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

February 1, 2024

VS WALLINGFORD LLC

RE: CHESTNUT RIDGE RETIREMENT LIVING
2700 CHESTNUT PARKWAY
CHESTER, PA, 19086
LICENSE/COC#: 14141

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/14/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *CHESTNUT RIDGE RETIREMENT LIVING* **License #**: *14141* **License Expiration**: *12/30/2023*

Address: *2700 CHESTNUT PARKWAY, CHESTER, PA 19086*

County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *VS WALLINGFORD LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *Other* **Date**: *10/19/1998* **Issued By**: *Commonwealth of Pennsylvania, L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *104* **Waking Staff**: *78*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *12/14/2023*

Inspection Dates and Department Representative

12/14/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *130* **Residents Served**: *83*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *22* **Residents Served**: *19*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *83*

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

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

Inspections / Reviews

12/14/2023 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/14/2024*

01/18/2024 - POC Submission

Submitted By: **Date Submitted**: *01/31/2024*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/23/2024*

Inspections / Reviews *(continued)*

01/22/2024 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/01/2024*

02/01/2024 - Document Submission

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

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

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On [redacted] at [redacted], a representative of the Department requested access to [redacted] resident records and four staff records in addition to several other items including staffing schedules, policies, description of services and completion of a department issued Partial Inspection form.

Staff person A, the Administrator stated [redacted] misunderstood and thought I was only requesting the resident's business files; however, the provided file contained the resident's Contract, Pre-Screen and the most recent DME and RASP.

The staff files provided only contained criminal background checks, qualifications, FA/CPR certification (if available) and DHS certification if applicable. The staff files were returned to staff person B, the Regional Director of Operations, stating the complete file was requested and should include trainings, disciplinary actions, reviews, etc.

Neither the complete resident files nor the complete staff files were provided before licensing representative left the facility.

Plan of Correction ***Accept [redacted] - 01/22/2024)***

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:
The representative of the Department requested access to [redacted] resident records and four staff records in addition to several other items including staffing schedules, policies, description of services and completion of a department issued Partial Inspection form at [redacted]. At that time, training records were not requested. At approximately [redacted], the representative requested training records. It was at that time that Staff Person A stated [redacted] misunderstood. Training records were then provided to the representative.

With Respect to Systemic Measures that have been put into place to address the stated concern:
Records were provided to the representative when they were asked for.

The Regional Director of Operations re-educated the Executive Director & Director of Health and Wellness on 1/18/24 on Regulation 2600.5a1, DHS Access.

With Respect to How the Plan of Corrective Measures will be Monitored:
On an ongoing basis, the home will continue to provide requested records to representatives of the Department when requested. Compliance monitoring on Regulation 2600.5a1, DHS Access, will be conducted x 2 quarters as part of Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: *01/19/2024*

Implemented [redacted] - 02/01/2024)

15b - Supervisor Plan

2. Requirements

15b - Supervisor Plan *(continued)*

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On [redacted] at [redacted], the home submitted an incident report alleging abuse of resident [redacted] by staff persons C and D. The home suspended both staff persons but allowed staff person D to return to work on [redacted], before the Department completed an investigation.

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:

Staff Persons C and D were immediately suspended upon notification to the Administrator. The Administrator immediately, along with area adult protective services, investigated the accusation and it was determined to be unfounded that Staff person D was involved in the incident. Due to this, no supervision plan for Staff person D was put into place. Staff Person C was terminated for the abuse allegation.

The home explicitly requests that this violation be retracted. A verbal request was submitted on [redacted] to the Department to have this violation withdrawn for erroneous citation. No response was received from the Department.

With Respect to Systemic Measures that have been put into place to address the stated concern:

Moving forward, the Administrator or Director of Health and Wellness will immediately suspend any staff member suspected of abuse while an investigation is carried out. If the investigation shows the accusation is false or unfounded by the community, protective services, or DHS investigation, the staff member will be returned to full duty under Department approved supervision.

The Regional Director of Operations re-educated the Executive Director & Director of Health and Wellness on 1/8/24 on Regulation 2600.15b, Abuse Reporting Covered by Law.

With Respect to How the Plan of Corrective Measures will be Monitored:

Compliance monitoring on Regulation 2600.15b, Abuse Reporting Covered by Law will be conducted x 2 quarters as part of Quality Assurance meetings.

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

Implemented [redacted] - 02/01/2024)

16c - Written Incident Report

3. Requirements

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

Description of Violation

On [redacted], resident [redacted] was found by staff member E restrained in a recliner in the memory care TV room

16c - Written Incident Report (continued)

. Staff member E took a picture of the resident with the restraints in place after contacting staff member F. Staff member F untied resident and returned to [redacted] duties. Staff member E then reported the incident to the nurse on duty, staff member G. Staff member G forwarded the pictures to the Director of Health and Wellness, staff member H, who did not see the pictures until returning to work on [redacted]. Staff member H then reported the incident to the Department on [redacted].

Repeat Violation: 02/09/23.

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:
The Administrator submitted the report of alleged resident abuse upon notification to the department on 11/25/23.

With Respect to Systemic Measures that have been put into place to address the stated concern:
The community re-trained the identified reporters on 1/8/24 regarding regulation 2600.16, Reportable Incidents and Conditions. The home's ED and DOW will remain available daily to submit reportable incidents to the department within 24 hours of the incident. An audit of reportable incidents was conducted on 1/8/24 with no other reporting issues discovered.

With Respect to How the Plan of Corrective Measures will be Monitored:
Compliance monitoring on Regulation 2600.16c, Written Incident Report Abuse Reporting Covered by Law, will be conducted x 2 quarters as part of Quality Assurance meetings.

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

Implemented [redacted] - 02/01/2024)

25a - Written Contract and Review

4. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident’s designated person if any, prior to signature.

Description of Violation

Resident [redacted] did not have a resident-home contract completed until [redacted]. Resident [redacted] was admitted [redacted] according to the home's "Rent Roll" report. However, the resident's face sheet and RASP dated [redacted] list the resident's date of admission as [redacted], The home could not verify the resident's date of admission during the investigation.

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

25a - Written Contract and Review (continued)

With Respect to the specific deficiency cited:
Resident [redacted] did not have a resident-home contract completed until [redacted], which is when an audit was conducted and found to not be in place.

With Respect to Systemic Measures that have been put into place to address the stated concern:
On [redacted] the Administrator executed a new resident-home contract with Resident [redacted] and [redacted] POA. The administrator was not present in the home during July of 2022 and corrected the deficiency when it was discovered on 9/21/22.

All resident-home contracts have been reviewed during Quality Assurance Meetings since [redacted]. An audit was conducted on [redacted] of all current resident-home contracts and no other files were affected.

With Respect to How the Plan of Corrective Measures will be Monitored:
The Executive Director and/or designee will audit the resident contracts after the agreements have been signed by the resident, before placing the executed agreement in the resident file. Compliance monitoring on Regulation 2600.25a, Written Contract and Review, will be reviewed x 2 quarters as part of Quality Assurance meetings.

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

Implemented [redacted] - 02/01/2024)

42b - Abuse

5. Requirements

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

Description of Violation

On [redacted], resident [redacted] was found by staff member E restrained in a recliner in the memory care TV room. This incident was reported to the Department on [redacted]. After an investigation it was determined that resident [redacted] was put in restraints by staff member C.

Repeat Violation: 03/04/22.

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:
Staff Member A was suspended immediately upon Administrator notification and an investigation was conducted beginning [redacted] and concluded on [redacted]. Staff Member A was terminated because of this investigation.

With Respect to Systemic Measures that have been put into place to address the stated concern:
All Staff completed education provided by the PA Department of Aging "Learning Management System". Online education was completed by 1/12/24. All staff will have additional re-education by Staff Person B on the Older Adult Protective Services Act, Resident's Rights, Mandatory Reporting by 1/31/24.

42b - Abuse (continued)

Residents are informed regularly of their rights (upon admission as well as during resident council). Residents are and will continue to be encouraged to promptly report if someone is allegedly mistreating or neglecting them.

With Respect to How the Plan of Corrective Measures will be Monitored:
Compliance monitoring on Regulation 2600.42b, Abuse/Neglect, will be reviewed x 2 quarters as part of Quality Assurance meetings. Resident rights and complaint procedures will be reviewed with residents upon admission and during monthly Council meetings.

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

Implemented - 02/01/2024)

42s - Privacy

6. Requirements

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

Description of Violation

On , resident was found by staff member E restrained in a recliner in the memory care TV room. Staff member E took a picture of the resident with the restraints in place after contacting staff member F. Staff member F untied resident and returned to duties. Staff member E then reported the incident and forwarded the pictures to the nurse on duty, staff member G. Staff member G forwarded the pictures to the Director of Health and Wellness, staff member H, who did not see the pictures until returning to work on . Staff member H then reported the incident to the Department on .

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:
Staff Member A was suspended immediately upon Administrator notification and an investigation was conducted beginning and concluded on . Staff Member A was terminated because of this investigation.

With Respect to Systemic Measures that have been put into place to address the stated concern:
All Staff completed education provided by the PA Department of Aging "Learning Management System". Online education was completed by . All staff will have additional re-education by Staff Person B on the Older Adult Protective Services Act, Resident's Rights, Mandatory Reporting by 1/31/24.

Residents are informed regularly of their rights (upon admission as well as during resident council). Residents are and will continue to be encouraged to promptly report if someone is allegedly mistreating or neglecting them.

With Respect to How the Plan of Corrective Measures will be Monitored:
Compliance monitoring on Regulation 2600.42s, Privacy of self and possessions, will be reviewed x 2 quarters as part of Quality Assurance meetings. Resident rights and complaint procedures will be reviewed with residents upon admission and during monthly Council meetings.

42s - Privacy *(continued)*

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

Implemented - 02/01/2024)

183d - Prescription Current

7. Requirements

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

Description of Violation

On , at several medications for residents no longer living in the home were found in the wellness office closet. Some of the medications included were , and .

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:
Discontinued medications were found in the Director of Health & Wellness' office closet awaiting pharmacy pickup. Medications were removed from the home during the investigation.

With Respect to Systemic Measures that have been put into place to address the stated concern:
An audit of all medication carts & storage closets was completed on 1/8/24 and 1/9/24 by the Director of Health & Wellness and all discontinued medications were absent from the home.

All Medication Administration staff members were re-educated on 1/12/24 on 2600.183d, Storage and Disposal of Medications and Medical Supplies.

With Respect to How the Plan of Corrective Measures will be Monitored:
The Director of Health & Wellness or designee will complete monthly audits of the medication carts to ensure discontinued medications are absent. Medication Dashboard Reports will be discussed during the morning standup meetings and x 2 quarters during the Quality Assurance Meetings.

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

Implemented - 02/01/2024)

183e - Storing Medications

8. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On multiple medications, some discontinued, some for former residents, were found in the Wellness Center closet left on a shelf in a disorganized manner.

183e - Storing Medications *(continued)*

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:
Discontinued medications were found in the Director of Health & Wellness' office closet awaiting pharmacy pickup. Medications were removed from the home during the investigation.

With Respect to Systemic Measures that have been put into place to address the stated concern:
An audit of all medication carts & storage closets was completed on 1/8/24 and 1/9/24 by the Director of Health & Wellness and all discontinued medications were absent from the home.

All Medication Administration staff members were re-educated on 1/12/24 on 2600.183e, Storage and Disposal of Medications and Medical Supplies.

With Respect to How the Plan of Corrective Measures will be Monitored:
The Director of Health & Wellness or designee will complete monthly audits of the medication carts to ensure discontinued medications are absent and medications stored in an organized manner. Medication Dashboard Reports will be discussed during the morning standup meetings and x 2 quarters during the Quality Assurance Meetings.

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

Implemented - 02/01/2024)

183f - Discontinued Medications

9. Requirements

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

Description of Violation

On , at , the following discontinued medications were found in a closet in the wellness office: and belonging to resident belonging to resident , and belonging to resident This is not an approved method of destroying medications according to the Department of Environmental Protection and Federal and State regulation.

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

183f - Discontinued Medications (continued)

With Respect to the specific deficiency cited:
Discontinued medications were found in the Director of Health & Wellness' office closet awaiting pharmacy pickup. Medications were removed from the home during the investigation.

With Respect to Systemic Measures that have been put into place to address the stated concern:
An audit of all medication carts & storage closets was completed on 1/8/24 and 1/9/24 by the Director of Health & Wellness and all discontinued medications were absent from the home.

All Medication Administration staff members were re-educated on 1/12/24 on 2600.183f, Storage and Disposal of Medications and Medical Supplies.

With Respect to How the Plan of Corrective Measures will be Monitored:
The Director of Health & Wellness or designee will complete monthly audits of the medication carts to ensure discontinued medications are absent and medications stored in an organized manner. Medication Dashboard Reports will be discussed during the morning standup meetings and x 2 quarters during the Quality Assurance Meetings.

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

Implemented - 02/01/2024)

184b - Labeling OTC/CAM

10. Requirements

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

Description of Violation

On , at a tube of , and a tube of were found in the Wellness Center closet without a resident's name.
A tube of was also found in the closet with a ripped label. The tube did not have any other resident identification information.

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:
Unlabeled discontinued medications were found in the Director of Health & Wellness' office closet awaiting pharmacy pickup. Medications were removed from the home during the investigation.

With Respect to Systemic Measures that have been put into place to address the stated concern:
An audit of all medication carts & storage closets was completed on 1/8/24 and 1/9/24 by the Director of Health & Wellness and all unlabeled discontinued medications were absent from the home.

All Medication Administration staff members were re-educated on 1/12/24 on 2600.184b, Storage and Disposal of

184b - Labeling OTC/CAM (continued)

Medications and Medical Supplies.

With Respect to How the Plan of Corrective Measures will be Monitored:
The Director of Health & Wellness or designee will complete monthly audits of the medication carts to ensure all medications are labeled and stored in an organized manner. Medication Dashboard Reports will be discussed during the morning standup meetings and x 2 quarters during the Quality Assurance Meetings.

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

Implemented [redacted] 02/01/2024)

185a - Implement Storage Procedures

11. Requirements

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

Description of Violation

On [redacted] the treatment cart and multiple medications were found unlocked and unattended in the Wellness Center closet.

Repeat Violation: 02/09/23, 11/03/21, et al.

Plan of Correction ***Accept [redacted] - 01/22/2024)***

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:
The treatment cart and multiple medications were found unlocked and unattended in the Wellness Center closet. The closet was not locked.

With Respect to Systemic Measures that have been put into place to address the stated concern:
The medications were immediately removed, and the closet was immediately locked at the time of notification. All Medication Administration staff members were re-educated on 1/12/24 on 2600.185a, Accountability of Medication and Controlled Substances.

With Respect to How the Plan of Corrective Measures will be Monitored:
The Director of Health & Wellness or designee will complete monthly audits of the medication/treatment carts & storage closets to ensure discontinued medications are absent and current medications stored in an organized manner. Medication Dashboard Reports will be discussed during the morning standup meetings and x 2 quarters during the Quality Assurance Meetings.

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

Implemented [redacted] - 02/01/2024)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident is prescribed - Take 1 Tablet by Mouth Once Daily. However, this medication was not administered to resident on because the medication was not available in the home.

Repeat Violation: 11/03/21.

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

Plan of Correction
Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:
Resident #2 was prescribed the above-mentioned medications but was not administered due to the medication being unavailable from the Pharmacy. The administering nurse contacted the Pharmacy and the Physician on 11/20/23 to make aware that the medication was not available and therefore not administered. The medication was delivered on 12/14/23. Staff will contact a local pharmacy to fill and deliver the ordered medication if a medication is unavailable or contact the attending physician to get an order for a substitution for any unavailable medication. The Pharmacy Provider will notify the Director of Health & Wellness or designee of any unavailable medications for proper follow-up.

With Respect to Systemic Measures that have been put into place to address the stated concern:
An audit of all medication carts was completed on 1/8/24 & 1/9/24 by the Health & Wellness Director and all medications were present in the home.

All Medication Administration staff members were re-educated on 1/12/24 on 2600.187d, Medication Records.

With Respect to How the Plan of Corrective Measures will be Monitored:
The Director of Health & Wellness or designee will review the electronic medication dashboard daily to identify medications that are unavailable. Direct Care Staff will contact a local pharmacy to fill and deliver the ordered medication if a medication is unavailable or contact the attending physician to get an order for a substitution for any unavailable medication. The Pharmacy Provider will notify the DHW, or designee of any unavailable medications for proper follow-up.

Ongoing compliance of Medication Dashboard Reports will be discussed during the morning standup meetings and x 2 quarters during the Quality Assurance Meetings.

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

Implemented - 02/01/2024)

201 - Positive Interventions

13. Requirements

201 - Positive Interventions *(continued)*

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident ██ wanders the memory care unit at night. The home has not implemented positive interventions to modify or eliminate this behavior. On ██████, resident ██ was found by staff member E restrained in a recliner in the memory care TV room. After an investigation it was determined staff member C put the restraints on resident ██ to stop this behavior.

Repeat Violation: 02/09/23.

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:

Staff member A did not follow the plan of care for resident ██ and their position with the company was terminated on ██████ following an internal investigation.

With Respect to Systemic Measures that have been put into place to address the stated concern:

Safe Management Techniques and positive interventions will be utilized to modify or eliminate a behavior that endangers the resident ██████ or others. Positive interventions were added to the support plan for Resident ██. Direct care staff will be re-educated on the community's policies regarding safe management techniques and positive interventions by the Executive Director or designee by ██████. Ongoing assessment and revision of the support plan will be made through the community care plan process and communicated to the staff by the Director of Health & Wellness or designee.

With Respect to How the Plan of Corrective Measures will be Monitored:

Compliance monitoring on Regulation 2600.201, Safe Management Techniques, will be reviewed x 2 quarters as part of Quality Assurance meetings. Resident rights and complaint procedures will be reviewed with residents upon admission and during monthly Council meetings.

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

Implemented ██ - 02/01/2024)

202 - Prohibitions

14. Requirements

2600.
202. The following procedures are prohibited:
1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2600.231 (relating to admission).
2. Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.
3. Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.

202 - Prohibitions *(continued)*

4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.
5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.
6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

On ██████ resident ██ was found by staff member E with restraints in place around the resident's arms and around the resident's ankles.

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:

Staff Member A was suspended immediately upon Administrator notification and an investigation was conducted beginning ██████ and concluded on █████. Staff Member A was terminated as a result of this investigation.

With Respect to Systemic Measures that have been put into place to address the stated concern:

All Staff completed education provided by the PA Department of Aging "Learning Management System". Online education was completed by █████ All staff will have additional re-education by Staff Person B on the Older Adult Protective Services Act, Resident's Rights, Mandatory Reporting by 1/31/24.

Residents are informed regularly of their rights (upon admission as well as during resident council). Residents are and will continue to be encouraged to promptly report if someone is allegedly mistreating or neglecting them.

With Respect to How the Plan of Corrective Measures will be Monitored:

Compliance monitoring on Regulation 2600.202, Prohibitions, will be reviewed x 2 quarters as part of Quality Assurance meetings. Resident rights and complaint procedures will be reviewed with residents upon admission and during monthly Council meetings.

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

Implemented ██ - 02/01/2024)

224a - Preadmission Screen Form

15. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

224a - Preadmission Screen Form *(continued)*

Description of Violation

Resident [redacted] was admitted to the home on [redacted] or [redacted], the home could not provide actual move in date during the investigation; however, the resident's preadmission screening form was completed on [redacted].

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

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

With Respect to the specific deficiency cited:
Resident [redacted] took financial possession of the apartment on [redacted] and physically moved into the community on [redacted]. On [redacted], an audit was conducted, and Resident [redacted] was found to not have any pre-admission paperwork, including preadmission screening form. At that time, the Administrator created one with accurate dating of her transfer to the Secured Dementia Care Unit which occurred on [redacted].

With Respect to Systemic Measures that have been put into place to address the stated concern:
A full audit of all pre-admission assessments was completed on 1/8/24 and no other residents were affected. The DHW or designee will complete pre-screens within 30 days prior to admission on the Department's preadmission screening form. New residents' pre-screen forms will be reviewed prior to admission by the Executive Director or designee, to ensure compliance.

The DHW and designees will be re-educated on the preadmission screening form and the time frames in which they are to be completed by 1/30/24.

With Respect to How the Plan of Corrective Measures will be Monitored:
Compliance monitoring on Regulation 2600.224a, Preadmission Screening, will be reviewed x 2 quarters as part of Quality Assurance meetings.

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

Implemented [redacted] 02/01/2024)