (DME) belonging to current residents to identify documentation omissions. For instances where omissions were identified, the DME was revised by a licensed nurse in consultation with the resident's medical provider, or the DME was re completed by the residents medical provider. (Exhibit K2 Comprehensive Audit Tool)

• Beginning January 2024, the PCHA or designee will audit 5 resident DME's weekly x 4 weeks, then bi weekly x 4 weeks, then monthly x 1 month to validate sustained compliance. (Exhibit K3 Tapering Audit Tool)

• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented [redacted] - 02/05/2024)

162c - Menus Posted

12. 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 home's menu for the week of 12/3/23 12/9/23 was posted. However, the menu for for 1 week in advance was not posted.

Plan of Correction ***Accept [redacted] - 12/26/2023)***

• On 12/08/2023, the PCHA posted the subsequent weeks' menu within the home.

• On 12/14/2023, the PCHA educated the Director of Food and Dining on the requirements within 2600.162c (Exhibit L1 In service)

162c - Menus Posted (continued)

• Beginning January 2024, the PCHA or designee will audit the posted menus weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit L2 – Tapering Audit Tools)
• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented [redacted] - 02/05/2024)

183d - Prescription Current

13. 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 [redacted] prescribed for individual resident 3, was in the home's medication cart; however, the medication was discontinued on [redacted]

Plan of Correction ***Accept ([redacted] - 12/26/2023)***

• On 12/07/2023, the PCHA removed Resident #3's discontinued [redacted] from the medication cart.
• On 12/08/2023, the PCHA and PC Nurse audited the homes medication carts for additional discontinued medications. (Exhibit M1- Audit Tool)
• On 12/20/2023, 12/21/2023 and 12/22/2023 the PCHA educated the homes licensed nurses and medication technicians on the requirements set within regulation 2800.183.d. (Exhibit M2– In-service)
• Beginning January 2024, a licensed nurse or designee will audit five current resident's medications weekly x 4 weeks, then bi-weekly x 4 weeks, the monthly x 1 month to validate sustained compliance. (Exhibit M3 – Audit Tool)
• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented ([redacted] - 02/05/2024)

185a - Implement Storage Procedures

14. Requirements

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

Description of Violation

On [redacted], resident 3's medication administration record reads [redacted] but the resident's glucometer reads 308.

On [redacted], resident 3's medication administration record reads [redacted] but the resident's glucometer reads 426.

On [redacted], resident 3's medication administration record reads [redacted] but the resident's glucometer does not have a reading for that date and time.

185a Implement Storage Procedures (continued)

On [redacted] at [redacted], resident 3's medication administration record reads 284 but the resident's glucometer does not have a reading for that date and time.

Repeat Violation: 5/3/22.

Plan of Correction ***Accept ([redacted] - 12/26/2023)***

• On 12/8/2023, the PCHA notified Resident # 3's medical provider of the incongruent documentation and glucometer readings.
• On 12/08/2023, the PCHA audited the homes additional glucometer (Exhibit N1 audit tool)
• On 12/20/2023, 12/21/2023 and 12/22/2023, the PCHA educated the homes licensed nurses and diabetic trained medication technicians on the requirements set within regulation 2600.185a. (Exhibit N2 In service)
• Beginning January 2024, the PCHA or designee will audit current resident glucometers weekly x 4 weeks, the bi weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit N3 Tapering Audit Tool)
• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented [redacted] - 02/05/2024)

227d - Support Plan Medical/Dental

15. 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 has a need for a bedside mobility device. The resident's most recent support plan does not mention 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, and identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Plan of Correction ***Accept ([redacted] - 12/26/2023)***

• On 12/08/2023, the PCHA revised Resident #1's Resident Assessment and Support Plan (RASP) to reflect the residents specific need, intended use and risks/benefits, ability to use, and whether a cover is required as per the FDA for their bedside mobility device. (Exhibit O1 Revised RASP)
• Currently, no additional residents reside in the home that utilize a bedside mobility device.
• Beginning, January 2024, the PCHA or designee will audit the RASPs of residents with mobility devices weekly x 4 weeks, then bi weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit O3 Tapering Audit Tool).
• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented [redacted] - 02/05/2024)

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

231b - Medical Evaluation

16. 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 2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]; however, the resident's medical evaluation does not indicate the need for SDCU.

Plan of Correction ***Accept [redacted] - 12/26/2023)***

• On 12/15/2023, a licensed nurse, in consultation with the resident's medical provider, revised Resident #2's DME to reflect their need for a secured dementia care unit (SDCU). (Exhibit P1 Revised DME)
• Currently, no additional residents reside in the SDCU.
• Beginning January 2024, the PCHA or designee will audit the DMEs of residents who move onto the SDCU weekly x 4 weeks, bi weekly x 4 weeks, and monthly x 1 month to validate sustained compliance. (Exhibit P2 Tapering Audit Tool)
• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented [redacted] - 02/05/2024)

233c - Key-Locking Devices

17. 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 back exit door to the Secure Dementia Care Unit (SDCU).

Plan of Correction ***Accept [redacted] - 12/26/2023)***

• On 12/08/2023, the PCHA conspicuously posted the numeric code to disengage the SDCU's rear exit door's magnetic lock.
• On 12/08/2023, the PCHA audited the SDCU's exit doors for the presence of the numeric code, which were present.
• On 12/20/2023, 12/21/2023 and 12/22/2023, the PCHA educated the medication technicians on the requirements set within 2600.233c. (Exhibit Q1 In service)
• Beginning January 2024, the PCHA or designee will audit the SDCUs posted numeric codes near the exit door's weekly x 4 weeks, then bi weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit Q2 Tapering Audit Tool)
• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

Licensee's Proposed Overall Completion Date: *12/22/2023*

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

Implemented [redacted] - 02/05/2024)

234a - Admission Support Plan

18. 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 2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 12/26/2023)***

• PCHA reviewed and revised Resident #2's RASP to ensure the residents needs and preferences are accurately captured.
• Currently, no additional residents reside in the SDCU.
• On 12/21/2023, the CED educated the PCHA on the requirements set within 2600.234a. (Exhibit R1 – In-service)
• Beginning January 2024, the PCHA or designee will audit the RASP of residents who have moved onto the SDCU weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month to validate sustained compliance. (Exhibit R2 – Tapering Audit Tool)
• Audit findings will be reviewed by the quality assurance team to evaluate the need for additional auditing.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented ([redacted] 02/05/2024)