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

October 22, 2024

[redacted], DIRECTOR OF FINANCE
SHANNONDELL INC
[redacted]

RE: THE MEADOWS AT SHANNONDELL
6000 SHANNONDELL DRIVE
AUDUBON, PA, 19403
LICENSE/COC#: 12837

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/15/2024, 04/16/2024, 04/17/2024, 04/18/2024 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: *THE MEADOWS AT SHANNONDELL* **License #**: *12837* **License Expiration**: *03/31/2025*

Address: *6000 SHANNONDELL DRIVE, AUDUBON, PA 19403*

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

Administrator

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

Legal Entity

Name: *SHANNONDELL INC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *11/28/2005* **Issued By**: *CWOPA*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *220* **Waking Staff**: *165*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *04/18/2024*

Inspection Dates and Department Representative

04/15/2024 - On-Site: [redacted]
04/16/2024 - On-Site:
04/17/2024 - On-Site:
04/18/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *184* **Residents Served**: *161*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Avondale & Chatham C* **Capacity**: *34* **Residents Served**: *34*

Hospice

Current Residents: *19*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *152*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *59* **Have Physical Disability**: *0*

Inspections / Reviews

04/15/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/26/2024*

Inspections / Reviews *(continued)*

06/11/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *09/05/2024*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *06/25/2024*

07/09/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *09/05/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/12/2024*

10/22/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *09/05/2024*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 4/15/24 the home's current license, dated 4/23/24- 3/31/25, was not posted in a conspicuous and public place on the 4th floor of the 5000 building.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The current license will be posted in a conspicuous location on the 4th floor of the 5000 building.

The Administrator will be in-serviced on this requirement before June 21, 2024 by reviewing the requirement and signing off on his understanding.

On an annual basis (or whenever an updated license is received), the Administrator will ensure that the updated copy is placed on the 4th floor of the 5000 building and in a conspicuous place in the 6000 building.

The Administrator or designee is responsible to ensure compliance.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

5a1 - DHS Access

2. Requirements

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

Description of Violation

On 4/18/24, at 8:38 am, two agents of the Department, requested access to the lower level Secured Dementia Care Unit (SDCU) by ringing the doorbell per the instructions that are posted at the entrance. Staff person A refused to provide access. Staff person A looked at the agents through the window to the left of the entrance, made eye contacts with the agents, then looked away. Agents rang the bell a second time and were granted access to the unit by a different staff person on duty.

On 4/15/24, during the entrance conference with staff person A and staff person B, the administrator, an agent of the department explained that staff person C needed to be interviewed for an incident investigation. Both staff persons reported that staff person C was not working and that staff person C's schedule was unknown. After the entrance conference, staff person A took agents of the department on a walk-through of the home. On 4/18/24, staff person B provided an agent of the department with time cards for 4/15/24. The time cards showed that staff person C was working in the home on 4/15/24 from 6:58 am until 3:16 pm. Neither staff person A nor B pointed out staff person C

5a1 - DHS Access (continued)

nor informed agents of the staff person's presence in the home. Staff person C was not interviewed as requested.

Plan of Correction ***Accept (- 07/09/2024)***

At no time were agents from the Department denied access to any part of our facility.
All direct care staff will be in-serviced on providing agents of the department, immediate access, upon request, to all areas of our facility on or before June 21, 2024.

The ADON's or designee will complete weekly audits to verify compliance by asking direct care staff if they have allowed access to appropriate individuals that have requested it. These audits will be completed until September 30, 2024 and will be re-evaluated at that time for continuation or completion. The facility QA committee will make determination based on outcomes of audits.

Staff person C is available to be interviewed.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 10/22/2024)

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 , at , reportables, resident care plan information, and residnet medication information were unlocked, unattended, and accessible in the second floor Assistant Director of Nursing office.

On , at , the direct care staff communication log was unlocked, unattended, and accessible in the Chatham hallway.

On , at , resident records were unlocked, unattended, and accessible in the Chatham C hallway.

Plan of Correction ***Accept - 07/09/2024)***

All records shall be maintained in a secure location, preserving confidentiality and privacy, at all times. The ADON office door will be closed when she is not in the office, direct care staff communication logs will be stored properly and the medical charts accessible on Chatham C have been relocated to a secure location.

17 - Record Confidentiality (continued)

The direct care staff will be in-serviced by the ADON on the importance of ensuring records are maintained correctly. This will be completed by June 21, 2024.

The ADON's or designee will complete weekly audits to verify compliance by asking direct care staff if they have allowed access to appropriate individuals that have requested it. These audits will be completed until September 30, 2024 and will be re-evaluated at that time for continuation or completion. The facility QA committee will make determination based on outcomes of audits

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 10/22/2024)

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.

Description of Violation

The assessment and support plan, dated , for resident 1 indicates the resident requires assistance with bi-lateral hearing aids. On , the resident did not receive this assistance as required. The resident was transferred out of the bed for breakfast which starts on or around 8:00 am, and left without hearing aids. The resident pressed the call bell at . Staff did not respond to the call bell until

The assessment and support plan, dated , for resident 2 indicates the resident requires assistance cutting up foods and verbal prompting during meals. On , the resident did not receive this assistance as required.

Resident 3 has a catheter bag that needs to be drained daily. On the bag was observed to be 3/4 full, and the resident's room had a strong smell of urine. The morning nurse stated the bag is supposed to be drained during the overnight shift which is from 7:00 pm to 7:00 am.

Plan of Correction ***Accept (- 07/09/2024)***

After interviewing direct care staff that care for Resident 1, they indicate that Resident 1 is offered and wears hearing aid on a regular basis. If, on , the resident did not have hearing aids in, this was an isolated situation. Resident #1 will continue to have their hearing aids placed as requested.

A copy of call bell activity was requested and provided to the department during survey. Representatives from the department did not ask for explanation on how to interpret the content of the reports and/or ask any follow up questions relative to the reports provided. At no time was Resident #1's call bell on from 10:47 AM to 11:29 AM. A copy of the call bell log for Resident #1's room on 4/17/2024 is attached. The facility requests that this detail be removed from the narrative under the violation on 23a as it is not factually supported.

23a - Activities of Daily Living Assistance (continued)

Resident #2 and all residents that require assistance with feeding will be provided such assistance by direct care staff.

Resident #3's catheter bag was drained on the overnight shift (7:00 PM - 7:00 AM) and a copy of the residents MAR is included verify such action. Representatives from the department did not verify that this was completed by reviewing the medical record and did not ask for assistance to gather this information from the record. The facility requests that this aspect of violation 23a be removed from the narrative as it is not factually supported.

All direct care staff will be in-serviced by the ADON on proper hearing aid assistance and feeding assistance for residents that require such service and proper catheter management. This will be completed by June 21 2024

Starting the week of 6/24, the ADON or designee will complete weekly audits (through observations, records review, resident and staff discussions) to verify that hearing aids are properly placed, that residents receive appropriate attention with meal service and that catheter bags are maintained properly. These audits will be completed until September 30, 2024 and will be re-evaluated at that time for continuation or completion. The facility QA committee will make determination based on outcomes of audits

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

23b - Instrumental Activities of Daily Living Assistance

5. Requirements

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

Description of Violation

The assessment and support plan for resident 4, dated [redacted], indicates the resident requires total assistance with obtaining clean, seasonal clothing. On [redacted], the resident did not receive this assistance as required.

The assessment and support plan for resident 5, dated [redacted] indicates the resident requires total assistance with obtaining clean, seasonal clothing. On [redacted], the resident did not receive this assistance as required.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

Resident #4 and Resident #5 have large amounts of clothing available to them in their room and have active involvement from their family members. Resident #4 and Resident #5 are assisted with dressing as they request, and, many times, they prefer to wear pajamas, a gown, etc... throughout their day.

Resident #4 and Resident #5 will continue to be provided assistance with dressing and the direct care staff will ensure that they have a sufficient amount of seasonal clothing available to them at all times.

23b Instrumental Activities of Daily Living Assistance (continued)

The direct care staff will be in serviced by the ADON on the importance of offering assistance with dressing as is needed. This will be completed by June 21, 2024.

Starting the week of 6/24, the ADON or designee will complete weekly audits (through observations, records review, resident and staff discussions) to verify that hearing aids are properly placed, that residents receive appropriate attention with meal service and that catheter bags are maintained properly. These audits will be completed until September 30, 2024 and will be re evaluated at that time for continuation or completion. The facility QA committee will make determination based on outcomes of audits

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

24 - Personal Hygiene

6. Requirements

2600.

24. Personal Hygiene - A home shall provide the resident with assistance with personal hygiene as indicated in the resident's assessment and support plan. Personal hygiene includes one or more of the following:

Description of Violation

The assessment and support plan, dated [redacted] for resident 6 indicates the resident requires assistance with personal hygiene. On [redacted] the resident did not receive assistance as required. The resident's nails were observed to be extremely thick and long and the resident stated during an interview that the resident did not like fingernails in this condition.

The assessment and support plan, dated [redacted], for resident 7 indicates the resident requires total assistance with personal hygiene. On [redacted], the resident did not receive assistance as required. The resident was observed wearing dirty clothing and had body odor.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

Resident #6 has a diagnosis of [redacted] and has [redacted] on both [redacted] toe nails and finger nails. Resident #6 has a long standing physician order for [redacted] gel Daily for nail [redacted] to [redacted] toenails. This medication is not able to be used on fingernails (they have the same fungus) because it can't be ingested. Resident #6's physician has added a new medication to treat his finger nails that is safe for ingestion. A copy of that order is attached. Resident #6 is followed by podiatry to attend to toenails and, attempts to manicure finger nails have proven to be unsuccessful and, at times, painful to resident #6. The department did not ask us about this condition or the plan / treatment for it.

The direct care staff attend to each resident's personal hygiene needs as they are needed. The facility was unaware that Resident #7 had soiled clothing during the survey and, would gladly change Resident #7 or any resident that needs attention in this area. Resident #7 is provided bathing ADL assistance twice per week,

24 - Personal Hygiene (continued)

Direct care staff will be in-serviced by the ADON on importance of providing assistance with personal hygiene assistance for our residents. This will be completed by June 21 2024

Starting the week of 6/24, the ADON or designee will complete weekly audits (through observations, records review, resident and staff discussions) to verify that hearing aids are properly placed, that residents receive appropriate attention with meal service and that catheter bags are maintained properly. These audits will be completed until September 30, 2024 and will be re-evaluated at that time for continuation or completion. The facility QA committee will make determination based on outcomes of audits

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

42b - Abuse

8. Requirements

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

Description of Violation

Resident 1 requires bi-lateral hearing aid and a chopped diet. On [redacted], the resident was transferred out of the bed for breakfast which starts on or around [redacted], and left without hearing aids. The resident was served a tray of food which contained 2 biscuits which were not chopped. An agent from the department went to the resident's room at [redacted] The resident was visibly upset, shaking and had tears in their eyes. The resident explained that they were awaiting a response to the call bell and they needed hearing aids. Staff responded to the call bell at [redacted]. Upon arrival to the resident's room, staff entered the room, removed the tray, and walked out of the room without speaking to the resident. An agent of the Department informed staff that the resident needed hearing aids. The resident's hearing aids were placed in at [redacted]. The call bell report shows the resident repeatedly pressed the call bell for assistance beginning at [redacted].

Resident 3 has a [redacted]. The bag requires a nurse drain it daily. Staff report that the bag is supposed to be drained during the overnight shift. During the overnight shift beginning [redacted], there was only one nurse scheduled on the overnight shift for 141 residents. On [redacted] the resident's [redacted] was observed to be 3/4 full and the resident's room and a strong odor of urine. The bag did not appear to have been drained overnight.

Resident 4 is confined to a hospital bed without access to repositioning the bed, television remote, and call bell. On [redacted], the resident was observed laying in the bed, in a uncomfortable position, and the television was left on a children's program that the resident did not want to watch. The resident reported that staff control the resident's bed

42b - Abuse (continued)

remote, television remote, and clothing. The resident's bed remote, television remote, and bedside light were observed out of the resident's reach. Resident 4 was observed wearing a hospital gown, and did not know if he/she had any clothing in the home. The resident is incontinent of bladder and bowel. The resident is not taken to the bathroom for toileting. The resident uses incontinence briefs and reusable underpads, and relies on staff to change them. In an interview with agents of the Department, the resident stated that he/she has to "yell for something" to get to staff to come in the room.

Resident 5 is confined to a hospital bed. The resident is unable to transfer in and out of bed independently and requires the assistance of two staff people for transfers. The resident is unable to ambulate independently and requires staff to propel the resident in a wheelchair. On [redacted], the seat of the resident's wheelchair was broken, preventing the resident from sitting in the chair. The length of time the wheelchair has been broken is unknown. In the event of an emergency, the resident needs total assistance to evacuate, however the resident does not a have a wheelchair that would be needed to evacuate. The resident requires total assistance to obtain clean, seasonal clothing. On [redacted], resident 5 was observed laying in a hospital bed wearing a hospital gown. The resident expressed the desire to be in his/her own clothes. The resident is incontinent of bladder and bowel. The resident is not taken to the bathroom for toileting. The resident uses incontinence briefs and reusable underpads, and relies on staff to change them. On [redacted] at [redacted] the resident reported to agents of the Department that he/she had a bowel movement prior to the agents entering the resident's room and was waiting to be changed. At [redacted] staff person entered the resident's room and stopped the call bell, but exited the room without changing the resident. The staff person expressed to agents of the Department that there were other residents in need of assistance at the same time, and that the only other person assigned to the floor was staff person D. While this was happening, staff person D was present on the unit delivering lunch trays to resident rooms and not responding to any call bells. Resident was not changed until [redacted]

Repeat Violation: 6/21/23

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

Resident #1 should have their hearing aids in when they are not sleeping. Direct Care staff will ensure that this happens.
Resident #1 is permitted to have biscuits on a chopped diet because they were moistened. The guidelines for this are included. The department did not ask about this during the survey.
The call bell report for [redacted] is included. There is no evidence that the call bell was on for the amount of time stipulated in this violation. The facility requests that this aspect of this violation summary be removed because it is not factually accurate.

Resident #3 has a physician order for the [redacted] to be changed each shift. According to the medical records included with this submission, the residents [redacted] was changed in the time period included. The presence of urine, in a [redacted] does not mean that the bag was not changed. The nurse on duty, on the overnight shift on [redacted], emptied the [redacted] as ordered. The department did not request evidence of catheter management during the survey. The facility requests that this content be removed from this violation because it is not factually supported.

42b - Abuse (continued)

Resident #4 and all residents should have all bed controls, include call bell, within reach at all times. Resident #4 and all residents should be within reach of their bedside lamp at all times.

The facility is unaware of any issue with Resident #5's wheelchair and Resident #5's wheelchair was inspected during the survey and was confirmed to be in proper working order. The department did not ask about this during the survey. In the event of an emergency, all residents will be evacuated in accordance with our facility fire safety plan and the facility has a large quantity of wheelchairs and other mobility devices available to assist with this process. Resident #5 will be dressed, in their own clothing according to their preference. Direct care staff will provide Resident #5 with ADL assistance when it is needed.

Direct care staff will be in-serviced by the ADON on wheelchairs, proper ADL assistance, hearing aids, catheter management, and the importance of keeping all aspects that a resident needs within their reach. This will be completed by June 21.

The direct care staff will complete training (on-line or in-person) from an agency or resource outside of the facility with a focus on neglect of care and staff roles in preventing abuse / neglect. This will be done by July 24th.

Beginning the week of June 24, The ADON or designee will complete weekly audits to verify compliance (by observations, resident discussion, staff discussion). These audits will be completed until September 30, at which time the facility QA committee will determine if the audits need to continue or conclude based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

42j - Clothing

9. Requirements

2600.
42.j. A resident shall receive assistance in obtaining and keeping clean, seasonal clothing. A resident's clothing may not be shared with other residents.

Description of Violation

Residents 4 and 5 do not have access to clean, seasonal clothing. Both residents require total assistance with obtaining clean, seasonal clothing and were observed on [redacted] in hospital gowns.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

Residents 4 and 5 have a large supply of seasonal clothing and it is readily available to them in their furniture in their room. Resident 4 and 5 have active involvement from family members who ensure that clothing supply is sufficiently maintained.

At times, Resident's choose to wear hospital gowns or pajamas throughout their day.

42j - Clothing (continued)

All direct care staff members will be in-serviced by the ADON or designee on the importance of ensuring that residents have access to clean, seasonal clothing and that they are dressed, in their clothing, when awake.

Beginning the week of 6/24, the ADON or designee will complete weekly audits to verify compliance. This will be done by direct observations and conversations with residents and staff. These audits will be completed until September 30, 2024 at which time the facility QA committee will determine if they audits end or continue based on outcome.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

42l - Personal Clothing

10. Requirements

2600.
42.l. A resident has the right to furnish his room and purchase, receive, use and retain personal clothing and possessions.

Description of Violation

The resident-home contract states that residents' furniture must be approved. During the inspection from [redacted] to [redacted], there were no residents observed to have their own beds.

Plan of Correction ***Directed ([redacted] - 07/09/2024)***

The facility requests that this violation be removed from this report because it is not factually supported.

As the department points out, residents are free to bring their own furniture into the facility. At the time of this survey, residents in rooms 240, 5125, 239 and all residents in rooms 110-140 have their own beds. This represents roughly 33 total residents that have their own bed. The department did not ask about this during the survey.

As complimentary service, our facility provides hospital type beds for residents that elect to use them in certain locations throughout both buildings. Most residents and families elect to utilize these beds because they are electric, are able to be operated by residents and staff and provide residents with a sense of safety knowing that their beds can be adjusted for ease with transfers and ADL Care.

A resident is welcomed to bring their own bed, at any time, in any location.

Direct care staff will be in-serviced by the ADON on the fact that residents are allowed to bring their own personal possessions at their request. This will be completed by June 21st.

42l Personal Clothing (continued)

Beginning the week of June 24, The ADON or designee will complete weekly audits to ensure compliance (through direct observation). These audits will be completed until September 30, at which time the facility QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

***Directed Plan of Correction**: In addition to the above plan of correction, within 30 calendar days of the receipt of this plan of correction, the administrator or designee shall provide communication to current residents and their responsible persons to remind them of their right to furnish their rooms as they prefer with their personal possessions and furniture, provided that the items brought in are in good repair. Should any resident express a desire to bring in their own items, even if they previously expressed a desire to use the facility provided items, the home shall accommodate the resident request within 30 days of receipt. This does not require that the home buy items for residents who do not wish to use the facility owned/provided items. Documentation of the communication to residents/responsible persons shall be kept and made available for Department review upon request.*

Directed Completion Date: *07/31/2024*

Implemented [redacted] - 10/22/2024)

42m - Resident Leave/Return

11. Requirements

2600.
42.m. A resident has the right to leave and return to the home at times consistent with the home rules and the resident's support plan.

Description of Violation

Residents are not able to freely leave the home. The home uses a key fob system to operate the elevators and exit doors. Residents of the home do not have key fobs.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The facility will update the "house rules" to include the hours that the doors will be secured. Once updated, the house rules will be emailed to family members and delivered to the residents in person.

The facility will make modifications to the control system on the elevators in both buildings to ensure residents can leave and return to the home freely. The elevators will be able to called, without the need for code or access card.

The facility will modify the safety door control system to allow residents to be able to leave and return to the home at the main entrances in both buildings, rear entrance of 6000, courtyard entrance in both buildings, balcony on 4th floor of 5000 to ensure that residents can leave and return to the home. Residents will be given individual access cards that will control these entry points during the hours consistent with the house rules.

The Administrator is responsible for ensuring that written communication is delivered to residents and their families.

The Administrator or designee is responsible to ensure compliance is maintained at all times.

42m - Resident Leave/Return (continued)

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

42p - Restraints

12. Requirements

2600.
42.p. A resident shall be free from restraints.

Description of Violation

On [redacted], resident 10 was laying in a hospital bed that had foam wedges on both sides which restricted the resident's movement.

Repeat Violation: 6/21/23.

Plan of Correction ***Accept [redacted] - 07/09/2024)***

The facility requests that this violation be removed from our report because it is not factually supported.

Our facility is a restraint free facility. Resident 10 was receiving hospice services at the time of survey. No facility staff are aware of any foam wedges being used for the care of this resident. Facility staff has confirmed that hospice did not provide such wedges. The facility does not have a supply of foam wedges. The family did not supply foam wedges. The department did not ask any clinical representatives about their observations in Resident #10's room.

Since 2023, the resident slept on a "scoop mattress" and this is ordered by her Doctor. The order is included with this submission. The mattress has elevated edges and is commonly used in all healthcare institutions. It is not a restraint as it does not restrict movement.

Direct Care staff will be in-serviced by the ADON on restraints and the importance of identifying possible restraint scenarios. This will be completed by June 24, 2024

Beginning the week of 6/24, the ADON or designee will complete weekly audits to verify compliance (by observations, resident and staff discussions). These audits will be completed until September 30 at which time the facility QA committee will determine if they should continue or end based on outcomes.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

42s - Privacy

13. Requirements

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

Description of Violation

There are surveillance cameras throughout the home but there is no signage at the cameras indicating there is video monitoring.

In the home's dining rooms, there are place cards that have residents' names and diets written on them. Room 223 has a sign on the door indicating the resident's diet.

On [redacted], resident 11 was laying in bed naked from the waist down and the resident's bedroom door was open. Resident 11 requires total assistance to ambulate and due to the resident's [redacted], is unable to operate a door knob.

On [redacted], staff person E changed resident 12's incontinence brief with the door open.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The facility objects to the wording in this violation as it is not accurate that as cameras are not "throughout" the facility. In 6000 building, there is a safety camera at the main entrance and a safety camera at the rear entrance. In 5000 building, there is a safety camera at main entrance.

Our facility has had surveillance cameras used at all entrance / exit points since 2006 and has never had a sign at any door. These cameras are for safety purposes at each main exit / entrance. We will be adding signs at these areas to inform residents and visitors that video is in use.

The sign on room 223 will be removed by June 21st.

The place cards in our dining rooms have been used since 2006. The content on them is necessary to ensure a safe meal service is provided to each resident. Meal service is not a "bathing, dressing, changing or medical procedure" as is stipulated in this regulatory provision.

Resident #11 shall have their door closed when that is appropriate.

Resident #12 should be provided ADL care in private, with their door closed.

Direct care staff should be providing ADL care in privacy. All direct care staff will be in-serviced by the ADON on the importance of respecting the privacy of our residents and providing them with ADL care accordingly. This will be completed by June 21.

Beginning the week of 6/24, The ADON or designee will complete weekly audits to verify privacy is being preserved during ADL care through direct observations and resident / staff discussion.

42s - Privacy (continued)

The maintenance director or designee is responsible to ensure compliance with the new signs installed.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented [redacted] - 10/22/2024)

57c - 2 Hours/Day

14. Requirements

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On [redacted], there were 153 residents in the home, including [redacted] residents with mobility needs, requiring a total minimum of 212 hours of direct care service. On this date, only 186 hours of direct care staffing was provided.

On [redacted], there were 141 residents in the home, including [redacted] residents with mobility needs, requiring a total minimum of 200 hours of direct care service. On this date, only 182 hours of direct care staffing was provided.

On [redacted], there were 141 residents in the home, including [redacted] residents with mobility needs, requiring a total minimum of 200 hours of direct care service. On this date, only 176 hours of direct care staffing was provided.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The facility objects to this violation and requests that it be removed from our violation report because it is not factually supported.

On the days listed, and all days, the facility provides direct care staff in excess of minimum requirements. The reports that were provided to DHS already deduct meal times out of hours included. Nursing staff assisting with distributing meal trays, is part of their job description in provide direct ADL support and care to our residents. While there is language outlining the removal of hours that direct care staff do on housekeeping, washing dishes, delivering trays to the residents that they are assigned to care for each day are part of the direct care responsibilities of our nursing department.

The ADON's will in-service direct care staff to review applicable duties while working. This will be completed by 7/5/24

The ADON's will complete audits to verify that direct care staff are completing direct care duties only during their workday. This will be done by observations and resident/staff discussions. These audits will be completed until September 30, 2024 at which time the QA Committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this

57c - 2 Hours/Day (continued)

Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

57d - Waking Hours

15. Requirements

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

Description of Violation

On [redacted], a total of 212 hours of direct care was required. However, only 136 of the required hours, or 65 percent, were provided during waking hours.

On [redacted], a total of 200 hours of direct care was required. However, only 126 of the required hours, or 63 percent, were provided during waking hours.

On [redacted], a total of 200 hours of direct care was required. However, only 129 of the required hours, or 64 percent, were provided during waking hours.

Plan of Correction ***Accept [redacted] - 07/09/2024)***

The facility objects to this violation and requests that it be removed from our violation report because it is not factually supported.

During the survey, multiple reports, from the homes payroll system, were provided to the inspectors. At no time were any staff members of the home asked any questions about interpreting these reports. On 3/24/24, 81% of hours were provided during waking hours, on 4/16/24, 78% of hours were providing during waking and on 4/17/24, 79% were provided during waking hours.

Direct care staff will be in-serviced by the ADON on Waking hours requirements and proper verification that minimum hours are delivered each day.

The ADON or designee, will complete random audits, at least weekly, to ensure that compliance is maintained with this requirement. These audits will be completed until September 30 at which time the QA Committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

57d - Waking Hours *(continued)*

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 10/22/2024)

60a - Staff/Support Plan

16. 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 , resident 5, did not receive assistance with incontinence care, as required by his/her assessment and support plan. According to staff and resident interviews, these services could not be provided due to lack of available direct care staffing in the home. Direct care staff were observed distributing food trays to resident rooms instead of responding to call bells.

On , resident 3 was observed wearing a that was 3/4 full and the resident's room had a strong odor of urine. According to staff interviews, the bag is supposed to be changed by the overnight staff but could not be changed due to lack of available direct care staffing in the home.

Plan of Correction ***Accept (- 07/09/2024)***

The facility is not aware of "lack of staff" in the home and provides sufficient staff to care for our residents at all times.

Direct care staff do assist with meal service and tray delivery, however, responding to call bells should be completed during this time period and take precedent over meal distribution.

Resident #3 has a physician order for the to be changed each shift. According to the medical records included with this submission, the residents was changed in the time period included. The presence of urine, in a does not mean that the bag was not changed. The nurse on duty, on the overnight shift on 4/17/24, emptied the as ordered. The department did not request evidence of management during the survey. The medical documentation to support this is included with this submission and the facility objects to this detail in this violation and requests that it be removed because it is not factually supported.
Direct care staff will be in-serviced on the importance of attending to resident's needs by responding to call bells efficiently at all times and proper catheter management.

Beginning the week of 6/24, The ADON or designee will complete weekly audits to verify compliance (through direct observations, report review, resident / staff discussion). These audits will be completed until September 30, at which time the facility QA committee will determine if the audits will continue or conclude based on results.

Direct Care staff will be in-serviced by the ADON on importance of responding to call bells during meal times and to observe catheter bags throughout the day. This will be completed by 6/21

The ADON or designee will complete weekly audits to verify that call bells are being responded to efficiently and that resident catheters are being managed appropriately. These audits will be completed until ongoing and consistent compliance is achieved.

60a Staff/Support Plan (continued)

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 10/22/2024)

60c - Housekeeping/Maintenance

17. Requirements

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

Description of Violation

On , direct care staff were observed serving food to resident rooms and in the dining rooms in both buildings of the home instead of performing direct care duties. According to staff and resident interviews, this is due to a lack of staff to complete the task.

Plan of Correction ***Accept (- 07/09/2024)***

The facility objects to this violation and requests that it be removed from our report because it is not factually supported. The question at hand is whether or not the direct care hours are sufficient to meet minimum standards as outline in 57c and 57d. The amount of housekeeping / maintenance hours is substantial and the facility does not understand the rationale of this violation. To suggest that the direct care staff are assisting with meal service is due to "lack of staffing" is erroneous as this is part of (and always has been part of) the direct care duties. The regulators did not ask about this during the survey.

On 4/16, the facility recorded 470.25 worked hours in laundry, food service and housekeeping.
On 4/17, the facility recorded 442.50 worked hours in laundry, food service and housekeeping.
On 4/18, the facility recorded 468 worked hours in laundry, food service and housekeeping.

The department did not ask about this during the survey. Labor reports are included.

The dining services department manages meal service in our main dining rooms during meal times. Each area has a cook and multiple servers to provide meals.

Our direct care staff are responsible to assist with meal service at all meals. When residents dine in our dining area, members of the dining department assist with this process, however, our direct care staff are also important parts of providing for an enjoyable meal service. It is the facilities position that serving food to our residents is a direct care staff responsibility and all residents in the same area, have the same meal service time, so the direct are staff provide assistance.

The facility provides more than enough staff to provide appropriate care and services in all departments at all times.

All direct care staff will be in serviced by the ADON on the importance of providing appropriate meal service and

60c - Housekeeping/Maintenance (continued)

direct care duties when they are needed. This will be completed by 6/21.

Beginning the week of 6/24, The ADON or designee will complete weekly audits to verify compliance (through observations and resident/staff discussion). These audits will be completed until September 30th at which time the QA committee will determine if they can stop or should continue based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

65f - Training Topics

18. Requirements

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

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

Description of Violation

Direct care staff persons A, F, and G did not receive training in medication self-administration training, care for residents with dementia and cognitive impairments during training year 2023.

Plan of Correction ***Accept [redacted] - 07/09/2024)***

Direct care staff person A, F and G will receive training on medication self-administration. This will be done by 6/21.

Staff person A, F and G did receive training for 2023 in caring for residents with dementia and cognitive impairments and evidence of said training was provided during the survey. It is included with this submission.

During the week of 6/24, The HR office will complete an audit of all remaining direct care staff to ensure compliance with 65f.

Beginning with July, The HR office will conduct regular audits, on a monthly basis, to ensure compliance is maintained. These audits will be completed until September 30 at which time the QA committee will determine if they should continue to end based on results.

65f - Training Topics (continued)

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

65g - Annual Training Content

19. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person A, F G, and H did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, and the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) during training year 1/1/23 to 12/31/23.

Plan of Correction ***Accept [redacted] 07/09/2024)***

Direct care staff persons A, F, G and H will receive training in fire safety completed by a fire safety expert or person trained to be a fire safety expert. This will be completed by June 28.

The week of 6/24, The HR staff will complete an audit on all other direct care employees to ensure that compliance with 65g is met.

The HR staff will complete audits, on a monthly basis, to ensure ongoing compliance with 65g. These audits will be completed until September 30 at which time the QA committee will determine if the audits should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented [redacted] - 10/22/2024)

81b - Resident Personal Equipment

21. 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 5 uses a wheelchair to ambulate. On [redacted], resident 5's wheelchair had a broken seat which prevented the resident from being able to sit in the wheelchair.

Bedside mobility devices that slide under the mattress and are not securely attached to the structure of the bed can move and create entrapment zones not always present upon inspection. These types of devices are not permitted under any circumstance. On 4/17/24, resident 9's bed was equipped with two bedside mobility devices. The device on the right side of the bed was a type that slid under the mattress and was not secured to the frame of the bed.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The facility is unaware of any time that Resident #5's wheel chair was broken at any time and during the survey, Resident #5's wheel chair was inspected and found to be in proper working order. This was not discussed during the survey. Resident #5's wheel chair is not currently broken.

The bedside mobility device on the right side of Resident #9's bed that is not secured to the bedframe will be removed from the bed. This will be done by June 21, 2024.

Direct care staff will be in-serviced by the ADON on the importance of communicating appropriately when resident equipment is in need of repair and any time a piece of equipment, not supplied by the facility, is identified. Completed by 6/21.

Beginning the week of June 24, 2024, the ADON's or designee will complete an audit on a weekly basis to ensure compliance with 81b. These audits will be completed until September 30 at which time the facility QA committee will determine if the audit will continue or end based on outcomes of the audits.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

82c - Locking Poisonous Materials

22. 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

[redacted], barrier cream ointment , with a manufacture's label indicating "if swallowed, get medical help or contact a

82c - Locking Poisonous Materials (continued)

Poison Control Center right away", was unlocked, unattended, and accessible to residents in the Chatham C hallway. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 07/09/2024)***

No poisonous material shall be accessible to any resident in the home. All direct care staff will be in-serviced on the importance of properly storing poisonous material so that it is not accessible to residents.

All residents are assessed for this important aspect of our operation and the outcome of that assessment can be found on each support plan.

Direct care staff will be in-serviced by the ADON on the importance of keeping poisonous material in a safe, secure place that is not accessible to residents. Completed by 6/21.

Current Resident Support plans will be audited (one time) by the nursing department to verify that they include the fact that residents have been assessed capable of recognizing and using poisons safely. This will be completed by 7/5/2024

Beginning the week of 7/8/2024, the ADON or designee will complete weekly audits to verify compliance with 82c. These audits will be completed until September 30, 2024 at which time the facility QA committee will determine if they should continue or end based on outcomes.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented - 10/22/2024)

85a - Sanitary Conditions

23. Requirements

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

Description of Violation

On , in the 4th floor kitchenette, the grill and stove were covered in grime and burnt on food, the juice dispenser was dirty and had a large collection of discarded juice at the bottom, and the inside of the refrigerated salad prep station was dirty.

85a - Sanitary Conditions (continued)

On [redacted], the bathroom in room 230 had a strong smell of urine and the floor was sticky. At [redacted] the toilet in room 233 was stained with dried fecal matter. At [redacted], in the second floor pantry, the microwave was not clean and there was a plate with a cheesesteak from the previous day's lunch. The food had begun to spoil and there was a rotten smell coming from it. At [redacted] a tray of discarded food was sitting on a table in the second floor hallway. At [redacted] the bathroom in room 135 had a strong smell of feces and there was fecal matter in the trash can.

On [redacted], the hallway in 1B had a strong smell of feces. At [redacted], the C wing on the 4th floor had a strong smell of urine. At [redacted] the B wing on the 4th floor had a strong smell of feces. At [redacted], the B wing on the first floor in the 6000 building had a strong smell of body odor. At [redacted], there was a plate of discarded food sitting on a table in the second floor hallway. At [redacted], room 5418 had a strong smell of urine.

Plan of Correction ***Accept [redacted] - 07/09/2024)***

The 4th floor kitchenette grill and stove will be cleaned. The 4th floor juice dispenser will be cleaned. The refrigerated salad prep station will be cleaned. This is all completed by 6/21.

Room 230 will be cleaned by 6/21. The resident who resides in room 230 has a chronic issue with incontinence and housekeeping services are provided to this room regularly. The facility was not asked about this during survey. The toilet in room 233 was cleaned. The 2nd floor microwave was cleaned and the bathroom in room 135 was cleaned.

The Director of Environmental Services will in-service the housekeeping staff on being aware of chronic incontinence issues and mitigating odors associated with this and properly communicating this to their supervisor. This will be completed by 7/12.
Direct care staff will be in-serviced by the ADON on the importance of maintaining a sanitary environment, cleaning any area that requires attention and disposing of food properly. This will be done by 6/21.

Beginning with the week of 6/24, The ADON's and dining services manager will complete weekly audits to ensure compliance with 85a These audits will be completed until September 30th at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

85b - Infestation

24. Requirements

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

Description of Violation

On 4/15/24 at 3:10 pm, gnats were present in the 4th floor kitchenette.

85b - Infestation (continued)

On 4/17/24 at 11:12 am, gnats were present in the 2nd floor pantry kitchen.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

"Infestation" is defined as "the presence of an unusually large number of insects in a place". At no time, ever, has there been an infestation of insects in our facility. The facility objects to this violation and requests that it be removed from our violation report because it is not factually supported.

Our facility has an agreement with a pest control service that visits our facility on a weekly basis to verify that there are not any needs that need to be addressed by reviewing a log at our concierge desk (copies of such log are included). As part of our ongoing plan, the pest control company provided monthly inspections for our kitchen areas only (documentation is included) In addition, for emergency cases, the pest control company is available 24/7. At no time, did the department ask about our pest control services.

Direct care staff will be in-serviced by the ADON or designee on the importance of alerting their supervisor if they observe an insect in any area. This will be completed by June 21.

Beginning the week of 7/1, the maintenance department will complete monthly audits to verify that our pest control services are effective. These audits will be completed until September 30 at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

85d - Trash Receptacles

25. Requirements

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

Description of Violation

On 4/15/24 at 11:00 am there was a 3/4 full, uncovered, unattended trash can in the Chatham C kitchenette.

On 4/15/24 at 3:10 pm there was a full, uncovered, unattended trash can in the 4th floor kitchenette.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The trash can in the chatham C kitchenette will be covered when not in use.

The trash can in the 4th floor kitchenette will be covered when not in use.

85d - Trash Receptacles (continued)

All trash cans in bathrooms and kitchens will be covered when not in use.

Direct care staff will be in-serviced by the ADON or designee on the importance of keeping trash cans in the bathrooms and kitchenettes covered. This will be completed by 7/5/2024

Beginning with the week of 7/8, The dining services and environmental services department will complete monthly audits to ensure that all trash cans in bathrooms and kitchens are covered appropriately. These audits will be completed until September 30th at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

88a - Surfaces

26. Requirements

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

Description of Violation

On 4/15/24 at 10:15 am, to the right of the 1st floor resident laundry room in the 6000 building, there were 3 ceiling tiles with water damage.

On 4/17/24 at 10:53 am, there was an electric razor and blades on the bedside table in room 267 which is located in the Secured Dementia Care Unit.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The ceiling tiles in the 1st floor resident laundry of the 6000 building were replaced. This will be done by June 21.

The electric razor in room 267 was removed. This was completed on 4/17

Direct Care staff will be in-serviced by the ADON on the importance of alerting the maintenance department about stained ceiling tiles and the importance of not having hazards present in resident rooms. This will be completed by 6/21

Beginning the week of 6/24, The ADON or designee will complete weekly audits to verify that there are no hazards in resident rooms. These audits will continue until September 30, at which time the QA committee will determine if they should continue or end based on results.

Beginning in July, The maintenance department will complete monthly audits to verify that ceiling tiles are

88a Surfaces (continued)

inspected and free from stains. These audits will be completed until September 30th at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented [redacted] - 10/22/2024)

89a - Water Pressure

27. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 4/16/24, the home did not have sufficient hot water to wash hands in room 5124. The water temperature was 95.3 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The water temperature in room 5124 has been adjusted and is in proper working order. This was done on 4/16.

The maintenance department will continue to complete water temperature audits throughout the facility

The maintenance department will be in serviced By the director of maintenance on the importance of maintaining water temperatures in the appropriate range. This will be completed by 6/28

The maintenance department will complete weekly audits verifying water temperatures are appropriate. These audits are part of the existing maintenance preventative maintenance schedule and will continue indefinitely.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] 10/22/2024)

89b - Hot Water Temperature

28. Requirements

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

Description of Violation

On 4/16/24 at 10:36 am

89b - Hot Water Temperature (continued)

, the hot water temperature at the bathroom sink in room 5407 measured 124.3 degrees Fahrenheit.

On 4/17/24 at 11:00 am, the hot water temperature at the bathroom sink in room 230 measured 127.7 degrees Fahrenheit.

On 4/17/24 at 11:12 am, the hot water temperature at the bathroom sink in room 233 measured 122.5 degrees Fahrenheit.

Plan of Correction ***Accept (- 07/09/2024)***

The water temperature in room 5407, 230 and 233 has been adjusted and is in proper working order. This was done on 4/16 and 4/17.
The maintenance department will continue to complete water temperature audits throughout the facility
The maintenance department will be in-serviced by the director of maintenance on the importance of maintaining water temperatures in the appropriate range. This will be completed by 6/28.

The maintenance department will complete weekly audits verifying water temperatures are appropriate. These audits are part of the facility preventative maintenance plan and will continue indefinitely.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 10/22/2024)

90b - Staff Communication

29. Requirements

2600.
90.b. For a home serving 9 or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

The home does not have a system that allows staff in different parts of the home to communicate with each other in an emergency. On 4/15/24-4/18/24, the home served 153 residents.

Plan of Correction ***Directed (- 07/09/2024)***

The facility does not agree with this violation and requests that it be removed from our violation report because it is not factually supported.

Representatives from the department did not ask us about the things that we have in place for this purpose during the survey.

Our home is equipped with the latest technology that is readily available for our direct care staff to communicate with one another in the event of an emergency. Communication methods include: emergency fire pull stations, an

90b - Staff Communication (continued)

intercom system in every resident room that can communicate back to the nursing station, a "code blue" feature in every resident room that any employee can activate in the event of an emergency. When code blue is activated, all employees in all areas of each facility are alerted. Additionally, each nursing station has a telephone that can call directly into each residents room. The communication options available to our direct care staff have been the same since 2006.

At not time were we made aware that these communication methods are not sufficient.

In addition to all of the options listed above, the facility will introduce a walkie talkie option for the direct care staff to use while they are working. This will allow direct care staff to communicate with each other during work hours. No other departments will use these walkie talkies. This will be in place by 7/31/24
While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Directed Plan of Correction: *In addition to the above plan of correction, the administrator or designee shall in-service all direct care staff on the availability and proper use of communication equipment. This in-service shall be completed within 10 calendar days of the implementation of the walkie system. Documentation of the in-service training shall be kept and made available for Department review upon request.*

Directed Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

95 - Furniture and Equipment

30. Requirements

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

Description of Violation

On 4/17/24, the toilet paper holder in room 233 was broken.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

Our facility has a comprehensive work order system and our maintenance department responds to any repair needs very efficiently. It is unfortunate that the toilet paper holder in room 233 was broken when an inspector observed this area.

No staff members were aware of the broken toilet paper holder and it has since been repaired.

Direct care staff will be in-serviced by the ADON on the importance of reporting all faulty equipment or any area in need of repair to their supervisor or concierge. This will be done by 6/21

Beginning the week of 6/24, the ADON will complete weekly audits to verify that there are no repair needs in resident rooms. These audits will be completed until September 30, at which time the QA committee will determine if the audits should continue or end based on results.

95 - Furniture and Equipment (continued)

The Maintenance department is responsible to address work orders and areas in need of repair to maintain compliance with 95.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

101j7 - Lighting/Operable Lamp

31. Requirements

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

Description of Violation

Residents 4, 5, 9, 10 and 13 do not have access to a source of light that can be turned on/off at bedside. On 4/17/24, Resident 13's bed was measured to be 55 inches away from the bedside light.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

Resident #4, 5, 9, 10 and 13 had their bedside light (which was present at the time of survey) moved closer to their bed.

The ADON or designee will complete an audit on all rooms to ensure that each resident has an operable, bedside lamp, within reach. This will be completed by 6/28.

Direct care staff will be in-serviced by the ADON on the importance of each resident have a bedside light source, within reach. Completed by 6/21

Beginning the week of 6/24, The ADON or designee will complete weekly audits to verify compliance with 101j7. These audits will be completed until September 30, at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented [redacted] - 10/22/2024)

101o - Walls, Floors, Ceilings

32. Requirements

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

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

Description of Violation

On 4/17/24 at 11:08 am, the carpet in bedroom 233 was stained and there was food smashed into it and scattered on the floor around the bed.

Plan of Correction ***Accept (- 07/09/2024)***

The carpet in room 233 will be cleaned by 6/21.

The ADON or designee will complete an audit on all rooms to ensure that the carpet or floor surface does not require housekeeping attention. This will be done by 6/28

Our housekeeping department, consisting of roughly 25 employees, provides housekeeping service to our resident regularly. If an area is identified as needed to be cleaned or a carpet extracted, that service is provided immediately.

Direct care staff will be in-serviced by the ADON on the importance of notifying housekeeping anytime a resident's floor needs to be cleaned. This will be done by 6/21

Beginning the week of 6/24, The ADON or designee will complete a weekly audit verifying that resident floors are clean free of stains. These audits will be completed until September 30, at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented - 10/22/2024)

103c - Food Protected

33. Requirements

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

Description of Violation

On 4/17/24 at 11:20 am there was an uncovered plate of chicken salad stored in the refrigerator in the 2nd floor pantry kitchen. At 11:23 am, the ice bin used for beverages in the dining room was uncovered.

Plan of Correction ***Accept (07/09/2024)***

The plate of chicken salad in the refrigerator on the 2nd floor pantry kitchen was discarded.

The ice bins, used for beverages are uncovered when they are being used and covered when they are not in use.

Dining Services staff will be in-serviced by dining services manager on proper food storage, preparation and transportation. This will be completed by 6/21

103c - Food Protected (continued)

Beginning the week of 6/24, The dining services department will complete a weekly audit in all pantry kitchens to ensure that food is properly stored and to ensure that the ice bins are being covered correctly. These audits will be completed until September 30 at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

103f - Refrigerator/Freezer Temps

34. Requirements

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

Description of Violation

On 4/15/24 at 3:01 pm the temperature in the freezer in the 1st floor Nourishment Room in the 5000 building was 10 degrees Fahrenheit.

On 4/15/24, there was no thermometer in the refrigerated salad prep station in the 4th floor kitchenette.

Plan of Correction ***Accept [redacted] - 07/09/2024)***

The freezer in the 1st floor nourishment room in the 5000 building has been inspected and adjusted as needed to ensure proper temperature. This was completed on 4/15

A thermometer has been added to the refrigerated salad prep station in the 4th floor kitchenette.

The dining services staff will be in-serviced by the dining services manager on the importance of maintaining freezer temperatures appropriately and to ensure that all areas that require a thermometer, have one. This will be completed by 6/21.

Beginning the week of June 24, The dining services manager or designee will complete weekly audits to verify compliance. These audits will be completed until September 30 at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

103f - Refrigerator/Freezer Temps *(continued)*

Implemented ([redacted] - 10/22/2024)

103g - Storing Food

35. Requirements

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

Description of Violation

The bag of croutons in the 2nd floor pantry kitchen was opened and unsealed on 4/17/24.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The bag of croutons identified in the 2nd floor pantry was discarded on 4/18

The dining services staff will be in-serviced by the dining services manager on the importance of food being stored and closed or in sealed containers. This will be completed by 6/21

Beginning the week of 6/24, The dining services team will complete weekly audits to verify compliance. These audits will be completed until September 30 at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

103i - Outdated Food

36. Requirements

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

Description of Violation

On 4/15/24, several bottles of Thick N Easy nectar were observed opened and not refrigerated on medication carts throughout both the 5000 and 6000 buildings. The label on each bottle read, "refrigerate unused portion". On the 1st floor medication cart in the 6000 building, there were 2 bottles of Thick N Easy that were expired on 3/24/24 and 3/31/24 and an open cup of applesauce dated 4/14. In the refrigerator in the 1st floor Nourishment Room in the 5000 building, there were two bottles that were expired on 1/6/24 and 3/27/24.

On 4/15/24, there was a tray of sliced cake on the counter and 3 bags of chicken gravy mix, not labeled and dated in the 4th floor kitchenette.

On 4/17/24, there was an unlabeled, undated tray of cookies on the counter in the 2nd floor pantry kitchen.

103i - Outdated Food *(continued)*

Plan of Correction ***Accept (- 07/09/2024)***

The facility contacted the manufacture of Thick N Easy and they have confirmed that our licensed nursing staff is using their product appropriately during medication administration (as was observed during survey). At the conclusion of the med pass, the nursing staff shall refrigerate any unused portion of the Thick N Easy.

All expired think N easy was discarded.
All opened applesauce was discarded.
The tray of sliced cake and 3 bags of chicken gravy mix were actively in use at time of observation.
The tray of unlabeled, undated cookies on the counter in the 2nd floor pantry were being used, as part of meal service at the time of observation.
All food that is outdated shall not be used. All food shall be labeled and dated appropriately at all times.

The dining services staff will be in-serviced by the dining services manager on the importance of ensuring that food is properly labeled and discarded of if expired. Completed by 6/21

The direct care staff will be in-serviced by the ADON on the importance of ensuring that food is properly labeled and discarded of if expired. Completed by 6/21

Beginning the week of 6/24, The ADON or designee and the dining services department will complete weekly audits to ensure compliance. These audits will be completed September 30 at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 10/22/2024)

104b - Dishes/Glassware/Utensils

37. Requirements

2600.
104.b. Dishes, glassware and utensils shall be provided for eating, drinking, preparing and serving food. These utensils must be clean, and free of chips and cracks. Plastic and paper plates, utensils and cups for meals may not be used on a regular basis.

Description of Violation

The home does not provide residents with glasses for drinking. Styrofoam cups are used on a regular basis.

Plan of Correction ***Directed (- 07/09/2024)***

The facility objects to this violation and requested that it be removed from our violation report because it is not factually supported.

Our residents are served all of their meals with glasses for drinking. Glasses are provided at our dining room tables, on our resident trays at all mealtimes and services.

104b - Dishes/Glassware/Utensils (continued)

The department did not ask about this during our survey.

Direct care staff will be in-serviced by the ADON on the importance of providing glasses for residents at all meals. Completed by 6/21

Beginning the week of 6/24, The dining services department will complete monthly audits to confirm compliance These audits will be completed until September 30 at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

***Directed Plan of Correction**: In addition to the above plan of correction, the home shall provide residents with appropriate glassware for all drinking needs, including drinks brought to residents in their apartments and not just at meal times in the dining rooms. Paper, or other disposable cups shall not be used on a regular basis. Within 14 calendar days of the receipt of this plan of correction, staff of the home shall receive an in-service on the importance of using regular plates, dishes and glassware versus using disposable items in order to create a dignified, home like environment for residents. Documentation of the in-service training shall be kept and made available for Department review upon request.*

Directed Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

104e - Daily Meals/Dining Room

38. Requirements

2600.
104.e. Breakfast, midday and evening meals shall be served to residents in a dining room except in the following situations:
1. Service in the resident's room shall be available at no additional charge when the resident is unable to come to the dining room due to illness.
2. When room service is available in a home, a resident may choose to have a meal served in the resident's room. This service shall be provided at the resident's request and may not replace daily meals in a dining room.

Description of Violation

On 4/16/24, lunch was served to rooms on the 2nd floor including room 5139. The resident in this room was not given the option to have lunch in the dining room before the meal was served to the room. The resident reported to an agent of the department that the resident would like to eat lunch in the dining room.

On 4/18/24, at 9:06 am, the lights were out in the 2nd floor dining room and the home's direct care were observed distributing breakfast trays to residents' room on the second floor in the 6000 building. Meal service was not provided in the dining room.

The dining room in the 5000 building is not open on the weekends. On Fridays, residents are asked to select what

104e - Daily Meals/Dining Room (continued)

they would like to eat for 3 days' worth of meals and the food is brought to their rooms.

Plan of Correction ***Directed [redacted] - 07/09/2024)***

The facility has a full time dining services liaison that meets with each resident, in person, to discuss meal service options. Additionally, meal service options are shared through our resident portal. The resident in 5139 was met with, in person, to discuss meal service locations and indicated to our liaison that they would like to enjoy their meals in their room. This choice is not given before every meal, rather on admission and changes are made any time a resident or their family communicates that a change is desired. Residents can change where they would like to eat their meals at any time.

Facility meal services will be modified to ensure that all meals are offered in each dining room each day. Meal services, in all dining rooms, for all meals, will be available beginning the week of 7/8

The direct care and dining services staff will be in-serviced by the ADON and dining service manager on ensuring that meals are offered and available in dining rooms for all meals.

The dining services department and ADON's will ensure that the modifications to our meal service are implemented.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Directed Plan of Correction: In addition to the above plan of correction, and within 14 calendar days of the receipt of this plan of corrections, the administrator or designee shall notify resident's and their responsible persons that resident's may choose to eat in their room and that they may change their mind at any time without notice. A staff in-service shall be conducted within 15 business days with an emphasis on promoting group dining as it raises quality of life for residents.

Directed Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

105g - Lint Removal and Duct Cleaning

39. Requirements

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

Description of Violation

On 4/18/24, there was an accumulation of lint in the lint trap of the dryer in the Berwyk nurses' station. There were no clothes in the dryer at the time.

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

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The facility understands the importance of maintaining lint traps in a matter that is free from debris.

The direct care staff will be in-serviced by the ADON or designee on the importance of monitoring this area and what measure to take in the event that there is lint identified on the trap. Completed by 6/21

Beginning the week of 6/24, the maintenance department will complete weekly audits to verify that lint traps on resident dryers are free from debris. These audits will be completed as part of the facility preventative maintenance plan and continue indefinitely as part of the program.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/24/2024*

Implemented [redacted] - 10/22/2024)

107d - Procedure Emergency Management Agency Submission

40. Requirements

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

Description of Violation

The home's written emergency procedures have not been local emergency management agency since 9/18/22.

Repeat Violation: 9/15/22 et al.

Plan of Correction ***Directed ([redacted] - 07/09/2024)***

The facility emergency management procedures was submitted to the local emergency management agency on _____ by the Director of Maintenance.

The maintenance department will be in-serviced by the maintenance director on the importance of the facility emergency management procedures being submitted to the local emergency management agency annually. This will be done by 6/28.

The Maintenance Director is responsible for maintaining compliance by submitting the emergency management plan annually.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Directed Plan of Correction: As there is no date indicated in the above plan of correction, the home shall follow this directed plan. Within 5 calendar days of the receipt of this plan of correction, the administrator or designee shall contact the local emergency management agency to inquire as to the best method of submission for the procedures (email, fax or certified mail) and then the procedures shall be submitted as indicated immediately. Documentation of

107d - Procedure Emergency Management Agency Submission *(continued)*

Directed Completion Date: *07/31/2024*

Implemented [redacted] - 10/22/2024)

121a - Unobstructed Egress

41. Requirements

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

Description of Violation

On 4/17/24 at 12:23 pm, a chair blocked egress from the home's back exit in Avondale.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The area identified in this violation is a sitting area on a memory care unit. Frequently, this area is enjoyed by the residents on this unit as well as the family members of the residents. Frequently, to maximize comfort, family members and resident re-arrange furniture to be able spend time together.

In this case, furniture was moved, by a non-staff member, and placed in front of an emergency use only egress door (not a regular entrance or exit). Once identified, the chair was moved.

The direct care staff will be in-serviced by the ADON on the importance of not blocking egress from any exit door. Completed by 6/21

Beginning the week of 6/24, The ADON or designee will complete weekly audits to verify that exit doors are not blocked. These audits will be completed until September 30, 2024 at which time the facility QA committee will make a determination to continue or end the audits based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/24/2024*

Implemented [redacted] - 10/22/2024)

123b - Emergency Procedures Posted

42. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 07/09/2024)***

A copy of the facility emergency procedures will be posted in a conspicuous and public place in the facility (in both buildings). In 5000 building this will be in the main floor (floor 1) living room and in the 6000 building this will be

123b - Emergency Procedures Posted (continued)

in the first floor living room.

The maintenance department will be in-serviced by the Director of Maintenance on the importance of ensuring that this is readily available in the intended locations. This will be done by 6/21/2024.

Beginning with the week of 6/24, The maintenance department is responsible to monitor for compliance and will complete weekly audits to ensure that this is readily available in the correct place. These audits will be completed until September 30, 2024.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/24/2024*

Implemented ([redacted] - 10/22/2024)

132h - Designated Meeting Place

43. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill in the 6000 building on 11/8/23 at 10:33 am, residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. 91 residents were in the home at the time and only 9 evacuated.

During the fire drill in the 5000 building on 11/18/23 at 12:35 pm residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. 61 residents were in the home at the time and only 6 evacuated.

The home's emergency procedures for fires states that after the smoke alarm sounds, "Residents not in immediate harms way will remain in their rooms with the doors closed until the order to evacuate is given." Further instructions in the emergency procedures are for staff in the beauty salon, dining, and therapy areas to remain where they are with residents when an alarm sounds. During staff and resident interviews, it was reported to agents of the Department that residents are not evacuated during fire drills. It was also reported that there is no designated meeting place.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The facility is in the process of partnering with a new fire safety consultant. This will be completed by 7/31/2024.

The maintenance Director and Administrator will work with the new fire safety consultant to establish fire evacuation methods that are consistent with regulatory expectations. This will be done by 7/31/2024

Once the modifications are made, the emergency management / fire safety plan will be updated. This will be done

132h Designated Meeting Place (continued)

by 8/14/2024

Staff members will be in serviced by the fire safety consultant to review the modifications and ensure understanding of such. This will be done by 8/31/2024.

The Maintenance Department will conduct fire drills, following updated evacuation proceedings as is required in regulatory provisions. These drills will be completed indefinitely.

The Maintenance Department will maintain documentation of such fire drill as is required.

The director of maintenance will continue to do fire drills as is required and provide education with each drill.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *08/31/2024*

Implemented ([redacted] - 10/22/2024)

161d - Dietary Needs

44. Requirements

2600.
161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

On [redacted], resident 1 was prescribed a [redacted]. However, on [redacted] at breakfast the resident was served bread that was not [redacted].

On [redacted], resident 2 was prescribed a [redacted] However, on [redacted] at lunch the resident was served a meal that consisted of pot roast that was not ground.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

Resident #1 was provided a piece of moistened bread. Moistened bread is appropriate for chopped diet. Dietary guidelines included. As a result, the facility requests that this content be removed from violation 161d as it is not factually supported. The facility was not asked about this during survey.

Resident #2 will be provided appropriately prepared food.

All staff will be in serviced by the ADON or designee on importance of following physician ordered diets. This will be completed by June 21 2024

Beginning the week of June 24, the ADON or designee will complete weekly audits during meal service to verify

161d - Dietary Needs (continued)

accuracy of food served to residents. These audits will be completed until September 30, 2024 at which time the facility QA committee will decide if they continue or end, based on outcomes.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/24/2024*

Implemented ([redacted] - 10/22/2024)

162c - Menus Posted

45. 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

On 4/15/24, the two-week menu was not posted in the 6000 building.

On 4/15/24, the home's menu for the weeks of 6/14/21- 6/26/21 and 6/27/21- 7/3/21 were posted in the Chatham C dining area. However, the current two-week menu was not posted.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

During the survey, the incorrect menus on Chatham C Wing were removed and current menus were posted.

Two week menus are posted in 3 locations in the 6000 building and were posted in these locations during the survey. The locations are next to the resident mailboxes on floor 1, in the middle of the entire unit on floor 2 and at the beginning of the hallway on lower level. They have been posted in these locations since 2006. The department did not ask for the location of these postings during the survey. As a result the facility objects to this part of the violation summary and requests that it be removed from the report because it is no factually supported.

Dining Staff will be in-serviced by dining managers on the importance of ensuring that menus are posted timely and accurately. This will be completed by 6/21/2024

Beginning the week of 6/24, the dining services department will complete audits to ensure that this is done correctly on a weekly basis. These audits will continue until September 30, 2024.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/24/2024*

Implemented ([redacted] - 10/22/2024)

182c - Medication Administration

46. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).

Description of Violation

On [redacted], the home did not place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4) for resident 14, who requires this assistance to take [redacted].

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

Resident 14 takes [redacted] medications by accepting them from the licensed nurse, in a cup, and [redacted] takes them with [redacted] own supply of water. The charge nurse will ensure that Resident 14 takes her medications appropriately during med pass.

All licensed nursing staff will be in-serviced by the ADON on proper medication administration to ensure that medications are administered appropriately an in accordance with each residents needs. Completed by 6/21

Beginning the week of 6/24, The ADON or designee will complete medication pass observations to ensure licensed nursing are following medication administration guidelines. These audits will be completed until September 30 at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented [redacted] - 10/22/2024)

183a - Original Containers and Injections

47. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

On [redacted], 2 clear, unlabeled vials of medication had been removed from their original container and placed in a plastic cup on top of the medication cart on wing B on the 4th floor.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

No medication should be improperly stored on any medication carts.

The licensed nursing staff will be in-serviced by the ADON on proper medication administration, including

183a - Original Containers and Injections (continued)

medication storage. Completed by 6/21.

Beginning the week of 6/24, The ADON or designee will monitor for compliance as part of their medication administration observations. These will be done on a weekly basis. These audits will be completed until September 30 at which time the QA committee will determine if they should continue or end based on results.

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Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

183b - Meds and Syringes Locked

48. Requirements

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

Description of Violation

On [redacted], 2 clear, unlabeled vials of medication was unlocked, unattended, and accessible on top of the medication cart in wing B on the 4th floor.

On [redacted], [redacted] were unlocked, unattended, and accessible in room 5405. At [redacted] prescription [redacted]ment was unlocked, unattended, and accessible in room 5407.

On [redacted], all of the medication carts in the 5000 building were unlocked, unattended, and accessible. There were blister packs of medication in the nurses station in 1B and a medication delivery on the 4th floor Wing C, all unlocked, unattended, and accessible.

Repeat Violation: 9/15/22 et al.

Plan of Correction ***Accept [redacted] - 07/09/2024)***

All medications and syringes should be secured at all times

Blister packs of medications shall be kept in a secure location at all times.

The direct care staff will be in-serviced by the ADON on the importance of keeping medications secured at all times. Completed by 6/21.

Beginning the week of 6/24, The ADON or designee will complete med pass observations and weekly audits (across all shifts) to verify compliance. These audits will be completed until September 30 at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this

183b Meds and Syringes Locked (continued)

Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

183d - Prescription Current

49. 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 [redacted], [redacted] prescribed for individual resident 15, was in the home's medication cart; however, resident 15 no longer resides in the home.

On [redacted], [redacted] nasal spray was in the home for resident 16. This medication is not prescribed to resident 16.

Repeat Violation: 9/15/22 et al.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The [redacted] for resident 15 was discarded.

The [redacted] for resident 16 was discarded.

The direct care staff will be in serviced by the ADON on the importance of ensuring that medications and glucagon kits are discarded appropriately. Completed by 6/21

Beginning the week of 6/24, The ADON or designee will complete medication cart audits on a weekly basis to verify compliance. These audits will be completed until September 30 at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] 10/22/2024)

183e - Storing Medications

50. Requirements

2600.

183e Storing Medications *(continued)*

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

Description of Violation

On [redacted], there were 10 loose pills in the first floor A/B medication cart, 7 loose pills in the first floor med cart B/C medication cart, 11 loose pills in the 5000 building 1B medication cart, and 4 loose pills on the 4C medication cart.

On [redacted] both prescribed to resident 16 were mixed together in a box that belonged to the [redacted]. Both medications are clear and in plastic vials.

On [redacted] pen prescribed to resident 17, was opened and not dated. According to the manufacturer's instructions the medication must be discarded after 28 days.

Repeat Violation: 12/5/22 .

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

Medication carts should not have loose pills in them at any time.

Resident medications should be stored, separately, according to each resident.

Novolog flex pends should be dated when opened.

The licensed nursing staff will be in serviced by the ADON on medication storage and labeling. Completed by 6/21.

Beginning the week of 6/24, The ADON or designee will complete med cart audits on a weekly basis to ensure compliance. These audits will be completed until September 30 at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

183f - Discontinued Medications

51. Requirements

2600.

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

183f - Discontinued Medications *(continued)*

Description of Violation

O[redacted], staff person D disposed of 3 loose pills by putting them in a sharps container. This is not an approved method of destroying medications according to the Department of Environmental Protection and Federal and State regulation.

Plan of Correction ***Accept[redacted] - 07/09/2024)***

Staff person D will be in-serviced on proper medication destruction practices.

All licensed nursing staff will be in-serviced by the ADON on proper medication destruction practices. Completed by 6/21.

Beginning the week of 6/24, The ADON or designee will complete weekly audits to ensure medications are discarded properly. These audits will be completed until September 30 at which time the QA committee will determine if they should continue or end based on results.

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Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

184a - Resident's Meds Labeled

52. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

On[redacted], there was an insulin pen on the 1B medication cart that did not have a pharmacy label.

On[redacted], there were[redacted] in individual packages with no pharmacy no label and no box in the 4C medication cart.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

All medications should be properly labeled by the pharmacy.

The licensed nursing staff will be in-serviced by the ADON on the importance of verifying that medications are properly labeled. Completed by 6/21.

Beginning the week of 6/24, The ADON or designee will complete med cart audits to verify that medications are labeled correctly. These audits will be completed until September 30 at which time the QA committee will determine if they should continue or end based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The

184a - Resident's Meds Labeled (continued)

Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 10/22/2024)

184b - Labeling OTC/CAM

53. Requirements

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

Description of Violation

On , a bottle of belonging to resident 16 was in the medication cart and was not labeled with the resident's name.

Plan of Correction ***Accept (- 07/09/2024)***

All medications should be properly labeled for all residents. Resident #16's nasal spray was correctly labeled.

The facility licensed nurses will be in-serviced by the ADONs on ensuring that medications are properly labeled at all times and steps to take to rectify any discrepancy. Completed by 6/21

Beginning the week of 6/24, The ADON or designee will completed audits to verify compliance. These audits will be completed until ongoing and consistent compliance is achieved.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented - 10/22/2024)

185a - Implement Storage Procedures

54. Requirements

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

Description of Violation

On , the glucometer that belongs to resident 17 was not calibrated for the correct time. On the was set to .

Resident 18 is prescribed , loratadine , as needed. On these medications were not available in the home.

On , Resident 18 's blood glucose reading was However, it was documented as on the

185a - Implement Storage Procedures (continued)

Medication Administration Record.

Repeat Violation: 9/15/22 et al and 12/5/22.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

The facility will ensure that glucometers are calibrated to correctly include the date and time. Resident #18's [redacted] are all PRN (As Needed) medications. During observations these medications were ordered and arrived prior to the resident requiring them to be administered.

The discrepancy for Resident 18's blood glucose is not understood by the facility as [redacted] is what is documented in the MAR. This is included with submission.

The facility licensed nursing staff will be in-serviced by the ADON on glucometer calibration and medication availability. Completed by 6/21.

Beginning the week of 6/24, The ADON or designee will complete week audits to ensure that glucometers are calibrated and meds are available. These audits will be completed until September 30 at which time the QA committee will determine if they should stop or continue based on results.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

187b - Date/Time of Medication Admin.

55. Requirements

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

Description of Violation

On [redacted] pm, Staff person I intialed and dated the medication administration record for resident 16 to indicate that [redacted] spray was administered. However this medication was not administered to resident 16 becasue it was not available in the home.

Repeat Violation: 9/15/22 et al and 12/5/22.

Plan of Correction ***Accept [redacted] - 07/09/2024)***

On [redacted], Resident #16's ocean nasal spray was administered according to physician orders. A copy of the MAR is attached.

The licensed nursing staff will be in-serviced by the ADON on the importance of administering medications in accordance with physician orders. Completed by 6/21.

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

Beginning the week of 6/24, The ADON or designee will conduct med pass observations. The ADON or designee will complete weekly med pass observations weekly. These observations will be completed until September 30 at which time the QA committee will decide if they should continue or end based on performance.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

187d - Follow Prescriber's Orders

56. Requirements

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

Description of Violation

Resident 16 is prescribed [redacted], spray 1 spray by nasal route in both nostrils 3 times per day. However, this medication was not administered to resident 16 on [redacted] because the medication was not available in the home.

Resident 17 is prescribed to check blood glucose level three times a day at [redacted]. However, on [redacted], the resident was not checked in the morning. The resident was checked at [redacted].

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

Resident #16 will receive their nasal spray in accordance with physician orders.

Resident #17 will have their blood sugar checked in accordance with physician orders.

Licensed nursing staff will be in-serviced by the ADON on the importance of administering nasal spray and verify blood sugars according to resident physician orders. Completed by 6/21.

Beginning with the week of 6/24, The ADON or designee will complete medication administration audits to verify compliance. These audits will be completed until ongoing and consistent compliance is achieved.

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)

227d - Support Plan Medical/Dental

59. Requirements

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

Description of Violation

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

The assessment for resident 9, dated [redacted], indicates the resident has a need for turning and positioning in bed. The resident's support plan, dated [redacted] does not document that the resident uses 2 bedside mobility devices, the specific need for the devices, the intended use and any risks associated with the use, the resident's ability to use the devices safely for the purpose they were intended, and identification of the specific devices to be used and whether covers are required to meet FDA guidelines.

Plan of Correction ***Accept[redacted] - 07/09/2024)***

Resident #5 and Resident #9 no longer have bedside mobility devices on their beds
The ADON's will be in-serviced by the Administrator or designee on the importance of completing support plans to include necessary details about bedside mobility devices if they are implemented for a resident. This will be completed by 6/21/2024

Beginning the week of [redacted], the ADON's or designee will complete weekly audit to verify that no bedside mobility devices are being used. These audits will be completed until September 30, 2024 and will be re-evaluated at that time for continuation or completion. The facility QA committee will make determination based on outcomes of audits

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/24/2024*

Implemented[redacted] - 10/22/2024)

252 - Record Content

60. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:

252 - Record Content *(continued)*

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident 8's record does not include a complete inventory sheet. The form states "various items" when referencing the resident's clothing.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

When completing an inventory sheet for new move ins, the facility has been including "various items" for over 10 years. With this being identified as being out of compliance in 2024, we will modify our practices to ensure that the inventory sheet is completed accurately.

The marketing staff will be in-serviced by the Administrator or designee on the importance of completing inventory sheets accurately. This will be completed by June 21 2024.

With new move ins, the marketing staff or designee will ensure that the inventory sheets are completed accurately.

Beginning on June 24, The marketing staff will complete an audit with new move in's to verify that all inventory sheets are completed correctly.

252 - Record Content (continued)

While we submit this Plan of Correction under procedures established by the Department of Human Services, this Plan of Correction in no way constitutes an admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 10/22/2024)