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

April 11, 2024

, COO
IVQ LANSDALE OPCO LP

RE: TRADITIONS OF LANSDALE
1800 WALNUT STREET
LANSDALE, PA, 19446
LICENSE/COC#: 14521

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/14/2024, 02/15/2024 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: *TRADITIONS OF LANSDALE* **License #**: *14521* **License Expiration**: *02/28/2025*

Address: *1800 WALNUT STREET, LANSDALE, PA 19446*

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

Administrator

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

Legal Entity

Name: *IVQ LANSDALE OPCO LP*

Address:

Certificate(s) of Occupancy

Type: *Other* **Date**: *02/28/1986* **Issued By**: *Hatfield Township*

Staffing Hours

Resident Support Staff: *69* **Total Daily Staff**: *187* **Waking Staff**: *140*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *02/15/2024*

Inspection Dates and Department Representative

02/14/2024 On Site:

02/15/2024 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served**: *90*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Daybreak* **Capacity**: *71* **Residents Served**: *18*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *89*

Diagnosed with Mental Illness: *6* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *28* **Have Physical Disability**: *9*

Inspections / Reviews

02/14/2024 - Full

Lead Inspector: **Follow Up Type**: *POC Submission* **Follow Up Date**: *03/09/2024*

Inspections / Reviews *(continued)*

03/11/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/29/2024*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *03/13/2024*

03/12/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/29/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/31/2024*

04/11/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/29/2024*

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

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On [redacted] the home's current violation report, dated 1/17/2024, and a copy of 55 Pa. Code Chapter 2600 was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 03/08/2024)***

Immediate Corrective Actions: On 3/5/24, the Regional Director of Operations posted both the violation report dated 1/17/24 and the Chapter 2600 regulations. They are in a binder on the front desk, where anyone can access them.

Additional Corrective Actions: The Regional Director of Operations will label the binder, with a note stating "Please do not remove" by 3/5/24. In addition, the Front Desk Concierge will visually confirm it is there every morning, beginning 3/5/24, and will replace it if it is removed.

Ongoing Quality Assurance Actions: The Executive Director will review that the daily confirmations have occurred and discuss any patterns, trends, or concerns at each Quarterly Quality Assurance Review Meeting, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *03/07/2024*

Implemented [redacted] 04/11/2024)

51 - Criminal Background Check

2. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

The home could not provide background checks for construction workers that were on site [redacted] and had unsupervised access to residents.

Plan of Correction ***Accept ([redacted] - 03/12/2024)***

Immediate Corrective Actions: On 3/6/24, the Vice President of Operations confirmed the door at the end of the hall under construction is locked, and only the Maintenance Director has a key to it. There is a notice on the locked door, clarifying that no residents may enter the construction area which is not an exit, and no construction workers may enter the community. There are no rooms currently inhabited by residents in the construction area. All construction workers enter the construction hallway using a separate entrance at the exterior end of the hallway, and do not have access to residents or their living quarters. Staff at the front desk are able to observe the locked door to ensure there is no access to it, in addition to observing everyone who enters the main entrance of the community.

Additional Corrective Actions: For bi-weekly construction update meetings, the three General Contractors overseeing the project enter the community as visitors, check in at the front desk, and are escorted to the Executive Director's office. At the closure of the meeting, they are escorted to the main entrance to exit the building. At no time, do they have access to the residents or their living quarters. Criminal Background Checks will be obtained for all

51 Criminal Background Check (continued)

construction workers working in the community by 3/20/24.

Ongoing Quality Assurance Actions: The Regional Director of Operations will be responsible for ensuring this process remains in place through direct monitoring, two to three times weekly, effective 2/15/24, until the construction project is complete.

Proposed Overall Completion Date: 03/20/2024

Licensee's Proposed Overall Completion Date: *03/20/2024*

Implemented (04/11/2024)

57c - 2 Hours/Day

3. Requirements

2600.
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 , there were 90 residents in the home, including 28 residents with mobility needs, requiring a total minimum of 118 hours of direct care service. On this date, only 101 hours of direct care staffing was provided.

Plan of Correction ***Accept (- 03/08/2024)***

Immediate Corrective Actions: On 3/8/24, the Business Office Director and Clinical Care Coordinator will be trained on the OnShift scheduling platform, which will allow them to show not only the hourly staff and when they are working, but also the salaried managers who fill in as direct care staff when needed.

Additional Corrective Actions: The new Executive Director and the new Resident Care Director are joining the team on 3/11/24. They will also be trained on this scheduling platform as part of their job orientation.

Ongoing Quality Assurance Actions: The OnShift platform calculates staffing needs based on the current census and state staffing requirements. The Executive Director will be responsible for ensuring compliance monthly beginning April 2024. This will be reviewed as part of the Quarterly Quality Assurance Review meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented - 04/11/2024)

57d - Waking Hours

4. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 1/15/2024, a total of 89 hours of direct care was required. However, only 83 of the required hours were provided during waking hours.

57d Waking Hours *(continued)*

Plan of Correction ***Accept [redacted] - 03/08/2024)***

Immediate Corrective Actions: On 3/8/24, the Business Office Director and Clinical Care Coordinator will be trained on the OnShift scheduling platform, which will allow them to show not only the hourly staff and when they are working, but also the salaried managers who fill in as direct care staff when needed.

Additional Corrective Actions: The new Executive Director and the new Resident Care Director are joining the team on 3/11/24. They will also be trained on this scheduling platform as part of their job orientation.

Ongoing Quality Assurance Actions: The OnShift platform calculates staffing needs based on the current census and state staffing requirements for total hours of care and waking hours of care. The Executive Director will be responsible for ensuring compliance monthly beginning April 2024. This will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 04/11/2024)

60a - Staff/Support Plan

5. Requirements

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

Description of Violation

Resident 1 waited 53 minutes after pushing their call bell at 9 am on [redacted], and 34 minutes after pushing their call bell 18 times at 1:33 pm on [redacted].

Resident 2 waited 42 minutes after pushing their call bell 2 times on [redacted] at 4:22 am, 41 minutes after pushing their call bell 2 times on [redacted] at 2:27 pm, 96 minutes after pushing their call bell on [redacted] at 3:00 am, 43 minutes after pushing their call bell 5 times on [redacted] at 3:30 am, 38 minutes after pushing their call bell 49 times on [redacted] at 3:48 pm, 84 minutes after pushing their call bell 48 times on [redacted] at 5:19 pm, 135 minutes after pushing their call bell 45 times on [redacted] at 7:33 am, 51 minutes after pushing their call bell on [redacted] at 7:09 am, 127 minutes after pushing their call bell 9 times on [redacted] at 7:26 am, 45 minutes after pushing their call bell 2 times on [redacted] at 12:18 am, 84 minutes after pushing their call bell on [redacted] at 8:31 am, 46 minutes after pushing their call bell 35 times on [redacted] at 8:48 am, 54 minutes after pushing their call bell 14 times on [redacted] at 7:21 am, 125 minutes after pushing their call bell 3 times on [redacted] at 5:38 am, 45 minutes after pushing their call bell 115 times on [redacted] at 7:21 am, 75 minutes after pushing their call bell 139 times on [redacted] at 10:21 am, 54 minutes after pushing their call bell 5 times on [redacted] at 12:25pm am, 189 minutes after pushing their call bell 10 times on [redacted] at 5:32 am, 40 minutes after pushing their call bell 46 times on [redacted] at 9:55 am, 90 minutes after pushing their call bell 7 times on [redacted] at 5:51 am.

According to staff interviews, residents are not receiving timely care related to their incontinence and bowel issues. These services could not be provided due to lack of available direct care staffing in the home.

Plan of Correction ***Accept ([redacted] - 03/08/2024)***

Immediate Corrective Actions: All Direct Care Staff will be trained on how to respond timely and acknowledge the

60a Staff/Support Plan (continued)

call bell system to cease the alarm. The Regional Director of Operations will complete the training and will ensure all direct care staff have completed it by 3/30/24.

Additional Corrective Actions: Additional iPhones will be available by 3/13/24 to ensure all direct care staff have adequate resources to receive call bell notifications and respond to them. In addition, the call bell notification escalation process will be changed as follows: the initial alert will go to direct care staff, with the 5 minute alert going to the Shift Supervisor, the 7 minute alert going to the Resident Care Director and Memory Care Director, and the 10 minute alert going to the Executive Director. This will be effective as of 3/29/24, and will ensure managers are able to reach out to staff any time a call bell is not answered timely.

Ongoing Quality Assurance Actions: The Resident Care Director, the Memory Care Director, and Executive Director will review the Daily Call Bell Report, and will discuss in Clinical Meetings any concerns, beginning at the end of the orientation process for the people newly hired for these roles, but no later than 3/29/24. Patterns, trends, and any issues will be reviewed at Quarterly Quality Assurance Review meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/29/2024*

Implemented [redacted] - 04/11/2024)

63a - First Aid/CPR Training

6. Requirements

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

Description of Violation

On [redacted], from 11:01 pm to 7:00 am, 90 residents were present in the home. During this time only 1 staff person was present in the home who was certified in obstructed airway techniques and CPR .

Repeat Violation date 9/28/2021 et al.

Plan of Correction ***Accept [redacted] - 03/08/2024)***

Immediate Corrective Actions: Certificates for staff who were trained in December 2023 were printed on 2/15/23 by the Regional Director of Operations, to verify those who were trained in the most recent class.

Additional Corrective Actions: Additional CPR training has been scheduled to be held by 3/15/24, for staff who still need certification, and will be conducted by the Wellness Nurse who is a certified trainer. A CPR and First Aid Training binder will be updated by the Wellness Nurse, who will schedule and track these trainings to ensure all direct care staff are trained by the end of their first 90 days of employment. This will be considered when calculating staffing hours and the number of trained staff scheduled per shift.

Ongoing Quality Assurance Actions: The CPR and First Aid Binder will be reviewed each quarter as part of the Quarterly Quality Assurance Review. Findings, patterns, and concerns will be addressed in the Quarterly Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 04/11/2024)

64c Annual Training

7. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person A, [redacted], completed only 13.75 hours of Department-approved training in training year January 2023 to December 2023.

Plan of Correction ***Accept ([redacted] - 03/08/2024)***

Immediate Corrective Actions: The Executive Director at the time of the inspection is no longer employed at the community.

Additional Corrective Actions: A new PCHA is beginning on 3/11/24 and will submit their credentials and training to BHSL at that time. At present, an Interim PCHA is in place as of 2/23/24, and submitted their credentials and training to BHSL electronically on that date.

Ongoing Quality Assurance Actions: The credentials and training of the PCHA will be reviewed as part of the Quarterly Quality Assurance Program, with the next Quarterly Review meeting scheduled in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented ([redacted] - 04/11/2024)

65a FS Orientation 1st Day

8. Requirements

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

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

Description of Violation

Staff person B, whose first day of work was on or before [redacted], did not receive orientation on the following topics: staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, evacuation procedures, 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.

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

Plan of Correction ***Accept (03/08/2024)***

Immediate Corrective Actions: Staff Person B is an agency staff member. We provided on 3/1/24 to the agency all of the training requirements for the first day of anyone referred to this community.

Additional Corrective Actions: All agency personnel will complete online the applicable training topics prior to arrival, with community specific fire safety and emergency information training being provided on site within their first shift.

Ongoing Quality Assurance Actions: The Resident Care Director or Clinical Care Coordinator will monitor the trainings to ensure anyone referred from the agency has been trained. For new agency personnel, the Resident Care Director or Clinical Care Director will ensure the training is completed. This will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024 to verify compliance.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented - 04/11/2024)

65b - Rights/Abuse 40 Hours

9. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person B completed his/her 40th scheduled work hour on by . 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.

Plan of Correction ***Accept (- 03/08/2024)***

Immediate Corrective Actions: Staff Person B is an agency staff member. We provided on 3/1/24 to the agency all of the training requirements for the first forty hours of anyone referred to this community.

Additional Corrective Actions: All agency personnel will complete online the required training topics within the first forty hours of training.

Ongoing Quality Assurance Actions: The Resident Care Director or Clinical Care Coordinator will monitor the trainings to ensure anyone referred from the agency has been trained. For new agency personnel, the Resident Care Director or Clinical Care Director will ensure the training is completed. This will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024 to verify compliance.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented - 04/11/2024)

81b Resident Personal Equipment

10. Requirements

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

Description of Violation

Home's bed side mobility device policy does not include periodic evaluations.

Resident's 3 and resident 4 bedside mobility devices are shoved between their mattresses and box springs and are not securely attached to the bed frame.

Resident 5's bedside mobility device is shoved between the mattress and box spring. There is no bed frame for the device to attach to because the resident's box spring is on the floor.

Resident 6 and resident 7's bedside mobility devices are not attached following manufactures instructions.

Plan of Correction ***Accept [redacted] - 03/08/2024)***

Immediate Corrective Actions: The previous PCHA provided an outdated policy to the Licensing Representatives. The Regional Director of Operations replaced the previous policy with the Bedside Mobility Device Policy, which was updated on 10/1/23 per BHSL guidance.

Additional Corrective Actions: All bedside mobility devices were inspected, and any that did not meet the policy were removed. PT was asked to reevaluate each of the five residents noted in the LIS (Residents 3, 4, 5, 6, and 7), and these were completed by 3/6/24.

Ongoing Quality Assurance Actions: The Executive Director will ensure that the Bedside Mobility Device Policy is implemented and maintained. Reassessment will be completed per this guidance and will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 04/11/2024)

85a Sanitary Conditions

11. Requirements

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

Description of Violation

On 2/15/2024, at 10:03 am, outside resident 8's room it smelled heavily of cat feces. Resident 8's room had an uncleaned litterbox filled with cat feces.

Plan of Correction ***Accept ([redacted] - 03/08/2024)***

Immediate Corrective Actions: The litter box was cleaned by the Housekeeper on 2/15/24.

Additional Corrective Actions: The Regional Director of Operations discussed care of the cat with the resident and

85a - Sanitary Conditions (continued)

responsible party. The responsible party has agreed to have the cat removed by 3/15/24.

Ongoing Quality Assurance Actions: Housekeeping staff will notify the PCHA of any concerns with odor. The Executive Director will provide oversight to ensure and review compliance of the Pet Policy, including that pets will be required to be removed if residents are unable to meet the Pet Policy, at the Quarterly Quality Assurance Review Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 04/11/2024)

85d - Trash Receptacles

12. Requirements

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

Description of Violation

On 2/14/24, at 11:02 am, there was an uncovered, unattended trash can in the b wing guest bathroom.

Plan of Correction ***Accept (- 03/08/2024)***

Immediate Corrective Actions: The trash can was replaced by the Regional Director of Operations on 2/14/24.

Additional Corrective Actions: Housekeeping staff will monitor trash cans for lids while completing trash removal, and will report any concerns to the Maintenance Director.

Ongoing Quality Assurance Actions: Compliance with this regulation will be monitored during Quarterly Quality Assurance Review Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 04/11/2024)

89b - Hot Water Temperature

13. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 2/15/2023, at 10:26 am, the water temperature in resident 6's bathroom was 122.3 degrees Fahrenheit.

On 2/15/2023, at 10:30 am, the water temperature in resident 9's bathroom was 122.3 degrees Fahrenheit.

Plan of Correction ***Accept (- 03/08/2024)***

Immediate Corrective Actions: The Maintenance Director adjusted the hot water heater to decrease the temperature on 2/15/24.

Additional Corrective Actions: The Maintenance Director will check water temperatures in a sample of locations on a weekly basis until the construction project is complete. In addition, temperatures in the C Wing (Memory Care) will be checked daily for two weeks, as that is where the elevated temperature was found.

89b Hot Water Temperature (continued)

Ongoing Quality Assurance Actions: Following the completion of the construction project, the Maintenance Director will resume checking temperatures on a monthly basis. Patterns, trends, and findings will be reviewed as part of the Quarterly Quality Assurance Review Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 04/11/2024)

96a - First Aid Kit

14. Requirements

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

Description of Violation

The first aid kit in the memory care area does not include eye coverings or a thermometer.

Repeat Violation date 09/28/2021 et al.

Plan of Correction ***Accept (- 03/08/2024)***

Immediate Corrective Actions: Regional Director of Operations added to the first aid kits a thermometer and eye covering on 3/1/24.

Additional Corrective Actions: Staff will be trained by 3/30/24 to report when they use items in the First Aid Kit so they can be replaced. The Clinical Care Coordinator will be responsible for auditing the First Aid Kit weekly, beginning 3/11/24.

Ongoing Quality Assurance Actions: Patterns, trends, and findings will be reviewed at Quarterly Quality Assurance Review Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 04/11/2024)

96b - First Aid Location

15. Requirements

2600.
96.b. Staff persons shall know the location of the first aid kit.

Description of Violation

Staff person C, D, and E did not know the location of the first aid kit.

Plan of Correction ***Accept [redacted] - 03/08/2024)***

Immediate Corrective Actions: On 2/15/24 The Regional Director of Operations confirmed the location of First Aid Kits in Personal Care and Memory Care.

Additional Corrective Actions: All staff will be trained as to the locations of the First Aid Kit by 3/30/24.

96b First Aid Location (continued)

Ongoing Quality Assurance Actions: Patterns, trends, and findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented - 04/11/2024)

96c - First Aid Accessible

16. Requirements

2600.
96.c. The first aid kit must be in a location that is easily accessible to staff persons.

Description of Violation

Staff person F believed there was a first aid kit in the medication cart, however they did not have access to the medication cart.

Plan of Correction ***Accept (- 03/08/2024)***

Immediate Corrective Actions: The Regional Director of Operations confirmed the location of First Aid Kits in Personal Care and Memory Care on 2/15/24.

Additional Corrective Actions: All staff will be trained as to the locations of the First Aid Kit by 3/30/24.

Ongoing Quality Assurance Actions: Patterns, trends, and findings will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 04/11/2024)

100b - Removal Snow/Obstructions

17. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On 2/14/2024, at 10:43 am, there was ice and iced over snow on the walkway outside the unlocked door across from the dining area.

Plan of Correction ***Accept - 03/08/2024)***

Immediate Corrective Actions: The Maintenance Assistance cleared and salted the walkway on 2/14/24.

Additional Corrective Actions: In the event of inclement weather, Maintenance staff will monitor interior walkways in courtyards in addition to those at the main entrances, effective 2/15/24.

Ongoing Quality Assurance Actions: Compliance with this regulation will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented - 04/11/2024)

101j1 - Mattress Fire Retardant

18. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:

1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

Resident 4's box spring was covered in manufacturers plastic.

Plan of Correction ***Accept (- 03/08/2024)***

Immediate Corrective Actions: The Maintenance Director removed the plastic cover on 2/15/24.

Additional Corrective Actions: Housekeeping staff will monitor the condition of mattresses during linen changes and report any concerns to the Maintenance Director, effective 2/15/24.

Ongoing Quality Assurance Actions: Patterns, trends, and concerns will be reviewed as part of the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 04/11/2024)

101j3 - Bed/Linens/Pillows/Blankets

19. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:

3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

The bed and foam mattress for resident 10, did not have sheets on 2/14/2024 at 10:45am. The resident was sleeping in the bed at the time.

Plan of Correction ***Accept (- 03/08/2024)***

Immediate Corrective Actions: Resident 10's linens had been stripped, as is the routine on shower days. When care staff returned to the resident's room, they placed clean sheets on the bed before assisting the resident to the shower room.

Additional Corrective Actions: Care staff will be trained to bring clean sheets with them to resident rooms when planning to strip beds, so they can immediately make the bed. Training will be completed by 3/30/24, by the Maintenance Director.

Ongoing Quality Assurance Actions: Compliance with this regulation will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 04/11/2024)

103f - Refrigerator/Freezer Temps

20. Requirements

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

Description of Violation

There was no thermometer in the freezer in the memory care area.

Plan of Correction ***Accept (- 03/08/2024)***

Immediate Corrective Actions: The Maintenance Director placed a thermometer in the freezer on 2/14/24.

Additional Corrective Actions: A temperature log will be placed on the refrigerator and temperatures will be recorded daily, per our Dining Services Standards Manual beginning 3/11/24. If a thermometer is not found, it will be reported to the Maintenance Director, so that it can be replaced.

Ongoing Quality Assurance Actions: Compliance with this regulation will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 04/11/2024)

103i - Outdated Food

21. Requirements

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

Description of Violation

There was an undated container of oven roasted turkey breast in the memory care refrigerator.

There was an unlabeled, undated cup of what appeared to be apple juice in the memory care refrigerator.

Repeat Violation date 09/28/2021 et al.

Plan of Correction ***Accept (03/08/2024)***

Immediate Corrective Actions: All unlabeled, undated items were removed by housekeeper on 2/14/24.

Additional Corrective Actions: The refrigerator and freezer will be monitored and cleaned daily by dining serves staff, beginning 3/11/24 to ensure proper storage procedures are followed. Any items not labeled and dated appropriately will be discarded.

Ongoing Quality Assurance Actions: Compliance with this regulation will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented - 04/11/2024)

105g - Lint Removal and Duct Cleaning

22. Requirements

2600.

105g Lint Removal and Duct Cleaning *(continued)*

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

Description of Violation

On 2/14/2024, at 10:47 am, there was a large rolled up log of lint under the lint trap in the dryer. There was also layers of lint on the lint trap screen. There were no clothes in the dryer at the time. Staff person in laundry area stated they had not checked the lint trap this morning.

Plan of Correction ***Accept - 03/08/2024)***

Immediate Corrective Actions: The Maintenance Director cleaned the lint traps on 2/14/24.

Additional Corrective Actions: All staff who use the laundry facilities will be re educated to remove lint from the trap after each cycle of use. This will be completed by Maintenance Director by 3/30/24.

Ongoing Quality Assurance Actions: Dryer ducts will continue to be cleaned by a professional vendor twice annually and the Maintenance Director will ensure cleanings are scheduled. Compliance with this regulation will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented - 04/11/2024)

23. Requirements

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

Description of Violation

Internal ducts of the dryer, in the space above the lint trap but below the dryer drum have a large amounts of buildup of lint that is wrapped around an internal cord.

Plan of Correction ***Accept (- 03/08/2024)***

Immediate Corrective Actions: The Maintenance Director cleaned the lint traps on 2/14/24.

Additional Corrective Actions: All staff who use the laundry facilities will be re educated to remove lint from the trap after each cycle of use. This will be completed by Maintenance Director by 3/30/24.

Ongoing Quality Assurance Actions: Dryer ducts will continue to be cleaned by a professional vendor twice annually and the Maintenance Director will ensure cleanings are scheduled. Compliance with this regulation will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 04/11/2024)

107a - Emergency Preparedness

24. Requirements

2600.
107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

107a Emergency Preparedness *(continued)*

Description of Violation

Staff person A, the [redacted] does not have the emergency preparedness plan for the local municipality.

Plan of Correction ***Accept [redacted] - 03/08/2024)***

Immediate Corrective Actions: The Maintenance Director had an electronic version of the emergency plan for the local municipality. It was printed on 3/1/24 and placed in the Survey Binder and Emergency Preparedness Binder.

Additional Corrective Actions: The Front Desk Concierge will visually confirm the emergency binder is present at the Front Desk, beginning 3/11/24 on a daily basis.

Ongoing Quality Assurance Actions: Compliance with this regulation will be reviewed at the Quarterly Quality Assurance Meeting, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 04/11/2024)

107d - Procedure Emergency Management Agency Submission

25. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to a local emergency management agency since 2/15/2022.

Plan of Correction ***Accept [redacted] - 03/08/2024)***

Immediate Corrective Actions: The previous Executive Director submitted the emergency procedures to the local emergency management agency on 2/22/24.

Additional Corrective Actions: This will be tracked (by the Interim Executive Director until the new Executive Director completes orientation) in the Survey Binder. This is reviewed at least quarterly, to ensure all emergency information is maintained and updated as needed.

Ongoing Quality Assurance Actions: Compliance with this regulation will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented ([redacted] - 04/11/2024)

124 - Notice to Fire Department

26. Requirements

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

124 - Notice to Fire Department *(continued)*

Description of Violation

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

Plan of Correction ***Accept (- 03/08/2024)***

Immediate Corrective Actions: The previous Executive Director submitted the written notification of the information in 2600.124 to the local fire department on 2/22/24.

Additional Corrective Actions: This will be tracked (by the Interim Executive Director until the new Executive Director completes orientation) in the Survey Binder. this is reviewed at least quarterly, to ensure all emergency information and the letter to the fire company is maintained and updated as needed.

Ongoing Quality Assurance Actions: Compliance with this regulation will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 04/11/2024)

131f - Fire Extinguisher Inspection

27. Requirements

2600.
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 the smoking area does not show that it has been inspected by a fire safety expert within the last year because the bottom of the tag was removed.

Plan of Correction ***Accept (- 03/08/2024)***

Immediate Corrective Actions: On 2/16/24, the Maintenance Director replaced the fire extinguisher with one that has an updated tag on it.

Additional Corrective Actions: The Maintenance Director has explored options to protect the exterior fire extinguisher from the elements and a box to house the extinguisher has been ordered as of 3/6/24.

Ongoing Quality Assurance Actions: Fire extinguishers will be monitored monthly and findings will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 04/11/2024)

144d - Smoking Outside

28. Requirements

2600.
144.d. Smoking outside of the smoking room is prohibited.

Description of Violation

On 2/15/2024, at 2:38 pm, resident 1's room

144d Smoking Outside (continued)

smelled of smoke, which is not the home's designated smoking area. The home's designated smoking area is outside in the gazebo in the parking lot. Staff interviews indicated that resident 1's adult child smokes in the room, and it's been an ongoing issue that has been reported to management.

Plan of Correction ***Accept (- 03/08/2024)***

Immediate Corrective Actions: The Maintenance Director confirmed no one was actively smoking in the room. There was no evidence or debris from smoking, nor were Managers aware of any concerns of someone smoking in the room. Resident #1 is moving out of the community on 3/13/24.

Additional Corrective Actions: All residents will be reminded of the community's smoking policy at the next Town Hall Meeting on 3/21/24. All staff will be reminded of the community's policy at the next Staff Meeting on 4/3/24. The smoking policy is also reviewed with new residents at the time of admission.

Ongoing Quality Assurance Actions: Staff will be advised that any concerns should be reported to a Manager. Compliance with this regulation will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented - 04/11/2024)

171b5 - First Aid Kit

29. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the bus used to transport residents does not include a breathing shield or eye protector.

Plan of Correction ***Accept (- 03/08/2024)***

Immediate Corrective Actions: A breathing shield and eye covering were placed in the First Aid Kit on 3/1/24.

Additional Corrective Actions: Staff will be trained by 3/30/24 to report when they use items in the First Aid Kit so they can be replaced. The Clinical Care Coordinator will be responsible for auditing the First Aid Kit weekly, beginning 3/11/24.

Ongoing Quality Assurance Actions: Patterns, trends, and findings will be reviewed at Quarterly Quality Assurance Review Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented - 04/11/2024)

182b - Prescription Medication

30. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

182b Prescription Medication *(continued)*

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On [redacted] staff person G administered medications to residents to include the following; Resident 11. Staff person G is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

On [redacted] staff person H administered medications to residents to include the following; Resident 12. Staff person H is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

On [redacted], staff person I administered medications to residents to include the following; Resident 13. Staff person H is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Plan of Correction ***Accept ([redacted] - 03/08/2024)***

Immediate Corrective Actions: Staff Members G, H, and I are no longer administering medications.

Additional Corrective Actions: They are registered to take the Medication Administration Course, and a Train The Trainer from a sister community will complete all modules, tests, and observations as required. They will not resume Medication Administration until they have completed all components.

Ongoing Quality Assurance Actions: The Resident Care Director will monitor the Medication Training for all Medication Technicians, so that all MAR reviews and Observations can be scheduled and completed per regulatory guidelines. Compliance with this regulation will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented ([redacted] - 04/11/2024)

183e - Storing Medications

31. 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 [redacted], there was a loose white oblong pill in second drawer of medication cart 1.

Plan of Correction ***Accept [redacted] - 03/11/2024)***

Immediate Corrective Actions: The pill was removed on 2/15/24 by the Medication Technician, and was destroyed.

Additional Corrective Actions: All Medication Technicians will be retrained on how to complete Weekly Medication Cart Audits by the Director of Quality Assurance Infection Prevention and Control by 3/30/24. These processes include looking for loose pills within the cart.

Ongoing Quality Assurance Actions: The Wellness Nurse will review the Weekly Medication Cart Audit Forms after they are completed. Findings, patterns, and trends will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 04/11/2024)

185a - Implement Storage Procedures

32. 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], at [redacted], resident 13's glucometer read [redacted]. On [redacted], at [redacted] resident 13's glucometer reading was [redacted] but it was transcribed on the medication administration record as [redacted]
On [redacted] at [redacted] resident 13's glucometer reading was [redacted] but it was transcribed on the medication administration record as [redacted]
On [redacted], resident 13's glucometer reading was [redacted], but it was transcribed on the medication administration record as [redacted]

On [redacted] PRN medications [redacted] tablet take 1 every 8 hours as needed for [redacted], and [redacted] packet as needed for [redacted] for resident 13 was not available.

On [redacted], at [redacted], resident 14's glucometer reading was [redacted] but was transcribed as [redacted] in the medication administration record.

On [redacted], Resident 14's Glutose 15 gel 40% as needed for blood glucose less then [redacted] was not available in home.

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept - 03/11/2024)***

Immediate Corrective Actions: A Medication Technician training is scheduled for 3/8/24 related to glucometer readings and documentation. Resident 13's PRN has been refilled and is now on the cart. Resident 15s is also now on the cart.

Additional Corrective Actions: All Medication Technicians will be retrained on how to complete Weekly Medication Cart Audits and the Change of Shift Responsibilities by the Director of Quality Assurance Infection Prevention and Control by 3/30/24. These processes include verifying medications are available as well as confirming the accuracy of glucometer documentation.

Ongoing Quality Assurance Actions: The Wellness Nurse will review the Weekly Medication Cart Audit Forms and ensure Change of Shift Responsibilities are completed, beginning after the trainings are completed. Findings, patterns, and trends will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented - 04/11/2024)

187a - Medication Record

33. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident 14 is prescribed as needed. However, this medication is not listed on the resident's medication administration record.

Resident 15 is prescribed by mouth daily. However, this medication is not listed on the resident's medication administration record.

Repeat Violation date 9/28/2021 et al.

187a - Medication Record *(continued)*

Plan of Correction ***Accept (- 03/11/2024)***

Immediate Corrective Actions: For Resident 14, the LPN received an order from the physician discontinuing medication.
For Resident 15, the prescribed was started on 2/15/24. The medication has since changed to , and this is what is currently on the medication administration record as of 3/1/24.

Additional Corrective Actions: The nurse and medication technician will be retrained to ensure that orders, MAR's, and med labels match. Training to be completed by 3/30/24 by the Director of Quality Assurance and Infection Prevention and Control.

Ongoing Quality Assurance Actions: Resident Care director will review EMAR and orders weekly to ensure compliance, following the completion of training. Findings, patterns, and trends will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 04/11/2024)

187b - Date/Time of Medication Admin.

34. Requirements

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

Description of Violation

On according to resident 14's medication administration record was administered at by staff person H, however the home's narcotic log does not indicate who administered this or at what time.

Repeat Violation date 9/28/2021 et al.

Plan of Correction ***Accept - 03/11/2024)***

Immediate Corrective Actions: An immediate count of resident 14's was conducted on 2/15/24, and found the count to be accurate.

Additional Corrective Actions: All Medication Technicians will be retrained on how to complete the Change of Shift Responsibilities by the Director of Quality Assurance Infection Prevention and Control by 3/30/24. These processes include verifying the administration and documentation of medications, as well as the count of narcotics.

Ongoing Quality Assurance Actions: The Wellness Nurse will review the Weekly Medication Cart Audit Forms and ensure Change of Shift Responsibilities are completed. Findings, patterns, and trends will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented 04/11/2024)

187d - Follow Prescriber's Orders

35. Requirements

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

Description of Violation

Resident 14 is prescribed per sliding scale. Resident 14's medication administration record shows that the resident's blood glucose level was indicating it was too high to read at on Resident should have received units. Record does not indicate that the resident received any units.

On Resident 13's apply to twice a day for wound was not available in home.

Repeat Violation date 9/28/2021 et al.

Plan of Correction ***Accept - 03/11/2024)***

Immediate Corrective Actions: Training will be completed by 3/30/24 for Medication Technicians related to proper insulin procedures, by the Director of Quality Assurance and Infection Prevention and Control. The Physician for resident 13 was contacted and a refill order for was secured.

Additional Corrective Actions: The Resident Care Director will use the EMAR Dashboard to review medication administration processes and documentation, to provide oversight for all sliding scale insulin orders. In addition, all Medication Technicians will be retrained on how to complete the Change of Shift Responsibilities by the Director of Quality Assurance Infection Prevention and Control by 3/30/24. These processes include verifying the administration and documentation of medications, as well as a review of all glucometers.

Ongoing Quality Assurance Actions: The Wellness Nurse will review the Weekly Medication Cart Audit Forms and ensure Change of Shift Responsibilities are completed, beginning when trainings have been completed. Findings, patterns, and trends will be reviewed at the Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (04/11/2024)

190a - Completion Medication Course

36. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person G, who has not successfully completed the Department-approved medications administration course because their renewal was incomplete. Staff person G administered medications to residents to include the following:
On

Staff person H, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:

190a - Completion Medication Course (continued)

On
On
On
On
On
On
On
On

Staff person I, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:
From to resident 13

Repeat Violation date 9/28/2021 et al.

Plan of Correction ***Accept (- 03/11/2024)***

Immediate Corrective Actions: Staff Members G, H, and I are no longer administering medications.

Additional Corrective Actions: They are registered to take the Medication Administration Course, and a Train The Trainer from a sister community will complete all modules, tests, and observations as required. They will not resume Medication Administration until they have completed all components.

Ongoing Quality Assurance Actions: The Resident Care Director will monitor the Medication Training for all Medication Technicians, so that all MAR reviews and Observations can be scheduled and completed per regulatory guidelines. Compliance with this regulation will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 04/11/2024)

190c - Record of Training

37. Requirements

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

Description of Violation

The home's medication administration training record for staff persons G, H, and I is signed by the practicum observer, not the trainer.

Plan of Correction ***Accept (- 03/11/2024)***

Immediate Corrective Actions: Staff Members G, H, and I are no longer administering medications.

Additional Corrective Actions: They are registered to take the Medication Administration Course, and a Train The

190c - Record of Training (continued)

Trainer from a sister community will complete all modules, tests, and observations as required. They will not resume Medication Administration until they have completed all components.

Ongoing Quality Assurance Actions: The Resident Care Director will monitor the Medication Training for all Medication Technicians, so that all MAR reviews and Observations can be scheduled and completed per regulatory guidelines. Compliance with this regulation will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 04/11/2024)

227d - Support Plan Medical/Dental

38. Requirements

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

Description of Violation

The assessment for resident 4, dated , indicates the resident has a need for transferring. The resident uses a bedside mobility device. However, the resident's support plan does not document that the resident uses a bedside mobility device, the specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, and identification of the specific device to be used and whether a cover is required to meet FDA guideline

The assessment for resident 5, dated , indicates the resident has a need for transferring. The resident uses a bedside mobility device. However, the resident's support plan does not document that the resident uses a bedside mobility device, the specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, and identification of the specific device to be used and whether a cover is required to meet FDA guideline

The assessment for resident 7, dated , does not indicate the resident has a need for transferring. The resident uses a bedside mobility device. However, the resident's support plan does not document that the resident uses a bedside mobility device, the specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, and identification of the specific device to be used and whether a cover is required to meet FDA guideline

The assessment for resident 16, dated does not indicate the resident has a need for transferring. The resident uses a bedside mobility device. However, the resident's support plan does not document that the resident uses a bedside mobility device, the specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, and identification of the specific device to be used and whether a cover is required to meet FDA guideline

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

Plan of Correction ***Accept (- 03/11/2024)***

Immediate Corrective Actions: All unapproved bedside mobility devices were removed by 3/1/24.

Additional Corrective Actions: PT has rescreened Residents 4, 5, 7, and 16 for need of bedside mobility device. Any determination of need, orders for equipment, resident understanding of purpose and use, and team review will be documented in the RASP, in addition to all required information as outlined in the Bedside Mobility Device Policy, dated 10/1/23.

Ongoing Quality Assurance Actions: The Executive Director will ensure that the Bedside Mobility Device Policy is implemented and maintained. Reassessment will be completed per this guidance and will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 04/11/2024)

227g -Support Plan Signatures

39. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident 17 participated in the development of his/her support plan on However, the resident did not sign the support plan.

Plan of Correction ***Accept (- 03/11/2024)***

Immediate Corrective Actions: The resident's signature was obtained on

Additional Corrective Actions: An audit of all RASPs was completed. Any missing signatures will be obtained by 4/12/24.

Ongoing Quality Assurance Actions: A sample of Resident Records will be audited every month by the Resident Care Director, per the community QA Process. Findings will be discussed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented 04/11/2024)

252 - Record Content

40. Requirements

2600.
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.

252 - Record Content *(continued)*

4. Language or means of communication spoken or used by the resident.
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 home, 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.
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 home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident 1's record does not include hospital records from emergency room stay [redacted]. Progress notes in residents file indicate these were left at the front desk.

Plan of Correction ***Accept ([redacted] - 03/11/2024)***

Immediate Corrective Actions: The hospital was contacted by the Regional Director of Operations on 3/7/2024 to request a copy of the records.

Additional Corrective Actions: All staff will be trained by the Regional Director of Operations that when residents return from the hospital, any paperwork should be given to the Resident Care Director, Wellness Nurse, or Clinical Care Coordinator to upload to the record. Training will be completed by 3/15/24.

Ongoing Quality Assurance Actions: Compliance with this regulation will be reviewed at Quarterly Quality Assurance Meetings, beginning in April 2024.

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (MJ - 04/11/2024)