pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **WYNDMOOR ASSISTED LIVING COMPANY LLC**
LEGAL ENTITY

To operate **SPRINGFIELD SENIOR LIVING COMMUNITY**
NAME OF FACILITY OR AGENCY

Located at **551 EAST EVERGREEN AVENUE, WYNDMOOR, PA 19038**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Assisted Living-Special Care**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **103** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Special Care Unit - 55 Pa.Code §§ 2800.231-239 - Capacity 34**

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

55 Pa.Code Chapter 2800: Assisted Living Residences
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **August 27, 2024** until **February 27, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **144841**

ISSUING OFFICER

Juliet Marsala
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: AUGUST 27, 2024

[redacted]
Wyndmoor Assisted Living Company, LLC
551 East Evergreen Avenue
Wyndmoor, Pennsylvania 19038

RE: Springfield Senior Living Community
License #: 144841

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections December 22, 2023 and January 3 and 4, 2024, January 22, 24, and 29, 2024, and February 12, 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. 2800 (relating to Assisted Living Residence), the Department hereby issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST 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 FIRST PROVISIONAL license is enclosed and is valid from August 27, 2024 to February 27, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

[redacted]

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2800.261-268 (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 2800 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
82c	II	36	$5	$180	5 calendar days from mailing date of this letter
187d	II	36	$5	$180	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.

If you disagree with the decision to issue a FIRST 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 FIRST PROVISIONAL license, a written request for an appeal must be received within 30 days of the date of this letter by:

[redacted]
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

[redacted]

This decision is final 31 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: *SPRINGFIELD SENIOR LIVING COMMUNITY* **License #**: *14484* **License Expiration**: *05/12/2024*

Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA 19038*

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

Administrator

Name: [redacted]

Legal Entity

Name: *WYNDMOOR ASSISTED LIVING COMPANY LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *11/16/1987* **Issued By**: *Commonwealth of PA, L&I*

Staffing Hours

Resident Support Staff: *44* **Total Daily Staff**: *110* **Waking Staff**: *83*

Inspection Information

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

Reason: *Renewal, Complaint, Monitoring* **Exit Conference Date**: *01/04/2024*

Inspection Dates and Department Representative

12/22/2023 - On-Site: [redacted]
01/03/2024 - On-Site:
01/04/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *103* **Residents Served**: *46*

Special Care Unit

In Home: *Yes* **Area**: *3rd floor* **Capacity**: *34* **Residents Served**: *5*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *33*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *20* **Have Physical Disability**: *20*

Inspections / Reviews

12/22/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/01/2024*

02/08/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/22/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/01/2024*

06/04/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *03/22/2024*

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

5a1 DHS access

1. Requirements

2800.
5.a. The administrator, administrator designee or staff person designated under § 2800.56(c) (relating to administrator staffing) shall provide, upon request, immediate access to the residence, the residents and records to:
1. Agents of the Department.

Description of Violation

On 1/4/2024 , at 9:45 am, agents of the department, requested access to door C in the basement. The home was unable to unlock this door and reported they did not have a key.

Plan of Correction ***Directed ([redacted] - 02/08/2024)***

1. Maintenance searched for the key and couldn't locate it.
2. Administrator will direct Maintenance to change lock on door.
3. Maintenance checked the additional doors and are accessible. An additional key will be placed in the Administrators office.

Proposed Overall Completion Date: 03/01/2024

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. *The administrator will ensure all doors of the home have an operable lock by 3/1/24, if keys are purchased for the door locks, a copy of the invoice or purchase order will be maintained for the Departments review.*
2. *The administrator will educate the administrative and management staff of the home on the accessibility of Department representatives as requested, by 3/1/24. Documentation of the training will be maintained for the Departments review.*
3. *The administrator or maintenance will monitor all doors, at least monthly, to ensure the locks are operable and have a key to open, starting immediately.*

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

16c Incident reporting

2. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On 12/30/2023, The home was without electricity for five hours, kitchen was closed due to a flood in the basement, MONTCO DOH closed the kitchen for three hours and the home used emergency food during this situation. The residence did not report this incident to the Department.

Plan of Correction ***Directed ([redacted] - 02/08/2024)***

1. Springfield Senior Living Staff will be educated on reportable incidents to the Department.
2. Administrator, DON, or ADON will monitor for and report any reportable incidents and timely to the department as per regulation

16c Incident reporting (continued)

Proposed Overall Completion Date: 03/01/2024

DIRECTED PLAN OF CORRECTION (SLW 2/8/24):
1. All clinical Springfield Senior Living Staff will be educated on reportable incidents to the Department, by 3/1/24, an annually thereafter. Documentation of the training will be maintained for the Departments review.
2. Administrator, DON, or ADON will monitor for and report any reportable incidents and timely to the department as per regulation, at least monthly, starting immediately.

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

17 Record confidentiality

3. Requirements

2800.
17. Confidentiality of Records - 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 12/22/2023 at 8:40 am, the binder containing resident's medical administration records were unlocked, unattended, and accessible to residents near the dining room.

On 1/4/2024, at 12:33 pm, the binder containing resident's medical administration records was unlocked, unattended, and accessible on top of a medication cart in the second-floor hallway while Staff member A was administering medication to resident 1 in their room.

Plan of Correction ***Accept ([redacted] - 02/08/2024)***

On 1/5/2024 all med techs/ nurses were in-serviced on locking the MAR binder's inside the med cart when med cart is unattended.
Starting 2/1/2024 the DON will do weekly cart audit checks for the next 60 days to ensure all MAR binder's are not left unattended and assessible.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

18 Other laws, regs, ordins.

4. Requirements

2800.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

18 Other laws, regs, ordins. *(continued)*

Description of Violation

Per the Care Facility Carbon Monoxide Alarms Standards Act of Jun. 23, 2016; Carbon Monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance.

- *In the first floor pantry kitchen a carbon monoxide detector was located within 15 feet of the gas grill, on a grimy plastic rack, surrounded by food items.*

34 Pa.Code Chapter 3, known as the Boilers and Unfired Pressure Vessels regulations. (governed by Department of Labor and Industry). If a residence has a boiler, it must have a valid "Certificate of Boiler or Pressure Vessel Operation" issued by the PA Department of Labor and Industry. Upon expiration of the certificate, boilers must be inspected, and if they pass inspection they will be issued a new certificate.

- *The home could not provide agents of the department with a certificate of boiler or Pressure Vessel Operation issued by the PA department of Labor and industry.*

FDA Food Code 3-501.16, hot foods must be maintained at 135°F or above.

- *In the pantry kitchen on 1/4/2023, at approximately 9:05 am oatmeal on the steam table was 105 degrees. The steam table was set at 136°F, however Mutiple sections of the table were open allowing hot air to escape.*

Plan of Correction ***Directed [redacted] - 02/08/2024)***

The carbon monoxide detector will be relocated to an area that is not less than 15 feet away from the gas grill

Maintenance will audit monthly x 3 months to ensure relocation of carbon monoxide detector remains at not less than 15 feet away from gas grill

A certificate of boiler pressure was provided to the agents of the department during the inspection

A new steam table was purchased and in use as of 01/ /24.
Temperatures will be checked every meal by cook to ensure food temperatures are reaching the proper holding temperature
Director of Food Service or Assistant will audit foof temperatures at the steam table at least weekly for 4 weeks then monthly x3 months

Proposed Overall Completion Date: 03/01/2024

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. *The carbon monoxide detector will be relocated to an area that is not less than 15 feet away from the gas grill in the grill area, by 3/1/24.*
2. *Maintenance will audit monthly x 3 months to ensure relocation of carbon monoxide detector remains at not less than 15 feet away from gas grill, starting 3/1/24.*
3. *The administrator or maintenance direction will obtain a certificate of the boiler inspection with the specific address of the Assisted Living, by 3/1/24.*
4. *A new steam table was purchased and in use as of 01/ 30 /24.*
5. *Temperatures will be checked every meal by cook to ensure food temperatures are reaching the proper*

18 Other laws, regs, ordins. (continued)

holding temperature on the new steam table, starting immediately. Documentation of the food temperatures will be maintained for the Department review.

6. *Director of Food Service or Assistant will audit food temperatures at the steam table at least weekly for 4 weeks then monthly x3 months., starting immediately.*

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

41e Signed statement

5. Requirements

2800.
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 2's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Directed ([redacted] - 02/08/2024)***

Marketing Director will have Resident 2 sign a statement and receive a copy of the resident's rights and procedures.

Marketing Director will audit the last 30 days of new admissions to ensure there is a statement acknowledging a receipt of a copy of the resident rights and complaint procedures. For any issue identified, the Marketing Director will correct the issue by having the resident sign an acknowledgement that they received a copy of the resident rights and complaint procedures.

Proposed Overall Completion Date: 03/01/2024

PLAN OF CORRECTION [redacted] 2/8/24):

1. *Marketing Director will have Resident 2 sign a statement and receive a copy of the resident's rights and procedures by 3/1/24.*
2. *Marketing Director will audit the last 30 days of new admissions to ensure there is a statement acknowledging a receipt of a copy of the resident rights and complaint procedures BY 3/1/24. For any issue identified, the Marketing Director will correct the issue by having the resident sign an acknowledgement that they received a copy of the resident rights and complaint procedures.*
3. *The administrator or administrative assistant will audit resident records at least bi-annually to ensure all documents have been signed, starting 3/1/24.*

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

42b Abuse/Neglect

6. Requirements

42b Abuse/Neglect *(continued)*

2800.
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

The home neglected to have heat for the residents from 10/15/23 with temperatures on 12/22/23, 1/3/24 and 1/4/24 in the range of 31 to 40 degrees Fahrenheit outside. Residents were forced to wear their coats, scarfs and hats to eat meals in the dining room. Temperatures in the home ranged from 61 to 66 degrees on these same dates.

The home neglected to have hot water available for the residents to bath from 12/22/23 through 1/4/24. The hot water temperature in resident bathrooms ranged from 65 to 89 degrees Fahrenheit.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

Starting Immediately, and continuing through 4/30/24, the administrator will monitor temperatures in at least one common area, two resident rooms on each floor, and the dining area daily.

If any is unable to maintain a temperature of at least 70 degrees, the administrator shall relocate residents to warmer areas and immediately contact an outside HVAC company for evaluation and repair. The administrator shall notify the department of such conditions.

Plumber was notified and replaced the circulator pump on January 4, 2024

2. The root cause of the issue that the circulator pump was leaking, Circulator pump was replaced and hot water is circulating throughout the home to accommodate the needs of the residents. Maintenance staff will test water temps at least weekly to ensure the residents have hot and cold water under pressure to accommodate the resident's needs, Administrator will review temperature logs for compliance with this requirement weekly x4 weeks then monthly

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. *The administrator of the home will contact a mechanical company to repair the heating/boiler system immediately to ensure all residents of the home have heat in all areas by 3/1/24. All estimates and invoices will be maintained for the Departments review.*
2. *The administrator or maintenance staff will ensure all residents of the home have hot water, daily, by testing the hot water in at least 5 rooms and maintain a log of the temperature for the Departments review. In the event a resident room is without hot water, a repair is initiated and fixed within 24 hours. This plan will be ongoing for the next six months and then monthly, thereafter for the next 12 months, starting immediately.*
3. *The administrator will conduct a training with all staff on neglect and abuse and how not providing essentials such as heat and hot water for bathing is abuse by 3/1/24. Document of the training will be maintained for the Department review.*
4. *The administrator will contact the Regional Licensing Office within 24 hours in the event the home is without heat or hot water, starting immediately.*
5. *The administrator or Activity director will meet with the residents at least monthly to discuss the heating,*

42b Abuse/Neglect (continued)

air-conditioning and hot water issues affect the residents. Documentation of the meeting minutes will be maintained for the Departments review.

6. *The administrator or director of nursing will conduct monthly staff meetings with all clinical and direct care staff on neglect/abuse and the essential needs of the residents of the home, starting immediately. Documentation of the monthly staff meetings will be maintained for the Departments review.*

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

42s Privacy - self/possessions

7. Requirements

2800.
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

During a resident council meeting in November 2023 staff member B, recorded residents without their knowledge until 10 minutes after the meeting had ended. Staff member C received a write up based on statements they made on this recording.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

1. Staff member B will be educated by the Director of Operations regarding recording during resident meetings.
2. Administrator will review write up based on the recording
3. Staff will be educated on resident privacy and not recording during resident meeting

Proposed Overall Completion Date: 03/01/2024

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):
1. Staff member B will be educated by the Director of Operations regarding recording during resident meetings by 3/1/24.
2. Administrator will review write up based on the recording and make a determination if the staff discipline was warranted by 3/15/24.
3. Staff will be educated on resident privacy and not recording during resident meeting, by 3/1/24.
4. Documentation of trainings will be maintained for the Departments review.

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

54a Direct care staff quals

9. Requirements

2800.

54a Direct care staff quals *(continued)*

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

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.
4. Be able to communicate in a mode or manner understood by the resident. Strategies that promote interactive communication on the part of direct care staff and individual residents shall be developed in accordance with the resident's final support plan under § 2800.227(e) (relating to development of the final support plan).

Description of Violation

Licensed Practical Nurse, staff member D, does not active registry status on the Pennsylvania nurse's registry on file in home.

Plan of Correction ***Accept [redacted] - 02/08/2024)***

1. The LPN active license verification was printed from the Department of State Website by 1/5/24.

2. HR will audit current staff files to ensure licensure verifications, active registry status, or high school diploma or GED is reflected in the file. Issues identified in the audit will be corrected with the file reflecting the required direct care staff qualifications, starting immediately.

3. New employee files will be audited monthly by the Administrator to ensure direct care qualifications are present. Issues identified will be corrected, starting immediately.

Proposed Overall Completion Date: 03/01/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

[redacted]

57b 1 hour/day/resident (continued)

[redacted]

Withdrawn[redacted] - 06/04/2024)

57c 2 hrs/day/immob. resident

11. Requirements

2800.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 12/13/2023, there were 34 residents in the residence, including 20 residents with mobility needs, requiring a total minimum of 54 hours of direct care service. On this date, only 44 hours of direct care staffing was provided.

On 12/23/2023, there were 34 residents in the residence, including 20 residents with mobility needs, requiring a total minimum of 54 hours of direct care service. On this date, only 48 hours of direct care staffing was provided.

On 12/24/2023, there were 34 residents in the residence, including 20 residents with mobility needs, requiring a total minimum of 54 hours of direct care service. On this date, only 48 hours of direct care staffing was provided.

On 12/27/2023, there were 34 residents in the residence, including 20 residents with mobility needs, requiring a total minimum of 54 hours of direct care service. On this date, only 44 hours of direct care staffing was provided.

Direct care staff reports they have to provide care, administer medications, serve food, complete housekeeping duties, take out trash and do laundry.

Plan of Correction ***Accept[redacted] - 02/08/2024)***

The facility approved overtime by Interim Administrator when staffing levels are below required hours, there is not dietary staff is available to serve, environmental issues affecting the home's operations, extreme weather, call offs,

57c 2 hrs/day/immob. resident (continued)

sicknesses and vacations.
The facility hired 3 PCAs,; 1 started on 01/01/24 and 1 is starting 01/18/2024. 1 who didn't show for on floor training. Dietary 1 cook was rehired 01/10/24 and 1 Dietary Aide 01/16/2024.
DON and ADON will review staffing daily to ensure compliance with this requirement. Administrator will monitor staffing daily x4 weeks then weekly ongoing. Administrator will reconcile hours for previous day in the timekeeping system with the schedule will review schedule for the next day and week ahead for variances in hours to identify if staffing levels are low. If staffing levels are lower than require additional staff will be provided by offering bonuses, overtime, or calling an agency if needed.
The Housekeepers are assigned to Springfield which will be reflected on their assignment sheets which are directed by the Housekeeping Supervisor. A housekeeper will be assigned to launder resident's clothes and taking out trash which will be reflected on their assignment sheets.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

60a Staffing/support plan needs

12. Requirements

2800.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

Description of Violation

There was no staff person licensed to administer medication on 12/13/2023 for the 7am to 3pm shift.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

The facility approved overtime by Interim Administrator when staffing levels are below required hours, there is not dietary staff is available to serve, environmental issues affecting the home's operations, extreme weather, call offs, sicknesses and vacations.

The facility hired 3 PCAs,; 1 started on [redacted]/24 and 1 is starting [redacted]/2024. 1 who didn't show for on floor training. Dietary 1 cook was rehired [redacted]/24 and 1 Dietary Aide [redacted]/2024.
DON and ADON will review staffing daily to ensure compliance with this requirement. Administrator will monitor staffing daily x4 weeks then weekly ongoing. Administrator will reconcile hours for previous day in the timekeeping system with the schedule will review schedule for the next day and week ahead for variances in hours to identify if staffing levels are low. If staffing levels are lower than require additional staff will be provided by offering bonuses, overtime, or calling an agency if needed.
The Housekeepers are assigned to Springfield which will be reflected on their assignment sheets which are directed by the Housekeeping Supervisor. A housekeeper will be assigned to launder resident's clothes and taking out trash which will be reflected on their assignment sheets.

DIRECTED PLAN OF CORRECTION ([redacted] 2/8/24):

1. In addition to the steps outlined for the Plan of Correction, the administrator or director of

60a Staffing/support plan needs (continued)

nursing/supervisor will ensure sufficient medication techs are on site to cover all three shifts by checking the schedule and call offs, at least daily, starting immediately.

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

[redacted]

Withdrawn[redacted] - 06/04/2024)

64a Initial admin training

14. Requirements

2800.
64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:
1. An orientation program approved and administered by the Department.

Description of Violation

Staff member E, the [redacted]r, has not successfully completed Assited Living Admin Orientation.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

1. Interim Administrator submitted a waiver on _____ and a revised waiver on _____ regarding Administrator qualifications.

2. Interim Administrator will schedule [redacted] for the competency exam
3. Recruitment is ongoing for the position.

64a Initial admin training (continued)

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. *The Director of Operations will ensure that all administrators in place have completed, or at least scheduled, the required trainings by 3/1/24.*
2. *The interim administrator will complete the required elements of this regulation by 3/1/24.*
3. *The administrator will continue recruitment for a full-time administration, who has completed all required trainings, immediately and ongoing.*

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Implemented [redacted] - 06/04/2024)

65a Fire Safety-1st day

15. Requirements

2800.

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 member F, whose first day of work was [redacted]/2023, 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 member D, whose first day of work was [redacted]/2022, 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 .

Plan of Correction ***Directed [redacted] - 02/08/2024)***

1. Staff Member D and Staff Member F will receive education related to fire safety. Staff Member D and F's files will

65a Fire Safety-1st day (continued)

reflect that they received education related to fire safety.

2. HR Director will audit current staff file to ensure staff is receiving fire safety education on or prior to 1st day of work.
3. Maintenance will provide fire safety education to an employee on their first day of work. Administrator will audit HR files monthly to fire safety education is being provided on their first day of work.

Proposed Overall Completion Date: 03/01/2024

DIRECTED PLAN OF CORRECTION[redacted] 2/8/24)
1. Staff Member D and Staff Member F will receive education related to fire safety. Staff Member D and F's files will reflect that they received education related to fire safety by 3/1/24.

2. HR Director will audit current staff file to ensure staff is receiving fire safety education on or prior to 1st day of work, starting immediately and bi-annually as needed.

3. Maintenance will provide fire safety education to an employee on their first day of work. Administrator will audit HR files monthly to fire safety education is being provided on their first day of work, starting immediately.

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

65e Rights/Abuse 40 Hours

16. Requirements

2800.
65.e. 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.
5. Safe management techniques.
6. Core competency training that includes the following:
   i. Person-centered care.
   ii. Communication, problem solving and relationship skills.
   iii. Nutritional support according to resident preference.

Description of Violation

Staff member F completed[redacted] 40th scheduled work hour before 1/3/2024. 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, safe management techniques, core competency training that includes the following: person-centered care , core competency training that includes the following: communication, problem solving and relationship skills , core competency training that includes the following: nutritional support according to resident preference .

65e Rights/Abuse 40 Hours (continued)

Staff member D completed [redacted]r 40th scheduled work hour before 1/3/2024. 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, safe management techniques, core competency training that includes the following: person-centered care , core competency training that includes the following: communication, problem solving and relationship skills , core competency training that includes the following: nutritional support according to resident preference .

Plan of Correction ***Directed [redacted] 02/08/2024)***

1. Staff member D will be provided education related to the topics in this subset.
2. HR Director will audit current employee files to ensure their orientations has been completed for the topics in this subset.
3. HR Director will ensure new employees received orientation/education as it relates to topics in this subset.
4. Administrator will review and audit new employee files monthly to ensure orientation is received as it relates to topics this subset

Proposed Overall Completion Date: 02/8/2024

1. Staff Member D and Staff Member F will receive education related to fire safety. Staff Member D and F's files will reflect that they received education related to fire safety, by 3/1/24.

2. HR Director will audit current staff file to ensure staff is receiving fire safety education on or prior to 1st day of work, and in-service any staff that did not complete the required orientation, by 3/1/24.

3. Maintenance will provide fire safety education to an employee on their first day of work. Administrator will audit HR files monthly to fire safety education is being provided on their first day of work, starting immediately.

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

65l Record of training

17. Requirements

2800.
65.l. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Direct care staff member A's annual's training does not include dates, length, instructors, or location.

Direct care staff member G's annual's training does not include dates, length, instructors, or location.

Direct care staff member H's annual's training does not include dates, length, instructors, or location.

Plan of Correction ***Accept [redacted] - 02/08/2024)***

1. Direct Care Staff A, G, H's training will be corrected by the DON to include the dates, length, instructors, or location utilizing the Adult Residential Licensing Record of Training Form, by 3/1/24.

65l Record of training (continued)

2. The remaining direct care staff's training record will be corrected by the DON utilizing the Adult Residential Licensing Record of Training Form, by 3/1/24.

3. The DON will utilize the Adult Residential Licensing Record of Training Form for the 2024 training period.

4. The Administrator will audit the Adult Residential Licensing Record of Training forms to ensure annual training includes dates, length, instructors and location

Proposed Overall Completion Date: 03/01/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Implemented [redacted] - 06/04/2024)

82b Poisonous materials-storage

19. Requirements

2800.
82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation

Foam wall cleaner with manufacturer's label indicating "Keep out of reach of children and pets. If ingested call local poison control ", was stored in the second room of the basement kitchen on the prep table next to green decorating sugar.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

1. The wall cleaner was removed from the basement kitchen's prep table by the Director of Food Service.

2. Dietary Staff will be inserviced regarding not leaving poisonous materials near food items and kept in an appropriate location.

3. Director of Food Service will audit weekly x4 then monthly x3 to ensure poisons are not near food items and kept in an appropriate location.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/2024):

1. The wall cleaner was removed from the basement kitchen's prep table by the Director of Food Service by 3/1/24.

2. Dietary Staff will be in serviced regarding not leaving poisonous materials near food items and kept in an appropriate location by 3/1/24.

3. Director of Food Service will audit weekly x4 then monthly x3 to ensure poisons are not near food items and kept in an appropriate location, starting immediately,

4. Documentation of trainings will be maintained for the Departments review.

82b Poisonous materials-storage (continued)

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented[redacted] - 06/04/2024)

82c Locked poisons

20. Requirements

2800.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

Description of Violation

An aerosol can of Febreze, with a manufacturer's label indicating "Keep out of reach of children and pets. If ingested call local poison control", was unlocked, unattended, and accessible to residents in the bathroom of the memory care hallway next to the nurse's station.

An open bottle of Amerikem glass cleaner, Chapman spray disinfectant, H-Chlor 12 Topical use only, and DermaVera skin and hair cleanser with a manufacturers label indicating "Keep out of reach of children and pets. Seek medical help if ingested", were unlocked, unattended, and accessible to residents in an unlocked office in of the memory care hallway next to the nurses station.

A tube of fresh mint toothpaste, with a manufacture's label indicating "Keep out of reach of children if accidently swallowed get medical help or contact poison control immediately", was unlocked, unattended, and accessible to residents in the bathroom of resident 3.

Not all the residents of the residence, including the five residents in memory care, have been assessed capable of recognizing and using poisons safely.

Repeat Violation Date: 11/17/22 et al; 7/27/22 et al

Plan of Correction ***Directed[redacted] - 02/08/2024)***

1. The can of Febreeze was removed from the bathroom on the memory care hallway next to the nurses station.

The office in the memory care hallway was locked containing the Amerikem glass cleaner, Dermavera skin and hair cleanser.

The tube of fresh mint toothpaste was removed from Resident 3's bathroom.

Staff will be inserviced regarding not leaving poisonous items that are unlocked or unattended.

DON/designee will audit the memory care unit weekly x4 weeks then monthly x 3 to identify any unlocked poisons

DIRECTED PLAN OF CORRECTION ([redacted]8/24):

82c Locked poisons (continued)

1. *In addition to the plan submitted, the administrator or nursing supervisor will conduct an inspection by 3/1/24 to ensure all poisonous materials have been locked up.*
2. *All poisonous materials and in-servicing of staff will be completed by 3/1/24.*
3. *A copy of the in-service will be maintained for the Departments review.*

Proposed Overall Completion Date: 02/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

83a Indoor temperature

21. Requirements

2800.
83.a. The indoor temperature, in areas used by the residents, must be at least 70°F when residents are present in the home.

Description of Violation

On 12/22/2023 at 8:45 am the dining room was 66.8 degrees, while residents were having breakfast. Residents were wearing coats, hats, scarfs and gloves.

On 12/22/2023 the following temperatures were also observed in the dining room:
9 am: 66.9 degrees
10 am: 61 degrees
3 pm: 62.6 degrees
4 pm: 61.2 degrees

On 1/3/2024 at 8:52 the dining room, which was serving residents breakfast was 66.9 degrees. A signed on was posted on the door to the dining room reading "Cold weather inside remember to bring a sweater"

On 1/3/2024 at 11:30 am the hallway on the first floor was 63.7 degrees

On 1/3/2024 at 11:38 am the memory care hallway was 62.7 degrees. At 5:03pm the hallway was 65.1 degrees.

Plan of Correction ***Accept [redacted] 02/08/2024)***

Starting Immediately, and continuing through 4/30/24, the administrator will monitor temperatures in at least one common area, two resident rooms on each floor, and the dining area daily.
If any is unable to maintain a temperature of at least 70 degrees, the administrator shall relocate residents to warmer areas and immediately contact an outside HVAC company for evaluation and repair. The administrator shall notify the department of such conditions.

Proposed Overall Completion Date: 03/01/2024

83a Indoor temperature *(continued)*

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

85a Sanitary conditions

22. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 1/3/2024, the floor of the first walk-in refrigerator in the basement contained food debris rotting and a whole red onion rotting. The third walk-in refrigerator had a smell of vinegar and rotting food. The dish area smelled of sewage, had two filthy uncovered trash cans, and old food, creamers, and plastic straws filled the garbage disposal.

On 1/3/2024 and 1/4/2023 In the freezer of the upstairs pantry kitchen unknown food items were stuck in solid ice and a pink substance was oozing from the left corner of the door seal.

On 1/3/2024 the 4-slice toaster next to the grill was dirty.

On 1/3/2024 resident 4's room had a large spill next to their bed which was the color of urine or apple juice. There was also a food container with mold in it on the kitchenette table, the floor of the bathroom was extremely sticky and there was water leaking from the bottom of the toilet.

On 1/3/2024 resident 5's room had a strong odor of urine.

On 1/3/2024 resident 6's room had a extremely pungent odor of cat urine, however no cat or litterbox was found in room.

On 1/4/2024 the ice machine in the upstairs pantry kitchen had brown residue on the inside white plastic piece blocking the ice making components. Two trash cans in the dish area were covered with grime, grease and dirt.

On 1/4/2024 at 5 pm the door frame of the guest bathroom was covered in a brown substance similar to feces.

On 1/4/2024 the basement storage area, next to the basement kitchen, had a significant pile of random broken furniture, chairs, sofas, window AC units, wood pallets, old paint, construction equipment, moldy pillows, wet blankets, and garbage.

Plan of Correction ***Directed ([redacted] 02/08/2024)***

The food debris rotting and rotting red onion were disposed of from the 1st walk-in refrigerator. The rotting food was removed from the third walk-in refrigerator. In the dish area, the two garbage cans were cleaned and old food, creamers, and plastic straws were removed and disposed of from the garbage disposal

85a Sanitary conditions (continued)

The freezer in the pantry kitchen was defrosted and cleaned including the seal
The toaster next to the grill was cleaned.

The large spill in Resident 4's room next to their bed was cleaned. There was also The food container with mold was disposed of. The floor of the bathroom was cleaned. The toilet was fixed with the leaking water.

The urine smell from Resident 5's room was mitigated by Housekeeping.
The cat urine smell in Resident 6's room was mitigated by Housekeeping
The pantry kitchen ice machine was cleaned by Dietary. A vendor for will be contacted by the Administrator to service the ice machine. The two trash cans were cleaned by Dietary Staff.
The door frame of the guest bathroom was cleaned by Housekeeping
The basement storage area was cleaned out by Maintenance.

The Director Food Service Inservice dietary staff on maintaining sanitary conditions in the pantry and basement kitchen. Administrator will Inservice Housekeeping and Maintenance on maintaining sanitary conditions throughout the residence.

The Director of Food Service will conduct sanitation audits within the pantry and main kitchen at a minimum of weekly. Areas identified will be corrected. Housekeeping and Maintenance will conduct sanitation rounds throughout the residence at a minimum of weekly. Areas identified will be corrected.

DIRECTED PLAN OF CORRECTION (SLW 2/8/24):

1. *In addition to the steps included in the submitted plan of correction, the administrator or director of food services will conduct an inspection of all food preparation areas by 3/1/24 to ensure all of the steps noted have been implemented.*
2. *All Inservice documents will be maintained for the Departments review.*

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] 06/04/2024)

85d Trash cans – kitchen/bath

23. Requirements

2800.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

85d Trash cans – kitchen/bath *(continued)*

Description of Violation

On 1/3/2024 trash cans in the basement kitchen. pantry kitchen, and kitchen in memory care were all uncovered.

Plan of Correction ***Accept[redacted] 02/08/2024)***

The trash cans in the basement kitchen, pantry kitchen and kitchen were covered with a lid, by 3/1/24.

Dietary Staff will be inserviced by the Director of Food service regarding keeping trash receptacles covered. Housekeeping Supervisor inservices housekeepers, nursing, and activities staff to ensure the garbage can is kept covered in the memory care kitchen by 3/1/24..

Director of Food Service will audit the trash receptacles in the basement and pantry kitchen weekly x4 and monthly x3 to ensure trash receptacles are kept covered. Housekeeping Supervisor will audit the trash receptacles weekly x4 weeks and monthly x3 to ensure the memory care kitchen garbage can is kept covered

Proposed Overall Completion Date: 03/01/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented[redacted] - 06/04/2024)

88a Floors, walls, ceilings, windows, doors

24. Requirements

2800.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 1/3/2024, the electrical closet in memory care, next to the nursing station, was unable to be locked. This room can easily be accessed by residents. In the closet were unlocked breaker boxes, a fire panel sitting on the floor, and broken glass.

There is a missing ceiling tile over the fire alarm in the guest bathroom.

The guest bathroom door in the hallway does not lock or provide privacy for the residents.

At 10:42 am A door leading outside with a sign "emergency exit, alarm will sound" was open and could not properly close, no alarm was sounding.

Plan of Correction ***Directed[redacted] - 02/08/2024)***

The electrical closet next memory care will be locked by Maintenance. Also the unlocked breaker boxes were locked, the fire panel will be removed unless needed, and the broken glass will be cleaned/replaced.

The missing tile over the fire alarm in the guest bathroom was replaced by maintenance.

The guest bathroom door locked will be repaired or replaced by maintenance.

88a Floors, walls, ceilings, windows, doors (continued)

The door was closed by Maintenance. Maintenance will inspect the door for further repairs. If needed repairs will be completed Maintenance or an outside vendor.

The Administrator will inservice maintenance regarding floors, walls, ceilings, and other services must be kept clean, in good repair and free of hazards.

Maintenance will round the facility at a minimum of weekly to identify areas in the resident that are not in good repair and repair items identified or notify an outside vendor.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. *In addition to the steps noted in this plan of correction, the administrator or maintenance director will conduct an inspection to ensure all items noted requiring repairs have been corrected no later than 3/1/24.*
2. *Documentation of the Inservice will be maintained for the Department review.*

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

89a Hot/cold water pressure

25. Requirements

2800.
89.a. The residence must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 1/3/2024 most residents complained about the lack of hot water. Resident 8's room water temp was 86.8 degrees, resident 4's water temp was 76 degrees, and resident 5's water temp was 69 degrees.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

The root cause of the issue that the circulator pump was leaking, Circulator pump was replaced and hot water is circulating throughout the home to accommodate the needs of the residents. Maintenance staff will test water temps at least weekly to ensure the residents have hot and cold water under pressure to accommodate the resident's needs, Administrator will review temperature logs for compliance with this requirement weekly x4 weeks then monthly.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. *The administrator or maintenance staff will ensure all residents of the home have hot water, daily, by testing the hot water in at least 5 rooms and maintain a log of the temperature for the Departments review, starting 3/1/24.*
2. *In the event a resident room is without hot water, a repair is initiated and fixed within 24 hours. effective 3/1/24.*
3. *This plan will be ongoing for the next six months and then monthly, thereafter for the next 12 months, starting immediately.*

Proposed Overall Completion Date: 03/01/2024

89a Hot/cold water pressure *(continued)*

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

90b Staff commnication

26. Requirements

2800.
90.b. For a residence serving nine or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

The residence does not have a system that allows staff in different parts of the residence to communicate with each other in an emergency. The staff utilizes personal cell phone for communication; however service is spotty throughout the building and nearly non-existent in the basement where the kitchen is located.

Plan of Correction ***Accept[redacted] - 02/08/2024)***

A walkie talkie system will be implemented to ensure staff will be able to communicate with each other in case of an emergency, by 3/1/24.

Proposed Overall Completion Date: 03/01/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Implemented [redacted] - 06/04/2024)

95 Furniture & Equipment

27. Requirements

2800.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 12/22/2023, The fire panel was missing exposing loose wires. This was in the front lobby and accessible to residents.

On 1/3/2024, Resident 8's dresser was broken, and mirror in the bathroom was not secured properly to the wall because the hinges on both sides were broken.

The eye wash sink in the pantry kitchen is broken and siting on the floor.

The stove in resident 9's unit is not working.

The sink in resident 10's room is blocked and has a strong sewage odor.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

When fire panel work concludes, the loose wires will be covered with a junction box.

Resident's 8 dresser wilk be repaired and mirror will be secured by Maintenance,

95 Furniture & Equipment (continued)

The eye wash sink in pantry kitchen will be repaired and reattached on the wall. If not repairable, another eye wash station will be purchased.

Resident 9's stove will be evaluated by Maintenance for repair. If not repairable the resident will be asked whether they will like it replaced.

Resident 10's sink was unclogged.

Maintenance will audit 10 rooms per week to determine whether furniture and equipment are in good repair. Maintenance will audit hallways and main areas of the residence weekly x4 and then monthly x3 to identify furniture and equipment that need to be repaired.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. *The administrator will contact the fire system installers. by 3/1/24, to mandate the fire panel be covered to ensure the safety of the residents, within the next 30 days.*
2. *Resident's 8 dresser wilk be repaired and mirror will be secured by Maintenance, no later than 3/1/24,*
3. *The eye wash sink in pantry kitchen will be repaired and reattached on the wall. If not repairable, another eye wash station will be purchased, no later than 3/1/24.*
4. *Resident 9's stove will be evaluated by Maintenance for repair. If not repairable the resident will be replaced by 3/1/24.*
5. *Resident 10's sink was unclogged by maintenance prior to 3/1/24 and the maintenance staff will conduct periodic inspections of at least 10 resident sinks, monthly, starting 3/1/24.*
6. *Maintenance will audit 10 rooms per week to determine whether furniture and equipment are in good repair. Maintenance will audit hallways and main areas of the residence weekly x4 and then monthly x3 to identify furniture and equipment that need to be repaired, starting 3/1/24*
7. *The administrator or Director of Operations will conduct monthly inspections of the physical site of the home, starting 3/1/24, to ensure everything is in good working order.*

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented ([redacted] - 06/04/2024)

96a First aid kit

28. Requirements

2800.
96.a. The residence 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. The residence shall have an automatic external defibrillation device located in each building on the premises.

Description of Violation

The first aid kit located in the memory care unit does not include scissors.

Plan of Correction ***Accept [redacted] - 02/08/2024)***

Scissors were placed in the first aid kit on the memory care unit by 3/1/24.

96a First aid kit (continued)

DON will audit the first aid kits monthly x3 months to ensure they are completed with required items.

Proposed Overall Completion Date: 03/01/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] 06/04/2024)

100a Exterior – free of hazards

29. Requirements

2800.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

There is a large pothole in front of the building that measures approximately 6' x 3'. This poses a tripping hazard.

On 1/3/2024 two broken bird feeders, cups, papers, and metal grates were outside next to the automatic door across from the reception desk.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

The pothole in the front of the facility will be repaired to ensure the tripping hazard is mitigated.

The two broken bird feeders, cups, papers, and metal grates were removed from the outside.

Maintenance will conduct at minimum a weekly round of the exterior of the building to identify an hazard. Any hazards identified will be corrected.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. All steps submitted for the plan of correction will be implemented by 3/1/24.
Proposed Overall Completion Date: 03/01/2024Al

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

[redacted]

[redacted]

101j3 Bed linens/pillows/blankets

31. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

Linens on resident 7's bed are dirty and filled with holes.

Plan of Correction ***Accept [redacted] 02/08/2024)***

The line from resident #7's bed was disposed of by Laundry by 3/1/24.

The housekeeping supervisor will audit linens at minimum weekly after the drying process to ensure residents are receiving clean linens that are in good repair.

Proposed Overall Completion Date: 03/01/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

101j7 Lighting/operable lamp

32. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident 3 does not have access to a source of light that can be turned on/off at bedside.
Resident 5 does not have access to a source of light that can be turned on/off at bedside.
Resident 11 does not have access to a source of light that can be turned on/off at bedside.

101j7 Lighting/operable lamp *(continued)*

Plan of Correction ***Accept [redacted] - 02/08/2024)***

Resident 3, 5, and 11 will be provided a light source that can be turned on or off at bedside by 3/1/24.

5 Rooms per week will be audited by Maintenance to ensure residents have access to a light source that can turned on and off at bedside.

Proposed Overall Completion Date: 03/01/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

101n Walls, floors & ceilings

33. Requirements

2800.
101.n. The living unit must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

Resident 5's wall has a fist sized hole in it near the floor on the right side.
Resident 12's room has a light and ceiling tile falling down
Resident 13's heater grate fell off the wall and is laying on the floor. The resident states she reported this and no one has come to fix it.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

Resident 5's wall will be repaired and Resident 12's room light and ceiling tile will be repaired by Maintenance.
Resident 13's grate will be reinstalled by Maintenance.

Maintenance Director will audit 5 rooms weekly to identify repair issues in the resident living units. Any issues identified will be corrected.

DIRECTED PLAN OF CORRECTION[redacted] 2/8/24):

1. *Maintenance staff will fix the drywall in resident #5's room by 3/1/24.*
2. *Maintenance staff will replace the light and ceiling tile in resident #12's room by 3/1/24.*
3. *Maintenance staff will replace resident #13's heater grate by 3/1/24.*
4. *Maintenance staff will audit 5 rooms weekly to identify repair issues in resident living units. Any issues will be corrected within 24 to 48 hours.*
5. *The maintenance director will conduct monthly physical site inspections of the home to observe the conditions of resident rooms and identify for repair any needed areas of concern, starting 3/1/24.*

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

101o Bedroom - doors

34. Requirements

2800.
101.o. In living units with a separate bedroom, there must be a door on the bedroom.

Description of Violation

Resident 6 has a living unit with a separate bedroom. The bedroom does not have a door.
Resident 13 has a living unit with a separate bedroom. The bedroom does not have a door.

Plan of Correction ***Accept [redacted] - 02/08/2024)***

A contractor will be contacted for measurements and pricing of doors for Resident 6 and Resident 13's room by 3/1/24.

Proposed Overall Completion Date: 03/01/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

102a Functioning toilet

35. Requirements

2800.
102.a. There must be one functioning flush toilet in the bathroom in the living unit.

Description of Violation

Resident 4's toilet is not functioning properly, it is constantly running and leaking creating a puddle on the bathroom floor.

Resident 9's toilet is not functioning properly, it is constantly running so that the water is filled to the top, the resident is unable to clean themselves without getting their hand wet.

Plan of Correction ***Accept [redacted] - 02/08/2024)***

Resident 4s toilet will be repaired by Maintenance and the puddle was cleaned
Resident 9s toilet will be repaired by Maintenance by 3/1/24.

Maintenance will audit 5 resident toilet a week to ensure they are functioning properly. If not functioning properly, they will be repaired Maintenance or a plumbing vendor

Proposed Overall Completion Date: 03/01/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

102h Toilet paper

36. Requirements

2800.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

The guest bathroom did not have toilet paper on 1/3/2024 or 1/4/2024

102h Toilet paper *(continued)*

Plan of Correction ***Accept [redacted] - 02/08/2024)***

Toilet paper was placed in the guest bathroom

Housekeeping Supervisor will be inserviced by the Administrator to keep additonal rolls of toilet paper at receptionist desk. Houskeepers and Receptionist will be inserviced to check guest bathroom throughout the to ensure guest bathroom is furnished with toilet paper.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Implemented [redacted] - 06/04/2024)

103c Food protected

37. Requirements

2800.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 1/3/2023 an open bag of undated cabbage was spilling out into a cardboard box in the first walk in refrigerator in the basement kitchen.

In the second walk in refrigerator on the top shelf there was a block of orange cheese that was not completely wrapped or dated.

In the pantry kitchen refrigerator, there was a container of lunch meat that was opened and undated. On top of a rack next to the refrigerator there was an opened, unlabeled and undated of rice crispy cereal in a clear plastic bin.

On 1/3/2024 and 1/4/2024 an open bag of fried onions that felt greasy when touched was on the food shelf next to the grill.

On 1/4/2024 there was an opened undated container of yellow cheese in the pantry kitchen.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

The undated bag of cabbage, unwrapped and undated block of orange cheese were disposed of from the walk-in refrigerator.

The undated and opened container of lunch meat and rice crispy cereal were disposed of.
Two containers of vegetable soup were disposed of
The opened bag of fried onions were disposed of
The opened and undated bag of yellow cheese was disposed of

The Director of Food Service will inservice the dietary staff regarding dating opened and unlabeled items.

The Director of Food Service will audit the kitchen daily x4 weeks then continue weekly to ensure items are

103c Food protected (continued)

unopened and labeled.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. In addition to the plan of correction noted, the administrator or director of food services will ensure all corrections are completed by 3/1/24.

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Implemented [redacted] - 06/04/2024)

103d Storing food off the floor

38. Requirements

2800.
103.d. Food shall be stored off the floor.

Description of Violation

On 1/3/2024 , at 9:32 am, a large cardboard box of banana's was stored on the floor in the kitchen in front of the dish room. At 12:22 pm a box of creamer was on the floor propping open the walk-in freezer door.

On 1/4/2024 at 9:10 am In the walk in freezer there was a box of apple juice, orange juice, and jimmy dean sausages on the floor.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

The large cardboard of bananas, box of creamers, apple juice, orange juice and jimmy dean sausages were removed from the floor and placed in their appropriate place.

The DIrector of Food Service will inservice the Dietary Staff on not placing food items on the floor.

The Director of Food Service will audit the kitchen daily x 4wwkes then monthy to ensure boxes of food are no on the floor

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):
In addition to the plan of correction noted, the administrator or director of food services will ensure all corrections are completed by 3/1/24 and or started immediately.

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Implemented [redacted] - 06/04/2024)

103e Leftovers

39. Requirements

2800.
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.

103e Leftovers *(continued)*

Description of Violation

On 1/3/2024 undated opened containers of potato salad were in the walk-in refrigerator in the basement and containers were not clean. Staff member I stated these were left over from the day before and should be thrown away. On 1/4/2024 these containers were still in the walk-in refrigerator.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

The undated containers of potato salad were removed from the Walkin refrigerator

The Director of Food Service will inservice the dietary staff regarding dating and labelling leftover containers.

The Director of Food Service will audit the dietary department daily x4 weeks then monthy to ensure leftovers are labeled and dated.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):
In addition to the plan of correction noted, the administrator or director of food services will ensure all corrections are completed by 3/1/24 or started immediately.

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Implemented [redacted] - 06/04/2024)

103f Fridge/Freezer Temps

40. Requirements

2800.
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

On 1/3/2024 the 3rd walk-in refrigerator was 41 degrees at 9:20 am, the pantry kitchen refrigerator was 46 degrees at 9:42 am, and the freezer in memory care was 9 degrees at 11:24 am.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

The 3rd walk-in refrigerator, pantry kitchen refrigerator, and freezer in memory care will be evaluated maintenance to ensure they are functioning properly. New thermometers will be placed in each refrigerator.
The Director Food Service will in-service Dietary staff about the proper temperatures of refrigerator and freezer temperatures. The Director of Food Service will audit refrigerator and freezer temp logs at a minimum of weekly.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):
In addition to the plan of correction noted, the administrator or director of food services will ensure all corrections are completed by 3/1/24.

103f Fridge/Freezer Temps (continued)

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Implemented [redacted] - 06/04/2024)

41. Requirements

2800.
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 in the memory care kitchen.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

A thermometer will be placed in the freezer in the memory care kitchen.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. *In addition to the plan of correction noted, the administrator or director of food services will ensure all corrections are completed by 3/1/24.*
2. *The director of food services will conduct monthly checks of all service-related refrigerators and freezers throughout the home at least monthly to ensure a thermometer is in place, starting 3/1/24.*

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Implemented [redacted] - 06/04/2024)

103g Storing food

42. Requirements

2800.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 1/3/2024 there was a pan of roast beef in the second walk-in refrigerator that was not properly sealed as there were holes in the top of the tin foil cover. On 1/4/2024 the same pan was still there, and it was still not sealed properly

On 1/4/2024 in the first kitchen walk in refrigerator, a large bowl of salad, loosely covered, was not labeled or dated, a thawed bag of green beans not dated or properly sealed, and an open unlabeled package of butter not properly sealed.

Plan of Correction ***Directed [redacted] 02/08/2024)***

The pan of roast beef was properly sealed. The large bowl of salad, thawed green beans, and butter was disposed of

The Director of Food Service will inservice dietary staff on storing food appropriately with proper labeling and dating. The Director of Food Service will audit daily x4 then monthly the proper labeling and dating of foods.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

103g Storing food (continued)

In addition to the plan of correction noted, the administrator or director of food services will ensure all corrections are completed by 3/1/24.

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Implemented [redacted] - 06/04/2024)

103h Thawing food

43. Requirements

2800.
103.h. Food shall be thawed either in the refrigerator, microwave, under cool water or as part of the cooking process.

Description of Violation

1/3/2024 at 4:15pm four plastic containers of veggie soup were being thawed on the metal top of large water boiler in the kitchen.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

The four plastic containers of veggie soup were being removed from being thawed on top of the large water boiler in the kitchen to an appropriate thawing device or process

The Director of Food Service will inservice the cooks on the proper thawing of food, The Director of Food Service will conduct an audit to ensure proper thawing food is being followed.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):
In addition to the plan of correction noted, the administrator or director of food services will ensure all corrections are completed by 3/1/24.

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Implemented ([redacted] - 06/04/2024)

103i Outdated food

44. Requirements

2800.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 1/3/2024 There was an unlabeled undated five gallon bucket of juice in the first walk-in refrigerator, and an undated half full gallon of milk.

On the top shelf of the 3rd walk in refrigerator there was mold on the rim of a gallon of honey mustard, a gallon of dill pickles, a tub of vanilla icing, and a jug of apple cider vinegar.

In the pantry kitchen the following items have instructions to "refrigerate after opening" but were being stored on a

103i Outdated food (continued)

shelf next to the grill: Gordan good choice Lemon juice, Kikkoman soy sauce, Sweet baby Ray's BBQ sauce, Minor's Sweet and sour sauce.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

The undated five gallon bucket of juice and half full gallon of milk were disposed of. The rim on the gallon of honey mustard. gallon of dill pickles, a tub of vanilla icing and a jug of apple cider vinegar were cleaned. The Gordon's Lemon juice, Kikkoman soy sauce, and Sweet Baby Rays barbeque, MInors sweet and sour sauce were relocated to the refrigerator.

The Director Food Service will in-service dietary staff regarding dating and labelling items, disposing of spoiled food and proper storage of foods that require refrigeration.

The Director of Food Service will audit the pantry and basement kitchen daily x 4 weeks then weekly to identify issues related to outdated or spoiled food.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):
In addition to the plan of correction noted, the administrator or director of food services will ensure all corrections are completed by 3/1/24.

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Implemented [redacted] 06/04/2024)

107c Food/water – 3 day supply

45. Requirements

2800.
107.c. The residence shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 1/3/2024, the residence served 46 residents, requiring 138 gallons of emergency drinking water. However, the residence had only 60 gallons. The residence does not have a contract with a local bottled water supplier.

On 1/3/2024, staff member I, the dietary director, the stated they did not have enough emergency food or water due to back-to-back emergencies over the weekend of 12/30 -12/31/23.

Plan of Correction ***Directed ([redacted] - 02/08/2024)***

The remaining 78 gallons of water was obtained during inspection. The residence does have a contract with the food purveyor.

Delivery of emergency food to replenish stock was delivered on 01/5/2024 and 01/09/2024.

The Director Food Service will be inservice by the Administrator to maintain a 3 day supply of non perishable food and drinking water

The Administrator will audit the emergency supply of food and water weekly x4 and then monthly to ensure

107c Food/water – 3 day supply (continued)

emergency supplies are maintained at the 3 day level.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):
In addition to the plan of correction noted, the administrator or director of food services will ensure all corrections are completed by 3/1/24.

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

125a Combustible storage

46. Requirements

2800.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 1/4/2024, a white and yellow blanket was jammed under the backup generator in the basement plus two buckets of assorted trash and one bucket of putty near the bottom of the generator on 1/4/24.

Plan of Correction ***Directed [redacted] 02/08/2024)***

The white and yellow blanket was removed from the backup generator, two buckets of assorted and putty was removed from the generator area.

Maintenance will be inserviced by the Administrator to ensure heat sources and or hot water heater are free of combustible and flammable materials.

Administrator or Maintenance will audit areas of heat sources or hot water sources weekly x 4 then monthly x3 to ensure they are clear of combustible and flammable materials.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. *The administrator or maintenance director will conduct a physical site inspection to ensure the plan of correction steps noted have all been implemented by 3/1/24 and monthly thereafter.*
2. *Documentation of the in-service will be maintained for the Departments review.*
   Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] 06/04/2024)

125b Combustible res. access

47. Requirements

2800.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

On 1/3/2024, at 11:08 am, an oxygen tank was unlocked, unattended, and accessible to residents in a closet behind

125b Combustible res. access (continued)

the nursing station in memory care.

Plan of Correction ***Directed ([redacted] - 02/08/2024)***

The oxygen tank was locked up in the closet by Nursing

DON will inservice the nursing staff on ensuring oxygen tanks are locked in the closet and inaccessible to residents on memory care.

DON/designee will audit the 02 tank on memory care weekly x4 weeks then monthly x 3 to ensure they are locked in the closet and inaccessible to resident.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. *In addition to the steps submitted for the plan of correction, the director of nursing or supervisor will ensure all steps have been completed or implemented by 3/1/24.*
2. *The ins-service documents will be maintained for the Departments review.*

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

127a Portable space heaters

48. Requirements

2800.
127.a. Portable space heaters are prohibited.

Description of Violation

On 1/3/2024 and on 1/4/2024, Space heaters were located in the following resident rooms: resident 12, resident 13, resident 14, resident 15, resident 16, and resident 17. Resident 13 had two space heaters in their living unit.

On 1/4/2024, an additional three space heaters were discovered; two were in the pantry kitchen office and one was in the basement kitchen.

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

On 1/4/2024 all space heaters were removed.
The Administrator or designee will complete rooms checks throughout the home to ensure no space heaters are located in the home.

Proposed Overall Completion Date: 03/01/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

130a Smoke detector - living unit

49. Requirements

130a Smoke detector - living unit *(continued)*

2800.
130.a. There shall be an operable automatic smoke detector located in each living unit.

Description of Violation

On 1/3/2024, Resident 14 did not hear a fire alarm go off in their room. They were alerted to the first drill after hearing the alarm go off in the hallway. When reviewing the resident's room it did not appear that the smoke detector was operable.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

The smoke detector in Room_____ will be evalauted and repaired by Maintenance to ensure it is operable.

Maintenance will be inserviced by the Administrator to ensure resident room smoke detectors are operable.

Maintenance will audit 5 rooms weekly to ensure smoke detectors are operable, If issues are identified they will be corrected

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. *In addition to the plan of correction steps noted, the administrator or maintenance director will conduct an inspection of all smoke detectors throughout the home to ensure they are operable by 3/1/24.*
2. *Documentation of the in-service will be maintained for the Departments review.*
3. *The maintenance director will conduct monthly physical site inspections to determine if all smoke detectors are operable, starting 3/1/24.*
   Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] 06/04/2024)

130d Hearing impairment

50. Requirements

2800.
130.d. If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

Description of Violation

Resident 7 is unable to hear the fire alarm system. The residence does not have a signaling device approved by a fire safety expert and tested to ensure that resident 7 is alerted in the event of a fire. The resident stated that they did not participate in the fire drill held 1/3/2024 because they could not hear the alarm.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

Resident's #7's room will be evaluated by a Fire Safety expert for an approved signalling device. An approved signalling device will be installed in Resident #7's room.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24)

1. *The maintenance director will obtain a visual signaling device for resident #7 and for any other resident that is unable to hear the fire alarms when they are alerted within 10 days of receipt of this pan of correction.*
2. *The Director of nursing or supervisor will report any resident with hearing impairments to the maintenance director to ensure a visual signaling device can be obtained, by 3/1/24.*

130d Hearing impairment (continued)

3. *The Maintenace director or staff will observe any hearing impaired resident during the monthly fire drill to ensure they are able to evacuate upon the signaling of the fire alarm, starting 3/1/24.*
4. *The administrator or maintenance staff will check the residents identified with a hearing impairment monthly to ensure their room signaling device is operable, starting 3/1/24.*

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

[redacted]

131f Fire extinguisher inspection

52. Requirements

2800.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in stair well of the 3rd floor memory care wing has not been inspected by a fire safety expert since June 2022.

131f Fire extinguisher inspection *(continued)*

Plan of Correction ***Directed [redacted] - 02/08/2024)***

The fire extinguisher in stairwell of memory wingwas inspected on_____

Maintenance will be inserviced regarding having the fire extinguishers inspected by a fire safety expert annually.

A fire safety expert will be contacted by the Administrator to inspect and approve the fire extinguishers in the residence.

DIRECTED PLAN OF CORRECTION[redacted]/8/24):

1. *The fire extinguisher in the memory care stairwell will be inspected by 3/1/24.*
2. *The maintenance director will in-service the staff on scheduling an inspection of the fire extinguishers by a fire safety expert annually, by 3/1/24.*
3. *The administrator will schedule the annual inspection of the home and fire extinguishers as required, starting 3/1/24.*
4. *Documents related to the in-service will be maintained for the Departments review.*

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented ([redacted] - 06/04/2024)

132d Evacuation

53. Requirements

2800.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the residence.

Description of Violation

The residence does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The residence exceeded an evacuation time of 2 minutes 30 seconds during the following drills: 1/3/2024. Most residents did not exit their rooms after 5 minutes and 7 second so the drill was ended.

On 1/3/2024 Five memory care residents were evacuated to the fire safe area on the 3rd floor. It took approximately 4 minutes with 2 staff members assisting residents. Staff members informed agents of the department it was unusual for two staff members to be in memory care at the same time.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

The Administrator will contact a fire safety expert to specify in writing the period of time it takes to evacuate the residence.

The Administrator will maintain the letter in a binder located in the Administrator's office.

132d Evacuation (continued)

The Administrator will audit the binder monthly to ensure the evacuation letter is maintained in there.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. *In addition to the steps noted in the Plan of Correction, the administrator will ensure the steps are completed by 3/1/24.*
2. *A copy of the fire safety expert letter will be maintained for the Departments review.*
3. *In the event a fire drill exceeds the maximum evacuation time, a second fire drill will be conducted later in the month, starting 3/1/24.*
4. *During the next resident council meeting, in April 2024, the Activities director or Maintenance director will discuss the importance of evacuating to a fire safe area during all monthly fire drills. The directors will educate the residents on the locations of the fire safe areas.*
   Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

132h Designated meeting place

54. Requirements

2800.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 1/3/2024, at 10:49 am, only memory care residents were evacuated to the fire safe areas. No other residents were evacuated. Staff of the home did not follow fire safety procedures and were overheard stating "it's just a drill". Several residents of the home came out and looked in the hallway and then went back to their room. Resident 7 and Resident 13 stated they were unaware that a fire drill had occurred because they did not hear it. Resident 2 and resident 18 stated no one came to get them so they figured it was just a drill and remained in their rooms.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

The receptionsit and nursing staff will be responsible to read the panel and announce where the "fire" is located during the drill

A mock fire drill will be conducted with signatures from staff and residents to ensure they understand when a drill is occurring and understand where the fire safe area or designated meeting place is located.

Residence staff will be inserviced by the Administrator regarding fire safety procedures.

The Administrator will review the current fire safety policy and procedures for any revisions. Any revisions to the policy will be communicated to residence staff and residents.

Fire Drills will be conducted weekly x4 weeks, then monthly to ensure proper fire safety procedures and resident's are being directed to fire safe areas during the drill.

During a resident's council, the fire drill or fire safety expert will educate the resident's what the fire alarms sounds

132h Designated meeting place (continued)

like and what they can expect during a fire drill.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. *In addition to the steps noted in the Plan of Correction, the administrator will ensure the steps are completed by 3/1/24.*
2. *During the next resident council meeting, in April 2024, the Activities director or Maintenance director will discuss the importance of evacuating to a fire safe area during all monthly fire drills.*
3. *The directors will educate the residents on the locations of the fire safe areas.*

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] 06/04/2024)

141a Medical evaluation

55. Requirements

2800.

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.
11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.
12. Information about a resident's day-to-day assisted living service needs.

Description of Violation

The medical evaluation for resident 2, dated [redacted]/2023, does not include medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

The medical evaluation for resident 4, dated [redacted]/2023, does not include medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

The medical evaluation for resident 10, dated [redacted]/2023, does not include medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

141a Medical evaluation *(continued)*

Plan of Correction ***Accept (- 02/08/2024)***

On 1/30/2024 the DOn and RCC pulled all resident's DME's to ensure all face sheets included medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
The DON will complete a tickler of all new admissions and yearly faces sheets to include medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
As of 2/1/2024 we have not had any new admissions.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented 06/04/2024)

144d Smoking outside

56. Requirements

2800.
144.d. Smoking outside of the smoking room is prohibited.

Description of Violation

On 1/3/2024 agents of the department observed cigarette butts in the memory care court yard which had a sign leading outside stating this was not a smoking area.

Plan of Correction ***Accept - 02/08/2024)***

All staff was inserviced on 1/5/2015 on the smoking policy and the designated smoking areas.
The Administrator and Maintenance will complete random checks in memeory court yard to ensure no one is smoking in a non smoking area.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented (- 06/04/2024)

161c Additional portions (continued)

[redacted]

161g Snacks

59. Requirements

2800.
161.g. Between-meal snacks and beverages shall be available at all times for each resident, unless medically contraindicated as documented in the resident's support plan.

Description of Violation

No between-meals snacks are available to the residents. Staff member I, dietary director stated snacks are only served at noon. Staff members reported that staff member I had taken the keys to the kitchen area and was away for the weekend, so no snacks were provided for the residents 12/30/2023-1/1/2024.

Plan of Correction ***Directed [redacted] - 02/08/2024)***

In between meal snacks will be made available to the residents. The snacks will be made available to the resident in the fireplace room by dietary staff at frequent time intervals throughout the day. When Director of Food Service is away, a key to kitchen area will be provided to the supervisor in case snacks need to be obtained by nursing staff for the residents.

Dietary Staff will be inserviced by the Director of Food Services on providing between meal snacks for the residents. The Director of Food Services will maintain a time log of when snacks and the type of snacks are delivered.

The snack delivery time log will be reviewed by the Administrator weekly x4 then monthly x 3 to ensure between meals snacks are being provided to residents at all times.

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. *In addition to the steps submitted for the plan of correction, the dietary manager will ensure all corrections are completed by 3/1/24.*
2. *Documentation of the planned in-service will be maintained for the Departments review.*
   Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

162e Menu changes

60. Requirements

2800.
162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On 1/3/2024, meatloaf, baked potato steamed cabbage, texas toast, assorted cookies, with an alternative menu of

162e Menu changes (continued)

pot roast, parsley potatoes and squash rounds were listed as the menu items for lunch. Residents were served beef tips, mashed potatoes and green beans and pie. No notice of change was provided to the residents in advance of the meal.

Plan of Correction ***Accept [redacted] - 02/08/2024)***

The menu changes will be communicated to the resident's by updating the daily menu boards as needed, starting 3/1/24.

The Director of Food Service will be inserviced on providing notices of change to the resident's when a meal changes.

The Director of Food Service will communicate to the Administrator when menu changes are made.

The Administrator will audit notices of menu changes weekly x4 then monthly x3 to ensure residents are being communicated to in advance of the changes.

Proposed Overall Completion Date: 03/01/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] 06/04/2024)

181c Self-Administer Assessment

61. Requirements

2800.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2800.227(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 13 had a bottle of Acetaminophen on [redacted] beside table. Resident 13 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner to have the ability to self-administer.

Plan of Correction ***Accept ([redacted] - 02/08/2024)***

All rooms were checked for medication by DON and MCC and no other medications were found.
DON will go over OTC medications , self administer medications and bringing medications into the home at the next resident council meeting this.
DON or designee will complete random rooms checks for medications for the next 60 days.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] 06/04/2024)

[redacted]

[redacted]

Description of Violation

[redacted]

Withdrawn [redacted]

[redacted]

Withdrawn [redacted]

183a Original containers / no pre-pour / injections

64. Requirements

2800.

183a Original containers / no pre-pour / injections *(continued)*

183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

On 1/4/2024, at 8:47am, an unattended, unlocked medication cart by the temporary dining room had three unlabeled proportioned cups of pills.

Plan of Correction ***Accept[redacted] - 02/08/2024)***

0n 1/5/2024 all med techs were in serviced on medications cart being unlocked while unattended.
Staff person was given a education on the spot, on leaving unlabled medication inside the cart.
The DON will randomly spot check each med cart to ensure med carts are locked and no unlabed medications were left in the medication.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented[redacted] - 06/04/2024)

183b Medications and syringes locked

65. Requirements

2800.
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 living unit.

Description of Violation

On 12/22/2023, at 8:45 am, a medication cart was unlocked, unattended, and accessible near the dining room. a lanyard of keys hung out of the lock.

On 1/4/2024, at 8:47am , an unattended, unlocked medication cart by the temporary dining room had three unlabeled proportioned cups of pills.

Resident 13 had a bottle of Acetaminophen on [redacted] beside table.

Plan of Correction ***Accept[redacted] 02/08/2024)***

on 1/05/2024 all med techs were in serviced on keeping the medication cart keys in their pocket or on their neck when not using, and should never walk away and leave the keys in the cart.
0n 1/5/2024 all med techs were in serviced on medications cart being unlocked while unattended.
Staff person was given a education on the spot, on leaving unlabled medication inside the cart.

The DON will randomly spot check each med cart to ensure med carts are locked and no unlabed medications were left in the medication.

183b Medications and syringes locked (continued)

The DON immediately went over the sel-administration policy with all residents who that sel-administer on 1/10/2024. All residents who self-administer has been encouraged to keep medications locked in drawer or lock box, the DON will provide a lock box to residents if needed.
The DON will conduct weekly room checks of all residents who self administer their own medications to ensure all medications are being kept locked in a lock box or drawer, or room remains locked at all times when resident is not present.
Each resident will be giving a copy of the self administer policy upon admission and the DON will keep a signed acknowledgement in residents chart.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented ([redacted] - 06/04/2024)

183d Current medications

66. Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

On 1/4/2024, Oyster shell 500mg tab, prescribed for resident 20, was in the residence's medication cart; however, the medication was discontinued.

Plan of Correction ***Accept [redacted] - 02/08/2024)***

The DON conducted a medication cart audit on 1/8/2024 to check for disconyinued medications.
The DON will concuct monthly medication cart audits and pull discontinued or expired medications out of the cart and reorder as needed per state regulations.
This will be ongoing starting 2/15/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented ([redacted] - 06/04/2024)

183e Storing Medications

67. Requirements

2800.
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 1/4/2024, There were seven loose pills in the 2nd drawer of second floor med cart – A blue oblong tablet, a small oval white tablet, a round white tablet, an orange oblong tablet, a round peach tablet, a small cream color capsule and a large white capsule.

There were eight very dirty pills in the second drawer of the 1st floor med cart- two white oblong pills, one peach oblong pill, one blue oval pill, a half of a white oval pill, two large round white pills and a small white pill.

There were two loose pills in the second drawer of the memory cart.

183e Storing Medications (continued)

There were two white round pills in the third drawer of the 1st floor med cart.

Plan of Correction ***Accept (02/08/2024)***

The DON conducted a medication cart audit on 1/8/2024 to check for disconyinued medications.
The DON will concuct monthly medication cart audits and pull discontinued or expired medications out of the cart, loose pills and reorder as needed per state regulations.
This will be ongoing starting 2/15/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented - 06/04/2024)

183f Discontinued medications

68. Requirements

2800.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the residence shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the residence, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the residence.

Description of Violation

Resident 7 is prescribed Albuterol Sulfate inhaler 0.5mg. This was on the medication cart and had expired 8/2023.

Plan of Correction ***Accept (- 02/08/2024)***

The DON conducted a medication cart audit on 1/8/2024 to check for disconyinued medications.
The DON will concuct monthly medication cart audits and pull discontinued or expired medications out of the cart and reorder as needed per state regulations.
This will be ongoing starting 2/15/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented - 06/04/2024)

184a Resident meds labeled

69. Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

184a Resident meds labeled *(continued)*

Description of Violation

Hydroxyurea 500mg did not have a pharmacy label. Staff stated this medication was for resident 21

Plan of Correction ***Accept [redacted] 02/08/2024)***

The DON conducted a medication cart audit on 1/8/2024 to check for disconyinued medications.
The DON will concuct monthly medication cart audits and pull discontinued or expired medications out of the cart, loose pills and ensure all medications are lable matching the name, medication, the prescription issued date, the prescribed dosage and instructions for administration, the name and tittle of the provider, and reorder as needed per state regulations.
This will be ongoing starting 2/15/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

184b - Labeling OTC/CAM

70. Requirements

2800.
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 the first-floor medication cart the following medications were unlabeled: Centrum, aspirin, acetaminophen, and a box of anti-diarrheal.

On the second-floor medication cart the following medications were unlabeled: 2 boxes of Fleet saline enema, and melatonin 3mg.

Plan of Correction ***Accept [redacted] 02/08/2024)***

The DON conducted a medication cart audit on 1/8/2024 to check for disconyinued medications.
The DON will concuct monthly medication cart audits and pull discontinued or expired medications out of the cart, loose pills and ensure all medications are lable matching the name, medication, the prescription issued date, the prescribed dosage and instructions for administration, the name and tittle of the provider, and reorder as needed per state regulations.
This will be ongoing starting 2/15/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

185a Storage procedures

71. Requirements

2800.
185.a. The residence 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 the following days resident 1's blood glucose meter had reading taken but they were not recorded on the medication administration record:
1/3/24 8:22 pm, Glucometer reading 425.
12/30/23 5:01 pm. Glucometer reading 150.

185a Storage procedures (continued)

12/28/23, 7:58 pm. Glucometer reading 201.

On 12/28/2023 at 8am and 12 pm The medication administration record was initialed but there was no readings on the glucometer for resident 1.

Resident's 3's last notation in the narcotic log for lorazepam 0.5mg as needed was 12/1/2023, the count indicated there should have been 16 remaining however there were only 15 in the narcotics drawer. There was not documentation that a dose was administered between 12/1/2023 and 1/4/2024. Staff member J indicated this medication had been discontinued but could not identify when it was discontinued.

Resident 12 had a glucose meter reading of 146 on 12/31/2023 documented at 149.
On the following days resident 22's blood glucose meter had reading taken but they were not recorded on the medication administration record:
12/31/2023 9:12 pm was 440 not recorded.
12/29/2023 6:32pm was 370 not recorded.
12/28/2023 12:47pm was 290 and not recorded.
12/26/2023 12:02 pm was 280 and not recorded.
On 12/27/2023 11:42 am the glucometer reading was 226, the medication administration record read 196.

Plan of Correction ***Accept[redacted] 02/08/2024)***

On 1/30/2024 all med techs have taken the diabetic training.
On 1/15/ 2024 and 1/17/2024 all med techs were retrained in the medication administration course.
On 1/5/2024 all med techs were inserviced on 2800.187.d. The home shall follow the directions of the prescriber.
On 1/10/2024 med techs were in serviced following prescribers incidents and reportable incidents.
The DON will concuct monthly medication cart audits and pull discontinued or expired medications out of the cart, loose pills and ensure all medications are lable matching the name, medication, the prescription issued date, the prescribed dosage and instructions for administration, the name and tittle of the provider, and reorder as needed per state regulations.

This will be ongoing starting 2/15/2024
The DON will report all medication errors to the PCP, DHS and Family.
The DON or designee will conduct weekly MAR audits.

Licensee's Proposed Overall Completion Date: 03/15/2024

Not Implemented[redacted] - 06/04/2024)

72. Requirements

185a Storage procedures *(continued)*

2800.
185.a. The residence 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 20 is prescribed Alendronate 70 mg, Calcium chewable tab 1250 mg, Famotidine, Tylenol 325 mg pen, Pepto Bismol (Bismuth Oral Suspension), and Lidocaine Patch 4%. However, this medication was not administered to resident 1/4/2023 because the medication was not available in the residence.

Plan of Correction ***Directed [redacted]/08/2024)***

The DON will concuct monthly medication cart audits and pull discontinued or expired medications out of the cart, loose pills and ensure all medications are lable matching the name, medication, the prescription issued date, the prescribed dosage and instructions for administration, the name and tittle of the provider, and reorder as needed per state regulations.

This will be ongoing starting 2/15/2024

DIRECTED PLAN OF CORRECTION [redacted]8/24)

1. *In addition to the plan of correction submitted, the DON will ensure all prescribed medications are available for resident administration by reviewing the recap monthly, starting 3/1/24.*
2. *The DON will order resident #20's prescribed medications by 3/1/24.*

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Not Implemented[redacted] 06/04/2024)

187a Medication record

73. Requirements

2800.
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.

187a Medication record *(continued)*

14. Name and initials of the staff person administering the medication.

Description of Violation

Resident 20 is prescribed Ferrous sulfate 325 mg 1 by mouth 2 times a day. However, resident's medication administration record indicates 1 by mouth daily.

Resident 20 is prescribed Folic Acid 1 mg tab 2 tablets by mouth 1 time daily. However, resident's medication administration record indicates 1 by mouth daily.

Plan of Correction ***Accept [redacted] - 02/08/2024)***

The DON conducted a medication cart audit on 1/8/2024 to check for disconyinued medications.
The DON will concuct monthly medication cart audits and pull discontinued or expired medications out of the cart, loose pills and ensure all medications are lable matching the name, medication, the prescription issued date, the prescribed dosage and instructions for administration, the name and tittle of the provider, and reorder as needed per state regulations.
On 1/15/2024 and 1/16/2024 all med techs were re trained in the medication course.
This will be ongoing starting 2/15/2024

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

[redacted]

Withdrawn ([redacted]

187d Follow prescriber's orders

75. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On 12/28/2023 7:58 Pm resident 1's glucose reading was 201 resident should have received 2 units of insulin, but

187d Follow prescriber's orders (continued)

was not administered.

Repeat Violation Date: 9/1/22, 7/27/22 et al

Plan of Correction ***Accept [redacted] 02/08/2024)***

On 1/5/2024 all med techs were inserviced on 2800.187.d. The home shall follow the directions of the prescriber.
On 1/10/2024 med techs were in serviced following prescribers incidents and reportable incidents.
On 1/15/2024 and 1/17/2024 all med techs were re trained on medication administration.
On 1/30/2024 all med techs was re certified in diabetic training.
The DON will report all medication errors to the PCP, DHS and Family.
The DON or designee will conduct weekly MAR audits.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented ([redacted] - 06/04/2024)

76. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 20 is prescribed Alendronate 70 mg, Calcium chewable tab 1250 mg, Famotidine,
Tylenol 325 mg pen, Pepto Bismol (Bismuth Oral Suspension), and Lidocaine Patch 4%. However, this medication was not administered to resident 1/4/2023 because the medication was not available in the residence.

Plan of Correction Repeat Violation Date: 9/1/22, 7/27/22 et al ***Accept ([redacted] - 02/08/2024)***

On 1/5/2024 all med techs were inserviced on 2800.187.d. The home shall follow the directions of the prescriber.
On 1/10/2024 med techs were in serviced following prescribers incidents and reportable incidents.
On 1/15/2024 and 1/17/2024 all med techs were re trained on medication administration.
On 1/30/2024 all med techs was re certified in diabetic training.
The DON will report all medication errors to the PCP, DHS and Family.
The DON or designee will conduct weekly MAR audits.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] 06/04/2024)

188b Medication error reporting

77. Requirements

2800.
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 did not receive medication on 12/28/2023,

Resident 2, resident 12, and resident 24 did not receive medications on 12/13/2023.

Resident 22 did not receive medications on 12/28/2023, or 12/26/2023.

These medication errors were not reported to the department.

Plan of Correction ***Accept (02/08/2024)***

On 1/5/2024 all med techs were inserviced on 2800.187.d. The home shall follow the directions of the prescriber.
On 1/10/2024 med techs were in serviced following prescribers incidents and reportable incidents.
On 1/15/2024 and 1/17/2024 all med techs were re trained on medication administration.
On 1/30/2024 all med techs was re certified in diabetic training.
The DON will report all medication errors to the PCP, DHS and Family.
The DON or designee will conduct weekly MAR audits.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented 04/2024)

[redacted]

190a Completion of course–meds *(continued)*

[redacted]

Withdrawn ([redacted]

190b Insulin injections

79. Requirements

2800.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff member A, staff member C, staff person H, staff member K and staff member L all who have not successfully completed of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months., administered insulin to residents in 12/2023

Plan of Correction ***Accept (*** [redacted] ***02/08/2024)***

On 1/30/2024 all med techs successfully completed a approved diabets patient education program.
The DON will create a tickler to ensure all med techs remain in compliance with the 2800 regulations.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] ***- 06/04/2024)***

[redacted]

Withdrawn [redacted]

231d No objection statement

81. Requirements

231d No objection statement *(continued)*

2800.
231.d. Resident admission to special care unit. Each resident record must have documentation that the resident or potential resident and, when appropriate, the resident's designated person or the resident's family have agreed to the resident's admission or transfer to the special care unit.

Description of Violation

Resident 4 was admitted to the special care unit on [redacted]021. However, the resident's record does not include documentation that the resident and the resident's designated person or the resident's family have agreed to the resident's admission to the special care unit.

Plan of Correction ***Accept ([redacted]- 02/08/2024)***

On 1/30/2024 resident [redacted] was notified that resident or resident's [redacted] have not agreed to th[redacted] residents admission to the special care unit. The DON is waiting for the [redacted] to come in and sign the paper.
The adminstrator will now sign off on new admissions to the special care unit after the resident and/or resident's family have signed that they agreed.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted]- 06/04/2024)

233a Lock approval

82. Requirements

2800.
233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The residence does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the locking devices, used on the exit doors located on the 3rd floor of the memory care unit.

Plan of Correction ***Directed [redacted] 02/08/2024)***

The Administrator will be obtain a locking approval letter from an appropriate local building authority to permitting the use of the specific locking system,

The locking system approval letter will be kept in a binder in the Administrator's office.

DIRECTED PLAN OF CORRECTION (SLW 2/8/24):

1. In addition, to the plan of correction steps noted, the administrator will obtain or locate a copy of the letter approving the locking mechanisms in the SDCU by 3/1/24.

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Implemented [redacted] 06/04/2024)

233b Lock manufact. statement

83. Requirements

2800.
233.b. A residence 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 residence does not have a statement from the manufacturer of the locking devices in the memory care unit verifying that the door locks will release when the fire alarm system is activated, the residence's power fails, and when the lock releasing device is operated.

Plan of Correction ***Directed [redacted] 02/08/2024)***

The Administrator will obtain a statement or manufacturer's recommendation that the door locks will release when the fire alarm system is activated, power failure to the home or the lock releasing device is activated.

The Administrator will maintain the statement regarding the residence locking system in a binder located in the Administrator's office.

The Administrator will audit binder monthly to ensure statement is available for review,
DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):
In addition, to the plan of correction steps noted, the administrator will obtain or locate a copy of the letter approving the locking mechanisms in the SDCU by 3/1/24.

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Implemented ([redacted] - 06/04/2024)

233e Fire alarm systems

84. Requirements

2800.
233.e. Fire alarm systems shall be interconnected to the local fire department, when available, or a 24-hour monitoring service approved by the local fire department.

Description of Violation

The residence did not provide proof the fire alarm system is correctly connected to the local fire Department or to a 24-hour monitoring service approved by the local fire Department. Staff member M states [redacted] receives round the clock phone calls from the fire alarm company that provide no information. When Agents of the department contacted County Fire company on 1/3/2024, they reported the daily occurrence of calls from the panel is because the phone lines are not connected. According to the county fire company the home has not paid for monitoring service, and it will be discontinued effective 1/15/2024.

233e Fire alarm systems *(continued)*

Plan of Correction ***Directed ([redacted] - 02/08/2024)***

The residence has paid the bill for the monitoring service.
County Fire Company resumed working on the fire panel and alarm system until project is completed.
County Fire Company will certify and commission fire panel and alarm monitoring system after completion of project

DIRECTED PLAN OF CORRECTION [redacted] 2/8/24):

1. *In addition to the plan of correction steps noted, the administrator will provide a copy of the paid invoice for the monthly monitoring of the fire alarm system, by 3/1/24.*
2. *The administrator will complete the fire alarm system within the next 30 days and or a letter from the fire system installer on the timeline for completion of the fire alarm system, by 3/1/24.*
3. *The administrator will ensure the fire alarm system is operational no later than 3/30/24.*

Proposed Overall Completion Date: 03/01/2024

Directed Completion Date: *03/01/2024*

Implemented [redacted] - 06/04/2024)

252 Records – content

85. Requirements

2800.
252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. A language, speech, hearing or vision need which requires accommodation or awareness of during oral or written communication.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the residence, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.

252 Records – content *(continued)*

20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the residence, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2800.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.
27. A record relating to any exception request under § 2800.229 (relating to excludable conditions; exceptions).
28. Ongoing resident progress notes.

Description of Violation

Resident 2's record does not include color of hair, color of eyes and identifying marks.
Resident 4's record does not include color of hair, color of eyes and identifying marks.

Plan of Correction ***Accept[redacted] 02/08/2024)***

On 1/30/2024 the DON and RCC pulled all residents charts to ensure all face sheets included race, eye color, hair color and any identifying marks.
The DON will create a tickler to ensure all of all new admissions and yearly face sheets include color of hair, color of eyes and identifying marks.
As 0f 2/1/2024 we have had no new admissions.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented [redacted] - 06/04/2024)

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

Facility Information

Name: *SPRINGFIELD SENIOR LIVING COMMUNITY* **License #:** *14484* **License Expiration:** *05/12/2024*

Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA 19038*

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

Administrator

Name: [redacted]

Legal Entity

Name: *WYNDMOOR ASSISTED LIVING COMPANY LLC*

Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA, 19038*
[redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *11/16/1987* **Issued By:** *Commonwealth of PA, L&I*

Staffing Hours

Resident Support Staff: *44* **Total Daily Staff:** *92* **Waking Staff:** *69*

Inspection Information

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

Reason: *Complaint, Monitoring* **Exit Conference Date:** *01/22/2024*

Inspection Dates and Department Representative

01/22/2024 - On-Site: [redacted]
01/24/2024 - Off-Site: [redacted]
01/29/2024 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *103* **Residents Served:** *31*

Special Care Unit

In Home: *Yes* **Area:** *3rd floor* **Capacity:** *34* **Residents Served:** *5*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *31*
Diagnosed with Mental Illness: *1*
Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *17*
Have Physical Disability: *17*

Inspections / Reviews

01/22/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/19/2024*

05/01/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/09/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/09/2024*

06/04/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/09/2024*

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

[redacted]

Withdrawn [redacted]

24 Personal hygeine

2. Requirements

2800.

24. Personal Hygiene - A residence shall provide the resident with assistance with personal hygiene as indicated in the resident's assessment and support plan. Personal hygiene includes one or more of the following:
    1. Bathing.
    2. Oral hygiene.
    3. Hair grooming and shampooing.
    4. Dressing, undressing and care of clothes.
    5. Shaving.
    6. Nail care.
    7. Foot care.
    8. Skin care.

Description of Violation

The residence did not provide hot water to residents on 1/19/2024, 1/20/2024, 1/21/2024 and the morning of 1/22/2024. Staff could not properly assist any residents with personal hygiene needs as they were not able to bathe or shower the residents. This was verified through resident and staff interviews.

Plan of Correction ***Directed ([redacted] - 05/01/2024)***

The circulator has been repaired. The Administrator and/or designee will ensure all residents of the home have hot

24 Personal hygeine (continued)

water, daily, by testing the hot water in at least 5 rooms daily for 5 months, then monthly for 11 months. In the event a resident room is without hot water, a repair is initiated and fixed within 24 hours.

Proposed Overall Completion Date: 04/26/2024

Directed Plan of Correction: In addition to the above plan of correction, documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/26/2024*

Not Implemented [redacted] 06/04/2024)

57c 2 hrs/day/immob. resident

3. Requirements

2800.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 1/21/2024, there were 31 residents in the residence, including 17 residents with mobility needs, requiring a total minimum of 48 hours of direct care service. On this date, based on time cards provided by the residence, only 37.5 hours of direct care staffing was provided.

Plan of Correction ***Directed [redacted] - 05/01/2024)***

The Home currently has housekeeping and laundry employees. The Administrator and/or designee is calculating DCS hours based on mobility needs prior to schedule and after schedule. The DON and/or designee has authority to approve overtime as needed to maintain staffing compliance.

Proposed Overall Completion Date: 04/26/2024
Directed Plan of Correction: In addition to the above plan of correction, documentation of monitoring process or audits of schedules shall be kept and made available to the Department for review. Specific information such as call offs, replacement staff and documentation of additional staff brough in due to low staffing hours shall be kept with past schedules.

Directed Completion Date: *04/26/2024*

Not Implemented [redacted] - 06/04/2024)

[redacted]

[redacted]

Withdrawn ([redacted])

[redacted]

Withdrawn ([redacted])

83a Indoor temperature

6. Requirements

83a Indoor temperature *(continued)*

2800.
83.a. The indoor temperature, in areas used by the residents, must be at least 70°F when residents are present in the home.

Description of Violation

On 1/22/2024, the following temperatures were recorded through out the building.
At the entrance: 64.9 degrees at 1:18 pm
Downstairs living room 65.6 degrees at 1:19 pm
Second floor area between B and C wings 64.9 degrees at 2:25 pm
Second floor end of B side hall 60.6 degrees at 2:51 pm near elevator and 57 degrees near cracked window
Resident 1's room was 68.5 degrees at approximately 3:00 pm.
Resident 2's room was 67.8 degrees at approximately 3:05 pm.
Resident 3's room was 67.6 degrees at approximately 3:54 pm.

At approximately 4:00 pm the 3rd floor memory care had the following temperatures:
near the Christmas tree was 63.6 degrees
Kitchen / Living room area that was occupied with 4 residents was 67.6 degrees
Hall by fire safe area was 67.6 degrees

Resident 4's room was 66.3 degrees at approximately 4:15 pm.
Main hallway downstairs was 68 degrees at 4:24 pm.
First floor B hallway was 66.3 degrees at 4:28 pm.

Plan of Correction ***Directed [redacted]/01/2024)***

The HVAC company has repaired the heating issues in the resident apartments. The dining room heater has been repaired 50%, Once the dining room temperature was consistently >70 degrees, the dining room was re-opened. The HVAC company will complete dining room hearting repair by end of summer. The Administrator and/or designee began monitoring room and common area temperatures in 1/2024-4/30/24. Failure to maintain temperature > 70 degrees will be referred to HVAC company for repair. The Home will notify the department of non-compliance.

Proposed Overall Completion Date: 04/30/2024
Directed Plan of Correction: In addition to the above plan of correction, documentation of invoices for repairs or service, monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/30/2024*

Not Implemented [redacted]/04/2024)

85b Infestation

7. Requirements

2800.
85.b. There may be no evidence of infestation of insects or rodents in the residence.

85b Infestation *(continued)*

Description of Violation

On 1/22/2024, there was a 1x1 floor tile near resident 1 and resident 2's room covered in mouse dropping. Resident 2 said [redacted] had seen a mouse in their room on 1/21/2024.

Plan of Correction ***Directed [redacted] - 05/01/2024)***

The Home is treated weekly and more frequently as needed by a pest control company. The residents were educated to report any sightings of mice or droppings to the front desk. Once reported, the exterminator will be asked to treat location, Maintenance and/or designee will check for any evidence of infestation throughout workday. Beginning 5/1/2024 the Administrator and/or designee will complete monthly apartment audits to ensure compliance is maintained.

Proposed Overall Completion Date: 05/01/2024

Directed Plan of Correction: In addition to the above plan of correction, all staff shall be in-serviced on reporting of suspected or found evidence of infestation with in 5 business days of the receipt of the acceptable plan of correction. Documentation of all resident council meetings, staff training, training materials presented at training and detailed documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *05/01/2024*

Not Implemented [redacted] - 06/04/2024)

88a Floors, walls, ceilings, windows, doors

8. Requirements

2800.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

A large hole was observed in the room of resident 1 where the heater grate should be.

Plan of Correction ***Directed [redacted] - 05/01/2024)***

The heating grate in the room of resident 1 was reinstalled by HVAC company when finishing repairing the heat in the room. Beginning 3/24, The Administrator and/or designee will complete monthly apartment audits to ensure compliance with 2800.88a. A work order will be completed for non-compliant items. The residents will be reminded monthly during the resident council meeting to report any unsanitary conditions to the front desk so that a work order can be initiated.

Proposed Overall Completion Date: 04/26/2024

Directed Plan of Correction: In addition to the above plan of correction, all staff shall be in-serviced on reporting of suspected or found building maintenance issues with in 5 business days of the receipt of the acceptable plan of correction. Documentation of all resident council meetings, staff training, training materials presented at training and detailed documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/26/2024*

Not Implemented [redacted] - 06/04/2024)

89a Hot/cold water pressure

9. Requirements

2800.
89.a. The residence must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

From 1/19/2024 through the morning of 1/22/2024 residents did not have hot water in any of the homes units.

On 1/22/2024, at approximately 4:00 pm, resident 4's bathroom had a water temperature of 87.2 degrees; resident 5's bathroom had a water temperature of 66 degrees; resident 6's bathroom had a water temperature of 81.0 degrees; resident 7's bathroom had a water temperature of 62 degrees; resident 8's bathroom had no running water.

Plan of Correction ***Accept [redacted] - 05/01/2024)***

The issue of circulator pump tripping was repaired by the contracted plumber. The administrator or maintenance staff will ensure the residents of the home will have hot water by testing the hot water in at least 5 rooms and maintain water temperature log for the Department to review starting 02/01/2024.
In the event a resident room is without hot water, a repair is initiated and fixed within 24-48 hours.

This plan will be ongoing for the next 6 months, then monthly for the next 12 months starting immediately.

Proposed Overall Completion Date: 04/26/2024

Licensee's Proposed Overall Completion Date: *04/26/2024*

Not Implemented ([redacted] 06/04/2024)

92 Windows/screens

10. Requirements

2800.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On the second floor of B wing the window across from the elevator had a crack that spans across two window panes.

Plan of Correction ***Directed ([redacted] - 05/01/2024)***

Maintenance will receive a quote to repair and/or replace window. The Administrator will complete an audit of common area windows by 5/15/24. Any issues will be reported to maintenance for repair and/or replacement. To ensure compliance is maintained, the Administrator will monitor throughout workday.

Proposed Overall Completion Date: 05/15/2024

92 Windows/screens (continued)

Directed Plan of Correction: In addition to the above plan of correction, all staff shall be in-serviced on reporting of suspected or found building maintenance issues with in 5 business days of the receipt of the acceptable plan of correction. Documentation of all staff training, training materials presented at training. invoices showing when work was completed, and detailed documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *05/15/2024*

Not Implemented [redacted] - 06/04/2024)

125a Combustible storage

11. Requirements

2800.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

In resident 4's bedroom, there were paper towels and aerosol cleaner were stored next to a working space heater.

Plan of Correction ***Directed [redacted] - 05/01/2024)***

The paper towels and aerosol cleaner were moved from being next to the working space heater. The working space heater was removed from Resident 4's room. The Administrator and/or designee completes monthly apartment audits to ensure no heaters are present, as well as any flammable or combustible materials. Residents are reminded during monthly resident council meeting.

The DON will in-service employees by 5/15/24, regarding residents not keeping combustible or flammable materials near heat sources. At the next resident's council meeting, resident will be educated on not keeping flammable or combustible materials near heat sources. Beginning 5/1/2024, the Administrator will complete monthly audits to ensure compliance with 2800.125a.

Proposed Overall Completion Date: 05/15/2024

Directed Plan of Correction: In addition to the above plan of correction, documentation of all resident council meetings, staff training, training materials presented at training, and detailed documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *05/15/2024*

Not Implemented [redacted] - 06/04/2024)

127a Portable space heaters

12. Requirements

2800.
127.a. Portable space heaters are prohibited.

Description of Violation

On 1/29/2024, space heaters were observed in the rooms of resident 1, resident 2, resident 4 and resident 9.

Plan of Correction ***Directed [redacted] - 05/01/2024)***

On 01/29/2024, the space heaters from rooms of residents 1, 2, 4, and 9 were removed.

127a Portable space heaters (continued)

The administrator or designee will complete monthly apartment checks to ensure heaters are not present. The residents will be reminded during the monthly resident council meeting.

Proposed Overall Completion Date: 04/26/2024

Directed Plan of Correction: In addition to the above plan of correction, all staff shall be in-serviced on reporting of suspected or found space heaters with in 5 business days of the receipt of the acceptable plan of correction. Documentation of all resident council meetings, staff training, training materials presented at training and detailed documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/26/2024*

Not Implemented ([redacted] - 06/04/2024)

130f Smoke detector repair

14. Requirements

2800.
130.f. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

Sitting on the window sills of the first and second floor of A wing, and by the Christmas tree on the 3rd floor in memory care were inoperable smoke detectors.

Smoke detectors could be heard chirping through out the first and second floor.

Plan of Correction ***Directed [redacted] - 05/01/2024)***

The inoperable smoke detectors found on first and second floor of A wing, and by the Christmas tree on 3rd floor were repaired by maintenance. Smoke detector batteries were replaced by Maintenance on the 1st and second floors.

By 5/15/24, the Administrator will re-educate Maintenance on repairing smoke detectors within 48 hours.

Maintenance staff will round the facility at least weekly to identify any inoperable smoke detectors. If any smoke detectors are identified as inoperable, they will be repaired within 48 hours.

Proposed Overall Completion Date: 05/15/2024

Directed Plan of Correction: In addition to the above plan of correction, all staff shall be in-serviced on reporting of suspected or found inoperable smoke detectors with in 5 business days of the receipt of the acceptable plan of correction. Additionally, battery operated smoke detectors located throughout the facility shall be tested monthly beginning in May 2024 for correct operation. Documentation of staff training, training materials presented at training, smoke detector testing, and detailed documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *05/15/2024*

Not Implemented [redacted] - 06/04/2024)

183b Medications and syringes locked

15. Requirements

2800.
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 living unit.

Description of Violation

On 1/22/2024, there were medications in the room of resident 2 that was accessible to resident 1. Resident 1 and 2 share a living unit. Resident 1 cannot self-administer medications. 2 boxes of Aspercreme, 3 prescription pill bottles and 2 white tablets were on a table, and accessible.

Plan of Correction ***Directed (05/01/2024)***

Resident #2 was given a lock box to store medications and was educated not to leave medications accessible. Self-medicating residents who share a living space with a non-self-medicating resident were re-educated on 2800.183b and given a lock box. The DON will re-educate the wellness team by 5/15/24 on 2800.183b and to report any non-compliance to DON and/or Administrator. To ensure compliance, the administrator and/or designee will verify during monthly apartment audits beginning 5/1/24.

Proposed Overall Completion Date: 05/15/2024

Directed Plan of Correction: In addition to the above plan of correction, documentation of resident education, staff training, training materials presented at training, and detailed documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *05/15/2024*

Not Implemented - 06/04/2024)

185a Storage procedures

16. Requirements

2800.
185.a. The residence 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 10 is prescribed finger sticks for blood sugar twice daily, sliding scale subcutaneous Humalog and Accucheck before meals. On 1/7/2024 and 1/9/2024 at 5:00 pm and 1/22/2024 at 8:00 am, resident 10's medication administration record is initialed however no blood sugar level, or units given were recorded.

Resident 10 is prescribed finger sticks twice daily with sliding scale Humalog subcutaneous, and Accucheck before meals. This was not recorded as completed on the residents MAR on 1/10/2024 at 5pm and 1/15/2024 at 12pm.

Resident 11 is prescribed finger sticks for blood sugars before meals, Humalog Kwikpen sliding scale. On 1/6/24, at 8:00 am, the injection site was not recorded.

Resident 11 is prescribed Lantus Solos 100/ML inject 20 units at bedtime/ 9pm: No site or blood glucose level was recorded 1/5/2024 and 1/18/2024, however it was initialed.

185a Storage procedures *(continued)*

Plan of Correction ***Directed [redacted] - 05/01/2024)***

On 1/30/24, the Medication Technicians were re-educated and re-trained in Diabetes Management by a Diabetes Educator. On 1/5/24, med technicians were in-serviced on appropriate medication administration. Beginning 2/15/24, the DON and/or designee will complete weekly MAR audits to ensure compliance is maintained.

Proposed Overall Completion Date: 04/26/2024

Directed Plan of Correction: In addition to the above plan of correction, within 5 calendar days of the receipt of the accepted plan of correction, all staff persons qualified to pass medications shall be provided education relating to glucometers and correct documentation of glucose levels and medication administration again given that this violation was cited after the previous training on 1/5/24 was conducted. Additionally, the DON or designee shall begin to complete twice weekly glucometer/log audits to ensure documentation is transcribed correctly from the meter to the log. Documentation of staff training, training materials presented at training, and detailed documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/26/2024*

Not Implemented [redacted] - 06/04/2024)

187d Follow prescriber's orders

17. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On 1/16/2024, at 12:00 pm resident 11 had a blood glucose level of 311 which required 8 units of humalog. On 1/17/2024, at 12:00 pm, resident 11 had a blood glucose level of 277 which required 6 units of humalog. On 1/16/24 and 1/17/24, at 12:00 pm, resident 11 was not administered insulin.

Resident 11 is prescribed Duloxetine cap 60 mg, Montelukast tab 10 mg, Levothyroxin tab 75 MCG, Carvedilol 12.5 MG 1 tab, Lantus Solos 100/ML inject 20 units at bedtime. However resident 11 was not administered these medications on the days and times:
Duloxetine cap 60 mg on 1/9/2024 at 9pm
Montelukast tab 10 mg on 1/9/2024 at 9pm
Levothyroxin tab 75 MCG on 1/10/2024 at 6:30 am
Carvedilol 12.5 MG 1 tab on 1/1/2024-1/4/2024, 1/7/2024-1/9/2024, 1/18/2024. at 9pm
Lantus Solos 100/ML inject 20 units at bedtime on 1/8/2024 and 1/9/2024

Resident 11 Blood pressure and heart rate were not taken at 9pm 1/7/2024 and 1/8/2024.

Repeat Violation Date: 9/1/22, 7/27/22 et al

Plan of Correction ***Directed ([redacted]/01/2024)***

On 1/5/24, med technicians were in-serviced on appropriate medication administration. Beginning 2/15/24, the DON and/or designee will complete weekly MAR audits to ensure compliance is maintained.

187d Follow prescriber's orders (continued)

Proposed Overall Completion Date: 04/26/2024

Directed Plan of Correction: In addition to the above plan of correction, within 5 calendar days of the receipt of the plan of correction, all staff persons qualified to pass medications shall be provided education relating to following prescribers order's and correct documentation of medication administration again given that this violation was cited after the previous training on 1/5/24 was conducted. Documentation of staff training, training materials presented at training, and detailed documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/26/2024*

Not Implemented [redacted] 06/04/2024)

188b Medication error reporting

18. Requirements

2800.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident 10 is prescribed finger sticks twice daily with sliding scale Humalog subcutaneous, and Accucheck before meals. This was not recorded as completed on the residents MAR on 1/10/2024 at 5pm and 1/15/2024 at 12pm. This was not reported to the resident, the resident's designated person and the prescriber.

Resident 11 is prescribed Duloxetine cap 60 mg, Montelukast tab 10 mg, Levothyroxin tab 75 MCG, Carvedilol 12.5 MG 1 tab, Lantus Solos 100/ML inject 20 units at bedtime. However resident 11 was not administered these medication on the days and times:
Duloxetine cap 60 mg on 1/9/2024 at 9pm
Montelukast tab 10 mg on 1/9/2024 at 9pm
Levothyroxin tab 75 MCG on 1/10/2024 at 6:30 am
Carvedilol 12.5 MG 1 tab on 1/1/2024-1/4/2024, 1/7/2024-1/9/2024, 1/18/2024. at 9pm
Lantus Solos 100/ML inject 20 units at bedtime on 1/8/2024 and 1/9/2024
Resident 11 Blood pressure and heart rate were not taken at 9pm 1/7/2024 and 1/8/2024.

These were not reported to the resident, the resident's designated person and the prescriber.

Plan of Correction ***Directed [redacted] 05/01/2024)***

On 1/5/24, med technicians were in-serviced on appropriate medication administration. On 2/12/24 and 3/12/24. wellness team members were re-educated on reportable incidents and to report non-compliance items to the in-house supervisor immediately. Beginning 2/15/24, the DON and/or designee will complete weekly MAR audits to ensure compliance is maintained. Non-compliance items will be reported to DHS, family and prescriber per 2800.188b.

Proposed Overall Completion Date: 04/26/2024

Directed Plan of Correction: In addition to the above plan of correction, within 5 calendar days of the receipt of the plan of correction, all staff persons qualified to pass medications shall be provided education relating to medication

188b Medication error reporting (continued)

errors and prevention of medication errors as this violation was cited after the previous training on 1/5/24 was conducted. Documentation of staff training, training materials presented at training, and detailed documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/26/2024*

Not Implemented [redacted] - 06/04/2024)

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

Facility Information

Name: *SPRINGFIELD SENIOR LIVING COMMUNITY* **License #**: *14484* **License Expiration**: *05/12/2024*

Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA 19038*

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

Administrator

[redacted]

Legal Entity

Name: *WYNDMOOR ASSISTED LIVING COMPANY LLC*

Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA, 19038*

[redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *11/16/1987* **Issued By**: *COPA L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *57* **Waking Staff**: *43*

Inspection Information

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

Reason: *Incident, Monitoring* **Exit Conference Date**: *02/12/2024*

Inspection Dates and Department Representative

02/12/2024 - On-[redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *103* **Residents Served**: *36*

Special Care Unit

In Home: *Yes* **Area**: *3rd Floor* **Capacity**: *34* **Residents Served**: *5*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *36*

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

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

Inspections / Reviews

02/12/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/08/2024*

Inspections / Reviews *(continued)*

05/01/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/08/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/09/2024*

06/04/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *05/08/2024*

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

18 Other laws, regs, ordins.

1. Requirements

2800.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Care Facility Carbon Monoxide Alarm Standards Act requires that a carbon monoxide detector be installed in close proximity to, but not less than, 15 ft away from a fossil fuel burning device.
On 1/12/24, at 9:28 am, a carbon monoxide detector could not be located in the grill area of the main kitchen, where there are gas burning devices.

Plan of Correction ***Directed [redacted] 05/01/2024)***

The Carbon Monoxide detector was installed. The Food Service Director and/or designee will ensure that the carbon monoxide detector is properly installed via rounds during the course of the workday. Maintenance will be immediately notified if an issue is observed.

Proposed Overall Completion Date: 04/03/2024
Directed Plan of Correction: In addition to the above plan of correction, documentation of all staff training, training materials presented at training and documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/03/2024*

Not Implemented [redacted] - 06/04/2024)

42c Dignity/Respect

2. Requirements

2800.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

During care on 2/6/2024, Resident 1 reported that Staff Member A was helping them move onto the bed and became impatient because Resident 1 was not moving fast enough. Staff Member A appeared frustrated and then called Resident 1 a "Mother [redacted]er". Resident 1 reported that they felt that if they argued with Staff Member A, it would have made things worse and was fearful Staff Member A would have gotten physical. Staff Member A admitted to the cursing event.

Plan of Correction ***Directed [redacted] - 05/01/2024)***

Staff Member A was terminated. Team members were re-educated on Elder Abuse by DON on 2/26/24. New Team Members will be educated upon hire and current team members will be re-educated annually and as needed. Resident #1 did not suffer any negative consequences.

Proposed Overall Completion Date: 04/03/2024

Directed Plan of Correction: In addition to the above plan of correction, documentation of all staff training, training materials presented at training and documentation of monitoring process or audits shall be kept and made

42c Dignity/Respect (continued)

available to the Department for review.

Directed Completion Date: *04/03/2024*

Implemented [redacted] - 06/04/2024)

82c Locked poisons

3. Requirements

2800.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

Description of Violation

Blue Glass and Window cleaner, was found to be in the 3rd floor (Memory Care) Janitor's Closet, unlocked, unattended, and accessible to residents. Residents of the Memory Care residence have not been assessed capable of recognizing and using poisons safely. Repeat Violation Date: 11/17/22 et al; 7/27/22 et al

Plan of Correction ***Directed [redacted] 05/01/2024)***

The Blue Glass and Window cleaner was immediately removed. The DON and/or designee will audit the memory care weekly times 4, then monthly times 3 to ensure poisons are locked. The staff were re-educated on ensuring poisons are locked on 2/20/24 and 3/12/24.

Proposed Overall Completion Date: 04/03/2024

Directed Plan of Correction: In addition to the above plan of correction, documentation of all staff training, training materials presented at training and documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/03/2024*

Not Implemented [redacted] - 06/04/2024)

85a Sanitary conditions

4. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 2/12/24, at 10:41 am, there was a basin with vomit on the floor of the bedroom in room A109.

Plan of Correction ***Directed [redacted] - 05/01/2024)***

A109 was immediately cleaned by housekeeping. Team members were educated on 3/12/24 to report any unsanitary conditions to their supervisor and housekeeping. The Administrator completes monthly apartment rounds to ensure sanitary conditions are maintained. This is also discussed with the residents during the monthly resident council.

Proposed Overall Completion Date: 04/03/2024

Directed Plan of Correction: In addition to the above plan of correction, documentation of resident council meeting, all staff training, training materials presented at training and documentation of monitoring process or audits shall

85a Sanitary conditions (continued)

be kept and made available to the Department for review.

Directed Completion Date: *04/03/2024*

Not Implemented [redacted] 06/04/2024)

88a Floors, walls, ceilings, windows, doors

5. Requirements

2800.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 2/12/24:

- *the carpets on the 2nd floor were soiled and had numerous stains*
- *the carpet was frayed in the doorway close to rooms 202 and 223*
- *there was a hole in the wall near the baseboard and before the bathroom door in room 319*

Plan of Correction ***Directed [redacted] - 05/01/2024)***

Housekeeping will clean carpets. Maintenance will repair the carpet in 202 and 223.
The hole in 319 was repaired, The Administrator and/or designee will complete community rounds throughout the workday. Work orders will be completed for any areas of concern. Starting 3/24, the Administrator and/or designee will also complete monthly apartment rounds to ensure compliance is maintained. Work orders will be completed for any areas of concern. The team members were re-educated on 3/12/24 to report any unsanitary conditions to their supervisor and/or maintenance. Residents will be asked for feedback during the monthly resident council.

Proposed Overall Completion Date: 04/26/2024

Directed Plan of Correction: In addition to the above plan of correction, documentation of resident council meeting, all staff training, training materials presented at training and documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/26/2024*

Not Implemented [redacted] - 06/04/2024)

89a Hot/cold water pressure

6. Requirements

2800.
89.a. The residence must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 2/12/24, at 9:55 am, the residence did not have sufficient hot water in room B319; water pressure was low and the temperature of the hot water did not get past 75.3 degrees.

Plan of Correction ***Directed [redacted] - 05/01/2024)***

The Administrator and/or designee will complete water temperatures daily until 9/1/24, then mont[redacted] In the event a resident room is without hot water, a repair will be initiated and fixed within 24 hours.

89a Hot/cold water pressure (continued)

Proposed Overall Completion Date: 04/03/2024

In addition to the above plan of correction, all staff shall be in-serviced on reporting of suspected or found building maintenance issues with in 5 business days of the receipt of the acceptable plan of correction. Documentation of all staff training, training materials presented at training. invoices showing when work was completed, and detailed documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/03/2024*

Not Implemented (- 06/04/2024)

95 Furniture & Equipment

7. Requirements

2800.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 2/12/24:

- *in room A102, the bathroom sink had a clogged/slow drain*
- *in room A109, there was a board that fell off of the center of the closet, lying on the floor with a nail cap next to it*
- *in room B110, the bathroom sink had a clogged/slow drain, and the vanity door was off and leaning against the vanity*

Plan of Correction ***Directed (05/01/2024)***

The sink in A102 and B110 has been repaired. Maintenance will repair closet in A109. Starting 3/24, the Administrator and/or designee will also complete monthly apartment rounds to ensure compliance is maintained. Work orders will be completed for any areas of concern. The team members were re-educated on 3/12/24 to report any unsanitary conditions to their supervisor and/or maintenance. Residents will be asked for feedback during the monthly resident council.

Proposed Overall Completion Date: 04/26/2024
Directed Plan of Correction: In addition to the above plan of correction, documentation of resident council meeting, all staff training, training materials presented at training and documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/26/2024*

Not Implemented - 06/04/2024)

102a Functioning toilet

8. Requirements

2800.
102.a. There must be one functioning flush toilet in the bathroom in the living unit.

Description of Violation

On 2/12/24, at 9:33 AM, the toilet in Room B110 would not flush.

102a Functioning toilet *(continued)*

Plan of Correction ***Directed [redacted] 05/01/2024)***

The toilet in B110 was repaired. Starting 3/24, the Administrator and/or designee will also complete monthly apartment rounds to ensure compliance is maintained. Work orders will be completed for any areas of concern. The team members were re-educated on 3/12/24 to report any unsanitary conditions to their supervisor and/or maintenance. Residents will be asked for feedback during the monthly resident council.

Proposed Overall Completion Date: 04/03/2024
Directed Plan of Correction: In addition to the above plan of correction, documentation of resident council meeting, all staff training, training materials presented at training and documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/03/2024*

Not Implemented [redacted] - 06/04/2024)

103h Thawing food

9. Requirements

2800.
103.h. Food shall be thawed either in the refrigerator, microwave, under cool water or as part of the cooking process.

Description of Violation

On 2/12/24, at 10:23 AM, frozen shrimp and steak were sitting on top of the prep table for thawing.

Plan of Correction ***Directed [redacted] 05/01/2024)***

The frozen shrimp and steak were discarded. The Food Service Director re-educated cooks on proper thawing procedure on 2/12/24. The Administrator will verify proper thawing procedure via rounds throughout workday. Any observed non-compliance items will be discarded, and team member re-educated.

Proposed Overall Completion Date: 04/03/2024

Directed Plan of Correction: In addition to the above plan of correction, documentation of resident council meeting, all staff training, training materials presented at training and documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/03/2024*

Not Implemented [redacted] - 06/04/2024)

[redacted]

[redacted]

- [redacted]
- [redacted]

[redacted]

[redacted]

[redacted]

Withdrawn [redacted]

105d Changing bed linens/towels

11. Requirements

2800.
105.d. Bed linens and towels shall be changed at least once every week and more often as needed to maintain sanitary conditions.

Description of Violation

On 2/12/24:

- *at 10:27 AM, there were no linens on the bed in Room A102 and the mattress pad on the bed was ripped/torn.*
-

Plan of Correction ***Directed*** [redacted] ***- 05/01/2024)***

The Director of Nursing will re-educate direct care staff on the importance of ensuring linens are clean and in good condition by 4/12/24. Starting 4/24 the administrator and/or designee will audit 10 apartments weekly to ensure compliance is maintained.

Proposed Overall Completion Date: 04/12/2024

Directed Plan of Correction: In addition to the above plan of correction, documentation of resident council meeting, all staff training, training materials presented at training and documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/12/2024*

Not Implemented [redacted] ***- 06/04/2024)***

121a Unobstructed egress

12. Requirements

2800.
121.a. Stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed.

Description of Violation

On 2/12/24:

- *the basement hallway near the fire panel was cluttered causing a fire hazard and blocked egress*
- *there were two mattresses and 1 bed frame located in the hallway of the 2nd floor*

Plan of Correction ***Directed (05/01/2024)***

The Director of Nursing will re-educate direct care staff on the importance of ensuring linens are clean and in good condition by 4/12/24. Starting 4/24 the administrator and/or designee will audit 10 apartments weekly to ensure compliance is maintained.

Proposed Overall Completion Date: 04/12/2024

In addition to the above plan of correction, all staff shall be in-serviced on reporting of suspected or found building maintenance issues with in 14 business days of the receipt of the acceptable plan of correction. Documentation of all staff training, training materials presented at training. invoices showing when work was completed, and detailed documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/03/2024*

Not Implemented - 06/04/2024)

127a Portable space heaters

13. Requirements

2800.
127.a. Portable space heaters are prohibited.

Description of Violation

On 2/12/24, at 9:25 AM, three portable space heaters were located in the 1st floor pantry kitchen office.

Plan of Correction ***Directed - 05/01/2024)***

The heaters were immediately removed. The Administrator will ensure compliance with 127a via rounds throughout the workday. Team members were re-educated on 127a on 3/12/24.

Proposed Overall Completion Date: 04/26/2024

In addition to the above plan of correction, all staff shall be in-serviced on reporting of suspected or found space heaters with in 5 business days of the receipt of the acceptable plan of correction. Documentation of all staff training, training materials presented at training. invoices showing when work was completed, and detailed documentation of monitoring process or audits shall be kept and made available to the Department for review.

Directed Completion Date: *04/26/2024*

Not Implemented /04/2024)

127a Portable space heaters *(continued)*

[redacted]

Withdrawn [redacted]

144c2 Smoking area distance

15. Requirements

2800.

144.c. A residence that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

2. Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

Upon arrival at the residence, there were three residents observed smoking immediately outside of the back exit doors of the lobby area; this location is not the designated smoking area for the facility.

Plan of Correction ***Directed*** [redacted] ***- 05/01/2024)***

The designated smoking signs have been posted away from the door. Residents were reeducated on the location of the smoking area. Residents will be re-directed to appropriate smoking area. Continued failure to follow policy will lead to a 30-day discharge. notice. The Administrator and/or designee will verify compliance throughout workday.

Proposed Overall Completion Date: 04/03/2024

Directed Plan of Correction: In addition to the above plan of correction, documentation of resident council meeting, all staff training, training materials presented at training, warning notices and/or 30 day notices to residents, and documentation of monitoring process or audits shall be kept and made available to the Department for review.

144c2 Smoking area distance *(continued)*

Directed Completion Date: *04/03/2024*

Not Implemented [redacted] - 06/04/2024)