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

May 7, 2024

[redacted], ED
DEER MEADOWS OPERATING II LLC
8301 ROOSEVELT BOULEVARD
PHILADELPHIA, PA, 19152

RE: DEER MEADOWS RESIDENCES
8301 ROOSEVELT BOULEVARD
PHILADELPHIA, PA, 19152
LICENSE/COC#: 14126

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/11/2024, 03/12/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *DEER MEADOWS RESIDENCES* **License #**: *14126* **License Expiration**: *12/01/2024*

Address: *8301 ROOSEVELT BOULEVARD, PHILADELPHIA, PA 19152*

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

Administrator

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

Legal Entity

Name: *DEER MEADOWS OPERATING II LLC*

Address: *8301 ROOSEVELT BOULEVARD, PHILADELPHIA, PA, 19152*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *10/14/2010* **Issued By**: *City of Philadelphia, L&I*

Staffing Hours

Resident Support Staff: *96* **Total Daily Staff**: *192* **Waking Staff**: *144*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *03/12/2024*

Inspection Dates and Department Representative

03/11/2024 - On-Site: [redacted]

03/12/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *182* **Residents Served**: *66*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *5th Floor* **Capacity**: *20* **Residents Served**: *19*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *66*

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

Have Mobility Need: *30* **Have Physical Disability**: *0*

Inspections / Reviews

03/11/2024 Full

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

04/15/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/03/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/19/2024*

Inspections / Reviews *(continued)*

04/23/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/03/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/03/2024*

05/07/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/03/2024*

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

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 3/11/24 around 10:05am, resident records were unlocked, unattended, and accessible in the personal care nurses' station in the basement. At the time, a laboratory worker, who is not a staff member of the home, was in the nurses' station printing some lab results.

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

Upon recognition of 2600.17 (Record Confidentiality) Administrator met with Health Center Staff who left the door open to the nurse's station to educate and review regarding Deer Meadows' Policies & procedures in relation to Privacy/Confidentiality Practices (see attached). Administrator also posted signage to remind staff to keep door closed (see attached). However, Administrator notes that as of 3/11/24 Deer Meadows was contracted with Centers Laboratory LLC and the Laboratory worker was visiting Deer Meadows as a contracted vendor providing services to Deer Meadows Residents as there was a Contract & HIPPA agreement in place. Therefor Administrator feels there is no violation of 2600.17 at this time.

***Edited 4/19/24:** Admin completed training in regards to Confidentiality on 3/13/24 with staff member that left door open to address immediate recognition of the violation (see attached). Admin conducted additional training with Residential Health Center Staff to review Confidentiality policies & practices on 4/17/24, (see attached). Residents' documents will remain confidential at all times, only Deer Meadows Residential Staff or contracted vendors with a HIPPA agreement in place for services, will continue to have limited access to the records. Administrator, Residential Health Center Coordinator, Social Worker and Administrative Assistant will complete daily audits to ensure records are secured, daily report will be given to Administrator at daily stand-up meeting, any issues will be addressed immediately and reported on during monthly QA meeting (see attached).*

Licensee's Proposed Overall Completion Date: *04/19/2024*

Implemented ([redacted] - 05/07/2024)

25b - Contract Signatures

2. 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], for Resident 1 was not signed by the resident.

Plan of Correction ***Accept ([redacted] - 04/15/2024)***

Upon recognition of violation 2600.25.b (Contract Signatures) Administrator met with resident 1 to review admission agreement. Resident was agreeable to sign agreement, agreement was updated. Resident was provided a copy of the updated agreement (see attached signature page).
Administrator also met with Admissions Director to review Resident home-contract & signatures (see attached).

25b Contract Signatures (continued)

Admissions Director completed an audit of all resident home contracts/admissions agreements and reported findings to Administrator. Admissions Director will continue to audit all new Resident Agreements on a monthly basis and will report findings at quarterly QA meeting (see attached).

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented [redacted] - 05/07/2024)

54a - Direct Care Staff

3. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person A and B do not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

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

Upon acknowledgment of violation 2600.54(a) Administrator met with Staff members A and B, upon further investigation it was found that staff members indeed do meet Education Requirements for DHS Direct Care Staff/Med Tech. Employees have Non U.S. College Degrees. Staff members A & B presented records & transcripts, and employee file was updated (see attached). However, DHS recommended that a waiver be acquired for each employee's continued employment as a Direct Care Staff member. Administrator has submitted waiver request for both staff members A & B, notified all residents of pending waiver request (see attached).
Edited 4/19/24: *Facility received staff member A's education records on hire date [redacted] updated records to reflect US education equivalency were received on 3/20/2024. Staff Member B's Non US degree records were also received on staff member's hire date, which was [redacted]. Monthly audits of 100% of new hires will continue to be completed by Director of Human Resources, any errors found will be reported immediately to Administrator, and reviewed at quarterly QA meeting. Director of Human Resources or designee will also continue to complete an ongoing audit of 25% of all employees quarterly, to ensure accuracy of employee records, findings will be submitted to Administrator and also reviewed at quarterly QA meeting. Upon further evaluation of violation 54a Administrator and Community Nurse Educator met with Human Resources staff to review hiring requirements regarding Direct Care Staff, all staff were educated on requirements and initiation of employee files audits on 4/17/24. (see attached)*

Licensee's Proposed Overall Completion Date: *04/19/2024*

Implemented ([redacted] - 05/07/2024)

81b - Resident Personal Equipment

4. 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 3/11/24, an uncovered bedside mobility device was present on each of the two residents' beds in Room 441, with

81b - Resident Personal Equipment (continued)

the bottom openings measuring 4 inches wide by 12 inches long, posing a possible hazardous condition for the residents.

Plan of Correction ***Accept ([redacted] - 04/15/2024)***

Upon acknowledgment of violation 2600.81.b Social Worker immediately met with both residents residing in room 441 to review the Bed Mobility Device Safety & requirements. Residents were agreeable for Social Worker to contact family members to purchase coverings for both devices. Social Worker contacted residents' POA, covers were provided and placed on both devices on 3/14/24 (see attached photos of covered devices). Administrator completed an audit of all bedside mobility devices on 3/13/2024, no other errors were found (see attached). Administrator or designee will complete a monthly bedside mobility device audit on an ongoing basis and will report all findings at quarterly QA meeting.

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented ([redacted] - 05/07/2024)

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

On 3/11/24 at 11:40am, Staff person C was observed using their bare, ungloved fingers to remove the medication from the blister card and put it into a small cup during the medication pass for Resident 2.

On 3/12/24 at 11:00 am, Staff person D was observed without their shoes on, exposing their socks in the dining room where the residents were having lunch.

Plan of Correction ***Accept ([redacted] - 04/15/2024)***

Upon acknowledgment of violation 2600.85.a Residential Health Center Coordinator completed Inservice with Staff member C regarding handwashing and sanitizing (see attached).

Staff member D was immediately educated verbally in front of inspectors by Administrator. Staff member D also received formal education from department supervisor regarding Sanitation (see attached). Administrator also met with Dietary Department Managers, who completed a staff in-service regarding employee break areas, kitchen audits and proper labeling. (see attached).

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented [redacted] - 05/07/2024)

103e - Left Overs

6. 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 five unlabeled, undated leftover sandwiches in the memory care kitchen fridge.

103e - Left Overs *(continued)*

Plan of Correction ***Accept (- 04/15/2024)***

Upon recognition of violation 2600.103.e (leftovers) all dietary staff were in-serviced on 3/14/2024 regarding proper labeling, leftovers and sanitation (see attached). Dietary Supervisor or designee will also complete a weekly audit of the kitchen, audit will be submitted with completed corrections to administrator and report of findings will be reviewed at quarterly QA meeting (see attached).

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented (- 05/07/2024)

103i - Outdated Food

7. Requirements

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

Description of Violation

There were unlabeled and undated cold cut turkey, ham, and cheese in the memory care fridge, a beef bologna in the main kitchen walk-in fridge, and a box of Krusteaz Vanilla Creme Icing in the dry food storage.

Plan of Correction ***Accept (- 04/15/2024)***

Upon recognition of violation 103i (outdated food) all dietary staff were in-serviced on 3/14/2024 regarding proper labeling, leftovers, outdated food and sanitation (see attached). Dietary Supervisor or designee will also complete a weekly audit of the kitchen, audit will be submitted with completed corrections to administrator and report of findings will be reviewed at quarterly QA meeting (see attached).

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented - 05/07/2024)

141a 1-10 Medical Evaluation Information

8. 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 3's medical evaluation dated did not include the immunization history and the mobility needs assessment of the resident.

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

Plan of Correction ***Accept (- 04/15/2024)***

Upon acknowledgement of violation 2600.141a-10 (Medical Evaluation Information) Residential Health Center contacted Resident 3's Primary Care Physician who was able to provide information current from 5/19/23. Resident's record was updated.

Residential Health Center Staff were educated by Administrator regarding Medical Evaluations, Pre Screening, RASP (see attached) on 3/20/24. Administrator completed an audit of all DMEs & Pre Screenings for residents, no other errors were found. Residential Health Center Coordinator or designee will complete a monthly ongoing audit of DME and Pre Screens for 25% of residents and will report all findings to Administrator. Administrator will report findings at quarterly QA meeting. (see attached)

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented (- 05/07/2024)

141b1 - Annual Medical Evaluation

9. Requirements

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

Description of Violation

Resident 1's most recent medical evaluation was completed on . The resident's previous medical evaluation was completed on .

Plan of Correction ***Accept - 04/15/2024)***

Upon recognition of violation of regulation 141.b. (Annual Medical Evaluation). Administrator completed education with Residential Health Center Staff regarding Annual Medical Evaluation (see attached.) Administrator also completed an Audit for all residents, no further errors were noted. (see attached)
Administrator or designee will continue to complete a monthly audit of 50% of all residents' Medical Evaluations and report findings at quarterly QA meeting.

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented (- 05/07/2024)

162c - Menus Posted

10. 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 menus for the 1st and 2nd weeks were posted. However, the lunch that was served to the residents on 3/11/24 and 3/12/24 did not follow the menu. On 3/11/24, the home served fried chicken instead of the BBQ chicken quarter, and on 3/12/24, the home served meat sauce on beer-battered fish instead of the Polish Sausage as indicated on the 2nd-week menu.

Plan of Correction ***Accept (- 04/15/2024)***

Upon recognition of violation 2600.162 C (Menus Posted) Administrator immediately notified Dietary supervisor of

162c Menus Posted (continued)

the posting error. Supervisor replaced the correct "advanced week at a glance menu" while inspector was on site. Supervisor met with all Dietary staff to in service regarding Menu Posting and accuracy. (see attached) Menu posting will also be audited on a weekly basis with kitchen audit to ensure accuracy moving forward. Findings will be reported to Administrator weekly, and any trends will be reported at the quarterly QA meeting.

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented (- 05/07/2024)

183e - Storing Medications

11. 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 3/12/24, a belonging to Resident 3 was in the home's medication cart in memory care. According to the manufacturer's instructions, the medication should be discarded after 42 days after opening, but there was no open date specified.

On 3/12/24, a belonging to Resident 4 was in the home's medication cart in personal care. According to the manufacturer's instructions, the medication should be discarded after 28 days after opening, but there was no open date specified.

Plan of Correction ***Accept (- 04/15/2024)***

Upon recognition of violation of 2600.183.e (Storing Medications) Residential Health Center Coordinator immediately removed Resident 3's , medication was disposed of properly. Coordinator notified resident and family of the error. Coordinator contacted pharmacy for a new supply of the Resident's medication, pharmacy delivered supply same day and medication was labeled correctly of the open date.

Resident 4 was immediately removed from the med cart by Residential Health Center Coordinator and disposed of properly. Resident & Resident's POA were made aware of the error. Resident had a supply of the on site to replace on medication cart and medication was labeled properly while DHS was on site.

Residential Health Center Coordinator met with Staff, and staff were educated in regard to storing of medication (see attached). Medication Cart Audits were completed by Health Center Coordinator and Administrator, and no further errors were found. Audits will continue for the next 12 months on a monthly basis and findings will be submitted to Administrator, Administrator will report findings at the quarterly QA meeting. (see attached)

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented (- 05/07/2024)

184a - Resident's Meds Labeled

12. Requirements

2600.

184a Resident's Meds Labeled *(continued)*

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 4's [redacted] does not include 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.

Plan of Correction ***Accept [redacted] - 04/15/2024)***

Upon recognition of violation 184a (Resident's Med Labeled) Residential Health Center Coordinator immediately removed Resident 4's [redacted] and medication was disposed of properly. Resident & Resident's POA were made aware of the error. Resident had a supply of the [redacted] on site to replace on medication cart and medication was labeled properly while DHS was on site.

Residential Health Center Coordinator met with Staff, and staff were educated in regards to storing of medication (see attached). Medication Cart Audits were completed by Health Center Coordinator and Administrator, and no further errors were found. Audits will continue for the next 12 months on a monthly basis and findings will be submitted to Administrator, Administrator will report findings at the quarterly QA meeting. (see attached)

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented [redacted] - 05/07/2024)

185a - Implement Storage Procedures

13. 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 3 is prescribed [redacted], one time a day [redacted], call MD if less than [redacted] and greater than [redacted]. The staff members initialed on MAR on [redacted] but there is no blood glucose level recorded on Medication Administration Record and no blood glucose readings on resident's glucometer as it malfunctioned on those dates.

Resident 3 is prescribed [redacted] give 1 tablet by mouth 2 times a day for [redacted]. On [redacted] at [redacted], the medication was administered to the resident as it was initialed on the Medication Administration Record, but it was not signed off on the narcotics declining inventory log as administered.

Resident 3 is prescribed [redacted] tab [redacted], give 1 tablet by mouth every 24 hours as needed for [redacted]. On

185a - Implement Storage Procedures (continued)

3/8/24, a staff initial was signed off on the narcotics declining inventory log as administered. However, per the director of nursing, the medication was not administered to the resident as the resident calmed down. The medication was destroyed but it was not indicated on the narcotics declining inventory log as destroyed.

On [redacted], Resident 5's blood glucose reading was [redacted] However, it was not documented on the Medication Administration Record.

Resident 6 is prescribed [redacted], give 2 tablets by mouth every 12 hours as needed for [redacted]. However, on 3/12/24, the medication was not available in the home.

Plan of Correction ***Accept [redacted] - 04/15/2024)***

Upon recognition of violation 2600.185(a) Administrator in-serviced Residential Health Center Staff Members regarding proper documentation and storage procedures (see attached). Malfunctioned glucose monitoring machine for Resident 3 was to be replaced, however prescribed [redacted] was discontinued [redacted] by Primary Care Physician, POA was notified.

Residential Health Center Coordinator met with Direct Care Staff member that was identified as not documenting on the Narcotics declining inventory sheet. Staff member was in-serviced on 3/13/24 (see attached). Residential Health Center Coordinator completed full audit of medication carts, no other errors were found (see attached). Medication Cart audit will continue to be completed on a monthly basis; all findings will be reported at quarterly QA meeting.

Upon recognition of violation 2600.185(a) medication for Resident #6 was immediately ordered, received same day and placed on med cart. PCP, POA and resident were made aware.

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented [redacted] - 05/07/2024)

224a - Preadmission Screen Form

15. Requirements

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

Description of Violation

Resident 7's preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home.

Resident 8's preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept ([redacted] - 04/15/2024)***

Upon recognition of violation of 224a- (Preadmission Screen Form) Residential Health Center Coordinator provided corrected forms for both Resident 7 & 8. (see attached). Resident 7 & 8's records have been updated. Administrator in-serviced Residential Health Center Staff Members regarding Pre Admission Screen Form. To help ensure no further errors, Administrator or designee will complete a monthly audit of 25% of all residents pre screening forms on a monthly basis and will report findings at quarterly QA meeting for the next 12 months.

224a Preadmission Screen Form *(continued)*

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented (- 05/07/2024)

225c - Additional Assessment

16. 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 3's current assessment was completed on . However, the resident's previous assessment was completed on .

Plan of Correction ***Accept (- 04/15/2024)***

Upon recognition of violation 225c Additional Assessment Administrator completed education regarding Resident Assessment and Support Plan with Residential Health Center Staff (see attached), Social Services Worker or designee will complete a RASP audit of 25% of resident population on a monthly basis and will report findings at quarterly QA meeting. Staff were educated and reminded of the importance of the annual assessment, all assessments of current residents are up to date, no further errors were noted.

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented (- 05/07/2024)

227d - Support Plan Medical/Dental

17. Requirements

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

Description of Violation

Resident 1 uses a bedside mobility device when transferring in and out of bed. The resident's assessment and support plan, dated , does not indicate that the resident has a need for a bedside mobility device and how this need will be met.

Resident 9 cannot self administer medication according to the most recent medical evaluation dated However, the resident's assessment and support plan, dated , indicates that the resident requires assistance with self administration and that the staff will assist the resident with remembering schedule, offering medications at prescribed times, and opening container or locked storage area.

Plan of Correction ***Accept - 04/15/2024)***

Upon further investigation, it should be noted that Resident 1 did not have a need for a bedside mobility device at the time of his admission while the support plan was being developed on . Resident 1 did not receive a recommendation or order from the physician for a bed side mobility device until . The current

227d - Support Plan Medical/Dental (continued)

Support plan, dated for [redacted] does indeed reflect the need for the bedside mobility device, (see attached) therefor Administrator feels there is no violation in this specific case.

Upon recognition of violation 227d- Support Plan Medical/Dental Resident 9's support plan was found to have a clerical error on Support plan regarding self-administration. Support Plan was corrected by Social Worker, resident's POA was notified of the correction (see attached). Administrator completed education regarding Resident Assessment and Support Plan with Residential Health Center Staff (see attached), Social Services Worker or designee will complete a RASP audit of 25% of resident population on a monthly basis and will report findings at quarterly QA meeting.

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented [redacted] - 05/07/2024)

227g -Support Plan Signatures

18. Requirements

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

Description of Violation

Resident 7 participated in the development of his/her support plan on [redacted]. However, the resident did not sign the support plan.

Plan of Correction ***Accept ([redacted] - 04/15/2024)***

Upon notification of violation 2600.227.g (Support Plan Signatures) Administrator met with Resident 7 to review support plan, Resident 7 declined to sign the Support Plan, Administrator noted the declination and offered copy of support plan, resident declined copy. Administrator completed education regarding Resident Assessment and Support Plan with Residential Health Center Staff (see attached), Social Services Worker or designee will complete a RASP audit of 25% of resident population on a monthly basis and will report findings at quarterly QA meeting.

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented [redacted] - 05/07/2024)

231c - Preadmission Screening

19. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident 3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the date when Resident 3's written cognitive preadmission screening was completed is unknown.

Plan of Correction ***Accept [redacted] - 04/15/2024)***

Upon recognition of violation of 2600.231.c (Preadmission Screening) Administrator completed an audit of all resident's Preadmission Screening, no further errors were found (see attached). Administrator or designee will

231c Preadmission Screening (continued)

complete a monthly audit of 50% of all residents' prescreening information for the next 12 months. All findings will be reported at quarterly QA meeting.

Administrator also met with Residential Health Center Staff and completed in service regarding Preadmission Screening. (see attached)

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented [redacted] - 05/07/2024)