pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **GREENFIELD OF PERKIOMEN VALLEY LLC**
LEGAL ENTITY

To operate **GREENFIELD OF PERKIOMEN VALLEY**
NAME OF FACILITY OR AGENCY

Located at **300 PERKIOMEN AVENUE, SCHWENKSVILLE, PA 19473**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **90**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 44**

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

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **July 2,** **2024** until **January 2,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **137351**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JULY 2, 2024

[redacted]
Greenfield of Perkiomen Valley, LLC
[redacted]

RE: Greenfield of Perkiomen Valley
300 Perkiomen Avenue
Schwenksville, Pennsylvania 19473
License #: 137351

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection October 31 and November 6 and 17, 2023, January 23, 2024, and March 5 and 6, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 137350 dated August 9, 2023 to August 9, 2024 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated August 9, 2023 to August 9, 2024 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from July 2, 2024 to January 2, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

[redacted]

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
51	2	51	$5	$255	5 calendar days from mailing date of this letter
82c	2	51	$5	$255	5 calendar days from mailing date of this letter
103i	3	51	$3	$153	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

[redacted]

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *GREENFIELD OF PERKIOMEN VALLEY* **License #**: *13735* **License Expiration**: *08/09/2024*

Address: *300 PERKIOMEN AVENUE, SCHWENKSVILLE, PA 19473*

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

Administrator

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

Legal Entity

Name: *GREENFIELD OF PERKIOMEN VALLEY LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/23/2012* **Issued By**: *Borough of Schwenksville*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *100* **Waking Staff**: *75*

Inspection Information

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

Reason: *Renewal, Complaint, Monitoring* **Exit Conference Date**: *11/06/2023*

Inspection Dates and Department Representative

10/31/2023 - On-Site: [redacted]
11/06/2023 - On-Site:
11/17/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served**: *69*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *The Willow* **Capacity**: *44* **Residents Served**: *15*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *69*

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

Have Mobility Need: *31* **Have Physical Disability**: *0*

Inspections / Reviews

10/31/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/14/2023*

12/21/2023 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/27/2023*

01/25/2024 - POC Submission

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

[redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/29/2024*

03/19/2024 - Document Submission

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

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

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

On 11/6/23, at 2:41 pm, medication administration records were unlocked, unattended, and accessible the Secured Dementia Care Unit medication room.

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

Administrator spoke with the Dementia Care Coordinator after exit interview regarding confidentiality of records. A training was held on Monday November 13, 2023 by the HCC to all nursing staff where [redacted] reiterated this regulation. Moving forward the staff was made aware of keeping records in a locked area used for charting and medicinal purposes. Dementia Care Coordinator or designee beginning 1/4/24, shall monitor the record storage area weekly and on going, to ensure the records are securely stored. Documentation shall be kept.

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

Not Implemented [redacted] - 03/19/2024)

18 - Compliance With Laws

2. Requirements

2600.

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

Description of Violation

On 10/31/23, there was no Carbon Monoxide detector for the kitchen which uses gas appliances. Per the Care Facility Carbon Monoxide Alarms Standards Act of Jun. 23, 2016; Carbon Monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance.

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

On 11/15/23, Hoodz---the name of the vendor-- did come to the community and clean the hood, fan, and duct work. They placed a certificate on the hood noting cleaning date. The maintenance director replaced the battery in the carbon monoxide detector on the same date as the surveyors were present. Moving forward, maintenance director will check all detectors in community on a monthly basis to ensure they are all in working condition. Dining Service director will notify maintenance director if an alarm goes off, so he is aware to recheck. The home will obtain a current copy of the food service license, and post a copy in the homes kitchen 1/4/24. DDS will ensure the kitchen is inspected and a copy of the license is obtained annually.

18 - Compliance With Laws *(continued)*

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

Not Implemented *- 03/19/2024)*

[redacted]

Plan of Correction ***Withdrawn*** *(MS - 01/18/2024)*

[redacted]

24 - Personal Hygiene

4. Requirements

2600.

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

Description of Violation

The assessment and support plan, dated [redacted]/23, for resident 3 indicates the resident requires assistance with personal hygiene. On 10/31/23, the resident did not receive assistance as required. The resident was observed on 10/31/23 at 12:41 pm, walking through the Secured Dementia Care Unit with a brown substance that appeared to be feces, on the back of the resident's pants.

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

Dementia Coordinator immediately while surveyors were present had staff take resident to her room and change [redacted] slacks. Residents slack was cleaned however had a permanent stain on them. D.C. called family and requested new slacks for resident to be brought to the community. At family request, slacks were discarded. Moving forward, staff

24 - Personal Hygiene (continued)

will inform DC when clothing appears to be ruined or stained and she will call families for additional clothing. Training was held on 11/9/23 by the Health care coordinator with all care manager and med techs on resident care, including but not limited too Adl's, including showers, shaving, nail care.

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

Not Implemented [redacted] - 03/19/2024)

25b - Contract Signatures

5. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated 3/8/23, for resident 4 was not signed by the resident.

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

Effective immediately, administrator, resident and family/POA will sign contract on day of admission or prior to admission. Administrator will not place resident file in cabinet until all signatures required are present. An initial audit will be performed by the Sales and Marketing director or designee by January 31, 2024. Any found to be out of compliance will be identified, corrected and as part of the POC.

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

Not Implemented [redacted] - 03/19/2024)

26a - Quality Management Plan

6. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home does not have a quality management plan.

Plan of Correction ***Accept [redacted] - 12/21/2023)***

The home does have a quality management plan. However, with several changes in the leadership role, no one carried through with this regulation. Moving forward, new executive director will start a state compliance book and a quarterly management book and hold meetings accordingly. The first quarterly meeting will begin in January with the new ED. [redacted] will be responsible to have these meetings in order to remain compliant with this regulation.

Licensee's Proposed Overall Completion Date: *12/20/2023*

Not Implemented [redacted] - 03/19/2024)

51 - Criminal Background Check

7. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A was hired on [redacted]/23. However, this person does not have a criminal background check.

Staff person B was hired on [redacted]/23, However this person's criminal background check was completed on 9/11/23.

Repeat Violation: 5/17/22 et al.

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

A new company was contracted for dining services. Resident care coordinator was told by owner that the checks are completed on [redacted] part. However, they were not present, and we did not have them in community. Moving forward, all contracted services will give all paperwork to community prior to employee coming on board. Resident Coordinator will then do the 40 hour training and staff will have a tour provided prior to working in community. All staff hired by Greenfield will have a background check completed prior to starting in the community. RCC is aware of this moving forward. Administrator was not hired on [redacted]23.[redacted] was hired on [redacted]/11/23 which means [redacted] paperwork was compliant. An initial audit will be performed by the Sales and Marketing director or designee by January 31, 2024. Any found to be out of compliance will be identified, corrected and as part of the POC.

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

Not Implemented ([redacted] - 03/19/2024)

60a - Staff/Support Plan

8. 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

On 11/17/23, residents 1 and 2, did not receive help getting out of bed and getting dressed. Additionally, residents in the Secured Dementia Care Unit did not receive their morning medication on time. According to staff interviews, these services could not be provided due to lack of available direct care staffing in the home.

Plan of Correction ***Accept [redacted] - 12/21/2023)***

Staff in the dementia care unit did not inform RCC or dementia coordinator or use our internal "Whats App" to let additional staff know they were staffing challenged as a result of a call out. When RCC learned of the situation, [redacted] immediately went to the unit and offered assistance. RCC was able to get residents #1 and #2 out of bed while MT gave am meds to both. Staff had been informed that it is their responsibility to communicate when a call out is received so additional staff can and will be provided at the staff meetings held on Mondays at 2 pm by the Healthcare director. Meeting was held on 11/20/23 in the Unit dining room.

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

Not Implemented ([redacted] - 03/19/2024)

65a - FS Orientation 1st Day

9. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was [redacted]/23, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

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

This team member was a dining service staff employee and paperwork was not completed on 1 st day of hire. Resident Care Coordinator was not informed that this was [redacted] role as the owner did not communicate with [redacted] of new employee coming to work in community. Moving forward, all employees contracted or hired directly will receive all trainings in their 1st 40 hours by the RCC. Outside contractors will communicate with RCC in advance so [redacted] is aware of any and all new hires prior to start date. On December 19, 2023, RCC did a complete orientation with contracted kitchen employees bringing all employees in Greenfield senior living up to compliance. Effective immediately, the RCC will audit all employee orientation records, and provide training upon new hires of outside vendors and Greenfield Senior living.

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

Not Implemented ([redacted] - 03/19/2024)

65b - Rights/Abuse 40 Hours

10. 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 A completed [redacted] 40th scheduled work hour on or around 4/3/23. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and

65b - Rights/Abuse 40 Hours (continued)

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 (- 01/18/2024)***

This team member was a dining service staff employee and paperwork was not completed on 1 st day of hire. Resident Care Coordinator was not informed that this was role as the owner did not communicate with new employee coming to work in community. Moving forward, all employees contracted or hired directly will receive all trainings in their 1st 40 hours by the RCC. Outside contractors will communicate with RCC in advance so is aware of any and all new hires prior to start date. Effective immediately, the RCC will audit all employee orientation records, and provide training upon new hires of outside vendors and Greenfield Senior living.

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

Not Implemented - 03/19/2024)

81b - Resident Personal Equipment

11. Requirements

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

Description of Violation

On 10/31/2023, a bedside mobility device was present on resident 5's bed, with openings measuring 12 inches by 8 inches between the top and the middle of the enabler, and a gap 6 inches wide between the bottom of the enabler and the mattress. The enabler was not covered and was not securely attached to the structure of the bed.

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

Resident Care Coordinator removed enabler while surveyors were still present in community. first covered enabler with a pillowcase and then realized it was not secure. Resident did not have an order to have enabler, so it was removed without incident. Staff was in serviced on this regulation and they are aware that all enablers must be covered or removed from bed if not secure.

Proposed Overall Completion Date: 01/31/2024
Directed Plan of Correction:
In addition to the above plan of correction, the administrator or designee shall complete an audit of all resident occupied rooms for the presence and proper installation of enabler bars within 5 calendar days of the receipt of this plan of correction. Any resident found to have an enabler bar present in their room shall be assessed for the need to have the enabler bar present and have their support plans updated/revised with the proper documentation for the residents need, ability to use and documented discussion about the risk/benefits of the presence of the device. Additionally within 15 business days of the receipt of this plan of correction, the administrator or designee shall in-service all staff on the use of enabler bars in the home. The training shall include the proper use, installation, risk/benefits and documentation in resident support plans for enabler bars. The administrator or designee shall create a plan to audit resident rooms/review resident records to ensure compliance with the use of these devices on an ongoing basis.
Documentation of audits and trainings shall be provided and maintained in the home for Department review.

Directed Completion Date: *02/29/2024*

Not Implemented (03/19/2024)

82c - Locking Poisonous Materials

12. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 10/31/23 at 12:30 pm, cleaning products, including degreaser and sanitizer, were unlocked, unattended, and accessible to residents the Secure Dementia Care Unit.

On 11/17/23, a bottle of hand sanitizer and a bottle of rug cleaner, were unlocked, unattended, and accessible in room 302. Dial hand soap, with a label that read, " if swallowed, get medical help or Poison Control Center immediately." was unlocked, unattended, and accessible on the bathroom sink in room 301. Both rooms are located in the Secure Dementia Care Unit.

Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Repeat Violations: 5/17/22 et al.and,1/19/23

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

Dementia Coordinator has accessed all residents living in the dementia community and all have and have had been assessed for being incapable of recognizing and using poisons safely. Dementia coordinator, had a child proof lock installed on the cabinet under the sink in the kitchen area of the memory unit. This was completed on 10/31/23. In room 301, soap was replaced with a non-toxic product and family was notified that they must bring in non-toxic products moving forward. In room 302, this is being utilized by staff and not residents. However, staff was given a key so this room will remain locked at all times keeping cleaning products and sanitizer inaccessible to residents. Dementia coordinator spot check daily to ensure compliance. Training was held on 11/9/23 by the health care coordinator, with all care manager and med techs on resident care, including but not limited too Adl's, including showers, shaving, nail care, poisonous materials.

Proposed Overall Completion Date: 01/31/2024
Directed Plan of Correction:
In addition to the above plan of correction, beginning within 5 calendar days of the receipt of this plan of correction, the administrator or designee shall audit all areas of the secure dementia care unit for unlocked poisons twice weekly for 4 weeks then weekly thereafter for 3 months. Audit documentation shall be kept to include any areas of non-compliance observed as well as the corrective action taken. Documentation of audits and trainings shall be provided and maintained in the home for Department review.

Directed Completion Date: *02/29/2024*

Not Implemented [redacted] - 03/19/2024)

85a - Sanitary Conditions

13. Requirements

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

85a - Sanitary Conditions *(continued)*

Description of Violation

On 10/31/23 at 10:09 am, room [redacted] had a strong smell of feces, and there was a trash can in the bedroom with paper towels that were covered in feces.

On 10/31/23 at 11:53 am, the sink in the kitchen was clogged with garbage.

On 10/31/23 at 12:45 pm, the toilet in room [redacted] had dried brown matter that appeared to be feces on the toilet seat, additionally, there was no method of hand drying in the bathroom.

On 11/6/23, resident 6's room was littered with trash throughout the entire room. The trash began at the door, and went throughout the sitting area, the resident's bedroom, and the resident's bathroom. There was also a pile of trash collected on the resident's bed. There was a strong odor in the room, and there were soiled incontinence products in an wastebasket next to the resident's bed. The carpet in the room is stained. On 11/17/23, a litter box with an large accumulation of cat feces was observed in the resident's closet.

The carpet throughout the entire personal care home hallways and common areas is stained and visibly dirty.
The basement off of the second floor has a large accumulation of debris, trash and various items stored in the area.

Repeat Violation Dates: 5/17/22 et al, and 1/29/23.

Plan of Correction ***Accept ([redacted] - 12/21/2023)***

Demetia Coordinator had a staff member immediately remove the trash can from room [redacted]. [redacted] also had housekeeping clean right away. [redacted] then went through all of the rooms, ordered new cans with lids and replaced any and all that had no lids with new receptacles. Staff will check daily to ensure all trash cans have lids in resident rooms and bring to [redacted] attention if not so one can be placed in that particular room. Dining Service Director was notified of the food clog and sent staff to do a complete and thorough cleaning of the kitchen area. Moving forward, staff were reminded of their responsibilities related to the thorough cleaning procedure after each meal. The cook will be responsible to check prior to leaving their shift to be sure all kitchen areas are cleaned. Resident #6's room was thoroughly cleaned by 2 housekeepers immediately following exit interview. They changed sheets, took out multiple trash bags and recyclable boxes. They removed all incontinent products in the wastebasket, ran the carpet cleaner, and thoroughly cleaned kitchen area including counter tops. The litter box was emptied by the resident. Healthcare coordinator and administrator had a conversation with resident about [redacted] room cleanliness and per [redacted] contract the care of the cat and its litter box. Resident acknowledged [redacted] understood and would take better care of the box in order to eliminate orders. Housekeeping was made aware to report any orders from litter box to the resident and administrator on a weekly basis when the room is cleaned. Housekeeping will do checks and maintenance director will spot check for foul odors. Maintenance director has been using our carpet clean in the heavily soiled areas where there is heavy foot traffic. We are actively seeking a part time assistant for these projects. We had a 30 yard dumpster placed in our parking area o help with eliminating things acquired in this community that are no longer needed. Maintenance director is removing all unnecessary items on a daily basis. Moving forward, new administration is not storing any unnecessary items in basement.

Licensee's Proposed Overall Completion Date: *12/11/2023*

Not Implemented ([redacted] - 03/19/2024)

85b - Infestation

14. Requirements

85b - Infestation *(continued)*

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On 11/17/23, gnats were present in rooms 401 and 402.

Plan of Correction ***Accept (- 12/21/2023)***

The room has water damage which resulted in gnats. There are no residents residing in these rooms. Maintenance director has been extracting water weekly and using sanitizing solutions and has not seen any gnats moving forward. will continue to check weekly as well as when it rains to ensure gnats do not return.

Licensee's Proposed Overall Completion Date: *12/11/2023*

Not Implemented - 03/19/2024)

85d - Trash Receptacles

15. 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 10/31/23 at 11:27 am there was a 3/4 full, uncovered, unattended trash can in the main kitchen.

On 10/31/23, the trash can in the Secured Dementia Care Unit kitchen was uncovered and unattended.

On 11/6/23, there are 2 uncovered trashcans in the bathroom in room 406.

Plan of Correction ***Accept - 12/21/2023)***

Kitchen staff was trained by Dining Service Director on 11/7/23 on this regulation and is aware that all trash cans need to be covered at all times when not in use. However, kitchen staff were using the trash cans at time of state survey as they were disposing of food left on lunch plates. They turned to get more plates and surveyor saw the open container. Moving forward, staff will be responsible to have all receptacles covered when not use.

Licensee's Proposed Overall Completion Date: *12/07/2023*

Not Implemented - 03/19/2024)

85e - Trash Outside Home

16. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 10/31/23, there were more than 20 bags of trash on the ground next to the dumpster and the dumpster was overflowing.

On 11/6/23, there is a bag of trash outside on the ground by the main breaker room.

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

There was an overflow from the supplementary dumpster, and we were using the 30 yard dumpster until disposal

85e - Trash Outside Home (continued)

services emptied the containers. Administrator called the service for additional pick up, but company was unable to accommodate. Staff was in serviced that all trash must be placed in the dumpster and not alongside of it. Housekeeping and maintenance removed all excess on the ground and placed in the 30m yard dumpster. Moving forward maintenance will spot check daily to ensure all trash is placed in proper receptacle with lids closed ensuring no trash in on the ground. Training was held on 11/9/23 by the HCC with all care manager and med techs on resident care, including but not limited too Adl's, including showers, shaving, nail care.

Directed plan of correction:
In addition to the above plan of correction, the administrator or designee shall provide in-service training to all staff of the home within 15 days of the receipt of this plan of correction. Training shall include proper disposal of refuse in covered receptacles. Documentation of audits and trainings shall be provided and maintained in the home for Department review.

Directed Completion Date: *02/29/2024*

Not Implemented [redacted] - 03/19/2024)

86a - Ventilation

17. Requirements

2600.
86.a. All areas of the home that are used by the resident shall be ventilated. Ventilation includes an operable window, air conditioner, fan or mechanical ventilation that ensures airflow.

Description of Violation

The bathroom in room 216, has no operable window, fan, air conditioner or other mechanical ventilation to ensure airflow.

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

On 11/28/23, maintenance director replaced the exhaust fan motor in the bathroom of room 216. This room now has ventilation. Maintenance director was unaware that this was not working. [redacted] spoke to the resident residing in that room and [redacted] was not aware of it now working either as [redacted] did not use it. Resident was advised to speak with any staff member should there be a nonfunctioning item in [redacted] room. At the nest resident council meeting, we will bring this to all residents residing in the community, so they are aware to report nonfunctioning items. All departments will report to the maintenance director if there are any malfunctions to be repaired or replaced. Effective immediately, Maintenance Director will preform random audits on 2-3 units per week, to ensure proper ventilation. Documentation of audit shall be kept.

Directed Plan of Correction:
In addition to the above plan of correction, within 15 calendar days of the receipt of this plan of correction, the Maintenance Director or designee shall complete an audit all resident bathrooms to ensure there is a proper working method of ventilation. Any areas of non-compliance shall be corrected within 15 calendar days. Weekly audits of 2-3 resident units shall continue after the initial audit is complete for 4 weeks then monthly thereafter. Documentation of audits and trainings shall be provided and maintained in the home for Department review.

Directed Completion Date: *02/29/2024*

Implemented [redacted] - 03/19/2024)

87 - Lighting

18. Requirements

2600.
87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

The exit sign at the bottom of the back ramp is not lit.

The stairwell leading to the 4th floor is not adequately lit.

On 10/31/23 at 10:24 am, the light in room 316 was flickering on and off.

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

Maintenance director inspected all rooms after[redacted] replaced new light bulb in room 316. No residents' rooms are flickering at present. Housekeepers and staff were made aware that as they see any maintenance issues to report to the director so[redacted] can correct immediately. Maintenance director walked the entire community and found [redacted] needed 11 exit signs in order to be in compliance. We ordered 12 new exit signs from Amazon and they should be here the week of the 18th. When they arrive, Maintenace director will replace by 12/21/23. Effective immediately, Maintenance Director will preform random audits on 2-3 units per week, to ensure proper ventilation. Documentation of audit shall be kept.

Directed Plan of Correction:
Within 15 calendar days of the receipt of this plan of correction, the Maintenance Director or designee shall complete an audit all resident accessible areas inside and outside of the of the facility to ensure there is a proper lighting. Any areas of non-compliance shall be corrected within 15 calendar days. Weekly audits shall continue after the initial audit is complete for 4 weeks then monthly thereafter. Documentation of audits and trainings shall be provided and maintained in the home for Department review.

Directed Completion Date: *02/29/2024*

Not Implemented ([redacted] - 03/19/2024)

88a - Surfaces

19. Requirements

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

Description of Violation

On 10/31/23, the carpet on the back ramp was lifting up and posed a tripping hazard. The transition strip at the entrance of the med room was in disrepair and posed a tripping hazard.

On 10/31/23, water was leaking from the ceiling in memory care near rooms 302 and 303. Water was dripping on electrical wires.

On 11/6/23 at 11:33 am, in the library, the ceiling was leaking. There were damaged ceiling tiles and water was being collected in a trash can placed on the floor.

88a - Surfaces (continued)

On 11/6/23, in the storage basement, the room to the left of the entrance had a large puddle of water. The basement ceiling has holes throughout. Paint on the walls was peeling and in disrepair. In the second basement, the ceiling has holes throughout.

On 11/6/23, room 403 had an active leak and room had water pooled on the floor and the carpet in the room was wet.

Plan of Correction ***Accept [redacted] - 01/23/2024)***

Maintenance director spoke to representative from Bluesky Restoration company for an estimate to replace carpeting throughout the community. [redacted] asked for an estimate for standard commercial carpeting. [redacted] was also asked to give roof estimates. Representative Effective immediately, Maintenance Director will preform random audits on 2-3 units per week, to ensure proper ventilation. Documentation of audit shall be kept. Representative explained that [redacted] would have to do a core sample so he could give accurate estimates. Unfortunately, Bluesky cannot come to community until after the new year. He may not--weather depending---be able to go on the roof. Maintenance director was able to reroute the electrical wiring near rooms 302 and 303. In room 403, water was extracted, and housekeeping mopped up all pooled water from on the floor. Housekeeping will notify maintenance director when room needs to be mopped for dryness or should carpet become wet. All staff is to monitor for areas of known leakage due to roofing issues and inform maintenance director of such areas. [redacted] will also spot check weekly to see if any leakage occurs after rain. Room 403 is vacant. Awaiting roof estimates so they can be relayed to the ownership for approval to have work completed. Staff were trained on reporting structure for all physical sight issues on 11/9/ 23, by the health care director.

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

Not Implemented [redacted] - 03/19/2024)

91 - Telephone Numbers

20. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in rooms 103, 109, 215, and 218.

Plan of Correction ***Accept [redacted] 01/23/2024)***

Maintenance Director compiled a list of all resident rooms that needed the emergency telephone list in such rooms. List is now posted at the bedside tables. Moving forward, housekeeping will be responsible to inform maintenance director of any rooms requiring emergency list during their cleaning schedule. Maintenance director will be responsible to attach list to bedside table of rooms requiring emergency list. Rooms 103, 109, 215, and 218 now contain the emergency list. Maintenance director completed this regulation on 11/22/23 in order to ensure compliance. Maintenance director will hold a training with the housekeeping staff by January 31, 2024.

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

Not Implemented [redacted] - 03/19/2024)

92 - Windows

21. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 11/6/23, there was a broken window on the 2nd floor ramp.

Plan of Correction ***Directed [redacted] - 01/23/2024)***

Maintenance director reached a representative from Bluesky Restoration for an estimate on the broken window. Since they are a complete restoration company, they will us of a date as to when they can come to the community and give an estimate on all repairs necessary. Bluesky will be here in then community on December 21, 2023 at 9am and estimates will be forwarded to the home office for approval. All Staff will receive training on report of work order process and what items need reporting, such as, but not limited to broken windows.

Directed Plan of Correction:
In addition to the above plan of correction, within 15 calendar days of the receipt of this plan of correction, the Maintenance Director or designee shall complete an audit all resident accessible areas inside and outside of the of the facility to ensure windows are in good repair. Any areas of non-compliance shall be corrected within 15 calendar days. Weekly audits shall continue after the initial audit is complete for 4 weeks then monthly thereafter. Documentation of audits and trainings shall be provided and maintained in the home for Department review.

Directed Completion Date: *02/29/2024*

Not Implemented [redacted] - 03/19/2024)

93a - Handrails

22. Requirements

2600.
93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

The entrance to the courtyard from the ramp has 1 step and no handrail. Further down the walkway is another step that does not have a handrail. The courtyard is on an incline and there is no handrail leading down the incline.

Plan of Correction ***Directed [redacted] - 01/23/2024)***

Maintenance director reached out to Blusky restoration requesting estimates and timeframes as to when they could come to community and complete this task. Maintenance director does not have equipment to reinforce handrails with the current structural integrity. Representative from Bluesky will be here on 12/21/23 at 9 am for estimates which will be forwarded to our home office for approval. All Staff will receive training on report of work order process and what items need reporting, such as, but not limited to broken windows. All Staff will receive training on report of work order process and what items need reporting, such as, but not limited to broken windows.

Directed Plan of Correction:
In addition to the above plan of correction, within 15 calendar days of the receipt of this plan of correction, the Maintenance Director or designee shall complete an audit all resident accessible areas inside and outside of the of the facility to ensure there is a properly secured handrail/railing at each ramp and stairway. Any areas of non-compliance shall be corrected within 15 calendar days. Weekly audits shall continue after the initial audit is complete for 4 weeks then monthly thereafter. Documentation of audits and trainings shall be provided and

93a - Handrails (continued)

maintained in the home for Department review.

Directed Completion Date: *02/29/2024*

Not Implemented [redacted] - 03/19/2024)

93b - Railings

23. Requirements

2600.
93.b. Each porch must have a well-secured railing.

Description of Violation

There are no handrails on the right hand side of each entrance to the deck which is elevated from the ground.

Plan of Correction ***Directed [redacted] - 01/23/2024)***

Maintenance director reached out to Blusky restoration requesting estimates and timeframes as to when they could come to community and complete this task. Maintenance director does not have equipment to reinforce handrails with the current structural integrity. Representative from Bluesky will be here on 12/21/23 or complete estimates. All Staff will receive training on report of work order process and what items need reporting, such as, but not limited to broken windows.

Directed Plan of Correction:
In addition to the above plan of correction, within 15 calendar days of the receipt of this plan of correction, the Maintenance Director or designee shall complete an audit all resident accessible areas inside and outside of the of the facility to ensure there is a properly secured handrail/railing at each ramp and stairway. Any areas of non-compliance shall be corrected within 15 calendar days. Weekly audits shall continue after the initial audit is complete for 4 weeks then monthly thereafter. Documentation of audits and trainings shall be provided and maintained in the home for Department review.

Directed Completion Date: *02/29/2024*

Not Implemented [redacted] - 03/19/2024)

95 - Furniture and Equipment

24. Requirements

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

Description of Violation

On 10/31/23, the ice maker, garbage disposal, and walk-in freezer in the main kitchen were all out of order.

On 10/31/23, the bathroom sink in room 306 was leaking.

On 10/31/23, the dresser that belongs to resident 3 had a broken drawer.

On 11/6/23, the sump pump in the second basement is covered in duct tape and was out of order. The boiler in this basement had water pooled at the bottom and was flashing an error message indicating that service was required. The exit door in the basement leading outside was rotted and falling apart at the bottom.

95 - Furniture and Equipment (continued)

On 11/6/23, in the first floor courtyard, there were two wood swing chairs that were in disrepair and falling apart.

Plan of Correction ***Directed [redacted] - 01/23/2024)***

Maintenance director replaced the faucet in room 306 on 11/2/23 when [redacted] became aware of the leak. All staff will notify director through a work order when they see maintenance issues so they can be corrected immediately. Housekeeping will report to maintenance director when they clean resident rooms and bathrooms as they see issues. The 2 wooden chairs were removed from the courtyard and thrown in the trash receptacle. The sump pump in the second basement appears to not be in use as it was there since the community was a high school and had a pool. The only items covered in duct tape is the insulation surrounding the water pipes. The maintenance director restarted the program on the interface and ran the diagnostics on that program and the boiler is now operational. There are no error messages currently. We reached out to the restoration company for estimates on windows and doors requiring repair or replacement within our community. Restoration company cannot give estimates until after the new year. The owner is aware of the kitchen equipment that needs repair or replacement. All Staff will receive training on report of work order process and what items need reporting, such as, but not limited to broken windows.

Directed Plan of Correction:
In addition to the above plan, within 15 calendar days of the receipt of this plan of correction, the Maintenance Director or designee shall complete an audit all resident accessible areas inside and outside of the of the facility to ensure furniture and equipment are in good repair. Any areas of non-compliance shall be corrected within 15 calendar days. Weekly audits shall continue after the initial audit is complete for 4 weeks then monthly thereafter. Documentation of audits and trainings shall be provided and maintained in the home for Department review.

Directed Completion Date: *02/29/2024*

Not Implemented ([redacted] - 03/19/2024)

97 - Elevators/Lifting Devices

25. Requirements

2600.
97. Elevators and Stair Glides - Each elevator and stair glide must have a certificate of operation from the Department of Labor and Industry or the appropriate local building authority in accordance with 34 Pa. Code Chapter 405 (relating to elevators and other lifting devices).

Description of Violation

The elevator certificate for Elevator 001 expired 4/30/23.

Plan of Correction ***Accept [redacted] - 12/21/2023)***

Maintenace director placed a telephone call to the Department of Labor and Industry. [redacted] spoke to a lady who was able to confirm the certificate is good until 4/30/25, However, [redacted] was instructed to apply for a duplicate which will cost $30.28. [redacted] was instructed to submit in writing that we needed the necessary paperwork in order to complete so a replacement could be sent. We are in the process of getting the duplicate at this time. Once in hand, it will be copied for our records, and one will be posted for compliance.

Licensee's Proposed Overall Completion Date: *12/13/2023*

Not Implemented [redacted] 03/19/2024)

100a - Exterior - Free of Hazards

26. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 10/31/23, the Secured Dementia Care Unit courtyard had overgrown weeds and the walkways have broken pavement posing a tripping hazard.

On 11/6/23, the first and second floor courtyards had overgrown weeds.

A portion of the home's flat roof is visible from the back of the home. On 11/6/23 there was water pooled on the roof.

On 11/6/23, the outside of the home in the back was in disrepair. There were holes in the stucco, portions of stucco were crumbling and falling off and vent covers were coming off.

Plan of Correction ***Directed (- 01/23/2024)***

Our maintenance director will contact a landscaping company to clear all overgrown weeds in the courtyards by 1/2/24. Bluesky our restoration company as repeated in prior violations will be here for all estimates on 12/21/23. At that time, from Bluesky will give an estimate for the roof repair and holes in the stucco. By 1/1/23 maintenance director will reattach vent covers that are coming off. All Staff will receive training on report of work order process and what items need reporting, such as, but not limited to broken windows.

Directed Plan of Correction:
In addition to the above plan of correction, within 15 calendar days of the receipt of this plan of correction, the Maintenance Director or designee shall complete an audit all resident accessible areas outside of the of the facility to ensure there are no hazardous conditions. Any areas of non-compliance shall be corrected within 15 calendar days. Weekly audits shall continue after the initial audit is complete for 4 weeks then monthly thereafter. Documentation of audits and trainings shall be provided and maintained in the home for Department review.

Directed Completion Date: *02/29/2024*

Not Implemented - 03/19/2024)

101j3 - Bed/Linens/Pillows/Blankets

27. 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

On 10/31/23, the bed for resident 3 had a brown stain that appeared to be feces.

On 11/6/23, the bed for resident 6 had soiled bed linens.

Plan of Correction ***Accept - 01/23/2024)***

Resident #3 had comforter removed on day of survey by Dementia Coordinator. washed and removed the stain and placed the clean comforter back on the bed. informed staff that they are responsible to remove all soiled linens, comforters, pillowcases as they see them ensuring clean linens at all times. Housekeeping will do the same each week as they clean the rooms and change sheets weekly with room cleanings. Resident #6 had 2 housekeepers go to that room and immediately clean the entire room including kitchen, trash, cat's litter box and changed the sheets for this resident. They have a weekly cleaning schedule with includes bed linens being washed

101j3 - Bed/Linens/Pillows/Blankets (continued)

and changed. dementia coordinator and maintenance coordinator and resident care coordinator will spot check to ensure all linens are clean at all times for all residents living in our community. On 11/9/23 by the Health care coordinator with all care manager and med techs on resident care, including but not limited too Adl's, including showers, shaving, nail care.

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

Not Implemented [redacted] - 03/19/2024)

101j7 - Lighting/Operable Lamp

28. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Residents 3, 7, 8, 9, and 10 do not have access to a source of light that can be turned on/off at bedside.

Repeat Violation: 5/17/22 et al., and 1/19/23.

Plan of Correction ***Accept [redacted] - 01/23/2024)***

Resident #3 is in our secure unit. [redacted] continually moves [redacted] belongings throughout [redacted] room and unplugs [redacted] lamp in order to move it. Maintenance director secured a lamp at the head of [redacted] bed mounted to the wall. Resident now has access and cannot remove the light. Staff in the unit will be responsible to see that it remains secure throughout each shift. Housekeeping will also monitor during cleaning schedule. Resident #7 has a floor lamp that needed to be placed closer to [redacted] bed. [redacted] was made aware of this regulation and has accommodated. Housekeeping and nursing staff will check on a daily basis to ensure compliance. Residents #8 and #10 also had wall mounted lamps attached to the wall at the head of their beds to ensure compliance as these residents reside in the secure unit. Resident #9 has a lamp on [redacted] nightstand at the head of [redacted] bed. All rooms will be monitored by housekeeping on a weekly basis as they clean the resident rooms and notify maintenance director if a light is not present. Nursing will notify maintenance director if a light is not present during doing rounds per shift in order to meet compliance of this regulation. 11/9/23 by the HCC with all care manager and med techs on resident care, including but not limited too Adl's, including showers, shaving, nail care.

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

Not [redacted] - 03/19/2024)

101o - Walls, Floors, Ceilings

29. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

The floor in bedroom 303 was bubbling and lifting up posing a tripping hazard.

The carpet in room 409 was stained.

Plan of Correction ***Directed [redacted] - 01/23/2024)***

Room 303 in no longer in service. No resident resides in that room. We are in the process of getting estimates for

101o - Walls, Floors, Ceilings (continued)

rug repairs throughout the community. Room 409 was clean in entirety on 11/7/23 and rug shampooed removing stains immediately after exit interview. Carpets will be cleaned as stains arise. Housekeeping will notify maintenance director if stains exist. Maintenance director will establish a quarterly rotation of carpet cleaning for all rooms containing residents which will be ongoing. Nursing will notify housekeeping or maintenance if a resident's carpet needs immediate attention. 11/9/23 by the HCC with all care manager and med techs on resident care, including but not limited too Adl's, including showers, shaving, nail care.

Directed Plan of Correction:
In addition to the above plan of correction, within 15 calendar days of the receipt of this plan of correction, the Maintenance Director or designee shall complete an audit all resident accessible areas inside and outside of the of the facility to ensure walls, floors and doors are in good repair. Any areas of non-compliance shall be corrected within 15 calendar days. Weekly audits shall continue after the initial audit is complete for 4 weeks then monthly thereafter. Documentation of audits and trainings shall be provided and maintained in the home for Department review.

Directed Completion Date: *02/29/2024*

Not Implemented [redacted] - 03/19/2024)

101r - Bedroom - shades/drapes/window covering

30. Requirements

2600.
101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

The window in bedroom 303 did not have shades, blinds, or shutters.

Plan of Correction ***Directed ([redacted] - 01/23/2024)***

Room 303 is not in current use; however new blinds have been placed in that room while resident resided there. Maintenance director had gone through all occupied rooms and currently all occupied rooms have window coverings on them. Staff will monitor for compliance and inform housekeeping and/or maintenance should a room need window coverings or replacements. 11/9/23 by the HCC with all care manager and med techs on resident care, including but not limited too Adl's, including showers, shaving, nail care.

Directed Plan of Correction:
In addition to the above plan of correction, within 15 calendar days of the receipt of this plan of correction, the Maintenance Director or designee shall complete an audit all resident rooms to ensure windows coverings or shades are present and in good repair. Any areas of non-compliance shall be corrected within 15 calendar days. Weekly audits shall continue after the initial audit is complete for 4 weeks then monthly thereafter. Documentation of audits and trainings shall be provided and maintained in the home for Department review.

Directed Completion Date: *02/29/2024*

Not Implemented [redacted] - 03/19/2024)

103b - Clean/Sanitized Kitchen Surfaces

31. Requirements

103b - Clean/Sanitized Kitchen Surfaces *(continued)*

2600.
103.b. Kitchen surfaces must be of a nonporous material and cleaned and sanitized after each meal.

Description of Violation

On 10/31/23, at 12:36 pm, the steam table in the Secured Dementia Care Unit kitchen was covered in grime and the water used to operate the steam table was cloudy, dirty and had accumulation of food particles and calcification buildup on the walls of the basin.

Plan of Correction ***Accept [redacted] - 12/21/2023)***

On 11/7/2023, Dining Service Director held an Inservice regarding this regulation. The cook was notified after exit interview and immediately went to the secure community and thoroughly cleaned steam table and accumulated food. [redacted] also emptied the cloudy dirty water and replaced with clean water to ensure compliance. Going forward all dining staff will be responsible to empty and clean steam table after each usage. Dining Service Director will spot check a meal daily to ensure this regulation is met. Cook will also spot check after each usage when DSD is unavailable.

Licensee's Proposed Overall Completion Date: *12/07/2023*

Not Implemented [redacted] - 03/19/2024)

103c - Food Protected

32. Requirements

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

Description of Violation

On 10/31/23, in the beverage and desserts refrigerator, there were 2 pitchers of clear liquid that were not covered. In the bistro refrigerator, there was a plastic container of fried chicken that was not covered. In the bistro freezer there was a cup of ice cream that was not covered.

Plan of Correction ***Accept ([redacted] - 01/23/2024)***

Dining Service Director held an inservice on 11/7/23 for all kitchen staff regarding this regulation. Staff were trained on labeling, dating, and covering all open food and liquids. While surveyors were still present, all food was removed that was not labeled or dated. Healthcare coordinator held an inservice regarding this regulation with the nursing department informing them to use the country kitchen for all staff food items. They must also label and date or anything unlabeled and undated will be thrown away. All staff will be responsible to comply with this regulation. Cooks will spot check daily and on a weekly basis the DSD will check all refrigerators. Please see attachment in 103b. 11/9/23 by the HCC with all care manager and med techs on resident care, including but not limited too Adl's, including showers, shaving, nail care.

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

Not Implemented [redacted] - 03/19/2024)

103d - Storing Food Off Floor

33. Requirements

2600.
103.d. Food shall be stored off the floor.

103d - Storing Food Off Floor *(continued)*

Description of Violation

On 10/31/23, six 5-gallon jugs of water were stored on the floor in the third floor hallway. There were twenty 5-gallon jugs being stored on the floor in room 117.

Plan of Correction ***Accept [redacted] - 12/21/2023)***

Maintenance Director removed water from floor after exit interview. [redacted] is aware that food and beverages need to be 6 inches or more from the floor. [redacted] placed the water on palates. DSD was also made aware and will have a staff meeting with all kitchen staff to inform of this regulation on 12/14/23. MD and DSD will be responsible to see compliance is met. All staff will inform MD or DSD if beverages or food in placed on floor. Please see attachment in 103b

Licensee's Proposed Overall Completion Date: *12/07/2023*

Not Implemented [redacted] - 03/19/2024)

103e - Left Overs

34. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There were unlabeled, undated bags of french fries, mozzarella, peppers and onions, and pizza rolls in the home's freezer. Repeat Violation: 5/17/22 et al.

Plan of Correction ***Accept [redacted] - 12/21/2023)***

Dining Service Director held an inservice on 11/7/23 for all kitchen staff regarding this regulation. Staff were trained on labeling, dating, and covering all open food and liquids. While surveyors were still present, all food was removed that was not labeled or dated. Cooks started to label and date freezer foods while surveyors were present. All open foods were thrown away immediately. DSD trained cooks on dating food when received by Sysco. Nothing is to go into freezer w/o having date of delivery. They must also label and date or anything unlabeled and undated will be thrown away. All kitchen staff will be responsible to comply with this regulation. Cooks will spot check daily and on a weekly basis the DSD will check all refrigerators and freezers. Please see attachment in 103b

Licensee's Proposed Overall Completion Date: *12/07/2023*

Not Implemented [redacted] - 03/19/2024)

103f - Refrigerator/Freezer Temps

35. 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

On 10/31/23, the temperature in the bistro freezer was 10 degrees Fahrenheit. The Secured Dementia Care Unit freezer did not have a thermometer. The temperature in the Secured Dementia Care Unit refrigerator was 46 degrees Fahrenheit.

103f - Refrigerator/Freezer Temps (continued)

Repeat Violation: 5/17/22 et al.

Plan of Correction ***Accept [redacted] - 12/21/2023)***

At time of survey, DSD showed surveyor the built in thermometer which regulates the correct temperature. However, on 11/1/23, DSD looked through all refrigerators and freezers and placed thermometers in all that did not have the built in system. Moving forward, cooks and DSD will check temperatures daily to ensure compliance is met with this regulation. DSD will check on a weekly basis to ensure thermometers are still present. Please see attachment in 103b

Licensee's Proposed Overall Completion Date: *12/07/2023*

Not Implemented [redacted] - 03/19/2024)

103g - Storing Food

36. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 10/31/23, there were sandwich rolls and a large bag of croutons in the dry storage area that were opened and unsealed.

Plan of Correction ***Accept [redacted] - 12/21/2023)***

DSD immediately threw the opened and unsealed food away while surveyors were present. On 11/7/23 DSD held a training for all kitchen personnel on this regulation. All kitchen personnel will be responsible to seal food upon opening food. They will also label and date when opening food before it goes on shelf in dry storage. Cooks will monitor for compliance. DSD will monitor and spot check weekly to ensure this regulation in met. Please see attachment in 103b

Licensee's Proposed Overall Completion Date: *12/07/2023*

Not Implemented ([redacted] - 03/19/2024)

103i - Outdated Food

37. Requirements

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

Description of Violation

On 10/31/23, in the beverage and desserts refrigerator, there was a pack of biscuits not labeled and dated.

On 10/31/23, in the main kitchen, there were large bins of rice, sugar, and flour that were not labeled and not dated.

On 10/31/23, in the dry storage area, there were bags of macaroni, spaghetti, egg noodles, lasagna, ½ loaf of bread, 1 pack of soup mix, 1 pack of cake mix, 4 plastic tubs of cereal, bag of powdered sugar, 2 bags of granola, and a bag of peanuts. All not labeled and not dated.

On 10/31/23, the following food items from the emergency food supply were expired: 6 cans of corned beef hash, 3 cans of chicken noodle soup, wheat cereal, and 6 cans of ravioli.

Repeat Violation: 5/17/22 et al, and 1/19/23

Plan of Correction ***Accept [redacted]S - 12/21/2023)***

On 10/31/23, DSD removed and threw away all unlabeled and undated food items while surveyors were present. Since the rice, sugar, and flour just came into the community on 10/25/23, DSD labeled and dated these items. Food had an expiration of 1 month from delivery date. All items in the dry storage were discarded as the DSD was not aware of an exact delivery date. All expired food was removed and discarded after exit interview. Food was reordered on 11/3/23 and replaced by Sysco on 11/8/23. On 11/7/23, DSD held an inservice regarding above regulation. Cooks will be responsible to look for expired, outdated opened and unlabeled food. DSD will spot check for compliance to be met. Please see attachment in 103b

Licensee's Proposed Overall Completion Date: *12/07/2023*

Not Implemented [redacted] - 03/19/2024)

103j - Utensils Cleaning

38. Requirements

2600.
103.j. Eating, drinking and cooking utensils shall be washed, rinsed and sanitized after each use by a method specified in 7 Pa. Code Chapter 46, Subchapter D (relating to equipment, utensils and linen).

Description of Violation

On 10/31/23, the toaster in the main kitchen was not clean. There was a buildup of crumbs in the bottom of the toaster and the outside was greasy.

On 10/31/23, the microwave in the main kitchen was covered in grime on the inside and outside.

On 10/31/23, the toaster in the Secured Dementia Care Unit kitchen that was not clean. There was a large accumulation of crumbs in the bottom.

Plan of Correction ***Accept[redacted] - 12/21/2023)***

After exit interview DSD threw the toaster in the main kitchen away and replaced it with a new one. The servers cleaned the microwave and beverage station on that same day. This was also added to their cleaning log to ensure compliance is met moving forward. Dementia unit toaster was cleaned and will be replaced. On 11/7/23 DSD held an inservice and made staff away that after each usage of beverage area all surfaces must be cleaned and sanitized. Cooks will check that all areas are cleaned and sanitized prior to leaving their shift. On job assignments and cleaning log, it is stated that a cook or supervisor must check the area prior to leaving their shift. DSD will hold cooks and servers accountable for their responsibilities each day. DSD will randomly check for compliance to ensure this regulation is met. Please see attachment in 103b

Licensee's Proposed Overall Completion Date: *12/07/2023*

Not Implemented [redacted] - 03/19/2024)

105f - Labeling/Return of Clothes

39. Requirements

2600.
105.f. Measures shall be implemented to ensure that residents' clothing are not lost or misplaced during laundering or cleaning. The resident's clean clothing shall be returned to the resident within 24 hours after laundering

Description of Violation

The home does not have a system to safeguard resident laundry from loss. On 10/31/23 a bag of unlabeled clothes was found in the third floor laundry room. On 11/17/23, there were bags of unlabeled clothes in the care room in the Secured Dementia Care Unit.

Plan of Correction ***Accept [redacted] - 01/23/2024)***

In review of the above regulation, it was found that the community was holding bags of clothing in the secure unit which belonged to a resident who had moved out. Family did not want these items and staff was not aware they were left behind purposefully. Per the contract, family must remove all possessions, but did not so staff held them. Directors had been inserviced by the Administrator that we do not per our contract hold any items. If they are left behind, family is to be notified to pick them up as we take no responsibility to discard possessions. Our system is in place for residents who live in the community. Clothing will be placed in a laundry bag with the room labeled on them to ensure each individual gets his or her possessions. This regulation will be repeated at our mandatory meeting on 12/14/23. All staff are responsible to get the clothing to the rightful owners as they are removed from their rooms moving forward.11/9/23 by the HCC with all care manager and med techs on resident care, including but not limited too Adl's, including showers, shaving, nail care.

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

Not Implemented [redacted] - 03/19/2024)

105g - Lint Removal and Duct Cleaning

40. 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

On 10/31/23, there was an accumulation of lint in the lint trap of the dryer on the third floor. There were no clothes in the dryer at the time.

On 11/6/23, there was an approximate 2 inch accumulation of lint in the lint trap of the dryer on the first floor. There were no clothes in the dryer at the time.

Plan of Correction ***Accept ([redacted] - 12/21/2023)***

Signage is posted informing staff to clean lint trap after each usage. Staff had been informed of this regulation by healthcare coordinator at a meeting held on 11/22/23. Maintenance director spoke with secure unit coordinator and made [redacted] and [redacted] staff aware of this regulation. Housekeeping and maintenance director will spot check daily to ensure compliance is met. Next monthly all staff meeting will be held on 12/14/23 and staff will be reminded of this regulation.

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

Not Implemented [redacted] - 03/19/2024)

107c - Food/Water 3 Day Supply

41. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 10/31/23, the home did not have a 3-day supply of nonperishable food. The home served 69 residents and had only the following expired food items on hand for the emergency supply: 6 cans of corned beef hash, 3 cans of chicken noodle soup, wheat cereal, and 6 cans of ravioli.
Repeat Violation: 5/17/22 et al.

Plan of Correction ***Accept [redacted] - 12/21/2023)***

On 10/31/23, DSD removed and threw away all unlabeled and undated food items while surveyors were present. All expired food was removed and discarded after exit interview. Food was reordered on 11/3/23 and replaced by Sysco on 11/8/23. On 11/7/23, DSD held an inservice regarding above regulation. Cooks will be responsible to look for expired, outdated opened and unlabeled food. DSD will spot check for compliance to be met. During our daily stand up morning meeting, DSD will obtain the number of residents present and ensure that each individual will have a 3 day supply of food in the emergency area.

Licensee's Proposed Overall Completion Date: *12/07/2023*

Implemented [redacted] - 03/19/2024)

107d - Procedure Emergency Management Agency Submission

42. 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 the local emergency management agency.

Plan of Correction ***Accept ([redacted] - 12/21/2023)***

The home has been through several leadership changes and this regulation had been missed. Moving forward in January, the new executive director will submit the required paperwork certified and return receipt required to the local agency in order to meet compliance. She will also be responsible to have a state compliance book which will show evidence of meeting this regulation.

Licensee's Proposed Overall Completion Date: *12/20/2023*

Not Implemented [redacted] - 03/19/2024)

121a - Unobstructed Egress

43. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 11/6/23, the bedroom door in room 409 could not be opened fully because it was obstructed by trash. This prevented immediate egress from the bedroom. Repeat Violation Date 1/19/23.

121a - Unobstructed Egress *(continued)*

Plan of Correction ***Accept [redacted] - 01/23/2024)***

There were 2 housekeepers in that room cleaning. They were taking cardboard boxes from that room and placing them outside the doorway in order to take them to the trash bin. Both staff and resident were informed that there cannot be any obstruction by the doorway which would prevent immediate egress from the bedroom. Resident was instructed to inform housekeeping as boxes arrive from her orders so they can be removed immediately and not piled up. Housekeeping and maintenance director will check as rooms are cleaned to ensure compliance with this regulation. Maintenance director will hold a training before January 31, 2024 to all staff. Staff will be trained on keeping egress clear from obstructed items, such as boxes. Maintenance director will preform and document random audits, monthly.

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

Not Implemented ([redacted] - 03/19/2024)

124 - Notice to Fire Department

44. 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.

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 [redacted] - 12/21/2023)***

The home has been through several leadership changes and this regulation had been missed. Moving forward in January, the new executive director will submit the required paperwork certified and return receipt required to the local agency in order to meet compliance. [redacted] will also be responsible to have a state compliance book which will show evidence of meeting this regulation. The home does have this information readily available throughout the community for the local fire department and they are aware of its location. However, this information will be formally sent by the ED who will be responsible for regulatory compliance.

Licensee's Proposed Overall Completion Date: *12/20/2023*

Not Implemented [redacted] - 03/19/2024)

125b - Combustible Restrictions

45. Requirements

2600.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

On 11/6/23, a propane tank was unlocked, unattended, and accessible to residents in the 1st floor courtyard.

Plan of Correction ***Accept [redacted] - 01/23/2024)***

On 11/7/23, maintenance director removed the propane from the grill and moved to a location inaccessible to any residents. [redacted] spoke with dining service director so they can coordinate when propane is needed and will be replaced to secure location after usage. It will be the responsibility of the cooks or dining service director to inform

125b - Combustible Restrictions (continued)

maintenance director when not in use. Maintenace director will resume audits when the grill is put back in service.

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

Implemented [redacted] - 03/19/2024)

127a - Portable Space Heaters

46. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

On 11/6/23, there were 2 portable space heaters in the basement storage area.

Plan of Correction ***Accept [redacted] - 01/23/2024)***

The maintenance director removed the space heaters as soon as [redacted] was made aware that they were in the basement storage area. [redacted] had not been aware of their existence as [redacted] was new to the position and did not know they were being stored there. [redacted] did however have a trash receptacle delivered with the intention of clearing that particular area of all unnecessary items. Moving forward, [redacted] is aware that portable space heaters are prohibited in our community to ensure compliance is met with this regulation. Maintenace director will preform a staff training before January 31, 2024 and obtain documentation of training.

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

Not Implemented [redacted] - 03/19/2024)

129a - Fireplace Screens

47. Requirements

2600.
129.a. A fireplace must be securely screened or equipped with protective guards while in use.

Description of Violation

On 10/31/23, the fireplace in the home's Secured Dementia Care Unit unit was not covered with a protective guard.

Plan of Correction ***Accept [redacted] - 12/21/2023)***

Maintenance director did secure the protective guard to the frame around fireplace and placed screws to the base in order to prevent from pulling forward. [redacted] did this on 11/2/23. The staff on the secure unit with monitor to assure screen protector remains in place and will inform maintenance should for any reason it is not in place.

Licensee's Proposed Overall Completion Date: *12/19/2023*

Implemented [redacted] - 03/19/2024)

131f - Fire Extinguisher Inspection

48. 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 extinguishers in the home's van and the bus have not been inspected.

131f - Fire Extinguisher Inspection *(continued)*

Plan of Correction ***Directed [redacted] - 01/25/2024)***

Our maintenance director checked the extinguishers and although they are inspected and in good repair, [redacted] reached out to the fire safety expert to see if [redacted] can stop by and give an official inspection. Maintenance director has also reached out to our local fire chief and asked where extinguishers can be taken for inspection and tags. Invoice is pending payment and approval from home office.

Directed Plan of Correction:
In addition to the above plan of correction, within 15 calendar days of the receipt of this plan of correction, the Maintenance Director or designee shall complete an audit all of all extinguishers in the building. Any areas of non-compliance shall be corrected within 15 calendar days. Weekly audits shall continue after the initial audit is complete for 4 weeks then monthly thereafter. Documentation of audits and trainings shall be provided and maintained in the home for Department review.

Directed Completion Date: *02/29/2024*

Not Implemented [redacted] - 03/19/2024)

162c - Menus Posted

49. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's 2-week menu was not posted in the Secured Dementia Care Unit.

Repeat Violation: 5/17/22 et al.

Plan of Correction ***Accept [redacted] - 12/21/2023)***

After exit interview, the DSD immediately posted menu in our secure community. Going forward DSD or cook in [redacted] absence, will be sure to post the 2-week menu in advance. Dementia Care Coordinator or staff of secure unit will spot check daily to ensure residents do not remove posted menu. This regulation will be reviewed, and staff made aware on 12/14/ 23 at mandatory meeting.

Licensee's Proposed Overall Completion Date: *12/07/2023*

Implemented [redacted] - 03/19/2024)

162e - Menu Changes

50. Requirements

2600.
162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On 10/31/23, there was no fruit, roast beef, cheddar, Swiss, provolone, tuna salad, chicken salad, egg salad, and butter in the home. These items all appeared on the always available menu. The breakfast for 10/31/23 also listed seasonal fruit and it was not served. No notice was provided to the residents in advance of the meal.

162e - Menu Changes *(continued)*

Plan of Correction ***Accept [redacted] - 12/21/2023)***

On 11/1/23, DSD met with administrator, and we updated the always available menu by shortening the items listed to ensure all food on always available menu would be present in the home. All food on new menu was ordered on 11/7/23 and delivered on 11/8/23. Staff was instructed to write on their internal white board anything that is not in house do DSD can order to ensure compliance. On 11/7/23, DSD held an inservice for cooks to be aware should the menu change for any various reason, they must post in a conspicuous area for all residents to be made aware of such change. DSD will check [redacted] menu each week and order accordingly. Should food not be available from purveyor, [redacted] or cook will post accordingly.

Licensee's Proposed Overall Completion Date: *12/07/2023*

Implemented ([redacted] - 03/19/2024)

171b5 - First Aid Kit

51. 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 van does not include an eye covering.
The first aid kit in the bus does not include an eye covering and antiseptic.

Plan of Correction ***Accept [redacted] - 01/23/2024)***

This violation should be removed as the kits were there in entirety in both van and bus. The vehicles had the required items necessary, however, surveyor did not want to thoroughly check and go back to the bus to see that the eye coverings--goggles--were present and on top of the kit when [redacted] pulled the box out from the area it sat. Staff tried to tell [redacted] the coverings were available to no avail. Antiseptic was underneath the gauze and surveyor did not see them. When asked to go and return to the vehicle, [redacted] refused to go. Activities director will audit and document quarterly checks on first aide kit.

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

Not Implemented [redacted] - 03/19/2024)

181d -Storing Medication

52. Requirements

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident 5 self-administers medications and stores medications in his/her room. On 11/6/23, there were several unlocked, unattended medications to include Tylenol and Saline Nasal Spray in resident 3's bedroom.

Resident 6 self-administers medications and stores medications in his/her room. On 11/6/23 and 11/17/23, there were several unlocked, unattended medications to include Tylenol and Clonidine in resident 4's bedroom.

181d -Storing Medication (continued)

Plan of Correction ***Accept [redacted] - 01/23/2024)***

Neither residents #5 nor #3 self medicate. However, resident #5 did have both Tylenol and Saline spray in [redacted] room and it was immediately removed from [redacted] room by our resident care coordinator at time of survey. Since it is an OTC medication family brought it to the resident and did not inform staff. Family and resident were notified that all medications must go through the prescriber. Moving forward residents will be informed of this regulation at the monthly resident council meeting which will be held 3rd week of December. Families will be reminded of this regulation at the next family function. Resident #4 does not self medicate, however resident #6 also had OTC's. They too were removed by the RCC and [redacted]e explained only medication prescribed by the physician and what is on the MAR can be in the community. Healthcare director and Wellness nurse did self-medication assessments with the residents who self-administer and were made aware that all medications must be in a locked compartment. Resident #6 acknowledged this regulation. Moving forward, nurse will do quarterly assessment to ensure residents are capable of self medicating and are aware of this regulation to keep medications locked and secure. If resident is not capable, nursing will resume this responsibility. 11/9/23 by the HCC with all care manager and med techs on resident care, including but not limited too Adl's, including showers, shaving, nail care, medication. Nurse will preform random quarterly audits and document.

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

Not Implemented [redacted] - 03/19/2024)

183b - Meds and Syringes Locked

53. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 11/6/23 at 2:41 pm, the Secured Dementia Care Unit medication room was unlocked, unattended, and accessible. The PRN medication cart was in this room and it was unlocked and there were medications on top of the PRN cart as well.

Plan of Correction ***Accept [redacted] - 01/23/2024)***

Staff was informed that the medication room must be locked at all times when unattended as well as the medication carts which includes prn meds. Healthcare coordinator held a meeting on 11/20/23 at 2pm in the secure dining room reviewing this regulation. The prn medication was removed by the med tech as they belonged to a resident no longer in the community. MT was doing her monthly cart audit. [redacted] was bringing all medications to the pharmacy return box located in the pc med room at the time of the survey. Moving forward, MT's will be responsible to lock all carts when not in use and lock med room when not present. Unit coordinator will spot check to ensure compliance. Please see attachment in 181d. 11/9/23 by the HCC with all care manager and med techs on resident care, including but not limited too Adl's, including showers, shaving, nail care.

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

Not Implemented [redacted] - 03/19/2024)

183d - Prescription Current

54. Requirements

183d - Prescription Current *(continued)*

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 11/17/23, resident 6 had Prevagen in the home. The resident does not have an order for this medication.

Plan of Correction ***Accept [redacted] - 12/21/2023)***

Heathcare coordinator spoke with resident #6 regarding medications in [redacted] room. Since this is an OTC, resident was reminded that [redacted] and family members cannot bring medicines into the community without an physician's order. The Prevagen was removed and discarded. Inservice was held on 11/22/23 by HCC and wellness nurse informing nursing to remove all medications from resident rooms that do not self-medicate. An in-service for all staff will be held on 12/14/23 alerting staff to look in residents' rooms and if medication is found unlocked to bring to the attention of the nursing department. Housekeeping will inform nursing as rooms are cleaned and nursing will report to the HCC when medication is found. Nursing department will spot check all rooms daily. Please see attachment in 181d

Licensee's Proposed Overall Completion Date: *12/13/2023*

Not Implemented [redacted] - 03/19/2024)

183e - Storing Medications

55. 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 11/6/23, there was a loose pill on the first cart drawer in the first floor medication room.

On 11/17/23, there was Insulin Lispro Injection in the refrigerator in the first floor medication room. The medication expired 10/2023.

Repeat Violation: 5/17/22 et al.

Plan of Correction ***Accept [redacted] - 01/25/2024)***

All Med Techs are responsible to go through the cart on each shift as meds are passed. The are to removed all loose pills, remove all expired, and assure all medication has a label and is correctly dated. On Friday 12/15/23, our Med Tech Train the Trainer is coming to do a "Back to Basics" in service with the med techs. Moving forward, med techs will monitor each cart daily after each shift. Resident care coordinator will monitor carts on a weekly basis. HCC will spot check to ensure compliance is met. All outdated medications will be removed from the med carts and refrigerators. Please see attachment in 181d. Nurse or designee, for example, lead med tech, resident care coordinator will preform weekly and spot check cart audits.

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

Not Implemented [redacted] - 03/19/2024)

184a - Resident's Meds Labeled

56. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

On 11/17/23, there was Insulin Lispro Injection in the refrigerator in the first floor medication room that does not have a pharmacy label.

Plan of Correction ***Directed [redacted] - 01/25/2024)***

On 11/22/23, HCC held a nursing meeting and reviewed this regulation. The insulin was removed and discarded on day of survey. Med Techs are aware that all medication must be labeled and dated. On 12/15/23, our medication trainer will be in the community to go over the basic procedures for the med techs. MT's per shift will be responsible to remove all medication that is not labeled on a daily basis. Resident care coordinator will check on a weekly basis to ensure compliance with this regulation. HCC will do random spot checks. Our pharmacy comes in on a monthly basis and switches medications ensure all are label prior to going into med carts. Quarterly pharmacy will come into community and check all carts labeling, dating, and no expired medications. Please see attachment in 181d. Nurse or designee, for example, lead med tech, resident care coordinator will preform weekly and spot check cart audits.

Directed Plan of Correction:
In addition to the above plan of correction, within 7 calendar days of the receipt of this plan of correction, the administrator or designee shall begin a weekly audit of each medication cart. Weekly audits shall continue for 8 weeks, then monthly thereafter. Documentation of audits and trainings shall be provided and maintained in the home for Department review.

Directed Completion Date: *02/29/2024*

Not Implemented [redacted] - 03/19/2024)

185a - Implement Storage Procedures

57. 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

Resident 7 is prescribed Acetaminophen 325 MG and Primatene Mist Inhalation as needed.
On 11/17/23, these medications were not available in the home.

Resident 10 is prescribed Ibuprofen 400 MG, Z-Guard, Diclofenac Gel 1%, and Prochlorperazine 10 MG as needed.
On 11/6/23, these medications were not available in the home.

Repeat Violation Date: 5/17/22 et al.

Plan of Correction ***Directed [redacted] - 01/25/2024)***

Our Healthcare coordinator held Monday meetings with nursing staff as well as set up a "Whats App" for nursing in order to better communicate any changes or updates in the nursing department. This would include medications

185a - Implement Storage Procedures (continued)

needed in the community. Med techs were informed to order medications 7-10 days in advance of running low or out of prescribed medications. A back to basic in-service will be held on 12/15/23 by our medication trainer and [redacted] *will review this regulation. Moving forward, the med tech will be responsible to order meds in advance when they do their daily cart audit after each shift. Resident Care Coordinator will review weekly to be assured all medication per the MARS are in the med cart. HCC will randomly spot check mediations in order to ensure compliance is met. Please see attachment in 181d. Nurse or designee, for example, lead med tech, resident care coordinator will preform weekly and spot check cart audits.*

Directed Plan of Correction:
In addition to the above plan of correction, within 7 calendar days of the receipt of this plan of correction, the administrator or designee shall begin a weekly audit of each medication cart. Weekly audits shall continue for 8 weeks, then monthly thereafter. Documentation of audits and trainings shall be provided and maintained in the home for Department review.

Directed Completion Date: *01/31/2024*

Not Implemented [redacted] ***- 03/19/2024)***

187a - Medication Record

58. 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 7 is prescribed Haloperidol 5 MG, Benzotropine Mes 0.5 MG, Divalproex Sod DR 500 MG, and Cefpodoxime 200 MG. However, the resident's November 2023 medication administration record does not indicate diagnosis or purpose for the medication. The medication administration record is also missing the initials of the staff person who administered medications on 11/17/23 at 8:00 am.

Resident 10 is prescribed Haloperidol. However, the resident's November 2023 medication administration record does not indicate diagnosis or purpose for the medication.

Resident 11's am medications are scheduled to be administered at 8:30am, however, on 11/17/23 at 10:00 am,

187a - Medication Record (continued)

resident's 11's AM medications were administered to the resident.

Plan of Correction ***Directed [redacted] - 01/25/2024)***

Med Techs are aware that no mediation is placed on the MARS without a diagnosis prescribed by a physician. The HCC held a meeting on 11/22/23 informing staff of this regulation. We are conducting a Back to Basics in-service by the medication trainer on 12/15/23 reminding all med techs of proper procedures. If a MT does not have a diagnosis, [redacted] is to contact the physician, pharmacy, resident care coordinator or HCC prior to writing in the MAR to ensure compliance. Please see attachment in 181d. Nurse or designee, for example, lead med tech, resident care coordinator will preform weekly and spot check MAR audit.

Directed Plan of Correction:

In addition to the above plan of correction, within 7 calendar days of the receipt of this plan of correction, the administrator or designee shall begin a weekly audit of each medication cart. Weekly audits shall continue for 8 weeks, then monthly thereafter. Documentation of audits and trainings shall be provided and maintained in the home for Department review.

Directed Completion Date: *02/29/2024*

Not Implemented[redacted] - 03/19/2024)

225c - Additional Assessment

59. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 5's assessment, dated [redacted]/23, does not include the need for a bedside mobility device.

Resident 6's assessment dated [redacted]/23, does not mention the resident's hoarding behavior.

Resident 10's assessment dated [redacted]/23, does not include an accurate mobility assessment.

Plan of Correction ***Accept[redacted] - 01/25/2024)***

Resident #5 had the mobility device removed while the surveyors were present as [redacted] did not have a physician's order to have a mobility device. When resident #6 moved into the community [redacted] did not exhibit hoarding behavior. Over time and with the transition of the HCC resident's behavior increased and it was missed on her RASP. The HCC did place this on the RASP after exit interview. The room was immediately cleaned and cleared by 2 housekeepers following the survey. Resident is aware that [redacted] cannot harbor as many contents in [redacted] room as previously. [redacted] acknowledged [redacted] was aware and would try to adhere to this regulation. Resident #10 resides in the dementia community and dementia coordinator was made aware of this regulation by the HCC. Dementia coordinator did update the mobility assessment. Moving forward, HCC, wellness nurse and resident care coordinator will update all assessments annually and when changes occur. It will be their responsibility to spot check for accuracy and use a tickler system to ensure compliance. On 11/9/23 Training was held on 11/9/23 by the HCC with all care manager and med techs on resident care. including but not limited too Adl's, including showers, shaving, nail care.

225c - Additional Assessment *(continued)*

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

Not Implemented (- 03/19/2024)

234b - Support Plan Needs Elements

60. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated /23, for resident 10 does not address the resident's frequent falls and skin tears.

Repeat Vioaltion Date: 1/19/23.

Accept - 12/21/2023)

Plan of Correction

When Dementia coordinator accepted this role, was unaware of the regulation regarding updating and addressing falls and skin tears as addressed this in the incident reports and monthly skin assessments. was given a copy of the regulatory guide for knowledge and understanding of what is required. Moving forward, dementia coordinator will review all RASPs and ensure all needs are met accordingly. Weekly communication with the HCC will transpire to assure compliance. HCC will randomly spot check.

Licensee's Proposed Overall Completion Date: *12/13/2023*

Not Implemented - 03/19/2024)

251b - Record Entries Legible

61. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on resident 7's November 2023 medication administration record.

Plan of Correction

Accept (- 01/25/2024)

On 12/15/23, our Med Tech trainer will have an in-service on back to basics. will reeducate the MT's so they are aware that correction fluid cannot be used on the MARS. It is the responsibility of each MT to inform resident care coordinator, wellness nurse or healthcare coordinator if correction fluid was used as they pass medicines so they can speak to MT associated with the usage. RCC will do random checks and nurse to weekly review all MARS. Please see attachment in 181d Nurse or designee, for example, lead med tech, resident care coordinator will preform weekly and spot check MAR audit.

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

Not Implemented - 03/19/2024)

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

Facility Information

Name: *GREENFIELD OF PERKIOMEN VALLEY* **License #**: *13735* **License Expiration**: *08/09/2024*

Address: *300 PERKIOMEN AVENUE, SCHWENKSVILLE, PA 19473*

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

Administrator

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

Legal Entity

Name: *GREENFIELD OF PERKIOMEN VALLEY LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/23/2012* **Issued By**: *Borough of Schwenksville*

Staffing Hours

Resident Support Staff: *96* **Total Daily Staff**: *181* **Waking Staff**: *136*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *01/23/2024*

Inspection Dates and Department Representative

01/23/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served**: *57*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Willow* **Capacity**: *44* **Residents Served**: *13*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *57*

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

Have Mobility Need: *28* **Have Physical Disability**: *0*

Inspections / Reviews

01/23/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/12/2024*

Inspections / Reviews *(continued)*

02/07/2024 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/12/2024*

02/07/2024 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/02/2024*

03/20/2024 - Document Submission

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

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

64a - Admin Training

1. Requirements

2600.
64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:

Description of Violation

Following the departure of staff person A, the home's administrator on [redacted] 2024, the home did not have an administrator with the required credentials.

Plan of Correction ***Directed [redacted] - 02/07/2024)***

The community has successfully appointed an Executive Director possessing administrator credentials, who is scheduled to commence duties tentatively on 02/26/2024. VP of Operations will ensure that the community has a required administrator at all times. Additionally, the community is proactively engaged in the recruitment process to secure another qualified individual with administrator credentials, serving as a backup resource to address potential changes or absences. The approximate date by which a backup resource will be secured is 04/01/2024.

Directed Plan of Correction 2/7/24 [redacted]
Only the overall completion date is directed, to 3/1/23 due to the home's circumstances.

Proposed Overall Completion Date: 04/01/2024

Directed Completion Date: *03/01/2024*

Implemented [redacted] - 03/20/2024)

65f - Training Topics

2. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
5. Personal care service needs of the resident.

Description of Violation

Direct care staff persons B and C did not receive training in the following topics for training year 2023:

- *Medication self-administration training*
- *Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan*
- *Personal care service needs of the resident*

Repeat Violation Date: 6/8/23.

Plan of Correction ***Accept ([redacted] - 02/07/2024)***

All direct care staff will be required to undergo Medication Self-Administration training, including training on the Pre-screening form, assessment tool, medical evaluation, and support plan. This training session will be held during the next town hall meeting scheduled for 02/07/2024. The training will be conducted by the Regional Director of Care and Resident Care Coordinator. The Business Office manager will audit all employee files from 2023/2024 to ensure that all direct care staff have the appropriate training per state regulation. To maintain ongoing compliance, the Executive Director and /or designee will conduct a review of staff audits every six months, making corrections as needed to ensure adherence to state regulations.

Proposed Overall Completion Date: 03/01/2024

65f - Training Topics *(continued)*

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

Not Implemented [redacted] - 03/20/2024)

65g - Annual Training Content

3. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Staff persons B and C were not trained in the following areas during training year 2023:

- *Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.*
- *Emergency preparedness procedures and recognition and response to crises and emergency situations.*

Plan of Correction ***Accept ([redacted] - 02/07/2024)***

All staff members are required to undergo training on Fire Safety and Emergency Preparedness Procedures during the upcoming town hall meeting scheduled for 2/6/2024. The training session will be conducted by the Maintenance Director and the Regional Director of Care. Simultaneously, the Business Office Manager will initiate an audit of all current staff files to ensure compliance. This audit will commence on 2/06/2024 and will continue until all staff files have been thoroughly reviewed. Additionally, the Business Office Manager will meticulously review all training logs to confirm the inclusion of all state-mandated trainings on the training calendar. To ensure continuous compliance, the Executive Director and/or designee will conduct a review of the training log every six months, making any necessary corrections to uphold adherence to state regulations and standards.

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

Not Implemented [redacted] - 03/20/2024)

82c - Locking Poisonous Materials

4. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 1/23/2024 at 11:31 am, a container of Suave powder deodorant and a container of Medline Remedy zinc oxide paste, both with manufacturers' labels indicating "If swallowed, get medical help or contact Poison Control Center right away", were unlocked, unattended, and accessible to resident #1 and other residents in room 304. At 11:34 am, there was a jar of sanitizing wipes, unlocked and unattended on a table outside of the Willows kitchenette, with a manufacturer's label indicating "hazardous to humans and domestic animals." Residents of the Willows, the home's secure dementia care unit, including resident #1, have not been assessed as able to safely use or avoid poisonous materials.

Repeat Violation Date: 1/19/23, 5/17/22 et al.

Plan of Correction ***Accept[redacted] 02/07/2024)***

The Regional Director of Care and Memory Care Director will conduct assessments on every resident in the secure

82c - Locking Poisonous Materials (continued)

dementia care unit on 02/06/2024 to evaluate their ability to recognize and use poisons safely. To complement this effort, training on handling poisonous materials and recognizing hazardous substances will be provided by the Maintenance Director during the town hall on
02/06/2024. As part of the implementation of these safety measures, a hazards/poisonous materials form will be devised. This form outlines that all hazards/ poisonous materials are properly lock and stored out of reach from residents. These form has a list of residents room numbers, that the lead medication tech will be responsible for signing off on this daily, submitting it to the Memory Care Director by the end of each shift. The Memory Care Director will maintain the signed forms in a designated binder for the Executive Director and/or their designee to review on a bi-weekly basis, ensuring ongoing adherence to safety protocols.

Proposed Overall Completion Date: 03/01/2024

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

Not Implemented [redacted] - 03/20/2024)

103e - Left Overs

5. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 1/23/2024 at 11:45 am, there were unlabeled, undated containers of pineapples, sponge cake, apple sauce, and mixed fruit in the Willows kitchenette. An unlabeled, undated container of ground meat was in a refrigerator in the main kitchen at 11:51am.

Plan of Correction ***Accept [redacted] - 02/07/2024)***

The Dining Service Director will conduct an inservice on 02/06/2024 for all kitchen staff focusing on the proper handling of leftovers and the correct labeling of food items. The training session will encompass instructions on labeling, dating, and covering all open food and liquids. To enforce and maintain compliance with these guidelines, the Cooks will perform daily spot checks after the initial audit is complete for 4 weeks then monthly thereafter. Additionally, on a weekly basis for 4 weeks then monthly thereafter, the Dining Service Director will conduct thorough inspections of all refrigerators and freezers to ensure that proper labeling, dating, and covering procedures are consistently followed by the kitchen staff is complete.

Proposed Overall Completion Date: 03/01/2024

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

Not Implemented [redacted] - 03/20/2024)

141a - Medical Evaluation

6. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

141a - Medical Evaluation *(continued)*

Description of Violation

The home was unable to provide documentation of a medical evaluation for resident #2.

Plan of Correction ***Accept [redacted] - 02/07/2024)***

The Regional Director of Care is set to initiate an audit of all current resident chart files for the year 2023/2024, with a focus on ensuring compliance with state regulations pertaining to medical evaluations. This comprehensive audit is scheduled to commence on 02/06/2024 and will be completed on 02/08/2024. The audit will identify if residents have a medical evaluation within 60 days prior to admission or within 30 days after admission.. Following the audit, the Regional Director of Care will conduct an in-service session on 02/07/2024 for the Business Office Manager, Marketing, Memory Care Director, and Resident Care Coordinator. This session will emphasize the significance of record-keeping and the proper execution of medical evaluations both prior to admission and upon admission. To sustain continuous compliance, the Executive Director and/or their designee will conduct a review of resident audits every six months. Any required corrections will be made promptly to ensure steadfast adherence to state regulations and the highest standards of resident care.

Proposed Overall Completion Date: 03/01/2024

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

Not Implemented [redacted] - 03/20/2024)

141b1 - Annual Medical Evaluation

7. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

The home was unable to provide documentation of a medical evaluation in the last year for resident #2.

Plan of Correction ***Accept [redacted] - 02/07/2024)***

The Regional Director of Care is set to initiate an audit of all current resident chart files for the year 2023/2024, with a focus on ensuring compliance with state regulations pertaining to annual medical evaluations. This comprehensive audit is scheduled to commence on 02/06/2024 and will completed on 02/08/2024. The audit will identify if the resident has a at least an annual medical evaluation. Following the audit, the Regional Director of Care will conduct an in-service session on 02/07/2024 for the Memory Care Director and Resident Care Coordinator. This session will emphasize the significance of the proper execution of Annual medical evaluations. The community is scheduled to utilize Yardi EHR systems which will automatically populate when a resident's annual assessment is due in March 2024. To sustain continuous compliance, the Executive Director and/or their designee will conduct a review of resident audits every six months. Any required corrections will be made promptly to ensure steadfast adherence to state regulations and the highest standards of resident care.

Proposed Overall Completion Date: 03/01/2024

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

Not Implemented [redacted] - 03/20/2024)

225c - Additional Assessment

8. Requirements

225c - Additional Assessment *(continued)*

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

The most recent assessment provided for resident #2 was completed on [redacted] 2017.

Plan of Correction ***Accept [redacted] - 02/07/2024)***

The Regional Director of Care is set to initiate an audit of all current resident chart files for the year 2023/2024, with a focus on ensuring compliance with state regulations pertaining to annual medical evaluations. This comprehensive audit is scheduled to commence on 02/06/2024 and will completed on 02/08/2024. The audit will identify if the resident has a at least an annual medical evaluation. Following the audit, the Regional Director of Care will conduct an in-service session on 02/07/2024 for the Memory Care Director and Resident Care Coordinator. This session will emphasize the significance of the proper execution of Annual medical evaluations. The community is scheduled to utilize Yardi EHR systems which will automatically populate when a resident's annual assessment is due in March 2024. To sustain continuous compliance, the Executive Director and/or their designee will conduct a review of resident audits every six months. Any required corrections will be made promptly to ensure steadfast adherence to state regulations.

Proposed Overall Completion Date: 03/01/2024

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

Not Implemented [redacted] - 03/20/2024)

227c - Support Plan Revision

9. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

The most recent support plan provided for resident #2 was completed on 12/18/2017.

Plan of Correction ***Accept [redacted] - 02/07/2024)***

The Regional Director of Care is set to initiate an audit of all current resident chart files for the year 2023/2024, with a focus on ensuring compliance with state regulations pertaining to support plan revisions. This comprehensive audit is scheduled to commence on 02/06/2024 and be completed on 02/08/2024. The audit will identify if the resident support plan was revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. Following the audit, the Regional Director of Care will conduct an in-service session on 02/07/2024 for the Memory Care Director and Resident Care Coordinator. This session will emphasize the significance of the proper execution of support plan revisions. The community is scheduled to utilize Yardi EHR systems which will automatically populate when a resident's support plan is due in March 2024. To sustain continuous compliance, the Executive Director and/or their designee will conduct a review of resident audits every six months. Any required corrections will be made promptly to ensure steadfast adherence to state regulations and the highest standards of resident care.

Proposed Overall Completion Date: 03/01/2024

227c - Support Plan Revision *(continued)*

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

Not Implemented [redacted] - 03/20/2024)

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

Facility Information

Name: *GREENFIELD OF PERKIOMEN VALLEY* **License #**: *13735* **License Expiration**: *08/09/2024*

Address: *300 PERKIOMEN AVENUE, SCHWENKSVILLE, PA 19473*

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

Administrator

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

Legal Entity

Name: *GREENFIELD OF PERKIOMEN VALLEY LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/23/2012* **Issued By**: *Borough of Schwenksville*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *73* **Waking Staff**: *55*

Inspection Information

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

Reason: *Complaint, Monitoring* **Exit Conference Date**: *03/06/2024*

Inspection Dates and Department Representative

03/05/2024 - On-Site: [redacted]

03/06/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served**: *51*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *The Willow* **Capacity**: *44* **Residents Served**: *8*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *51*

Diagnosed with Mental Illness: *9* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *22* **Have Physical Disability**: *1*

Inspections / Reviews

03/05/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/06/2024*

04/11/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/04/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/15/2024*

06/03/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/15/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/06/2024*

06/07/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/06/2024*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 3/5/24, at 9:17 am, a Medication Administration Record binder was unlocked, unattended, and accessible near the Health Care Coordinator office.

Plan of Correction ***Accept (- 04/23/2024)***

Resident Care coordinator removed all MARs during non-administration times from above carts and locked inside medication carts on 4/1/2024. Director of Nursing/Resident care coordinator will complete weekly audits of medication carts starting 5/1/2024 for 8 weeks. Medication administration education to be completed by Director of nursing by 5/1/2024 to all medication administration staff.

Licensee's Proposed Overall Completion Date: *05/01/2024*

Not Implemented - 06/07/2024)

18 - Compliance With Laws

2. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

On 9/19/23, the Montgomery County Office of Public Health, cited the kitchen in the home for the following violations, and as of 3/6/24 the these deficiencies have not been corrected:

• 4-301.11- Cooling, Heating, and Holding Capacities- Equipment. The walk-in freezer not operational at time of inspection.
• 4-501.11- Good Repair and Proper Adjustment- Equipment. Ice machine out of service at time of inspection.
• 6-201.12- Floors, Walls, and Ceilings, Utility Line. Ceiling tiles loose throughout kitchen area.

Plan of Correction ***Accept - 04/23/2024)***

Executive Director received quotes on 4/10/24 for freezer repairs. Dietary director will complete daily temperature logs on substitute freezers starting 4/1/2024. Executive director placed ice machine order on 4/5/2024, and received ice machine on 4/8/2024. Maintenance director will properly install ice machine by 5/1/2024. Dietary Director will be educated on proper maintenance request procedures, as well as doing weekly spot checks starting 4/15/2024 for 8 weeks.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Not Implemented - 06/07/2024)

23a - Activities of Daily Living Assistance

3. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated [redacted]/23, for resident 1 indicates the resident requires assistance with toileting and bladder management. On 3/5/24, the resident did not receive this assistance as required. The resident was observed wearing an adult brief that was full of urine.

Plan of Correction ***Directed[redacted] - 04/23/2024)***

Director of nursing will complete ADL training with all wellness staff on 4/17/2024. Resident care coordinator will perform weekly checks to ensure that all ADL's are completed for 8 weeks starting on 4/17/2024. Resident 1 was discharged 4/1/24.

Directed Plan of correction: *In addition to the above POC, the Director of Nursing or designee shall in-service all staff on the location of and following the support plan instructions for each individual resident when providing ADL's to residents. Additionally, the Director of Nursing or designee shall interview random 5 residents weekly for 2 months to assess that residents are receiving care and assistance as required by their support plans. In-service training and resident interviews shall begin within 7 calendar days of the receipt of this POC. Documentation of resident interviews and documentation of the in-service trainings shall be kept and made available for Department review.*

Directed Completion Date: *05/10/2024*

Not Implemented[redacted] - 06/07/2024)

24 - Personal Hygiene

4. Requirements

2600.
24. Personal Hygiene - A home shall provide the resident with assistance with personal hygiene as indicated in the resident's assessment and support plan. Personal hygiene includes one or more of the following:
    1. Bathing.
    2. Oral hygiene.
    3. Hair grooming and shampooing.
    4. Dressing, undressing and care of clothes.
    5. Shaving.
    6. Nail care.
    7. Foot care.
    8. Skin care.

Description of Violation

The assessment and support plan, dated [redacted]/23, for resident 1 indicates the resident requires assistance with overall personal hygiene. On 3/5/24, the resident did not receive assistance as required. The resident smelled of urine and the resident's face was not clean.

24 - Personal Hygiene *(continued)*

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Director of nursing will complete ADL/resident personal hygiene training with all wellness staff on 4/17/2024. Resident care coordinator will perform weekly checks to ensure that all ADL's are completed for 8 weeks starting on 4/17/2024. Resident 1 was discharged [redacted]24. Resident 1 was discharged [redacted]/24.

Directed Plan of correction: *In addition to the above POC, the Director of Nursing or designee shall in-service all staff on the location of and following the support plan instructions for each individual resident when providing ADL's to residents. Additionally, the Director of Nursing or designee shall interview random 5 residents weekly for 2 months to assess that residents are receiving care and assistance as required by their support plans. In-service training and resident interviews shall begin within 7 calendar days of the receipt of this POC. Documentation of resident interviews and documentation of the in-service trainings shall be kept and made available for Department review.*

Directed Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

25b - Contract Signatures

5. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted]/24, for resident 2 was not signed by the resident and administrator.

The resident-home contract, dated [redacted]/22, for resident 3 was not signed by the resident.

Plan of Correction ***Accept ([redacted] - 04/23/2024)***

Business office director will audit current resident-home contracts for appropriate signatures to be completed by 5/15/2024. Business office director will start audits 5/1/2024 and complete monthly audits thereafter, beginning 6/1/24.Resident 2 contract will be signed by the Executive director, resident and payee on 4/12/2024

Licensee's Proposed Overall Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

26b - Quality Management Plan Content

6. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:
1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.

26b - Quality Management Plan Content *(continued)*

5. Resident or family councils, or both, if applicable.

Description of Violation

The home's quality management review dated 2/8/24 did not address licensing violations and plans of correction and resident or family council.

Plan of Correction ***Accept [redacted] - 04/23/2024)***

The executive director will hold the monthly quality management plan starting 5/7/2024 including licensing violations, plan correction and resident council minutes. Executive Director will have monthly sign off sheets starting 5/7/2024

Licensee's Proposed Overall Completion Date: *05/07/2024*

Implemented [redacted] 06/07/2024)

41e - Signed Statement

7. Requirements

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

Description of Violation

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

Resident 3's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept [redacted] - 04/23/2024)***

Business office director will audit current resident-home contracts for signed resident rights and complaint procedures, to be completed by 5/15/2024. Business office director will start audits 5/1/2024 and complete monthly audits, thereafter, beginning 6/1/24. Resident 3 was discharged [redacted]/2024.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

42b - Abuse

8. 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

42b - Abuse (continued)

The home moved residents who were living on the fourth floor due to the water leaking and presence of mold, however their quality of life has been reduced, as they were placed in rooms that are significantly smaller than the rooms they were previously living in. As a result of this, residents are unable to have all their belongings with them. Residents 4 and 5 are living in a shared room that is not big enough for the two of them. Resident 5 is in a motorized wheelchair and is unable to maneuver around the room because there is not enough space. Resident 5 can only come into the room as far as the recliner where the resident sleeps. Resident 5 is not able to take a shower because the opening for the shower is not wide enough for the resident to pull the wheelchair up.

Plan of Correction ***Directed [redacted] 04/23/2024)***

Executive director received estimates on 4/8/2024 to resolve leaks. Executive director removed buckets on 4/10/24 to eliminate the obstruction of hallways and hazardous conditions. Executive director will receive Quotes for mold mitigation for 4th floor rooms with mold by 4/19/2024. Extension cord was removed from basement floor on 4/12/24 by executive director. Resident 4 and 5 have been relocated to room 115 0n 4/12/2024, which is

approximately 450 square feet. Resident 5 receives bed bath according to the care plan dated ..... Maintenance

director will replace all door knobs/locks by 5/15/2024 on all unoccupied rooms in SDCU. Executive director will receive quotes for the unfinished room with exposed wires, wall studs and metal. Executive Director/Business office director started providing updated daily census on 3/27/2024 in morning meeting.

Proposed Overall Completion Date: 05/15/2024

Directed Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

51 - Criminal Background Check

11. Requirements

51 - Criminal Background Check *(continued)*

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

Staff person D started working in the home on [redacted]4. This staff person did not have a criminal background check completed 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).

Repeat Violation: 5/17/22 et al.

Plan of Correction ***Accept [redacted] - 04/23/2024)***

Staff Person D's Criminal background was completed on 4/21/2023, and has no criminal background. Business office Director will audit all current staff for proper criminal backgrounds, and provide dates they were completed by 5/1/2024, and upon new hire.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

57c - 2 Hours/Day

12. 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 2/23/24, there were 52 residents in the home, including 22 residents with mobility needs, requiring a total minimum of 74 hours of direct care service. On this date, only 51 hours of direct care staffing was provided.

On 2/25/24, there were 52 residents in the home, including 22 residents with mobility needs, requiring a total minimum of 74 hours of direct care service. On this date, only 51 hours of direct care staffing was provided.

On 3/3/24, there were 52 residents in the home, including 22 residents with mobility needs, requiring a total minimum of 74 hours of direct care service. On this date, only 44 hours of direct care staffing was provided.

Plan of Correction ***Accept [redacted] - 04/23/2024)***

Executive Director held an education on 4/8/2024 for proper staffing ratios for residents with mobility needs. Executive director holds a daily scheduling meeting which started 4/8/2024, to review current staff, and to discuss our needs. Memory care coordinator will post for agency staff to cover current needs of the facility. Daily schedule checks for correct staffing have started from 4/8/2024 and will continue for 8 weeks by the Memory Care Coordinator.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Implemented [redacted] - 06/07/2024)

57d - Waking Hours

13. 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 2/23/24, a total of 74 hours of direct care was required. However, only 40 of the required hours, or 54 percent, were provided during waking hours.

On 2/25/24, a total of 74 hours of direct care was required. However, only 40 of the required hours, or 57 percent, were provided during waking hours.

On 3/3/24, a total of 74 hours of direct care was required. However, only 40 of the required hours, or 51 percent, were provided during waking hours.

Plan of Correction ***Accept [redacted] - 04/23/2024)***

Executive Director held an education on 4/8/2024 for proper staffing ratios for waking hours. Executive director holds a daily scheduling meeting which started 4/8/2024, to review current staff, and to discuss our needs. Memory care coordinator will post for agency staff to cover current needs of the facility. Daily schedule checks for correct staffing have started from 4/8/2024 and will continue for 8 weeks by the Memory Care Coordinator.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Implemented [redacted] - 06/07/2024)

60c - Housekeeping/Maintenance

14. Requirements

2600.
60.c. Additional staff hours, or contractual hours, shall be provided as necessary to meet the laundry, food service, housekeeping and maintenance needs of the home.

Description of Violation

The home does not have any maintenance staff to meet the needs throughout the home.

Plan of Correction ***Accept ([redacted] - 04/11/2024)***

Hired a maintenance director, starting [redacted]024.

Licensee's Proposed Overall Completion Date: *04/09/2024*

Implemented [redacted] - 06/07/2024)

62 - Contact List

15. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person A, the [redacted] maintains a list of staff persons that does not include dining staff and substitute or agency personnel.

62 - Contact List *(continued)*

Plan of Correction ***Accept [redacted] - 04/11/2024)***

Creation and implementation of updated list for all staff including dining and substitute agency personal created 4/3/2024.

** Provide list of staff members including dining and substitute agency personnel.*

Licensee's Proposed Overall Completion Date: *05/01/2024*

Implemented [redacted] - 06/07/2024)

65a - FS Orientation 1st Day

16. 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 D, whose first day of work was [redacted]/24, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Staff person E, whose first day of work was [redacted]/24, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Staffing coordinator will provide FS 1st day training to all personal starting 4/22/2024 and continue for all new hires on an ongoing basis. Executive director will educate staffing coordinator on FS training on 4/22/2024. Business office director will audit all current staff for FS 1st day training by 5/1/2024. Due to outside staffing fluctuations, staff members D and E will be educated on fire safety by 5/1/2024.

65a - FS Orientation 1st Day (continued)

***Directed Plan of Correction**: In addition to the above plan of correction, the FS 1st day training shall be provided to all agency staff on the first date they are assigned to work in the home. Documentation of agency staff training shall be kept for Department review.*

Directed Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

65b - Rights/Abuse 40 Hours

17. 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 E , whose first day of work was [redacted]/24, 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 ***Directed [redacted]/23/2024)***

Director of Nursing will provide resident right/abuse training to all personal starting 4/22/2024 and continue for all new hires on an ongoing basis. Executive director will educate director of nursing on rights/abuse training on 4/22/24. Business office director will audit all current staff for rights/abuse training by 5/1/2024. Due to outside staffing fluctuations, staff member E will be educated on rights/abuse upon arrival.

***Directed Plan of Correction:** In addition to the above plan of correction, the Director of Nursing or designee shall create a tracking system to document the days/hours that individual agency staff persons are working in the home and shall provide rights, emergency medical plan/OAPSA/reporting of incidents training to all agency staff prior to or by their 40hr worked. Documentation of agency staff training shall be kept for Department review.*

Directed Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

65d - Initial Direct Care Training

18. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.

65d - Initial Direct Care Training *(continued)*

Description of Violation

Direct care staff person D, hired on [redacted]/24, began providing unsupervised ADL services on 3/1/24. However, the staff person did not complete training that included a demonstration of job duties, followed by supervised practice, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test, and the staff person did not complete the following initial direct care staff person training: Safe management techniques, ADLs and IADLs, Personal hygiene, Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities, The normal aging-cognitive, psychological and functional abilities of individuals who are older, Implementation of the initial assessment, annual assessment and support plan, Nutrition, food handling and sanitation, Recreation, socialization, community resources, social services and activities in the community, Gerontology, Staff person supervision, if applicable, Care and needs of residents with special emphasis on the residents being served in the home, Safety management and hazard prevention, Universal precautions, The requirements of this chapter, Infection control, Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Direct care staff person E, hired on [redacted]/24, began providing unsupervised ADL services on 2/19/24. However, the staff person did not complete training that included a demonstration of job duties, followed by supervised practice, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test, and the staff person did not complete the following initial direct care staff person training: Safe management techniques, ADLs and IADLs, Personal hygiene, Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities, The normal aging-cognitive, psychological and functional abilities of individuals who are older, Implementation of the initial assessment, annual assessment and support plan, Nutrition, food handling and sanitation, Recreation, socialization, community resources, social services and activities in the community, Gerontology, Staff person supervision, if applicable, Care and needs of residents with special emphasis on the residents being served in the home, Safety management and hazard prevention, Universal precautions, The requirements of this chapter, Infection control, Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Plan of Correction ***Accept [redacted] - 04/23/2024)***

Director of nursing will complete ADL training with all wellness staff on 4/17/2024. Resident care coordinator will perform weekly checks to ensure that all ADL's are completed for 8 weeks starting on 4/17/2024 for safety to 6/19/24, and as needed. Due to outside staffing fluctuations, staff member E and D will be educated on ADL Training upon arrival of next shift.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

65e - 12 Hours Annual Training

19. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person F received only 2.5 hours of annual training in training year 2023.

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Staff member F received 8 hours of annual training related to job duties on 4/10/24. On 4/17 staff member F will

65e - 12 Hours Annual Training (continued)

receive 2 hours of annual training related medication administration, incident reporting and other job duties. Staff member F will receive 3 hours of Insulin training on 4/26/2024. Resident care coordinator will audit all 12 hours annual training for staff members by 5/1/2024.

Directed Plan of Correction: *Within 15 business days of the receipt of this POC, the administrator or designee shall create a tracking system to be used to monitor staff training throughout the training year. The system shall be updated on a monthly basis to ensure that staff are receiving training in conjunction with the homes designated annual staff training plan. Documentation of trainings, tracking system and training plan shall be kept and made available for Department review.*

Directed Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

65f - Training Topics

20. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

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

Description of Violation

Direct care staff person F did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques , care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2023.

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Director of nursing will complete ADL training with all wellness staff on 4/17/2024. Resident care coordinator will perform weekly checks to ensure that all ADL's are completed for 8 weeks starting on 4/17/2024. Medication administration education/Infection control to be completed by Director of nursing by 5/1/2024 to all medication administration staff. Dementia/ IDD /Mental illness training to be completed by outside healthcare agency by 5/1/2024

Directed Plan of Correction*: Within 15 business days of the receipt of this POC, the administrator or designee shall create a tracking system to be used to monitor staff training throughout the training year. The system shall be updated on a monthly basis to ensure that staff are receiving training in conjunction with the homes designated annual staff training plan. Documentation of trainings, tracking system and training plan shall be kept and made available for Department review.*

65f - Training Topics *(continued)*

Directed Completion Date: *05/10/2024*

Not Implemented ([redacted] - 06/07/2024)

65g - Annual Training Content

21. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person F did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention during training year January 2023 to December 2023.

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Annual fire safety training education for all staff will be held on 4/18/2024 by fire and life safety company. Executive director will hold emergency preparedness, resident rights, older adult protective services act Inservice by 4/17/2024. Director of nursing will hold education on 4/17/2024 for falls and accident prevention and new population groups. Resident care coordinator will audit annual trainings for staff by 5/1/2024

Directed Plan of Correction: Within 15 business days of the receipt of this POC, the administrator or designee shall create a tracking system to be used to monitor staff training throughout the training year. The system shall be updated on a monthly basis to ensure that staff are receiving training in conjunction with the homes designated annual staff training plan. Documentation of trainings, tracking system and training plan shall be kept and made available for Department review.

Directed Completion Date: *05/10/2024*

Not [redacted] - 06/07/2024)

81a - Accomodation

22. Requirements

2600.
81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Description of Violation

Resident 9's bed is equipped with a bedside mobility device. The device has an opening of approximately 9 inches

81a - Accomodation (continued)

wide an 7 inches high. It has another opening of approximately 17 3/4 inches wide by 16 inches high. Both openings exceed the FDA guidelines for areas of entrapment. The device was not covered.

Plan of Correction ***Accept ([redacted] - 04/23/2024)***

Executive director removed bedside mobility device from resident 9's bed on 3/29/2024. Director of nursing will re-assess for residents need for a mobility device and update the care plan by 4/26/2024. Resident Care coordinator will do weekly checks for mobility devices within the home for 8 weeks starting 4/22/2024, and as needed.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

82c - Locking Poisonous Materials

23. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 3/5/24, a bottle of Febreeze and a can of Lysol, were unlocked, unattended, and accessible to residents in room [redacted] in the Memory Care Unit. Not all the residents of the home, have been assessed capable of recognizing and using poisons safely.

Repeat Violation: 5/17/22 et al.

Plan of Correction ***Directed [redacted] /23/2024)***

Memory care coordinator discarded Febreeze and Lysol on 3/6/2024. Memory care coordinator will be educated by the executive director on utilizing the MSDS material by 4/22/2024. Memory Care coordinated will begin weekly room audits for 8 weeks to ensure all poisonous materials are secured.

***Directed Plan of Correction**: Within 7 business days of the receipt of this POC, the administrator or designee shall in-service all staff on the proper procedures for poisons in the home. Training should include how to identify poisons and what is/is not permitted to be accessible to residents who are not assessed as capable of safely using poisons, and what to do if they observe unlocked poisons. Documentation of trainings, and weekly room audits shall be kept and made available for Department review.*

Directed Completion Date: *05/10/2024*

Not Implemented [redacted] 06/07/2024)

85a - Sanitary Conditions

24. Requirements

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

Description of Violation

On 3/5/24, there was an opened Ensure bottle with a straw in the Memory care medication refrigerator. There were spills and food particles inside the door and at the bottom of the refrigerator in memory care nursing station where narcotics and Ensure bottles are stored.

85a - Sanitary Conditions (continued)

On 3/5/24 at 2:12 pm, staff person C was observed using bare, ungloved fingers to remove the medication from the blister cards to put the medication into a small cup during a medication pass.

On 3/5/24 and 3/6/24, there was an opened box of egg rolls in the medication refrigerator in the Personal Care medication room.

On 3/5/24 There is large area of what appears to be black mold on the walls in several areas of room [redacted]

Plan of Correction ***Accept*** [redacted] ***- 04/23/2024)***

The resident care coordinator discarded the opened ensure bottle and box of egg rolls on 3/6/2024, as well as wiping the inside of medication refrigeration down with sanitary wipes. Director of nursing will start weekly cart/medication refrigeration audit starting 4/22/2024 through 6/17/2024, and continue monthly audit thereafter. Director of nursing will educate medication technicians on how to properly administrate medications from blister packs in a safe, sanitary manner on 4/17/2024. Executive director will receive Quotes for mold mitigation for 4th floor rooms with mold by 4/19/2024.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Implemented [redacted] ***- 06/07/2024)***

85d - Trash Receptacles

25. 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 3/5/24, there was an uncovered, unattended trash can in the kitchen in Memory Care.

Plan of Correction ***Directed*** [redacted] ***- 04/23/2024)***

Executive director Covered trash can in the kitchen of the memory care unit on 3/6/2024 to prevent penetration of insect and rodents. Dietary director will complete daily trash lid checks in Memory care starting 4/22/2024 for 4 weeks, and then continue weekly checks thereafter starting 6/1/2024.

Directed Plan of Correction*: In addition to the above POC, and within 15 business days, the administrator or designee shall provide an in-service to staff of the home on the importance covered trash cans in the kitchen and throughout the home where applicable. Documentation of the in-service trainings and weekly checks shall be kept and made available for Department review.*

Directed Completion Date: *05/10/2024*

Not Implemented [redacted] ***- 06/07/2024)***

88a - Surfaces

26. Requirements

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

88a - Surfaces *(continued)*

Description of Violation

Water is leaking from the ceilings in the hallway outside rooms 109, 114, 219, and 220.

The carpet throughout the Memory Care area has mildew stains.

Plan of Correction ***Accept [redacted] - 04/23/2024)***

Executive director received estimates on 4/8/2024 to resolve leaks. Executive director removed buckets on 4/10/24 to eliminate the obstruction of hallways and hazardous conditions. Maintenance director will complete weekly ceiling checks outside of the rooms 109, 114, 219 and 220 for 8 weeks starting 4/22/2024.Weekly carpet cleaning will start on 4/22/2024 by housekeeping staff and continue on a as need basis.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

95 - Furniture and Equipment

27. Requirements

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

Description of Violation

The locks on the doors of rooms 304, 306, 308, and 321 are broken.

On 3/5/24, the thermostat in the Memory Care dining room was not working.

Plan of Correction ***Accept [redacted] - 04/23/2024)***

Maintenance director will replace locks on room 304,306,308 and 321 by 5/1/2024. Executive director will receive quotes for thermostat to be fixed or replaced by 5/1/2024. Maintenance director will do weekly thermostat checks throughout the building starting 4/22/2024 for 8 continuous weeks.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

96a - First Aid Kit

28. 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 Nursing station does not include antiseptic, adhesive bandages, thermometer, scissors, breathing shield, eye coverings, and tweezers.

The first aid kit in Personal Care did not include disposable gloves, antiseptic, adhesive bandages, thermometers, breathing shield, eye coverings, tweezer, and the scissors

96a - First Aid Kit (continued)

Plan of Correction ***Accept [redacted] - 04/11/2024)***

All first aid kits will be properly stocked with nonporous gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye covering and tweezers. Weekly First aid kits will be completed by resident care coordinator for 3 weeks starting 4/8/2024., then become monthly checks starting. 5/1/2024.

**Weekly First aide audit sheets will be kept in POC Binder.*

Licensee's Proposed Overall Completion Date: *05/01/2024*

Implemented [redacted] - 06/07/2024)

101c - Bedroom Mobility Needs

29. Requirements

2600.
101.c. Each bedroom for one or more residents with a mobility need must have at least 100 square feet per resident, to allow for easy passage between beds and other furniture, and for comfortable use of a resident's assistive devices, including wheelchairs, walkers, special furniture or oxygen equipment. This requirement does not apply if there is a medical order from the attending physician that states the resident can maneuver without the necessity of the additional space. A legal entity with a personal care home license for the home as of October 24, 2005, that has one or more bedrooms serving a resident with physical mobility needs as of October 24, 2005, shall be exempt from the requirements specified in this subsection for the bedroom. If a bedroom is exempt in accordance with this subsection, additional square footage may be required sufficient to accommodate the assistive devices of the resident with mobility needs.

Description of Violation

Bedroom [redacted] is occupied by 2 residents including 1 resident who uses a motorized wheelchair requiring a minimum total of 160 square feet. However, the bedroom only measures 88 square feet.

Plan of Correction ***Accept [redacted] - 04/23/2024)***

The executive director moved the residents that occupied room [redacted] to room [redacted] on 4/12/2024, which is approximately 450 square feet. Maintenance director will audit current double occupancy rooms to verify they all meet the minimum 100 square feet by 5/1/2024.

Licensee's Proposed Overall Completion Date: *05/01/2024*

Not Implemented [redacted] - 06/07/2024)

101o - Walls, Floors, Ceilings

30. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

The wall in bedroom 320 is unfinished and has exposed metal studs and exposed wires.

The wall in bedroom 312 is cracked and there is a hole in the ceiling.

101o - Walls, Floors, Ceilings *(continued)*

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Executive director will receive quotes for renovations of room [redacted] by 5/1/24. Maintenance director will start cleaning and repairs in room [redacted], and provide check list for items that need completed by 5/1/24.

Directed Plan of Correction: *In addition to the above POC, and within 15 business days, the administrator or designee shall a weekly audit of resident rooms to ensure all walls, floors, ceilings, and surfaces are clean and in good repair. Any area of non-compliance identified shall have a repair work order placed and shall be repaired within a reasonable amount of time according to the home's maintenance/repair policies. Documentation of the weekly checks and identified areas of concern and the repair shall be kept and made available for Department review.*

Directed Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

103d - Storing Food Off Floor

31. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 3/5/24, there was a box of potatoes stored on the floor of the walk-in refrigerator.

Plan of Correction ***Accept [redacted] - 04/23/2024)***

Executive Director removed 5-gallon bottles of water off of the floor on 3/5/2024 and relocated them to 117 stored off the floor. Director of dining removed box of potatoes that were stored on the walk-in refrigerator floor on 3/5/2024. Executive director placed table next to water dispenser for proper water storage on 3/5/2024. Director of dining will educate dietary staff on 4/19/2024 for proper storage of food and start weekly checks storage checks starting 4/22/2024.

Licensee's Proposed Overall Completion Date: *04/22/2024*

[redacted] - 06/07/2024)

103e - Left Overs

32. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

103e - Left Overs *(continued)*

Description of Violation

On 3/5/24, there was an unlabeled, undated container of chicken and rice in the refrigerator in Memory Care.

Plan of Correction ***Directed ([redacted] - 04/23/2024)***

Memory care coordinator discarded the food on 3/5/2024. Memory care coordinator will do daily checks starting 4/22/24 for food that is not labeled or dated and continuing daily checks thereafter. Dietary director will educate Memory care coordinator on dating and labeling leftover foods within the memory care refrigerator on 4/19/2024

Directed plan of correction: *In addition to the above POC, within 15 business days of the receipt of this POC, education on labeling and dating left over food items shall be provided to all staff of the home. Documentation of the in-service trainings shall be kept and made available for Department review.*

Directed Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

103i - Outdated Food

33. Requirements

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

Description of Violation

There was an unlabeled, undated peeled tangerine, pudding, and applesauce in the Memory Care refrigerator.

Repeat Violation: 5/17/22 et al.

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Memory care coordinator discarded the food on 3/5/2024. Memory care coordinator will do daily checks starting 4/22/24 for food that is not labeled or dated and continuing daily checks thereafter. Dietary director will educate Memory care coordinator on dating and labeling all foods within the memory care refrigerator on 4/19/2024.

Directed plan of correction*: In addition to the above POC, within 15 business days of the receipt of this POC, education on labeling and dating left over food items shall be provided to all staff of the home. Documentation of the in-service trainings shall be kept and made available for Department review.*

Directed Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

131f - Fire Extinguisher Inspection

34. 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 kitchen has not been inspected by a fire safety expert.

131f - Fire Extinguisher Inspection *(continued)*

Plan of Correction ***Accept (- 04/23/2024)***

Keystone fire and safety will inspect the kitchen fire extinguisher on 4/25/24. Maintenance director will do monthly fire extinguisher checks to ensure compliance starting 5/1/2024 indefinitely.

Licensee's Proposed Overall Completion Date: *05/01/2024*

Not Implemented - 06/07/2024)

141a 1-10 Medical Evaluation Information

35. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 2's medical evaluation dated /24 did not include special health or dietary needs of the resident, health status.

Resident 3's medical evaluation dated /23 did not include health status.

Plan of Correction ***Accept - 04/23/2024)***

Director of nursing educated Executive director, Resident Care Coordinator, Business office director and Memory Care Coordinator on proper DME technique on 4/4/2024. Resident 2's medical evaluation will be completed by the Director of nursing by 5/1/2024. Resident 3 was discharged on February 29th 2024. Resident care coordinator will perform monthly chart audits beginning 5/1/2024. Director of nursing completed chart audit on 4/12/202

Licensee's Proposed Overall Completion Date: *05/01/2024*

Not Implemented - 06/07/2024)

141b1 - Annual Medical Evaluation

36. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident 10's most recent medical evaluation was completed on /23.

Plan of Correction ***Directed - 04/23/2024)***

Resident 10 deceased on 024. Executive director received death certificate by 5/1/2024.

141b1 - Annual Medical Evaluation (continued)

***Directed Plan of Correction**: Within 15 business days, the Director of Nursing or designee shall audit all current resident files to ensure resident have a completed annual DME on file. Any resident identified to have a missing annual DME shall have an evaluation scheduled with their PCP and a DME shall be completed within 30 calendar days. Education shall be provided to staff responsible resident files within 5 calendar days of the initial audit completion. A system to track DME due dates shall be in use after the initial audit to ensure that ongoing compliance with annual DME's can be maintained. Documentation of audit and tracking system shall be kept any made available for Department review.*

Directed Completion Date: *05/01/2024*

Not Implemented [redacted] - 06/07/2024)

171c - Home's Vehicle Documents

37. Requirements

2600.
171.c. The home shall maintain current copies of the following documentation for each of the home's vehicles used to transport residents:
3. Vehicle insurance.

Description of Violation

The home does not have a copy of vehicle insurance for the bus used to transport residents.

Repeat Violation: 5/17/22 et al.

Plan of Correction ***Accept [redacted] - 04/23/2024)***

Executive director spoke with regional for insurance cards on 4/9/2024 for the bus that transport residents. The updated insurance will be received by 5/1/2024 and the copy will be placed in the bus. Activity director will do monthly checks for proper vehicle documentation starting 5/1/2024 for 4 months.

Licensee's Proposed Overall Completion Date: *05/01/2024*

Implemented [redacted] - 06/07/2024)

183f - Discontinued Medications

39. 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

Acetaminophen Tab 325mg belonging to resident 11 expired January 2024. The medication was still in the home.

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Resident care coordinator destroyed resident 11's expired meds on 3/5/2024.Resident care coordinator will complete weekly audits of medication carts starting 5/1/2024 for 8 weeks and continues thereafter.

183f - Discontinued Medications (continued)

Directed Plan of Correction: *In addition to the above POC, the administrator or designee shall provide education to all medication trained staff on the homes medication policies including proper storage procedures and the medication cart audit process. Education shall begin within 15 business days of receipt of this POC and shall continue until all current medication trained staff have received training. Documentation of the education and completed weekly audits shall be kept and made available for Department review.*

Directed Completion Date: *05/01/2024*

Not Implemented ([redacted] - 06/07/2024)

184a - Resident's Meds Labeled

40. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident 12's Mirtazapine 15mg does not include a pharmacy label.

Plan of Correction ***Directed ([redacted] - 04/23/2024)***

Resident care coordinator destroyed resident 12's expired meds on 3/5/2024.Resident care coordinator will complete weekly audits of medication carts starting 5/1/2024 for 8 weeks and continues thereafter. Medication administration education for staff occurred on 4/10/24, including proper labeling of resident's medications.

Directed Plan of Correction: *In addition to the above POC, the administrator or designee shall provide education to all medication trained staff on the homes medication policies including proper storage procedures and the medication cart audit process. Education shall begin within 15 business days of receipt of this POC and shall continue until all current medication trained staff have received training. Documentation of the education and completed weekly audits shall be kept and made available for Department review.*

Directed Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

184b - Labeling OTC/CAM

41. 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 3/5/24, a package of Biofreeze Gel 4% belonging to resident 13 was in the medication cart and was not labeled with the resident's name.

Plan of Correction ***Directed ([redacted] - 04/23/2024)***

Resident care coordinator labeled resident 13's medication packaging on 3/5/2024. Resident care coordinator will

184b - Labeling OTC/CAM (continued)

complete weekly audits of medication carts starting 5/1/2024 for 8 weeks and continues thereafter. Medication administration education for staff occurred on 4/10/24, including proper labeling of resident's medications.

Directed Plan of Correction: *In addition to the above POC, the administrator or designee shall provide education to all medication trained staff on the homes medication policies including proper storage procedures and the medication cart audit process. Education shall begin within 15 business days of receipt of this POC and shall continue until all current medication trained staff have received training. Documentation of the education and completed weekly audits shall be kept and made available for Department review.*

Directed Completion Date: *05/01/2024*

Not Implemented [redacted] - 06/07/2024)

185a - Implement Storage Procedures

42. 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 3/5/24 at 2:07pm, Resident 13's glucometer was not calibrated to the correct time. The glucometer was set to 3/5/24 at 7:39am.

On 3/5/24 at 1:49 am, Resident 14's glucometer was not calibrated to the correct time. The glucometer was set to 3/5/24 at 12:19pm.

On 3/5/24 at 1:56pm, Resident 15's glucometer was not calibrated to the correct time. The glucometer was set to 3/5/24 at 12:28pm.

3/2/24 at 12:46pm, Resident 15's blood glucose reading was 226. However, it was not documented on the Medication Administration Record.

3/2/24 at 8:26am, Resident 15's blood glucose reading was 129. However, it was not documented on the Medication Administration Record.

3/1/24 at 5:22pm, Resident 15's blood glucose reading was 193. However, it was documented as 197 on the Medication Administration Record.

Repeat Violation: 5/17/22 et al.

Plan of Correction ***Directed [redacted] 04/23/2024)***

Director of nursing completed glucometer calibration on 4/1/2024. Resident care coordinator will complete weekly audits of medication carts starting 5/1/2024 for 8 weeks and continues thereafter. On 4/17 all wellness staff will receive 2 hours of annual training related medication administration.

Directed Plan of Correction: *In addition to the above POC, the administrator or designee shall provide education to all medication trained staff on the homes medication policies including glucometer use and glucose documentation, proper storage procedures and the medication cart audit process. Education shall begin within 15 business days of receipt of this POC and shall continue until all current medication trained staff have received training. Documentation of the education and completed weekly audits shall be kept and made available for Department review.*

185a - Implement Storage Procedures *(continued)*

Directed Completion Date: *05/10/2024*

Not Implemented ([redacted] - 06/07/2024)

187a - Medication Record

43. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident 7 is prescribed various medications including Divalproex Sod DR 500 MG, Haloperidol 5 MG Tab, and Benztropine Mes 0.5 MG. However, resident's December 2023 medication administration record does not indicate diagnosis or purpose for the medications, including pro re nata (PRN).

Plan of Correction ***Directed ([redacted] - 04/23/2024)***

Resident 7 was discharged [redacted] 2024. Director of nursing completed chart audit on 4/12/2024.

Directed Plan of Correction: *Within 7 calendar days of the receipt of this POC, the administrator or designee shall audit all current resident MARS to ensure purpose or diagnosis is listed for all resident's medications. The administrator or designee shall provide education to all medication trained staff on the homes medication policies including proper MAR documentation and procedures and the medication cart audit process. Education shall begin within 15 business days of receipt of this POC and shall continue until all current medication trained staff have received training. Documentation of the education and completed weekly audits shall be kept and made available for Department review.*

Directed Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

187b - Date/Time of Medication Admin.

44. 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 3/5/24 at 1:32pm, a staff initialed that [redacted] administered Donepezil tab 10mg and Eliquis tab 2.5mg to resident 1 on 3/5/24 at 8pm.

Resident 16 is prescribed Budesonide 0.5mg, Citalopram tab 20mg, Ipratropium, Irbesartan tab 300mg, Loratadine tab 10mg, Montelukast tab 10mg, and Simvastatin tab 10mg. Resident 16's March 2024 medication administration record does not include the initials of the staff person who administered these medications on 3/3/24 at 4:30pm, 8:00pm, and 9:00pm.

187b - Date/Time of Medication Admin. *(continued)*

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Medication administration education for staff occurred on 4/10/24

Directed Plan of Correction: *In addition to the above information, and beginning within 7 calendar days of the receipt of this POC, the administrator or designee shall audit resident MAR's weekly for 6 weeks to ensure staff are documenting the administration of medications correctly. Documentation of the completed audits shall be kept and made available for Department review.*

Directed Completion Date: *05/01/2024*

Not Implemented [redacted] - 06/07/2024)

187d - Follow Prescriber's Orders

45. Requirements

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

Description of Violation

Resident 17 is prescribed Calprotect Ointment, apply topically to buttocks twice a day. However, this medication was not administered to resident 17 on 3/4/24 from 11pm-7am because the medication was not available in the home.

Plan of Correction ***Directed [redacted] 04/23/2024)***

Resident care coordinator will complete weekly audits of medication carts starting 5/1/2024 for 8 weeks and continues thereafter. Resident 10 deceased on [redacted]/2024. Resident number 11's Duloxetine HCL 60mg was discontinued on 2/24/24. Resident 17 prescribed calprotect is currently in home as of 4/14/2024.Resident care coordinator will complete weekly audits of medication carts starting 5/1/2024 for 8 weeks and continues there after.

Directed Plan of Correction: *In addition to the above POC, the administrator or designee shall provide education to all medication trained staff on the homes medication policies including proper documentation, storage procedures, and the medication cart audit process. Education shall begin within 15 business days of receipt of this POC and shall continue until all current medication trained staff have received training. Documentation of the education and completed weekly audits shall be kept and made available for Department review.*

Directed Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

190a - Completion Medication Course

46. Requirements

2600.

190a - Completion Medication Course *(continued)*

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

Medication administration training was not properly done for all the medication technicians in the home because the person who observed the annual practicum had a practicum observer certification that expired in 6/6/22.

Plan of Correction ***Accept [redacted] - 04/23/2024)***

On 3/22/24, 4 Med techs were recertified by a person with a current observer certification. On 4/10/2024, the remainder of our med techs were re-certified by the same person with current observer certification. Director of nursing will do monthly certification audits starting 5/1/2024 for 4 months.

Licensee's Proposed Overall Completion Date: *05/01/2024*

Not Implemented [redacted] - 06/07/2024)

190b - Insulin Injections

47. Requirements

2600.

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

Description of Violation

Staff persons B, C, F, and G, who have not successfully completed the Department-approved medications administration course, administered insulin to residents.

Plan of Correction ***Accept [redacted] - 04/23/2024)***

Staff Person B, C, F and G will successfully complete the department-approved medication course, insulin administration to residents on 4/26/2024. Director of nursing will do monthly certification audits starting 5/1/2024 for 4 months.

Licensee's Proposed Overall Completion Date: *05/01/2024*

Not Implemented [redacted] - 06/07/2024)

191 - Resident Right to Refuse

48. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident 2, admitted [redacted]/24, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident 3, admitted [redacted]22, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

191 - Resident Right to Refuse *(continued)*

Plan of Correction ***Accept [redacted] - 04/23/2024)***

Executive director and resident 2 completed/signed new contract on 4/12/2024 which entails the right to refuse medication. Resident 3 was discharged on 2/29/24. Business office director will audit all current residents for signed/updated resident right contracts starting 4/22/2024, and continue monthly audits thereafter.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

224a - Preadmission Screen Form

49. 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.

Description of Violation

Resident 2 was admitted to the home on [redacted]/24; however, there was no preadmission screening form completed.

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Director of nursing educated Executive director, Resident Care Coordinator, Business office director and Memory Care Coordinator on proper DME technique on 4/4/2024. Director of nursing completed chart audit on 4/12/2024

Directed Plan of Correction: *Education to be provided to Executive Director, Resident Care Coordinator, Business Office Director and Memory Care Coordinator on the proper process for Pre-Admission screening forms. within 14 business days of the receipt of this POC. Documentation of education shall be kept and made available for Department review.*

Directed Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

225a - Assessment 15 Days

50. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for resident 2, who was admitted to the home on [redacted]/24.

Resident 9's current assessment does not include the resident's need for a bedside mobility device.

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Director of nursing will complete assessment for resident 2 and 9 by 5/1/2024. PT will evaluate resident number 9 for bedside mobility device by 5/1/2024. Director of nursing completed chart audit on 4/12/2024

Directed Plan of Correction: *In addition to the above POC, and within 15 business days, the Director of Nursing or designee shall audit all current resident files to ensure residents have a completed annual assessments on file or additional assessments if applicable. Any resident identified to have a missing annual or needed additional assessment shall have one completed within 10 calendar days. Education shall be provided to staff responsible*

225a - Assessment 15 Days *(continued)*

Directed Completion Date: *05/01/2024*

Not Implemented [redacted] - 06/07/2024)

225c - Additional Assessment

51. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 5's most recent assessment was completed on [redacted]/22.

Plan of Correction ***Directed ([redacted] - 04/23/2024)***

Director of nursing will complete assessment for resident 5 by 5/1/2024. Director of nursing completed chart audit on 4/12/2024.

Directed Plan of Correction: *In addition to the above POC, any resident identified to have a missing annual or needed additional assessment shall have one completed within 10 calendar days of the receipt of this POC. Education shall be provided to staff responsible resident files within 10 calendar days of the receipt of this POC. A system to track assessment due dates shall be in use after the initial audit to ensure that ongoing compliance with annual assessments can be maintained. Documentation of audit and tracking system shall be kept any made available for Department review.*

Directed Completion Date: *05/01/2024*

Not Implemented [redacted] - 06/07/2024)

226b - Mobility Requirements

52. Requirements

2600.
226.b. If a resident is determined to have mobility needs as part of the initial or annual assessment, specific requirements relating to the care, health and safety of the resident shall be met immediately.

Description of Violation

On 12/20/22, resident 5 was assessed to have a need for an electric wheelchair to ambulate. The resident resides in a room that is not wheelchair accessible. The resident cannot enter the shower because the opening to the shower is only 25 inches.

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Resident 5 has been moved to room 115 on [redacted]/2024 to meet their mobility needs. Resident 5 transfers to commode for bathing per resident's request to meet personal hygiene requirements, according to assessment completed 5/1/2024 by the director of nursing.

226b - Mobility Requirements (continued)

Directed Plan of Correction: *In addition to the above POC, and within 15 business days, the Director of Nursing or designee shall audit all current resident files to ensure residents have an accurate assessment of their mobility needs on their current RASP. Any resident identified to have a missing or inaccurate assessment of their mobility need shall have one completed within 10 calendar days. Education shall be provided to staff responsible resident files within 5 calendar days of the initial audit completion. A Documentation of audit shall be kept any made available for Department review.*

Directed Completion Date: *05/01/2024*

Not Implemented [redacted] - 06/07/2024)

227a - Support Plan 30 Days

53. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident 2 was admitted on [redacted]/24; however, the resident's initial support plan was not completed.

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Director of nursing will complete assessment for resident 2 by 5/1/2024. Director of nursing completed chart audit on 4/12/2024 and continue monthly audits thereafter.

Directed Plan of Correction: *In addition to the above POC, and within 15 business days of the receipt of this POC,. any resident identified to have a missing or incomplete support plan shall have one completed within 10 calendar days. Education shall be provided to staff responsible resident files within 10 calendar days of the receipt of this POC. A system to track assessment and support plan due dates shall be in use after the initial audit to ensure that ongoing compliance with annual assessments and support plan can be maintained. Documentation of audit and tracking system shall be kept any made available for Department review.*

Directed Completion Date: *05/01/2024*

Not Implemented [redacted] - 06/07/2024)

227d - Support Plan Medical/Dental

54. 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 support plan for resident 5, dated [redacted]/22, does not mention resident's preference to sleep in a recliner.

Plan of Correction ***Directed ([redacted] - 04/23/2024)***

Director of nursing will complete support plan/assessment for resident 5 by 5/1/2024. Director of nursing completed chart audit on 4/12/2024 and will continue monthly audits thereafter.

227d - Support Plan Medical/Dental (continued)

Directed Plan of Correction: *In addition to the above POC, and within 15 business days of the receipt of this POC,. any resident identified to have a missing or incomplete support plan shall have one completed within 10 calendar days. Education shall be provided to staff responsible resident files within 10 calendar days of the receipt of this POC. A system to track assessment and support plan due dates shall be in use after the initial audit to ensure that ongoing compliance with annual assessments and support plan can be maintained. Documentation of audit and tracking system shall be kept any made available for Department review.*

Directed Completion Date: *05/01/2024*

Not Implemented [redacted] - 06/07/2024)

228h - Grounds Discharge/Transfer

55. Requirements

2600.
228.h. The only grounds for discharge or transfer of a resident from a home are for the following conditions:

Description of Violation

On 2/14/24, the home sent a discharge notice to resident 7 stating the home made "numerous attempts to collect a payment to no avail." The only documentation the home could provide related to money owed is dated 2/27/24 and it shows the resident's amount owed for February 2024 and March 2024. There is no documentation that the home has attempted to collect any payments.

On 2/14/24, the home sent a discharge notice to resident 8 stating the resident needs a higher level of care. The resident was not assessed for a higher level of care. Staff person B stated resident 8 needs a higher level of care because the resident is an amputee. The resident's preadmission screening and initial DME indicate the resident was an amputee when the resident moved in on 1/31/23.

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Executive director discharged resident 7 financially [redacted]/2024. Director of nursing will do a re-assessment on resident 8 for higher level of care by 5/1/24. Director of nursing completed chart audit on 4/12/2024 and continue monthly audits thereafter.

Directed Plan of Correction: *Within 15 business days of the receipt of this POC, education to well ness staff and to persons responsible for admissions and discharges shall be provided regarding the acceptable grounds for discharge. Additionally, the administrator or designee shall review and update the homes admission and discharge criteria to ensure the homes policies are in compliance with the regulation. If a change to the homes admission and discharge criteria or delivery/management of services policies occurs, a 30 day written notice shall be provided to residents and responsible parties before implementation of any change. Documentation of education and policy review and changes, and any notice to residents shall be kept and made available for Department review.*

Directed Completion Date: *05/01/2024*

Not Implemented [redacted] - 06/07/2024)

234a - Admission Support Plan

56. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident 10 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/23. However, the resident's initial support plan was not completed.

Plan of Correction ***Directed ([redacted] - 04/23/2024)***

Resident deceased on [redacted]/24 and include death certificate by 5/1/2024. Director of nursing completed chart audit on 4/12/2024 and continue monthly audits thereafter.

***Directed Plan of Correction**: Within 7 business days of the receipt of this POC, any SDCU resident identified to have a missing or incomplete support plan shall have one completed within 3 calendar days. Education shall be provided to staff responsible resident files within 10 calendar days of the receipt of this POC. A system to track assessment and support plan due dates shall be in use after the initial audit to ensure that ongoing compliance with annual assessments and support plan can be maintained. Documentation of audit and tracking system shall be kept any made available for Department review.*

Directed Completion Date: *05/01/2024*

Not Implemented [redacted] 06/07/2024)

236 - Staff Training

57. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person F, who works in the Secure Dementia Care Unit (SDCU) had only 2.5 hours of training in dementia care during the 1/1/23 to 12/31/23 training year.

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Staff member F will receive 6 hours of annual training related to dementia care services by outside agency by 5/1/2024. Resident care coordinator will complete wellness staff certification audit by 5/1/2024, and as needed with new hires moving forward.

***Directed Plan of Correction:** Within 15 business days of the receipt of this POC, the administrator or designee shall create a tracking system to be used to monitor staff training throughout the training year. The system shall be updated on a monthly basis to ensure that staff are receiving training in conjunction with the homes designated annual staff training plan. Documentation of trainings, tracking system and training plan shall be kept and made available for Department review.*

Directed Completion Date: *05/01/2024*

Not Implemented [redacted] - 06/07/2024)

251b - Record Entries Legible

58. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on resident 1's support plan dated 10/11/23.

Correction fluid was used on resident 2's emergency contact form.

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Executive director removed all correctional fluid from the wellness office on 3/6/2024.Resident 1 was discharged on 4/1/2024. Director of nursing re-wrote Resident 2's emergency contact properly without any correction fluid. Director of nursing will perform support plan and emergency contact form audits starting 5/1/2024 for 8 weeks.

Directed Plan of Correction: *In addition to the above POC, the administrator or designee shall provide education to all staff who handle or update resident records on resident record legibility and the prohibition of the use of correction fluid. Education shall be provided within 15 business days of the receipt of this POC.*

Directed Completion Date: *05/10/2024*

Not Implemented [redacted] - 06/07/2024)

252 - Record Content

59. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident 2's record does not include a photograph of the resident that is no more than 2 years old and an inventory of the resident's belongings.

Resident 18's record does not include a copy of the resident's death certificate.

Plan of Correction ***Directed [redacted] - 04/23/2024)***

Resident care coordinator took photo of resident 2 for [redacted] records on 4/12/2024. Memory care coordinator will provide a copy of Residents death certificate by 5/1/24. Resident care coordinator will update all of the current residents photos, and include them in the resident records by 5/1/2024. Resident care coordinator will do monthly audits for residents' photos to make sure they are up to date starting 5/1/2024, for 4 months.

Directed Plan of Correction: *In addition to the above POC, the administrator or designee shall provide education to all staff who handle or update resident records on resident record content. Education shall be provided within 15 business days of the receipt of this POC. Documentation of training shall be kept and made available for Department review.*

Directed Completion Date: *05/01/2024*

Not Implemented [redacted] - 06/07/2024)