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

June 17, 2024

[REDACTED], CEO/PRESIDENT
PRESBYTERIAN SENIOR CARE INC
1215 HULTON ROAD
OAKMONT, PA, 15139

RE: WOODSIDE PLACE OF OAKMONT
1215 HULTON ROAD
OAKMONT, PA, 15139
LICENSE/COC#: 42973

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/17/2024, 04/17/2024 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: *WOODSIDE PLACE OF OAKMONT* **License #**: *42973* **License Expiration**: *08/02/2024*

Address: *1215 HULTON ROAD, OAKMONT, PA 15139*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *PRESBYTERIAN SENIOR CARE INC*

Address: *1215 HULTON ROAD, OAKMONT, PA, 15139*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/04/1991* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *72* **Waking Staff**: *54*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *04/17/2024*

Inspection Dates and Department Representative

04/17/2024 - On-Site: [redacted]

04/17/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *37* **Residents Served**: *36*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire home* **Capacity**: *37* **Residents Served**: *36*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *36*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *36*
Have Physical Disability: *0*

Inspections / Reviews

04/17/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/23/2024*

05/28/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/15/2024*

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

Inspections / Reviews *(continued)*

06/06/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/15/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/15/2024*

06/17/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *06/15/2024*

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

15a - Resident Abuse Report

1. Requirements

2600.

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

Description of Violation

On 4/12/24, at approximately 8:15 p.m. direct care staff person A, was shadowing direct care staff person C. Both staff entered resident #1's bedroom to get the resident ready for bed. Direct care staff person C, said to resident #1, "time to get ready for bed." Resident #1 seated on a chair in the bedroom replied, "No." Direct care staff person A, indicated, direct care staff person C looked at [redacted] and said, "this is how I handle this" and proceeded to grab resident #1's left hand and then with the other hand grabbed the resident's left wrist and pulled the resident up out of the chair. Resident #1 was loudly saying, "No, ouch, No". Direct care staff person C holding the resident's left hand with [redacted] right hand on the resident back pushing the resident into the bathroom. Direct care staff person C was trying to push resident #1 to the toilet with [redacted] left hand and the resident tripped over direct care staff person C's foot, causing resident #1 to lose balance, banging [redacted] right shoulder into the wall. Resident #1 was directed onto the toilet. Direct care staff person A indicated resident #1 kept saying "NO" repeatedly, approximately 10 times. Direct care staff person C had told resident #1 several times to be quiet. Direct care staff person C was roughly undressing the resident while on the toilet. While direct care staff person C was taking off resident #1's socks, stated, "I am tired of this [redacted] and was very rough with the resident's feet while removing the resident's socks. Direct care staff person C did not wash up the resident, did not apply any barrier cream, only putting a clean brief on the resident. Interviews indicated direct care staff person C pulled resident #1 from the bathroom by [redacted] right arm while resident #1 was resisting backwards. Resident #1 had grabbed [redacted] shoes while being pulled from the bathroom. Direct care staff person C grabbed them out of the resident's hands telling the resident, "You don't need to be messing with this" grabbing them out of the resident's hands, throwing them into [redacted] room on the floor. Direct care staff person C positioned resident #1 with [redacted] back facing the bed and with both hands pushed the resident backwards onto the bed. Resident #1 caught [redacted] and fell on [redacted] forearms and elbows, otherwise, the resident would have hit [redacted] head. Direct care staff person C, then grabbed the resident's ankles and threw [redacted] legs onto the bed, threw a blanket over the resident, and told resident #1, "Now go to sleep" and walked out of the room. Direct care staff person A indicated resident #1 kept saying, "NO, OUCH, NO" multiple times throughout the incident. Direct care staff person A immediately reported it to direct care staff person B, who informed the administrator. Direct care staff person C was placed on suspension and left the building at approximately 10:00 p.m. This abuse was not reported to the local Area Agency on Aging until 4/13/24, at approximately 7:43 p.m.

Plan of Correction ***Accept ([redacted] - 06/06/2024)***

The following training through the Pennsylvania Department of Aging Learning system will be completed by team members by June 10th. The website is located here https://www.pda-lms.org/. Each team member must complete the training and the test and return the certificate of completion to the administrator by June 10th. Administrator, [redacted] will use the attached monitor tool to track all abuse allegations and reporting of abuse allegations beginning 5/30/2024 for the rest of the year to make sure abuse allegations are being reported appropriately. This tool will be reviewed in all QA management meetings.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented ([redacted] - 06/17/2024)

42b - Abuse

2. Requirements

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

Description of Violation

On 4/12/24, at approximately 8:15 p.m. direct care staff person A, was shadowing direct care staff person C. Both staff entered resident #1's bedroom to get the resident ready for bed. Direct care staff person C, said to resident #1, "time to get ready for bed." Resident #1 seated on a chair in the bedroom replied, "No." Direct care staff person A, indicated, direct care staff person C looked at ██ and said, "this is how I handle this" and proceeded to grab resident #1's left hand and then with the other hand grabbed the resident's left wrist and pulled the resident up out of the chair. Resident #1 was loudly saying, "No, ouch, No". Direct care staff person C holding the resident's left hand with ██ right hand on the resident back pushing the resident into the bathroom. Direct care staff person C was trying to push resident #1 to the toilet with ██ left hand and the resident tripped over direct care staff person C's foot, causing resident #1 to lose balance, banging ██ right shoulder into the wall. Resident #1 was directed onto the toilet. Direct care staff person A indicated resident #1 kept saying "NO" repeatedly, approximately 10 times. Direct care staff person C had told resident #1 several times to be quiet. Direct care staff person C was roughly undressing the resident while on the toilet. While direct care staff person C was taking off resident #1's socks, stated, "I am tired of this ██ and was very rough with the resident's feet while removing the resident's socks. Direct care staff person C did not wash up the resident, did not apply any barrier cream, only putting a clean brief on the resident. Interviews indicated direct care staff person C pulled resident #1 from the bathroom by ██ right arm while resident #1 was resisting backwards. Resident #1 had grabbed ██ shoes while being pulled from the bathroom. Direct care staff person C grabbed them out of the resident's hands telling the resident, "You don't need to be messing with this" grabbing them out of the resident's hands, throwing them into ██ room on the floor. Direct care staff person C positioned resident #1 with ██ back facing the bed and with both hands pushed the resident backwards onto the bed. Resident #1 caught ██ and fell on ██ forearms and elbows, otherwise, the resident would have hit ██ head. Direct care staff person C, then grabbed the resident's ankles and threw ██ legs onto the bed, threw a blanket over the resident, and told resident #1, "Now go to sleep" and walked out of the room. Direct care staff person A indicated resident #1 kept saying, "NO, OUCH, NO" multiple times throughout the incident. Direct care staff person A immediately reported it to direct care staff person B, who informed the administrator.

Plan of Correction ***Accept (██ - 06/06/2024)***

Staff person C was immediately suspended upon investigation and key fob was disabled. After investigation, this organization terminated ██ employment. The following training through the Pennsylvania Department of Aging Learning system will be completed by team members by June 10th. The website is located here https://www.pda-lms.org/. Each team member must complete the training and the test and return the certificate of completion to the administrator by June 10th. The administrator or social worker will conduct private interviews for three residents a week for three months, then move to three residents a month until the end of the year. Please find first week of interviews attached starting the week of May 27, 2024.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (██ - 06/17/2024)

65i - Training Record

3. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

65i - Training Record *(continued)*

Description of Violation

On 4/16/24, the home's training record for direct care staff person D's, 2023 annual direct care staff training does not include the date, content, or source for any of the annual trainings.

Plan of Correction ***Accept (- 06/06/2024)***

Team member D completed education missed starting on 5/29/2024 through 6/2/2024. Administrator researched better ways to meet regulation and re-educated and created a training record tool to use for trainings on 5/24/2024. The administrator completed an audit of up-to-date training on all team members as seen attached on 05/23/2024. A monitoring tool was created by the administrator to up-date monthly at QA meetings beginning 6/5/2024 at next meeting.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (- 06/17/2024)

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

On 4/16/24, at approximately 10:47 a.m., there were no paper towels, mechanical air blower, or other sanitary method of hand drying by the sink in the common spa/bathroom by room #301, in Treehouse.

On 4/16/24, at approximately 11:20 a.m., there were no paper towels, mechanical air blower, or other sanitary method of hand drying by the sink in the common spa/bathroom in Schoolhouse.

Plan of Correction ***Accept (- 06/06/2024)***

On 4/16/24, paper towels were ordered by Environmental Service Director. As interim, a roll of paper towels was placed in each spa area by administrator on 4/16/24. They came in on 4/18/24. Unfortunately, they were not the right side. Administrator ordered the correct paper towels on 4/19/24 from Amazon. Paper towels were delivered by 4/20/24 and set up in the paper towel dispensers by administrator. Education to the team on paper towels and their location will be completed by 6/10/2024. Checking all common bathrooms and choosing three Resident bathrooms will be added to monthly monitoring tool which began on 5/31/2024. Administrator, social worker, and assessment coordinator will rotate each month on facilitating the tool. All woodside place team members (PCA's, nurses, housekeeping, office team, recreation therapist) will be educated starting 5/31/2024 by administrator.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (- 06/17/2024)

91 - Telephone Numbers

5. Requirements

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

Description of Violation

On 4/16/24, there were no emergency phone numbers posted on or near the telephone on the wall by the common

91 - Telephone Numbers (continued)

spa/bathroom and bedroom #310. Also, there were no directions posted on or near the phone indicating to dial out must first dial #9, then #1 prior to dialing the phone number.

On 4/16/24, at 11:10 a.m., there were no emergency phone numbers posted on or near the phone on resident # bedside table in bedroom #204 in Schoolhouse.

Plan of Correction ***Directed (- 06/06/2024)***

The administrator printed out emergency phone labels the evening of 4/16/2024 and placed on all phones that needed them in the building. All woodside place team members (PCA's, nurses, housekeeping, office team, recreation therapist) will be educated starting 5/31/2024 by administrator.

Proposed Overall Completion Date: 12/31/2024

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator or designee shall audit all telephones in the home monthly to ensure telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Directed Completion Date: *06/11/2024*

Implemented (- 06/17/2024)

95 - Furniture and Equipment

6. Requirements

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

Description of Violation

On 4/16/24, the dishwasher was inoperable/broken in the kitchenette in Treehouse. It has been broken for approximately 2 months.

Plan of Correction ***Accept (- 06/06/2024)***

The dishwasher in question was serviced multiple times while broken. Unfortunately, each new repair did not completely stop the dishwasher from leaking. There was another dishwasher for this household to use at the time so it did not delay any sanitation concerns. We were in the process of bidding out rental vs. purchase of a new dishwasher. We did decide rental would be best and ordered the dishwasher from EcoLab. They delivered the dishwasher on 5/20/2024 and a EcoLab representative came out to hook it up on May 21, 2024. The dishwasher is now completely operable as of 11:30am 5/21/2024. These regulations will be kept in accordance with doing monthly rounds on our site checks to check equipment and make sure it is in good repair. This monitoring tool began on 05/31/2024 by social worker, assessment coordinator and administrator as a train the trainer so all three know what to look for and how to properly document and follow up on any concerns in the future. These tools will be completed in rotation with social worker, administrator, and assessment coordinator.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (- 06/17/2024)

102k - No Common Towel

7. Requirements

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

On 4/16/24, at approximately 10:47 a.m., there was an unlabeled white hand towel hanging on the grab bar by the toilet in the common spa/bathroom by room #301.

Plan of Correction ***Accept (█ - 06/06/2024)***

Administrator removed towel on 4/16/2024. All woodside place team members (PCA's, nurses, housekeeping, office team, recreation therapist) will be educated starting 5/31/2024 by administrator. These regulations will be kept in accordance with doing monthly rounds on our site checks to check common bathrooms are free of towels. This monitoring tool began on 05/31/2024 by social worker, assessment coordinator and administrator as a train the trainer. These tools will be completed in rotation with social worker, administrator, and assessment coordinator.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (█ - 06/17/2024)

103e - Left Overs

8. Requirements

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

Description of Violation

On 4/16/24, at approximately 10:55 a.m., there were two 16oz pastry bags containing whipped cream stacked on top of each other on the right door of the refrigerator section of the stainless-steel refrigerator/freezer in the treehouse kitchenette. The pastry bags were undated, with the top of the bags folded over. The bottom bag was approximately, ½ full inside an open unsealed Ziploc baggie and the other pastry bag was laying on top of the other bag, approximately ¼ full.

On 4/16/24 at approximately, 11:05 a.m., the following items were undated in the refrigerator section of the refrigerator/freezer in the kitchenette in Schoolhouse:
** A condiment bottle full of Italian Dressing.*
** A condiment bottle full of Ranch Dressing.*

On 4/16/24, at approximately 11:30 a.m., there were two undated condiment bottles on the left door of the Starhouse kitchenette filled with ranch dressing and one half full of Italian dressing.
On 4/16/24, at approximately, 11:30 a.m., there was a 16oz. pastry bag of whipped cream that was not dated when opened in the refrigerator section of the refrigerator/freezer in the Starhouse kitchenette.

On 4/16/24, at approximately, 11:35 a.m. in the upper cabinet on the right side of the sink in Starhouse kitchenette were the following items, to include:
** A condiment bottle containing pancake syrup, that was not labeled or dated.*
** A condiment bottle with an unidentified brownish liquid, not labeled or dated.*

Plan of Correction ***Accept (█ - 06/06/2024)***

All condiment bottles were immediately labeled and dated by administrator on 4/16/2024. The whipped cream was thrown away by administrator on 4/16/2024. All woodside place team members (PCA's, nurses, housekeeping, office team, recreation therapist) will be educated starting 5/31/2024 by administrator. Daily monitoring tool for proper

103e - Left Overs (continued)

sealing of food and labeling created by administrator and was started in June 1st by night PCA's.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (- 06/17/2024)

103f - Refrigerator/Freezer Temps

9. 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 4/16/24, at approximately 10:59 a.m., the freezer section of the stainless-steel refrigerator/freezer measured 20 degrees Fahrenheit in the Treehouse kitchenette.

On 4/16/24, at approximately 11:10 a.m., The freezer section of the refrigerator/freezer measured 4 degrees Fahrenheit in the Schoolhouse kitchenette.

On 4/16/24, at approximately 11:40 a.m., the freezer section of the refrigerator/freezer measured 2 degrees Fahrenheit in the Star house kitchenette.

Plan of Correction ***Accept (- 06/06/2024)***

The freezers and refrigerator temperatures are checked each night by the 11p-7a shift leader. The schoolhouse and Starhouse freezers were adjusted by the administrator to set at -2 instead of 0 on 4/16/24. Temperatures have maintained correct temperatures as seen on the temperature log. The treehouse freezer was temping up and down for the entire day of 4/16/24. Food was pulled to another freezer by administrator on 4/16/24. Maintenace was called by administrator on 4/16/24 and they came down and cleaned the coils. This was still unsuccessful. LG appliance service was called on 4/17/24 by administrator to request a service call. LG maintenance came to the community on 4/22/24 and ordered parts needed (compressor). On 4/24/24, LG maintenance repaired the freezer. Assessment Coordinator and Social Worker were educated by and with administrator on 5/31/2024 on Regulation 2600.65i. These regulations will be kept in accordance with doing monthly rounds on our site checks to check equipment and make sure it is in good repair. This monitoring tool began on 05/31/2024 by social worker, assessment coordinator and administrator as a train the trainer so all three know what to look for and how to properly document and follow up on any concerns in the future. These tools will be completed in rotation with social worker, administrator, and assessment coordinator.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (- 06/17/2024)

103g - Storing Food

10. Requirements

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

Description of Violation

On 4/16/24, at approximately 10:55 a.m., there were two 16oz pastry bags containing whipped cream stacked on top of each other on the right door of the refrigerator section of the stainless-steel refrigerator/freezer in the treehouse

103g - Storing Food (continued)

kitchenette. The pastry bags were open and unsealed, with the top of the bags folded over. The bottom bag was approximately, ½ full inside an open unsealed Ziploc baggie and the other pastry bag was laying on top of the other bag, approximately ¼ full.

On 4/16/24 at approximately, 11:05 a.m., the following items were open and unsealed in the refrigerator section of the refrigerator/freezer in the kitchenette in Schoolhouse:
** A condiment bottle full of Italian Dressing that was open and unsealed. The pour spout is broken off at the base, leaving a hole. There is a heavy coating of Italian Dressing over the outside of the lid and top of bottle.*
** A condiment bottle full of Ranch Dressing that was open and unsealed.*

On 4/16/24, at approximately 11:30 a.m., there were two open and unsealed condiment bottles on the left door of the refrigerator filled with ranch dressing and one half full of Italian Dressing in the refrigerator section of the refrigerator/freezer in Starhouse kitchenette.

On 4/16/24, at approximately, 11:35 a.m. in the upper cabinet on the right side of the sink were the following items, to include:
** A condiment bottle containing pancake syrup open with no cap.*
** A condiment bottle with an unidentified brownish liquid with no cap.*

Plan of Correction ***Accept (█ - 06/06/2024)***

The administrator threw out whipped cream on 4/16/2024. All condiment bottles were wiped down 4/16/2024 by administrator. The condiment bottle that was cut was thrown out by administrator on 4/16/2024. New condiment bottles were ordered by administrator on 4/19/2024 and were delivered 4/24/24. All condiment bottles with no lids were thrown away by administrator on 4/24/24 when new bottles were delivered. The bottle with brown sauce that was unlabeled was thrown out immediately by administrator on 4/16/2024. These bottles twist to close to prevent loss of small cap. All woodside place team members (PCA's, nurses, housekeeping, office team, recreation therapist) will be educated starting 5/31/2024 by administrator. Daily monitoring tool for proper sealing of food and labeling created by administrator and was started in June 1st by night PCA's.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (█ - 06/17/2024)

103i - Outdated Food

11. Requirements

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

Description of Violation

On 4/16/24, at approximately, 10:25 a.m. there was a package of lunchmeat with a use by date of 3/23/24, in the freezer section of the GE refrigerator/freezer in the kitchenette in the recreation area.

Plan of Correction ***Accept (█ - 06/06/2024)***

The lunchmeat was immediately thrown away by the administrator on 4/16/2024.
All team members of WSP (PCA's, nurses, office team, recreational therapist, and housekeeping) will be completing the training by 6/10/2024. Please find education started attached done by administrator. Also, please find new temperature logs created by administrator that include checking for expired food which started 6/1/2024 by night PCA's daily.

103i - Outdated Food *(continued)*

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (- 06/17/2024)

187b - Date/Time of Medication Admin.

12. 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 4/16/24, resident #3's is prescribed Refresh Plus 0.5% Solution 50ML Eye Drops -Instill 2 drops in both eyes three times a day. The resident's April 2024 medication administration record (MAR) was not initialed by the staff person that administered the medication on 4/5/24 at 3:00 p.m.

Plan of Correction ***Accept (- 06/06/2024)***

Beginning 5/31/2024, all med techs and nurses began education by nurse coordinators on our policy on medication administration and a competency on how to check to make sure all meds are signed off on at end of each med pass time. Administrator completed an audit on 5/29/2024 on all resident MAR's. Please find the monitoring tool that was started on 6/1/2024 and will be done on each day for all shifts by our resident service coordinator.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (- 06/17/2024)

227c - Support Plan Revision

13. Requirements

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

Description of Violation

According to documents and interviews resident #3 has had some recent changes in behavior that have required changes in medication and being followed by The support plan, dated for resident #3, was not updated to include services provided and frequency. Also, the resident's support plan does not address the recent behavior changes with an increase in agitation, confusion, yelling at residents and staff, exhibiting physical and verbal aggression towards residents and staff. By grabbing other residents arms and squeezing them, pushing other residents and staff persons, as well as, an increase in wandering into other resident rooms, when asked to leave room will yell at the other residents, refuse to leave rooms, and become physically aggressive.

Plan of Correction ***Accept (- 06/06/2024)***

The assessment coordinator updated the support plan on 5/21/2024 with formal support information from 15-minute checks and increase in agitation level to reflect distressed reactions. Assessment Coordinator was educated on 5/21/2024 on regulation 2600.65i and our procedure to review all residents with a significant change, new service, reportable or distressed reactions will be reviewed each QA monthly meeting. Audits began 5/31/2024 by assessment coordinator. All resident records were audited on 5/31/2024 and changes found are listed on attached audit. Monthly auditing will be completed by assessment coordinator and reviewed in monthly QA meetings.

Licensee's Proposed Overall Completion Date: *12/31/2024*

227c - Support Plan Revision *(continued)*

Implemented (█ - 06/17/2024)

231c - Preadmission Screening

14. Requirements

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

Description of Violation

Resident #4, admitted to the home's SDCU on █ however, █ cognitive prescreening was completed on █

Plan of Correction ***Accept (█ - 06/06/2024)***

See attached. The assessment team which consists of the assessment coordinator and admissions/social worker coordinator will complete and sign education by May 31st and give signed sheet to the administrator for their file. All current Resident records were checked by assessment coordinator on 5/30/2024 and audit is attached. Auditing tool for new admissions is attached and will be updated by the assessment coordinator and reviewed at monthly QA meetings.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (█ - 06/17/2024)

233c - Key-Locking Devices

15. Requirements

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

Description of Violation

On 4/16/24, there were no codes posted on or near the locking mechanisms from the courtyard to re-enter the home in the following areas:

* *The gate on the far-right side of the courtyard identified as the employee entrance/exit.*
* *The gate on the upper left side of the courtyard by the gazabo.*
* *The two exit doors leading from the courtyard into Schoolhouse.*
* *The two exit doors leading from the courtyard into Treehouse.*
* *The two exit doors leading from the courtyard into Starhouse.*
* *The exit door leading from the courtyard into the home by the beauty shop.*
* *The exit door leading from the courtyard into the home near entrance to Starhouse.*

Plan of Correction ***Accept (█ - 06/06/2024)***

On 5/17/24, Allied Services came on a service call to our community. The updated the code numbers for the doors. We separated the codes from the courtyard doors and the doors that have immediate access the leave the community. The administrator made signs and laminated them to post on the inside and outside of all courtyard doors, so visitors can go in and out when doors are locked as needed for emergencies. The administrator then placed labels at each gate in the courtyard and at the entrance doors for emergencies. After using the monthly monitoring tool, the administrator found that the Residents were taking down the signs. Acrylic frames were ordered and came in 6/4/24 and were put up at the bottom of each door. The monthly tracking tool will continue to be completed by the administrator and reviewed in QA monthly. It started 5/31/24, please see highlighted areas that were added

233c - Key-Locking Devices (continued)

for monitoring to our rounds. Education is being completed with all WSP team members including PCA's, nurses, housekeeping, maintenance, and office team.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (- 06/17/2024)