pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **TOWAMENCIN OPERATING COMPANY, LLC**
LEGAL ENTITY

To operate **MORNINGSIDE HOUSE OF TOWAMENCIN**
NAME OF FACILITY OR AGENCY

Located at **900 TOWAMENCIN AVENUE, LANSDALE, PA 19446**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

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 **144** (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 59**

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 **November 1, 2024** until **May 1, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **151052**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: NOVEMBER 1, 2024

Towamencin Operating Company, LLC

RE: Morningside House of Towamencin
900 Towamencin Avenue
Lansdale, Pennsylvania 19446
License #: 151052

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection April 3, 2024 and June 25 and 26, 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 issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from November 1, 2024 to May 1, 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.

If you disagree with the decision to issue a SECOND 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 SECOND PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

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
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *MORNINGSIDE HOUSE OF TOWAMENCIN* **License #**: *15105* **License Expiration**: *07/16/2024*

Address: *900 TOWAMENCIN AVENUE, LANSDALE, PA 19446*

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

Administrator

Name:

Legal Entity

Name: *TOWAMENCIN OPERATING COMPANY, LLC*

Address:

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *102* **Waking Staff**: *77*

Inspection Information

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

Reason: *Complaint, Provisional, Incident, Monitoring* **Exit Conference Date**: *04/03/2024*

Inspection Dates and Department Representative

04/03/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *144* **Residents Served**: *69*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Opal* **Capacity**: *59* **Residents Served**: *27*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *69*
Diagnosed with Mental Illness: *2*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *33*
Have Physical Disability: *1*

Inspections / Reviews

04/03/2024 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/28/2024*

04/30/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/25/2024*

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

05/03/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/25/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/19/2024*

08/21/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/25/2024*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted] 2024 at 06:45 AM, resident #1 was observed being touched inappropriately by resident #2. This incident was observed by staff person A. However, this allegation of abuse was not reported to the local area agency on aging (AAA) until 02:00 PM on 03/26/2024.

Plan of Correction ***Accept ([redacted] - 05/03/2024)***

It is important for the safety and well-being of all residents that all incidents or suspected incidents of abuse be reported to the local area of agency and the Department of Human Services immediately or within 24 hours. A new process for reporting incidents of abuse was created and implemented by the Regional Director of Operations. This director is licensed as a PCHA and CALA. On 4/24/24, the Regional Director of Operations conducted training on reportable incidents and the process of notification for the Director of Health and Wellness and the Director of Memory Care. Staff were trained on reportable incidents and notification of incidents on 5/1/24 and 5/2/24. The Executive Director or designee will review all reportable incidents monthly with the team during QAPI to ensure ongoing compliance. QAPI will be held on 5/8/24 and will be held on the second Wednesday of each month ongoing.

See QAPI Guideline Attachment

Proposed Overall Completion Date: 05/08/2024

Licensee's Proposed Overall Completion Date: *05/08/2024*

Not Implemented ([redacted] - 08/21/2024)

16c - Written Incident Report

2. Requirements

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

Description of Violation

On 03/24/2024 at 06:45 AM, resident #1 was observed being touched inappropriately by resident #2. This incident was observed by staff person A. However, this allegation of abuse was not reported to the department until 12:33 PM on 03/26/2024.

Plan of Correction ***Accept ([redacted] - 05/03/2024)***

It is important for the safety and well being of all residents that all incidents or suspected incidents of abuse be reported to the local area of agency and the Department of Human Services immediately or within 24 hours. A new process for reporting incidents of abuse was created and implemented by the Regional Director of Operations. This director is licensed as a PCHA and CALA. On 4/24/24, the Regional Director of Operations conducted training on reportable incidents and the process of notification for the Director of Health and Wellness and the Director of Memory Care. Staff were trained on reportable incidents and notification of incidents on 5/1/24 and 5/2/24. The

16c - Written Incident Report (continued)

Executive Director or designee will review all reportable incidents monthly with the team during QAPI to ensure ongoing compliance. QAPI will be held on 5/8/24 and will be held on the second Wednesday of each month ongoing.

See QAPI Attachment

Proposed Overall Completion Date: 05/08/2024

Licensee's Proposed Overall Completion Date: *05/08/2024*

Not Implemented ███ - 08/21/2024)

17 - Record Confidentiality

3. 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 04/03/2024 at 01:30 PM, the controlled substance log and assignment sheet for the 2nd floor residents were unlocked, unattended, and accessible to anybody. They were placed on the medication cart in plain sight.

Plan of Correction ***Accept ███ - 05/03/2024)***

It is important to safeguard and protect our residents' private healthcare information. Staff will now lock the narcotic binder inside the medication cart when not in use. The Director of Health and Wellness and Director of Memory Care were re-educated on HIPAA and Confidentiality on 4/24/24 by the Regional Director of Operations. This director is a licensed PCHA and CALA. The Director of Health and Wellness and Director of Memory Care then met with staff that afternoon on 4/24/24 to re-educate on HIPAA and Confidentiality. The Director of Health and Wellness and the Director of Memory Care will conduct random medication cart checks weekly to ensure all medical information is locked inside the medication carts. These checks will begin the week of 5/1/24. The Executive Director will monitor for ongoing compliance at the monthly QAPI meetings. This meeting will be held 5/8/24 and then on the second Wednesday of each month going forward.

See Medication Cart Audit Tool

Proposed Overall Completion Date: 05/08/2024

Licensee's Proposed Overall Completion Date: *05/08/2024*

Not Implemented ███ - 07/16/2024)

23a - Activities of Daily Living Assistance

4. Requirements

2600.

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

23a - Activities of Daily Living Assistance *(continued)*

Description of Violation

The assessment and support plan, dated 01/10/2024, for resident #1 indicates the resident requires extensive supervision. On 03/24/2024 early in the morning around 06:45 AM, the resident was left in the common area living room with a male resident without any supervision, who touched the resident's private parts inappropriately.

Plan of Correction ***Accept[redacted] - 05/03/2024)***

It is important to follow all residents' care plans to ensure proper care and necessary supervision is being followed by staff. All memory care staff were re-educated on care plans and the different levels of supervision and what each level entails on May 1, 2024 and May 2, 2024. The staff were re-educated by the Regional Director of Operations. This director is a licensed PCHA and CALA. All care plan changes will be added to the unit's daily shift report as well as an alert for change in care in ECP, our electronic medical record. This process went into effect 4/24/24. The Director of Health and Wellness and the Director of Memory Care were trained on supervision levels and notification to staff on 4/24/24 by the Regional Director of Operations. The Director of Memory Care will complete walking rounds to ensure staff are following care plans, including supervision and care of residents. These rounds will be conducted daily for 30 days. Then randomly once a week ongoing. These rounds will begin on 5/1/24. The Executive Director monitor for ongoing compliance by conducting random weekly rounds as well and reviewing rounds monthly during QAPI. QAPI will be held on 5/8/24 and will be ongoing on the second Wednesday of each month.

See Memory Care Rounds Audit

Proposed Overall Completion Date: 05/08/2024

Licensee's Proposed Overall Completion Date: *05/08/2024*

Not Implemented[redacted] - 07/16/2024)

42b - Abuse

5. Requirements

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

Description of Violation

On [redacted]24 about 10:00 AM, resident #1 was observed being touched by resident #2 inappropriately in the common area. Resident #1 was dozing in the common area when resident #2, sitting next resident #1 started rubbing resident #1's arm, leg and then [redacted] area over clothing. The residents were separated immediately and staff were instructed to keep resident #2 away from resident #1.

On 0[redacted]/2024 around 06:45 AM, resident #1 and #2 were unsupervised in the common area. Resident #2 was again observed touching and rubbing resident #1's [redacted] area over clothing. Both residents reside in the Secured Dementia Care Unit (SDCU).

Plan of Correction ***Accept[redacted] - 05/03/2024)***

It is important to ensure the safety of all residents in our facility at all times. Resident #1 was evaluated by the PCP. Care times were changed for resident #1 to ensure extensive supervision will be provided while in any common areas of the unit. The facility immediately implemented a 1:1 for resident #2 for 12 hours a day during waking hours.

42b - Abuse (continued)

The PCP implemented medication changes for resident #2 and when a bed became available, resident #2 was admitted to a [redacted] hospital for further evaluation and treatment on [redacted]/24. Resident was discharged back to facility on [redacted]24. Resident was placed on 15 minute safety checks 4/22/24 through 4/23/24. Resident was then placed on 30 minute safety checks 4/24/24 through 4/25/24. Resident was placed on 45 minute checks from 4/26/24 through 4/28/24. Resident is currently and will remain on 1 hour safety checks. All memory care staff were trained on care plans, supervision, abuse and behaviors/interventions on May 1, 2024 and May 2, 2024, by the Regional Director of Operations. This director is a licensed PCHA and CALA. The Director of Memory Care or designee will monitor the unit daily beginning 5/1/24, and will continue daily to ensure ongoing compliance with supervision throughout the unit. The Executive Director will review all behaviors, reportable incidents and staffing levels monthly during QAPI to monitor for ongoing compliance. QAPI will be held on 5/8/24, and then the second Wednesday of each month ongoing.

See QAPI Guidelines and Rounds Audit Tool

Proposed Overall Completion Date: 05/08/2024

Licensee's Proposed Overall Completion Date: *05/08/2024*

Not Implemented [redacted] - 07/16/2024)

54a - Direct Care Staff

6. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

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

Plan of Correction ***Accept [redacted] - 05/03/2024)***

It is important to ensure all employees meet the direct care qualifications for DHS, prior to working in the facility. Staff person B was removed from the care schedule until verification of the high school diploma. A waiver was submitted to DHS on 4/18/24. Once the waiver is approved, this individual can resume work. The Regional Director of Operations educated the Business Office Manager on 4/24/24 on direct care staff requirements, the onboarding paperwork process and completion of a waiver. The Regional Director of Operations conducted audits of all employee files on 4/25/24 and 4/26/24. The Executive Director will conduct a monthly audit of all new employee files to ensure ongoing compliance. This audit will begin May 1, 2024, and will be ongoing will all new hires. The Executive Director will review new hires monthly during QAPI. QAPI will be held on 5/8/24 and will be ongoing the second Wednesday of each month.

Proposed Overall Completion Date: 05/08/2024

Licensee's Proposed Overall Completion Date: *05/08/2024*

Not Implemented [redacted] - 08/21/2024)

60a - Staff/Support Plan

7. 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 03/24/2024 around 06:45 AM, resident #1 did not receive proper supervision as required by ████ support plan and an incident that happened previous day. There were two direct care staff working on the secured dementia care unit (SDCU). While one staff member was in another resident's room providing care, the other staff member left the SDCU, leaving resident #1 alone in the common area without any supervision, which resulted in resident #1 being touched by resident #2 inappropriately.

Plan of Correction ***Directed ███ - 05/03/2024)***

It is important for the facility to ensure the safety of all residents at all times with correct supervision from staff. All memory care staff were trained on 5/1/24 and 5/2/24 on the required supervision levels for all memory care residents. This training was conducted by the Regional Director of Operations. This director is a licensed PCHA and CALA. The Director of Memory Care and shift supervisor will conduct walking rounds throughout each shift to ensure there is always supervision for residents, especially when in the common areas. The Executive Director will monitor behaviors and staffing levels monthly during QAPI to ensure ongoing compliance. QAPI will be held on 5/8/24 and then ongoing on the second Wednesday of each month.

See attachment #5

Proposed Overall Completion Date: 05/08/2024

Directed Plan of Correction 5/3/24 ███

Immediately, the administrator or designee shall review all resident assessments and support plans to determine the appropriate level of staffing needed to provide the appropriate level of supervision to meet the health and safety needs of residents as identified in the residents' assessments and support plans. This person shall monitor the staffing schedule weekly to ensure the staffing levels are met.

Starting immediately, and continuing daily for 4 weeks, then weekly for 4 weeks, and monthly thereafter, the Director of Memory Care or shift supervisor shall conduct walking rounds at least twice per shift to ensure there is always supervision for residents, especially when in the common areas. Documentation of audits shall be kept.

Directed Completion Date: *06/18/2024*

Not Implemented ███ - 08/21/2024)

65a - FS Orientation 1st Day

8. Requirements

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

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

Description of Violation

Staff person C, whose first day of work was [redacted] 2024, did not receive 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.

Plan of Correction ***Accept ([redacted] - 05/03/2024)***

It is important for the facility to ensure the safety of all residents by being trained in fire safety and evacuation procedures. This includes agency staff. A training guide has been created for all agency staff to review prior to working on the floor in the facility. This training was created by the Regional Director of Operations. This director is a licensed PCHA, CALA and has their Fire Safety Expert certification. The Director of Health and Wellness and the Director of Memory Care were trained on the training materials on 4/24/4 by the Regional Director of Operations who holds a PCHA, CALA and Fire Safety Expert certification. The director or designee will ensure this training packet is reviewed whenever a new agency staff person begins a shift in the facility. An Acknowledgement form has been created for agency staff to sign after receiving the required trainings. The Executive Director will monitor this process monthly during QAPI to ensure ongoing compliance as long as agency is in use in the facility. QAPI will be held on 5/8/24 and will be ongoing the second Wednesday of each month.

Proposed Overall Completion Date: 05/08/2024

Licensee's Proposed Overall Completion Date: *05/08/2024*

Not Implemented [redacted] - 08/21/2024)

82c - Locking Poisonous Materials

9. 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 04/03/2024 around 10:30 AM, Sensodyne tooth paste, with a manufacture's label indicating "If more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible in resident #2's bathroom. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 05/03/2024)***

It is the responsibility of the facility to protect our residents' health and safety from poisonous materials. The Director of Health and Wellness and the Director of Memory Care were re-educated on poisonous materials on 4/24/24. All memory care staff were re-educated on poisonous materials on 5/1/24 and 5/2/24. These trainings

82c - Locking Poisonous Materials (continued)

were conducted by the Regional Director of Operations. This director is a licensed PCHA and CALA. Staff began on 5/1/24, performing daily audits to ensure all items, including toiletries and cleaning products are always locked away when not in use. This audit will be completed daily for 30 days. Beginning June 1, 2024, a new process will be implemented for each staff person to initial their assignment sheet daily that all poisonous materials were locked up after use. The Director of Memory Care will monitor the audits to ensure completion and will review assignment sheets weekly to ensure the new process of documenting locking all items up is being followed. The May audits will be reviewed during the June 2024 QAPI. These random assignment sheet audits will be reviewed monthly by the Executive Director during QAPI. QAPI is held the second Wednesday of each month.

See QAPI Guidelines and Poisonous Materials Audits

Proposed Overall Completion Date: 05/01/2024

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

Not Implemented - 07/16/2024)

132b - Safety Inspection/Fire Drill

10. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The most recent fire safety inspection and fire drill conducted by a fire safety expert was completed on 01/30/2023.

Plan of Correction ***Directed - 05/03/2024)***

It is important for the facility to ensure the safety of all residents, staff and visitors. This includes having processes in place for emergencies, including fire. A fire inspection and drill must be completed annually by a fire safety expert. The facility had their inspection and drill on 4/17/24. The Director of Plant Operations will be responsible for ensuring a fire safety inspection and drill will be conducted annually. The facility has contracted with Croker Fire Safety to conduct our monthly fire drills. The facility contracted with Fire and Life Safety, LLC to conduct our annual drills and we are on their schedule for April 2025. All fire drills monthly and annual will be reviewed during QAPI by the Executive Director. QAPI is scheduled for 5/8/24 and will the second Wednesday of each month ongoing. Proposed Overall Completion Date: 05/08/2024

Directed Plan of Correction 5/3/24

Immediately, the administrator or designated staff person shall develop and implement a process and procedure to ensure a fire drill and fire inspection is conducted by a fire safety expert at least annually.

Directed Completion Date: *05/08/2024*

Implemented - 08/21/2024)

224a - Preadmission Screen Form

11. Requirements

2600.

224a - Preadmission Screen Form *(continued)*

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 #3's preadmission screening form, dated [redacted]/2024, does not include the resident's level of supervision needed.

Plan of Correction ***Accept [redacted] 05/03/2024)***

It is important that all fields in the DHS Pre-admission Screening Form are completed to ensure we have correct and accurate information for a new admission to our facility. An audit tool has been created to ensure the form is completed in its entirety. The Director of Health and Wellness and the Director of Memory Care were trained on this audit tool on 4/24/24 by the Regional Director of Operations. This director is licensed as a PCHA and CALA. The Regional Director of Operations completed pre-screen audits on 4/29/24 and 4/30/24. The Directors of Health and Wellness and Memory Care will utilize this tool and audit each other's Pre-admission screening within 48 hours of completion. This audit was completed on 5/1/24 for a new admission on 4/30/24. The Executive Director will monitor for ongoing compliance by completing random pre-screen audits on a quarterly basis to ensure ongoing compliance. The Pre-admission screening audit tool will be reviewed at QAPI. QAPI will be held on 5/8/24 and then ongoing on the second Wednesday of each month.

Licensee's Proposed Overall Completion Date: *05/08/2024*

Implemented [redacted] - 08/21/2024)

234d - Support Plan Revision

12. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident #2's support plan was revised on [redacted]/2024 after the resident was observed touching another resident inappropriately on [redacted]2024. According to the revised support plan, the resident is placed on every 2 hour check during the overnight shift. The resident is also on 1-1 supervision from 07:00 AM ~ 07:00 PM, provided by a private duty aid. However, the resident's supervision need is checked on minimal and the resident's judgement portion is checked on minimal too.

Plan of Correction ***Accept [redacted]- 05/03/2024)***

It is the responsibility of the facility to ensure that all care plans are revised whenever a resident's condition changes. The Director of Health and Wellness and the Director of Memory Care were re-educated on care plans on 4/24/24 by the Regional Director of Operations. This director is a licensed PCHA and CALA. The training included when a RASP is to be updated as well as how to notify staff of changes to the care plan. The RASP sections regarding judgment and supervision for the resident was immediately updated by the Director of Memory Support on 4/24/24. Staff were notified of these changes on 4/24/24 via shift report and assignment sheets. The Director of Health and Wellness and the Director of Memory Care reviewed all Memory Care RASPs on 4/30/24,5/1/24 and 5/2/24 to ensure all RASPs were current and up to date. The Executive Director will conduct random RASP reviews on a quarterly basis beginning May 6, 2024 to ensure compliance. The Executive Director will review 4 RASPs on a monthly basis (2 for

234d - Support Plan Revision (continued)

personal care and 2 for memory care) for 6 months to ensure ongoing compliance. Behaviors and incidents will be reviewed monthly by the Executive Director during QAPI. The Executive Director will review the RASPs of any residents discussed at the time of QAPI to ensure RASPs are current and accurate. QAPI will be held on 5/8/24 and ongoing the second Wednesday of the month thereafter.

See RASP Audit

Licensee's Proposed Overall Completion Date: *05/08/2024*

Not Implemented [redacted] - 08/21/2024)

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

Facility Information

Name: *MORNINGSIDE HOUSE OF TOWAMENCIN* **License #**: *15105* **License Expiration**: *07/16/2024*

Address: *900 TOWAMENCIN AVENUE, LANSDALE, PA 19446*

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

Administrator

Name:

Legal Entity

Name: *TOWAMENCIN OPERATING COMPANY, LLC*

Address:

Certificate(s) of Occupancy

Type: *Other* **Date**: *12/21/2023* **Issued By**: *Towamencin Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *112* **Waking Staff**: *84*

Inspection Information

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

Reason: *Renewal, Provisional, Monitoring* **Exit Conference Date**: *06/26/2024*

Inspection Dates and Department Representative

06/25/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *144* **Residents Served**: *72*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Opal* **Capacity**: *59* **Residents Served**: *25*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *72*

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

Have Mobility Need: *40* **Have Physical Disability**: *0*

Inspections / Reviews

06/25/2024 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/09/2024*

08/19/2024 - POC Submission

Submitted By: [redacted]
[redacted]

Date Submitted: *09/16/2024*
Follow-Up Type: *POC Submission* **Follow-Up Date:** *08/24/2024*

08/30/2024 - POC Submission

Submitted [redacted]
Reviewer: [redacted]

Date Submitted: *09/16/2024*
Follow-Up Type: *Document Submission* **Follow-Up Date:** *09/16/2024*

10/03/2024 - Document Submission

Submitted By: [redacted]
Reviewer: [redacted]

Date Submitted: *09/16/2024*
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 6/26/24 at 10:30am, the medication room/resident chart room in the Secured Dementia Care Unit (SDCU) was unlocked, unattended, and accessible to anybody. All SDCU resident charts were out and accessible on a shelf.

Plan of Correction ***Accept - 08/30/2024)***

It is important to always safeguard our residents' personal and medical information. On, 7/11/24, the Regional Director of Operations conducted an in-service on HIPAA and Confidentiality. The nursing staff as well as the new Director of Health and Wellness and the new Director of Memory Care participated in this in-service. On 7/22/24, the new Executive Director received training on HIPAA and Confidentiality from the Regional Director of Operations. To prevent an incident like this from occurring again, The Executive Director and/or designee will conduct inspections to ensure office doors are shut and always locked when unoccupied. These audits will begin the week of August 19, 2024. These audits will be completed weekly for 6 weeks, bi-weekly for 6 weeks, monthly for 6 months and randomly thereafter. All audits will be reviewed monthly in QAPI beginning 9/10/24 to monitor ongoing compliance.

Proposed Overall Completion Date: 9/15/2024

Licensee's Proposed Overall Completion Date: *09/15/2024*

Not Implemented - 10/03/2024)

23a - Activities of Daily Living Assistance

2. 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 0 /2024, for resident #1 indicates that the resident requires extensive supervision due to lack of safety unawareness and that the resident should remain in high supervision areas. On 06/01/2024, the resident eloped from the home's Secured Dementia Care Unit (SDCU) without supervision and was unaccounted for over an hour until the resident was found in the on the ground, in the parking, with injuries.

Plan of Correction ***Accept - 08/30/2024)***

It is important that staff adhere to the care plan and provide the required supervision to ensure the safety of our residents. On 6/5/24, the Regional Director of Operations completed staff training on the community's elopement procedures and memory care alarm procedures. On 7/1/24, a new Director of Memory Care joined our leadership team. On 7/8/24, the Regional Director of Operations reviewed the Elopement and Alarm Procedures with the Director of Memory Care. On 7/22/24, the Regional Director of Operations also reviewed these processes with the new Executive Director. An unannounced elopement drill will be conducted by the Executive Director and the Director of Plant Operations on 8/27/24. An unannounced elopement drill will then be conducted again by

23a - Activities of Daily Living Assistance (continued)

December 31,2024. The Elopement Procedure and Memory Care Alarm Procedure has also been added to the training portion for New Employee Orientation. The Regional Director of Health and Wellness and the Regional Director of Operations will be re-educating all Directors of Health and Wellness and all Directors of Memory Care for all our communities on the levels of supervision and their requirements as per the RASP, when to update a resident's supervision level and how to effectively notify staff of any increase in supervisory needs for a resident. This training is scheduled for 8/21/24. The Executive Director will be responsible for conducting random interviews with staff to ensure they understand supervision levels and how to provide the supervision required. These interviews will take place monthly for 6 months then randomly thereafter. The interviews will begin the week of September 2, 2024. These interviews will be documented by the Executive Director and reviewed monthly at the QAPI meetings beginning September 2024 to ensure ongoing compliance.

Proposed Overall Completion Date: 9/15/24

Licensee's Proposed Overall Completion Date: *09/15/2024*

Not Implemented [redacted] 10/03/2024)

25b - Contract Signatures

3. 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]/2024, for resident #2 was not signed by the administrator or by the resident or the resident's designated person.

Plan of Correction ***Accept [redacted] - 08/30/2024)***

It is important that our residents and their designated persons have the opportunity to review all contracts, have all details explained and that the Sales & Marketing Director answers any questions the resident/designated person may have. It is equally important to ensure all parties sign off on the contract as required by regulations. The resident/designated person and Executive Director reviewed and signed off on the contract on 3/2/24 . The previous Executive Director printed off a scanned copy but did not give DHS the signed paper copy of the contract from the resident's financial file. This Executive Director is no longer employed with our organization. On 6/17/24, a new Sales and Marketing Director joined our team. On 8/8/24, The Regional Director of Operations, The Regional Director of Sales, and the Regional Director of Health & Wellness completed a training for every Sales & Marketing Director, Executive Director, Director of Health and Wellness and Director of Memory Care for all our communities on Admissions and Contracts. The Executive Director and/or designee will conduct monthly audits of Resident Files at the end of each month for any new move in for each month. These audits will begin on 8/31/24 and will continue monthly thereafter. All audits will be reviewed during each monthly QAPI meeting beginning 9/10/24 to monitor for ongoing compliance.

Proposed Overall Completion Date: 9/15/24
Proposed Overall Completion Date: 09/15/2024

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented [redacted] - 10/03/2024)

41e - Signed Statement

4. 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.

Plan of Correction ***Accept (█ - 08/30/2024)***

It is important that all residents are educated in Resident Rights and the community’s Complaint Procedure. A copy of the Resident Rights and Complaint Procedure is now readily available to residents/designated persons by being displayed on our public bulletin board. These items were placed on our bulletin board on 7/30/24. All residents/designated persons are educated on Resident Rights and Complaint Procedure upon move in via our Resident Handbook. The resident/designated person will sign an acknowledgement form that they received this information. All Sales and Marketing, Executive Directors, Directors of Health & Wellness and Directors of Memory Care received training on these new forms on 8/8/24. This training was conducted by the Regional Directors of Sales, Operations and Health & Wellness. On 8/29/24, the community will be holding their monthly Resident Council Meeting. At this time, all current residents will receive a resident handbook, and the Executive Director will review the Resident Rights and Complaint Procedure. An acknowledgement with be signed and placed in each resident file after this meeting. For any residents who may not attend this meeting, the Executive Director along with the Life Enrichment department will meet with each resident individually to review the handbook along with Resident Rights and the Complaint Procedure. All current residents will have received a copy of all information by 9/6/24. On 9/9/24, all designed persons will receive a copy of the handbook via email and be asked to return the signed acknowledgement form to the front desk by 9/11/24. The Business Office Manager and/or designee will complete an audit of all current resident files to ensure that an acknowledgement form has been signed and placed in all residents’ files. The Executive Director and/or designee will conduct monthly audits of Resident Files at the end of each month for any new move in for each month. These audits will begin on 8/31/24 and will continue monthly thereafter. All audits will be reviewed during each monthly QAPI meeting beginning 9/10/24 to monitor for ongoing compliance.

Proposed Overall Completion Date: 9/15/24
Proposed Overall Completion Date: 09/15/2024

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented █ - 10/03/2024)

42b - Abuse

5. Requirements

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

Description of Violation

On 06/01/2024 around 04:00 PM, resident #1, who resides in the home's Secured Dementia Care Unit (SDCU) and requires extensive supervision due to lack of safety awareness, was able to elope from the unit unnoticed through the door to the enclosed courtyard. The door is equipped with a magnetic lock and requires a code to operate. At the time

42b - Abuse (continued)

of the incident, the door was propped open. The resident went out to the courtyard and exited through the gate which also needed a code but was not latched completely. The door alarm went off at 03:58 PM but staff A cleared the alarm without checking the courtyard door or the gate. Staff did not notice the resident's absence until 04:30 PM when the resident had not been seated for meal time. The resident was found at 05:08 PM on the ground of the parking lot with blood and a laceration on the forehead and was awake and alert. The resident was transported via EMS to the hospital, and was discharged with a broken left maxillary sinus and a fracture of the left lateral orbital wall with a forehead laceration.

Plan of Correction ***Accept [redacted] - 08/30/2024)***

It is important that our community and all staff ensure all residents are safe and always protected from harm. An immediate investigation was carried out concerning this incident. It was determined that staff were using the memory care courtyard as a short cut to enter the memory care unit and the gate was not fully latched. Staff were re-educated on 6/3/24, during shift reports by the previous Director of Memory Care, that doors leading to the courtyard were no longer to be propped open for safety. The courtyard gate that did not latch was repaired on 6/10/24. The code to the gate was immediately changed. Only the Director of Plant Operations, the Director of Memory Care and the Executive Director have the code to access the gate. On 6/5/24, the Regional Director of Operations completed staff training on the community's elopement procedures and memory care alarm procedures. On 7/1/24, a new Director of Memory Care joined our leadership team. On 7/22/24, the Regional Director of Operations reviewed the Elopement and Alarm Procedures with the new Director of Memory Care. On 8/15/24, the Regional Director of Operations also reviewed these processes with the new Executive Director. An unannounced elopement drill will be conducted by the Executive Director and the Director of Plant Operations on 8/27/24. An unannounced elopement drill will then be conducted again by December 31, 2024. The Elopement and Memory Care Alarm Procedure has also been added to the agenda for New Employee Orientation. The Director of Plant Operations and/or designee will complete a monthly inspection to ensure all doors in the memory care unit are closed, magnetic locking doors are latched and the courtyard gates are in good repair and latched. This audit will begin the week of 8/19/24. This audit will be completed weekly for 6 weeks, bi-weekly for 6 weeks and monthly there. This audit will be brought to the monthly QAPI meeting beginning 9/10/24 for the Executive Director to review and monitor for ongoing compliance.

Proposed Overall Completion Date: 09/15/2024

Licensee's Proposed Overall Completion Date: *09/15/2024*

Not Implemented ([redacted] - 10/03/2024)

62 - Contact List

6. 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

On 6/25/24, the staff list provided by staff person B, the administrator, was not current. It did not include newly hired staff including the administrator and it also included staff members who were no longer employed by the home.

Plan of Correction ***Accept [redacted] - 08/30/2024)***

It is important to have and maintain a current contact list of the community's staff persons, volunteers and substitute staff. On 7/1/24, the Business Office Manager (BOM) was trained in how to run a current staff roster from our ADP

62 - Contact List (continued)

(payroll system). This training was conducted by our Corporate Human Resources Director. The Executive Director and/or designee will have the BOM run a current staff list on the first of each month for review to ensure the list is current and accurate. This will begin on 9/1/24. On 8/15/24, a new process was implemented to ensure that as agency staff enter the community to work, we are receiving their contact information at the time of their initial Day One training. The Director/Assistant Director will review the contact sheets weekly for 6 weeks, bi-weekly for 6 weeks and monthly to ensure ongoing compliance. The audits will begin the week of 8/26/24. The audits will be reviewed monthly at QAPI beginning 9/10/24.

Proposed Overall Completion Date: 02/28/2025
Proposed Overall Completion Date: 09/15/2024

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented ███ - 10/03/2024)

81b - Resident Personal Equipment

7. 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

Resident #3's bed is equipped with a bedside mobility device, which is not securely attached to the bed frame. It is secured by resting between the mattress and the frame of the bed. It moves from side to side easily along the bed and away from the mattress, creating entrapment zones not always present upon inspection. These types of devices are not permitted under any circumstances.

Plan of Correction ***Accept ███ 08/30/2024)***

It is important to ensure the safety of all our residents by ensuring mobility devices are always secured in place. Bayada therapy immediately secured the mobility device for our resident on 6/26/24. On 8/22/24, the Regional Director of Health & Wellness held a training for the Directors of Plant Operations on mobility devices and proper safety/installation for all our communities. The Director of Plant Operations and/or designee will conduct safety Inspections on all mobility devices. These audit will begin the week of 8/26/24 and monthly thereafter, to ensure all mobility devices are in good condition and secured in place to safeguard our residents from injury. These monthly inspections will be brought to the QAPI meetings beginning 9/10/24, for the Executive Director to review and monitor for ongoing compliance.

Proposed Overall Completion Date: 09/15/2024

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented ███ - 10/03/2024)

82c - Locking Poisonous Materials

8. 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.

82c - Locking Poisonous Materials *(continued)*

Description of Violation

A Great Value Mouthwash, with a manufacture's label indicating "if ingested, get medical help or contact a poison control center right away" was unlocked, unattended, and accessible in resident room #25, located in the Secured Dementia Care Unit (SDCU). Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Repeat Violation: 01/25/2024

Plan of Correction ***Accept - 08/30/2024)***

It is important that all staff keep all items considered poisonous if ingested securely locked away when not in use to safeguard our residents' health and well-being. On /24, the community hired two new and seasoned LPNs to join our team as our Director of Health & Wellness and the Director of Memory Care. 7/22/24, the Regional Director of Operations reviewed current issues and concerns with the two Directors and conducted training on poisonous materials. On 8/21/24, the Regional Director of Health and Wellness held a training on poisonous materials for the Directors of Health & Wellness and the Directors of Memory Care for all our communities. A new audit tool was created to ensure that staff receive on the spot immediate re-education of any poisonous items that are left out after use. After an initial on the spot retraining is provided with an employee, should any items be found again, the employee will receive immediate corrective action, up to and including termination. The Directors of Health & Wellness and Memory Care will be in-servicing all nursing staff (personal care and memory care) on 9/11/24, to ensure they have all had proper training and to give them advance notice of corrective action and termination if our procedure to lock up poisonous materials are not followed. The Executive Director will add a section in the upcoming September newsletter for residents and families about what items are considered poisonous and cannot be left unsecured in a memory care resident's room or bathroom. Poisonous Materials will also be added to our 2025 Annual Training Schedule for all staff. Audits will be completed weekly for 6 weeks, bi-weekly for 6 weeks, monthly for 6 months and then randomly thereafter. The new audit will begin the week of 8/19/24 and will be completed by the Director of Memory Care and/or designee. All audits will be reviewed by the Executive Director at the monthly QAPI meetings beginning 9/10/24 to monitor for ongoing compliance.

Proposed Overall Completion Date: 9/15/24
Proposed Overall Completion Date: 09/15/2024

Licensee's Proposed Overall Completion Date: *09/15/2024*

Not Implemented - 10/03/2024)

95 - Furniture and Equipment

10. Requirements

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

Description of Violation

On 06/26/2024, the dryer in the home's SDCU was broken.

Plan of Correction ***Accept [redacted] /30/2024)***

It is important to ensure all our appliances are in working order. Staff on our night shift will be responsible for checking the dryers each night to ensure all lint traps are free from lint as well as in working condition. The log includes directions on reporting repairs needs immediately. The maintenance team will receive an electronic notification of any repairs needed and will immediately fix the appliance. Staff also have access to the washers/dryers throughout the community if needed if and when one required repair. The Director of Plant Operations and/or designee will also be responsible for physically checking all dryer lint trap monthly when completing the Environmental Checklist. The Directors of Health & Wellness and Memory Care will educate 3rd shift on this duty the week of 8/19/24. The lint log will be implemented daily beginning 9/1/24. The monthly lint log and Environmental Checklist will be reviewed monthly during QAPI starting 9/10/24 by the Executive Director to monitor for ongoing compliance.

Proposed Overall Completion Date: 9/15/24
Proposed Overall Completion Date: 09/15/2024

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented [redacted] - 10/03/2024)

105g - Lint Removal and Duct Cleaning

11. 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.

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

Description of Violation

On 06/26/2024, there was a build up lint, in the lint trap of the home's commercial dryer. The dryer was located on the first floor of the memory care unit.

Plan of Correction ***Accept - 08/30/2024)***

It is important to safeguard our residents by ensuring there is no lint build up in any of our dryers throughout the community. Staff on our night shift will be responsible for checking the dryers each night to ensure all lint traps are free from lint and signing off the traps were checked and cleaned. The Director of Plant Operations and/or designee will review these lint logs weekly to ensure compliance. The Director of Plant Operations and/or designee will also be responsible for physically checking all dryer lint trap monthly when completing the Environmental Checklist. The Directors of Health & Wellness and Memory Care will educate 3rd shift on this duty the week of 8/19/24. The lint log will be implemented daily beginning 9/1/24. The monthly lint log and Environmental Checklist will be reviewed monthly during QAPI starting 9/10/24 by the Executive Director to monitor for ongoing compliance.

Proposed Overall Completion Date: 9/15/24
Proposed Overall Completion Date: 09/15/2024

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented - 10/03/2024)

183d - Prescription Current

12. Requirements

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

Description of Violation

On 06/26/2024, Furosemide 80 mg prescribed for resident #4 was in the home's 3rd floor medication cart; however, the medication was discontinued on 06/10/2024.
Morphine and Lorazepam syringes prescribed for resident #6, who passed away on 2024, were still in the 2nd floor medication cart and 1st floor med refrigerator.

Plan of Correction ***Accept - 08/30/2024)***

It is important to ensure the correct and current medications are in the community's medication carts and medication refrigerators to safeguard our resident's health and prevent potential medication errors from occurring. On 7/1/24, we hired a new Director of Health and Wellness to join our team. The week of 7/8/24, the Director audited all med carts and ensured no expired or discontinued medications were in the carts or refrigerators. Effective 8/5/24, we now have a Regional Director of Health and Wellness on our team. This Director is a nurse as is also a DHS certified Med Tech trainer. will be conducting random medication cart audits in our community and will provide additional training to med techs and nurses as needed. On 8/21/24, the Regional Director of Health and Wellness will be conducting a training on best practices for medication administration and will be implementing monthly med cart audit for all our communities. The Director of Health and Wellness and the Director of Memory Care will be responsible for completing these monthly audits. The audits will begin the week of 8/26/24, and will be completed weekly for 6 weeks, bi-weekly for 6 weeks and monthly thereafter. These audits will be reviewed monthly at QAPI beginning 9/10/24, by the Executive Director to monitor for ongoing compliance.

Proposed Overall Completion Date: 9/15/24
Proposed Overall Completion Date: 09/15/2024

183d - Prescription Current *(continued)*

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented [redacted] 10/03/2024)

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 #5 is prescribed Tramadol 50 mg 1/2 tab twice a day. On 06/26/2024 at 10:30 AM, 14 tablets of Tramadol 50 mg were present. However, the controlled medication log for this medication indicated 15 tablets were present after 06/25/2024 07:40 PM administration. The resident was given one tab (50 mg) on 06/26/2024 at 08:00 AM by staff C who did not record it on the controlled medication log.

Resident #5 is prescribed accuchek 3 times a week on Monday, Wednesday, and Friday. There are mismatches in the readings on the resident's glucometer and medication administration record (MAR): 233 on the glucometer vs. 237 on the MAR on 06/24/2024, 154 vs 151 on 06/14/2024, 127 vs 124 on 06/07/2024.

Plan of Correction ***Accept [redacted] - 08/30/2024)***

It is important to ensure all controlled medications are accounted for and the administration of the medication is documented corrected. It is also equally important to ensure we are properly documenting glucometer reading as this may affect the amount of medication a resident would receive. On 7/1/24, we hired two LPNs as our new Director of Health and Wellness and Director of Memory Care. They have reviewed our controlled substance count process and will be retraining all nurses and med techs on administering and documenting controlled substances on 9/11/24. The Director of Health and Wellness and the Director of Memory Care will be responsible for completing monthly audits of the controlled substances being administered to ensure the documentation is current and the count of medications is accurate. This audit will begin the week of August 26, 2024. This audit will be completed weekly for 6 weeks, bi-weekly for 6 weeks and then monthly thereafter. Also on 9/11/24, the Directors will be re-educating the nurses and med techs on proper usage of glucometers and the process for documenting blood sugar readings. The shift supervisor for evenings or designee will be responsible for conducting glucometer audits. These audits will be completed weekly for 6 weeks, bi-weekly for 6 weeks and monthly thereafter. The Directors of Health and Wellness and Memory Care will be responsible for reviewing each audit after completion. These audits will be brought to the monthly QAPI meeting beginning 9/10/24 for the Executive Director to monitor and review for ongoing compliance.

Proposed Overall Completion Date: 9/15/2024

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented [redacted] - 10/03/2024)

187b - Date/Time of Medication Admin.

14. Requirements

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

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

Description of Violation

Resident #8 is prescribed Lorazepam 0.5 mg twice daily as needed. The resident's June MAR does not include the initials of staff D who administered this medication on 06/09/2024 at 08:08 AM.

Plan of Correction ***Accept █ - 08/30/2024)***

It is important that all medication is administered in a timely manner and that staff complete the appropriate documentation when administering medications. On 9/11/24, all med tech and nurses will be re-educated on the proper way to document in ECP when administering a medication by the Director of Health and Wellness. The Director of Health and Wellness and the Director of Memory Care or designee, will run a medication report in ECP. This report shows the following: if all medications were administered in the timeframe allotted, if any doses of medications were missed, and if anyone did not sign off after administering a medication. If there are any issues or concerns, the Director will immediately meet with the med tech/nurse to re-educate and provide corrective action if needed. The Regional Director of Health and Wellness will train the Director of Health and Wellness and the Director of Memory Care on how to run this report and review it. This training will take place on 8/21/24. The Directors will run these reports beginning 8/26/24. These reports will be run daily for 1 week, weekly for 6 weeks, bi-weekly for 6 weeks and will continue monthly thereafter. The Director will sign off on these reports and bring them to the monthly QAPI meeting beginning 9/10/24 for the Executive Director to review and monitor for ongoing compliance.

Proposed Overall Completion Date: 09/15/2024

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented (█ - 10/03/2024)

187d - Follow Prescriber's Orders

15. Requirements

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

Description of Violation

Resident #4 is prescribed Tramadol 50 mg one tab at 06:00 AM and 02:00 PM and two tabs at bedtime. However, the resident was administered only one tab at bedtime on 06/04/2024 and 06/05/2024 by staff E.

Resident #5 is prescribed Tramadol 50 mg 1/2 tab (25 mg) every 12 hours. However, the resident was administered Tramadol 50 mg on 06/24/2024 at 08:33 PM by staff C, 06/25/2024 at 07:03 AM by staff F and 07:45 PM by staff E, and 06/26/2024 at 08:00 AM by staff C.

Plan of Correction ***Accept █ - 08/30/2024)***

It is important for the health and well-being of our residents that all medications are administered correctly. The Director of Health and Wellness and the Director of Memory Care will be re-educating all med techs and nurses on proper medication administration on 9/11/24. The Director of Health and Wellness and the Director of Memory Care or designee, will run a medication report in ECP. This report shows the following: if all medications were administered in the timeframe allotted, if any doses of medications were missed, and if anyone did not sign off after administering a medication. If there are any issues or concerns, the Director will immediately meet with the med tech/nurse to re-educate and provide corrective action if needed. The Regional Director of Health and Wellness will train the Director of Health and Wellness and the Director of Memory Care on how to run this report and review it. This training will take place on 8/21/24. The Directors will run these reports beginning 8/26/24. These reports will

187d - Follow Prescriber's Orders (continued)

be run daily for 1 week, weekly for 6 weeks, bi-weekly for 6 weeks and monthly thereafter. The Director will sign off on these reports and bring them to the monthly QAPI meeting beginning 9/10/24 for the Executive Director to review and monitor for ongoing compliance.

Proposed Overall Completion Date: 09/15/2024

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented ██ - 10/03/2024)

191 - Resident Right to Refuse

16. 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 ██ 2024, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***██ - 08/30/2024)***

It is important that all residents are made aware of their right to refuse medications. The right to refuse medications was added to our contract effective 8/15/24 by the Regional Director of Operations, and will be reviewed with all new residents at the time of contract signing with the Director of Sales & Marketing. The right to refuse is also reviewed when going over Resident Rights in the Resident Handbook. All current residents will be re-educated on their right to refuse medications at the next Resident Council meeting to be held on 8/29/24, by The Executive Director. For any residents who may not attend this meeting, the Executive Director along with the Life Enrichment department will meet with each resident individually to review the handbook along with Resident Rights which includes the right to refuse medications. All current residents will have received a copy of all information by 9/6/24. These audits will begin the week of 8/31/24 and will be completed weekly for 6 weeks, bi-weekly for 6 weeks and monthly thereafter. The Business Office Manager will complete the Resident File Checklist after every admission to ensure all paperwork is provided to and signed off on by the new resident.

Proposed Overall Completion Date: 09/06/2024
Proposed Overall Completion Date: 09/15/2024

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented ██M - 10/03/2024)

233c - Key-Locking Devices

17. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 06/25/2024 around 03:20 PM, the directions for operating the home's locking mechanism are not conspicuously posted near the exit door to the enclosed courtyard and near the gate to the outside of the home.

233c - Key-Locking Devices *(continued)*

Plan of Correction ***Accept (- 08/30/2024)***

It is important to have codes posted for all locked doors for easy egress. The code was immediately posted on 6/25/24. The Director of Plant Operations or designee will complete inspections to ensure all locked doors with a key pad, have the code properly displayed. This inspection will begin 8/19/24. The inspections will be conducted weekly for 6 weeks, bi-weekly for 6 weeks and monthly thereafter. These inspections be reviewed at the monthly QAPI meeting beginning 9/10/24, for the Executive Director to monitor for ongoing compliance.

Proposed Overall Completion Date: 9/15/24

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented - 10/03/2024)