pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **LW ALLENTOWN OPCO LLC**
LEGAL ENTITY

To operate **LEGEND PERSONAL CARE AND MEMORY CARE OF ALLENTOWN**
NAME OF FACILITY OR AGENCY

Located at **6043 LOWER MACUNGIE ROAD, MACUNGIE, PA 18062**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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

The total number of persons which may be cared for at one time may not exceed **100** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 40**

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

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

and shall remain in effect from **June 11, 2024** until **December 11, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **231391**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: [redacted]
Sent via email to: [redacted]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JUNE 11, 2024

[redacted]
LW Allentown OPCO LLC
[redacted]

RE: Legend Personal Care and Memory Care
of Allentown
6043 Lower Macungie Road
Macungie, Pennsylvania 18062
License #: 231391

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on December 13, 2023, February 1, 2024, March 5, 2024, and April 18, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (231390) dated December 1, 2023 to December 1, 2024 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated December 1, 2023 to December 1, 2024 is NOT reinstated upon expiration of the FIRST PROVISIONAL license. This decision is made pursuant to <62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3); (4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from June 11, 2024 to December 11, 2024.

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

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 or § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 or 2800 Section:	Class of Violation	Census at Inspection	X	Fine Per resident Per day	=	Calculated Fine Per day	Mandated Correction Date (to avoid Fine)
185a	II	71		$5		$355	5 calendar days from mailing date of this letter
187d	II	71		$5		$355	5 calendar days from mailing date of this letter

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

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

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

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

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF ALLENTOWN* **License #**: *23139* **License Expiration**: *12/01/2024*

Address: *6043 LOWER MACUNGIE ROAD, MACUNGIE, PA 18062*

County: *LEHIGH* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *LW ALLENTOWN OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *05/18/2018* **Issued By**: *Lower Macungie Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *98* **Waking Staff**: *74*

Inspection Information

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

Reason: *Complaint, Interim* **Exit Conference Date**: *04/26/2024*

Inspection Dates and Department Representative

04/18/2024 - On-Site: [redacted]

04/26/2024 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *71*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *n/a* **Capacity**: *32* **Residents Served**: *25*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *71*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *27*

Have Physical Disability: *0*

Inspections / Reviews

04/18/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/10/2024*

05/28/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/10/2024*

Reviewer: [redacted] **Follow-Up Type**: *Bypass Document Submission*

05/28/2024 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted**: *05/28/2024*

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

16c - Written Incident Report

1. Requirements

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

Description of Violation

Resident #5 has a prescription for a Novolog Flexpen. Resident #5 did not receive the Novolog on 4-9-24 at 8pm as the resident was out with family. The medication was not able to be administered, and a reportable incident was not completed by the home regarding the missed medication administration.

Resident #8 has a prescription for a 13.3 mg /24hr. Rivastigmine Patch. Resident #8 did not receive the Rivastigmine patch from 3-11-24 to 3-22-24 as it was not available in the home. The missed medication was reported to the Department on 3-24-24.

A complaint was submitted to the Department on 4/1/24 regarding a call received from Resident #'1s [redacted] reporting that on 3/27/24 the resident had an unwitnessed fall at approximately 4:00am and was sent to Lehigh Valley Hospital where the resident was treated for lacerations to their face and back. The hospital reported that when the Resident #1 arrived, they were dressed in only a shirt and brief. The resident's [redacted] drove them back to the home at approximately 9:00am, fed them breakfast, changed their adult brief, dressed them, and put them to bed. When the [redacted] returned to the home at approximately 6:45pm. to check on Resident #1, [redacted] found the resident in bed with a small blanket but had no pants or socks on. The resident was lying on a dry pad, but the sheets were soaked with urine. When the [redacted] asked the 4 staff members sitting in the dining area which one of them left Resident #1 in that condition, no one replied. When one of the aides assisted the [redacted] with toileting Resident #1, dried feces and a sore was noted on the resident's buttocks. The home submitted a report to the Department on 3/27/24 and described Resident #1's fall and subsequent hospitalization. An incident report was not submitted to the Department on 3/27/24 indicating that the Resident #1's daughter contacted Lehigh County AAA to report the condition she found the resident in when [redacted] checked on them at 6:45pm that evening.

Plan of Correction ***Directed [redacted] - 05/20/2024)***

With Respect to the specific deficiencies cited:
We respectfully request that the violation for resident #5 be removed, as the resident was not in the community when the medication was to be administered. By regulation "Only medication given by staff members of the home are to be documented on the MAR"
Relative to 16c, Resident #1 & #8, the home failed to report the incidents on the above-mentioned dates. The Administrator is aware of the requirement/regulation however failed to follow procedure/protocol.
With Respect to Systemic Measures that have been put into place to address the stated concern:
Reporting incidents allows the Department to respond promptly to serious situations.
Effective 05/10/24 to prevent this from happening again the Administrator/designee will file reports timely in alignment with the regulatory requirement and a copy of the incident will be retained on record. The home's Administrator/Designee will remain available daily to submit reportable incidents to the department within 24 hours of the incident.
An audit of reportable incidents was conducted on 4/29/24 with no other reporting issues discovered.
To avoid future violations of this nature effective immediately 4/11/24, all reportable incidents will be completed

16c - Written Incident Report (continued)

and/or reviewed by the Administrator/designee within 24 hours daily to ensure accurate resident information is captured and reported appropriately and timely.
With Respect to How the Plan of Corrective Measures will be Monitored:
Compliance monitoring on Regulation 2600.16c, Written Incident Reports & Abuse Reporting Covered by Law, will be conducted x 2 quarters as part of Quality Assurance meetings. All records will be retained.

Proposed Overall Completion Date: 05/10/2024

(Directed)
The Administrator will immediately and ongoing train all staff in reportable incidents and conditions, as well as the homes internal policy on who is responsible for reporting the incidents to the Department as required including weekends and holidays. The home will keep documentation of the training for review upon the Departments request. All future incidents including medication errors will be reported as required.

Directed Completion Date: *06/09/2024*

Not Implemented [redacted] - 05/28/2024)

23a - Activities of Daily Living Assistance

2. Requirements

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

Description of Violation

On 3/27/24 Resident #1 had an unwitnessed fall at approximately 4:00am and was sent to Lehigh Valley Hospital where they were treated for lacerations to their face and back. The hospital reported that when Resident #1 arrived, they were dressed in only a shirt and brief. The resident was driven back to the home at approximately 9:00am by their [redacted] who fed them breakfast, changed their adult brief, dressed them, and put them to bed. When the [redacted] returned to the home at approximately 6:45pm. to check on Resident #1, [redacted] found the resident in bed with a small blanket but had no pants or socks on. The resident was lying on a dry pad, but the sheets were soaked with urine. When the [redacted] asked the 4 staff members sitting in the dining area which one of them left Resident #1 in that condition, no one replied. When one of the aides assisted the [redacted] with toileting Resident #1, dried feces and a sore was noted on the resident's buttocks. The Resident Assessment Support Plan for Resident # 1 dated 1/4/24 indicates they require total physical assistance with bladder and bowel management and personal hygiene. Staff failed to provide Resident # 1 with the care they require by allowing them to be sent the hospital in only a shirt and brief and by leaving Resident #1 lying in bed on urine-soaked sheets without pants and socks on.

Plan of Correction ***Accept [redacted] - 05/15/2024)***

With Respect to the specific deficiencies cited:
The Administrator Immediately met with the [redacted] on 3/28/24 upon being notified of this incident.
The staff person in question was suspended pending investigation. Investigation showed that the staff person was disrespectful to family members and failed to provide the level of care the resident required. The staff person was terminated on 4/4/2024 upon completion of the investigation.

23a - Activities of Daily Living Assistance (continued)

With Respect to Systemic Measures that have been put into place to address the stated concern:
Requested care changes were made to the resident care plan and subsequent RASP was updated on 4/29/24. All associates will continue to be provided with task sheets accordingly to clearly understand the resident care needs on each shift. Effective 4/19/24, a weekly review will be inclusive between the Healthcare Director, Assistant Healthcare Director and Residence Director for any changes in the resident's plan of care. The RASP will continue to be maintained up to date with any changes in ADL or IADL needs and will remain on the resident record accordingly.
With Respect to How the Plan of Corrective Measures will be Monitored:
Compliance monitoring on Regulation 2600.23a, Activities, will be conducted x 2 quarters as part of Quality Assurance meetings. All records will be retained.

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

Not Implemented ([redacted] - 05/28/2024)

132c - Fire Drill Records

3. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home's fire drill logs were reviewed for drills conducted on 3-25-24 and 4-3-24. The fire drill log for 3-25-24 listed that there were. 75 residents in the home and 72 were evacuated. The fire drill log for 4-3-24 indicated there were 73 residents in the home and 71 were evacuated. As per interviews the individuals who were out of the home on a bed hold were included in the count of residents in the home when the fire drills were conducted. The fire drill logs were incorrectly documented.

Plan of Correction ***Directed [redacted] - 05/15/2024)***

MD was educated immediately, while surveyors were present, on the requirement for all residents to evacuate in a fire drill.
With Respect to the specific deficiency cited:
The violation occurred as a result of the Maintenance Director's failure to follow regulatory requirements.
With Respect to Systemic Measures that have been put into place to address the stated concern:
The Maintenance Director received training on this regulation from the Administrator on 4/29/24 with the importance of conducting drills monthly as well as capturing the necessary data to complete a record of the drill emphasized.
With Respect to How the Plan of Corrective Measures will be Monitored:
To prevent future occurrence, beginning 5/8/24 the Maintenance Director will complete monthly fire drills in accordance with the regulation and provide that documentation to the Administrator for review and recording of each drill.
Compliance monitoring on Regulation 2600.132c, Fire Drill Record, will be conducted x 2 quarters as part of Quality Assurance meetings. All records will be retained.

Proposed Overall Completion Date: 05/10/2024

132c - Fire Drill Records (continued)

(Directed)

The Administrator will immediately and for the next 3 months participate with the Maintenance Director in conducting the monthly fire drill. The Administrator will ensure the fire drills are being conducted and documented correctly per the regulations. The Administrator will review the documentation from the monthly fire drills thereafter. The fire drill log will be documented accordingly when these reviews are completed.

Directed Completion Date: *06/19/2024*

Not Implemented [redacted] - 05/28/2024)

181c - Self-administration Assessment

4. Requirements

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

The Documentation of Medical Evaluation for Resident #2 dated 4-4-24 indicates they cannot self-administer medications. On 4/18/24, a bottle of Refresh Eye drops was noted on the table in the resident's room.

Plan of Correction ***Directed [redacted] - 05/16/2024)***

With Respect to the specific deficiencies cited:
The Healthcare Director failed to recognize the resident's physician had assessed the resident as unable to self-administer his/her medications.
The Refresh eye drops were immediately removed with the resident's permission. This measure ensures that the medication will be administered safely and following best practices by trained professionals.
With Respect to Systemic Measures that have been put into place to address the stated concern:
Effective 5/13/24 the Healthcare Director/designee will conduct a weekly review with the residents of their apartments and specifically medications and complete interviews to maintain accountability for an accurate MAR.
The audit information will be reviewed weekly with the Administrator/designee x 4 weeks.
With Respect to How the Plan of Corrective Measures will be Monitored:
Compliance monitoring on Regulation 2600.181c, Self Administration Management, will be conducted x 2 quarters as part of Quality Assurance meetings. All records will be retained.

Proposed Overall Completion Date: 05/10/2024

(Directed)

The home will immediately and ongoing ensure that all residents that self medicate are assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders. All direct care staff members will be retrained in the medication self-administration training. The Administrator will audit these records monthly thereafter. Documentation of the training and audits will be kept for review by the Department upon request.

Directed Completion Date: *06/09/2024*

Not Implemented [redacted] - 05/28/2024)

181c - Self-administration Assessment *(continued)*

181f - Record of Medication

5. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

The Documentation of Medical Evaluation for Resident #2 dated 4-4-24 indicates they cannot self-administer medications. On 4/18/24, a bottle of Refresh Eye drops was noted on the table in the resident's room. The Medication Administration Record for Resident #2 does not list this OTC medication

Plan of Correction ***Directed [redacted] - 05/16/2024)***

With Respect to the specific deficiencies cited:
This regulation requires that homes keep an updated record of all of the medications that a resident is currently taking, and the Healthcare Director failed to support up to date records to include the OTC medication.
With Respect to Systemic Measures that have been put into place to address the stated concern:
The Refresh eye drops were immediately removed with the resident's permission.
Families, staff and residents were educated by the Administrator on 4/26/24 via email letter regarding regulation 181f, Record of Medication.
With Respect to How the Plan of Corrective Measures will be Monitored:
Effective 5/13/24 the Healthcare Director/designee will conduct a weekly review with the residents of their apartments and specifically medications and complete interviews to maintain accountability for an accurate MAR.
The audit information will be reviewed weekly with the Administrator/designee x 4 weeks.
Compliance monitoring on Regulation 2600.181f, Record of Medication, will be conducted x 2 quarters as part of Quality Assurance meetings. All records will be retained.

Proposed Overall Completion Date: 05/10/2024

(Directed)
The home will immediately and ongoing audit the records of all residents who self-administer medication and ensure that a current list of medications is present inside. The Administrator will audit these records monthly thereafter. The home will keep documentation of these audits for review upon the Departments request.

Directed Completion Date: *06/09/2024*

Not Implemented [redacted] - 05/28/2024)

182c - Medication Administration

6. 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

When interviewed, Resident #2 and Resident #3 both reported that some med techs will leave their medications in a

182c - Medication Administration (continued)

cup on the table next to their chairs if they are not in their rooms or if they are in the bathroom and cannot take the medication immediately.

Plan of Correction ***Accept [redacted] 05/16/2024)***

Beginning 6/3/2024 residents will go back to coming to the med suite for medications
All med techs will be re-educated on proper administration of medications by the Health Care Director and the Assistant Health Care Director by 5/10/2024.
Med techs will be required to demonstrate how to properly administer
medications and witness the consumption of medication by residents with the Health Care Director.
After the reeducation has been provided, Med Techs will be required to have one additional med pass observed with either the Health Care Director or designee.
New med tech training class was held by HCD (train the trainer) on 4 30 2024.
Beginning immediately, all med techs will be observed monthly by the HCD during a med pass for the next 6 months.
Observations will be reviewed at monthly QMM meetings for the next 3 months.

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

Not Implemented [redacted] - 05/28/2024)

185a - Implement Storage Procedures

7. Requirements

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

Description of Violation

Resident #4's glucometer was reviewed. The glucometer indicates a blood sugar level of 164 at 7:04a on 3/21/24; a level of 132 is recorded on the resident's Medication Administration Record

The glucometer for Resident#6 was not calibrated and indicated it was 2:15am on 2-12-24 on 4-18-24 at 10:12am.

On 4-16-24 at 9:30pm Resident #5 had a blood glucose reading of 164 as seen in the resident's glucometer. The resident's blood glucose was documented in the medication administration record as 240.

Repeat Violation 6-8-23.

Plan of Correction ***Directed [redacted] - 05/16/2024)***

The glucometer for resident #6 was immediately corrected in front of the surveyors by AHCD
The HCD and AHCD will reeducate med techs on glucometer calibration and documentation by 5/9/2024. Documentation of the training shall be kept. (training documentation will be submitted upon completion)
• The HCD/designee will audit daily for 4 weeks beginning 4/22/2024 to ensure compliance in dates, time, calibrations and missed entries. Documentation of the audits shall be kept. (see attached audit form to be used)
RD will review audits at monthly QMM meetings

185a - Implement Storage Procedures (continued)

Proposed Overall Completion Date: 05/10/2024

(Directed)
All staff who administer medications will be trained on the medication procedures.
The home's policy shall include training on the following:
1. Use of a medication delivery log that documents the receipt of controlled substances and prescription medications.
2. Proper narcotic documentation and accountability. A process to investigate and account for missing medications and medication errors, including who is responsible for completing the investigation, how the investigation will be completed, and how the findings will be reported to the Department.
3. Policy and procedures for locking medications, and which staff persons will have access to the medications.
4. Use of a Medication Administration Record as required by 187a-d.
5. Proper documentation of Glucometer readings and required blood sugar recordings.
Documentation of training will be kept for review by the Department upon request. The administrator or designee shall monitor for ongoing compliance.

Directed Completion Date: *06/09/2024*

Not Implemented ([redacted] - 05/28/2024)

187d - Follow Prescriber's Orders

8. Requirements

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

Description of Violation

Resident #5 receives Novolog per a sliding scale. On 4-16-24 at 8pm the resident had a blood glucose reading of 164 documented in the glucometer and should have received 1 unit of Novolog for a blood glucose of 156-195. The Medication Administration Record noted an incorrect blood glucose reading of 240 and the resident was administered 3 units of insulin instead of 1 unit of insulin.

Resident #8 has a prescription for Rivastigmine 13.3 MG/24hr. patch. The resident did not receive the medication from 3-11-24 through 3-22-24 as the medication was not available in the home.

Repeat Violation 6-8-23

Plan of Correction ***Directed [redacted] - 05/16/2024)***

Health Care Director immediately prepared a medication error reportable on 4/18/24 for resident #5
Health Care Director/Assistant Health Care Director to educate med techs on regulation 187d by 5/9/2024
Health Care Director to request sliding scale insulin to be discontinued, as blood glucose has been stable
HCD/AHCD to audit glucose readings weekly for 4 weeks in eMAR system
Audits to be reviewed by RD at monthly QMM meetings

Proposed Overall Completion Date: 05/10/2024

187d - Follow Prescriber's Orders (continued)

(Directed)

The home shall immediately and ongoing follow the directions of the prescriber. Staff shall be retrained on the requirements of this regulation. The administrator or designee will audit MAR's weekly x 6 months to ensure ongoing compliance. Documentation of staff training and audits shall kept for review upon the Departments request.

Directed Completion Date: *06/09/2024*

Not Implemented [redacted] - 05/28/2024)

231c - Preadmission Screening

9. 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 #7 moved into the home on [redacted]-24. The residents cognitive screening was completed on 1-25-24 outside of the 72-hour window prior to admission to the home.

Plan of Correction ***Directed [redacted] - 05/16/2024)***

Residence Director immediately educated HCD/AHCD on reg 231c

A 100% audit of all memory care prescreens will be completed by 4/30/2024 by AHCD for accurate cognitive screening information

AHCD will complete 10% monthly audits of cognitive screenings for 3 months

HCD will review all new memory care admissions for accurate cognitive screening data

Resident chart audits will be reviewed by RD at monthly QMM meetings

Proposed Overall Completion Date: 05/10/2024

(Directed)

The home will ensure that all residents admitted after receiving this directed plan have a preadmission screening completed that includes the cognitive screening completed within 72 hours of admission. The administrator will ensure that the preadmission/cognitive screening is accurate and completed in its entirety, including signing and dating the screening form. If the home determines that the resident's needs cannot be met by the home based on the preadmission screening, the home will refer the resident to the appropriate local assessment agency.

Directed Completion Date: *06/19/2024*

Not Implemented [redacted] - 05/28/2024)

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

Facility Information

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF ALLENTOWN* **License #:** *23139* **License Expiration:** *12/01/2024*

Address: *6043 LOWER MACUNGIE ROAD, MACUNGIE, PA 18062*

County: *LEHIGH* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *LW ALLENTOWN OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *07/15/2018* **Issued By:** *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *111* **Waking Staff:** *83*

Inspection Information

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

Reason: *Complaint, Incident, Interim* **Exit Conference Date:** *03/05/2024*

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served:** *81*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *n/a* **Capacity:** *30* **Residents Served:** *28*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *81*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *30*
Have Physical Disability: *0*

Inspections / Reviews

03/05/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/25/2024*

04/12/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/12/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/17/2024*

05/16/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *04/12/2024*

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

5a1 - DHS Access

1. 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

Staff training records were requested to verify mandatory training at approximately 9:20am. The Administrator was not available on site and there is no designee with access to the records. The inspectors on site were unable to verify the training was completed.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

• Effective immediately, agents of the Department shall have immediate access to records.
• Immediately, the Maintenance Director (MD) will check that there is a key to access paper records stored in a lock box to ensure access to Agents of the department, and other regulatory required agents immediately. Completed 3/19/2024 (see attached photos)
• The Customer service Assistant (CSA)will train the Health Care Director (HCD) Assistant Health Care Director (AHCD) and a Designee on how to access and print electronic records (Relias Training) by 4/5/2024. Documentation of the training shall be kept. (training sheet to be submitted immediately after training completed))
• Violation will be reviewed by RD at next 3 monthly QMM meetings.

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

Implemented [redacted] - 04/19/2024)

17 - Record Confidentiality

2. 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

The Privacy Coding page was posted with the LIS dated 9-5-23 in a binder in the front lobby of the home, allowing resident information to be accessed by unauthorized persons.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

• The privacy coding page was removed by the HCD on the day of the inspection, 3/5/2024.
• The Residence Director (RD) or designee will train all community leadership on resident record confidentiality by 4/5/2024. Documentation of the training shall be kept. (training sheet to be submitted by 4/5/2024)
• Beginning 3/19/2024, The RD or designee will conduct random audits of public postings and proper confidential records.
• Privacy requirements will be reviewed by RD at next 3 QMM meetings

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

Implemented [redacted] - 04/19/2024)

26b - Quality Management Plan Content

3. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:

Description of Violation

The home conducts quality management meetings monthly. The quality management minutes for the 2-28-24 meeting were reviewed and did not address the following topics required by the department: The reportable incident and condition reporting procedures, complaint procedures, licensing violations and plans of correction, and resident or family councils.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

• PA State specific content was added to the monthly quality management meeting (QMM) agenda on 3/21/2024 by the interim RD (see attached)
• The RD or designee will hold a QMM meeting by 4/5/2024 to review reportable incident and condition reporting procedures, complaint procedures, licensing violations and plans of correction, and resident or family councils. (meeting minutes will be submitted by 4/6/2024)
• Effective 4/5/2024 and ongoing, all QMM meeting will now review the state required items.

Licensee's Proposed Overall Completion Date: *04/06/2024*

Implemented [redacted] - 04/19/2024)

63a - First Aid/CPR Training

4. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 2-9-24 the resident census was 84. The shift from 10pm to 6am there was only 1 person First Aid CPR trained, not meeting the 1:50 requirement.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

• Effective immediately, the HCD or designee shall review current CPR and First aid training for all associates and cross reference them with the current schedule to ensure adequate coverage as well as generate a list of staff who need training.
• On 4/3/2024 a first aid and CPR training will be held. Documentation of the training shall be kept until cards or certificates are issued. (signature training sheet will be submitted upon completion of CPR class)
• CPR classes will be held twice yearly.
• All new hires will be put on a running list to attend the next scheduled CPR class
• Beginning immediately, The HCD or designee shall review the staff schedule before it is posted to ensure required CPR and first aid coverage. (see attached)
• CPR requirements will be reviewed by RD at next 3 QMM meetings

Licensee's Proposed Overall Completion Date: *04/03/2024*

Implemented [redacted] - 04/19/2024)

65b - Rights/Abuse 40 Hours

5. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Staff member C and Staff member D were both hired by the home on [redacted]24. The home could not provide documentation that Staff Member C and Staff Member D completed training on the emergency medical plan, mandatory reporting of abuse or neglect, reporting of reportable incidents or conditions within the first 40 hours worked.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

• Staff persons C and D have completed their initial training on [redacted]28/2024. (see attached documentation of training)
• Effective immediately, the CSA or designee will utilize a new hire checklist to ensure all new hires receive the required training during their onboarding. (see attached checklist)
• The CSA or designee will audit all training records for staff hired in the past year, by 4/10/2024, to ensure all staff have completed their first 40 hours of required training.
• Beginning 3/25/24, The CSA or designee will review all new hire files monthly for three months to ensure compliance.
• All new hires will be reviewed at monthly QMM meetings

Licensee's Proposed Overall Completion Date: *04/10/2024*

Implemented [redacted] - 04/19/2024)

103e - Left Overs

6. Requirements

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

Description of Violation

In the main kitchen the refrigerator contained opened but unlabeled and undated iced cinnamon buns.

In the main walk-in refrigerator there were cut red onions and pickles in metal trays that were unlabeled and undated.

In the main walk-in refrigerator there was an opened bag of kale unlabeled and undated.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

• The identified items were labeled and dated by the Dining Director (DD) at the time of the inspection, 3/5/2024.
• The DD will conduct an in-service with all dietary staff on proper food storage by 3/29/2024. Documentation of the training shall be kept. (see attached training signature sheet)
• Effective 3/25/2024, the Dining director or designee will audit all food storage areas for the main kitchen weekly for one month to ensure compliance is being maintained. Documentation shall be kept. (see attached audit sheet)

Licensee's Proposed Overall Completion Date: *03/29/2024*

Implemented [redacted] - 04/19/2024)

103e - Left Overs *(continued)*

132c - Fire Drill Records

7. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The home's fire drill logs for December of 2023 through February 2024 do no indicate the number of residents in the home at the time of evacuation, the number of residents evacuated and the number of staff persons participating in the fire drill.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

• The State inspectors provided a copy of the Fire drill record and reviewed the requirements with the MD at the time of the inspection, 3/5/2024.
• Effective immediately, the MD shall record the number of residents in the home at the time of evacuation, the number of residents evacuated and the number of staff persons participating in the fire drill on the recommended form.
• An evening fire drill was completed on 3/25/2024. (see attached documentation)
• Effective 3/30/2024, the RD or designee, shall review the fire drill log monthly to ensure that it is completed per state requirements.
• Fire drills will be reviewed by RD at monthly QMM meetings

Licensee's Proposed Overall Completion Date: *03/30/2024*

Not Implemented [redacted] - 04/19/2024)

162c - Menus Posted

8. 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

Upon entry of the facility on 3-5-24, the only menu posted was for the current week. The week 3-10-24 through 3-16-24 was not posted.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

• The DD posted the correct menus on the day of the inspection, 3/5/2024.
• The DD will train their lead cooks on the menu posting requirements by 3/29/2024 to ensure the current and following weeks menus are always posted. Documentation of the training shall be kept. (see attached training documentation)
• The DD will audit the menu postings weekly to ensure compliance, beginning 3/5/2024.
• Menus will be reviewed at monthly QMM meetings

Licensee's Proposed Overall Completion Date: *03/29/2024*

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

Facility Information

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF ALLENTOWN* **License #:** *23139* **License Expiration:** *12/01/2024*

Address: *6043 LOWER MACUNGIE ROAD, MACUNGIE, PA 18062*

County: *LEHIGH* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *LW ALLENTOWN OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *05/18/2018* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *111* **Waking Staff:** *83*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *02/20/2024*

Inspection Dates and Department Representative

02/01/2024 - On-Site: [redacted]

02/20/2024 - On- [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served:** *81*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *n/a* **Capacity:** *40* **Residents Served:** *28*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *81*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *30*

Have Physical Disability: *0*

Inspections / Reviews

02/01/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/04/2024*

03/05/2024 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/08/2024*

04/12/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/08/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/17/2024*

05/16/2024 - Document Submission

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

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

15a - Resident Abuse Report

1. Requirements

2600.

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

Description of Violation

The following incidents were not immediately reported to the Area Agency on Aging as required:

On 12/5/23 resident #1 pushed resident #2 to the floor. The incident was not reported until 12/21/23.

Also, during a record review it was determined that resident #1 pushed and/or punched residents on the following dates:

4/27/23, 7/15/23, 8/8/23. In all three incidents the home does not have documentation that the Area Agency on Aging was notified of the incidents.

Plan of Correction ***Accept [redacted] - 03/11/2024)***

Resident Director educated Health Care Director and Assistant Health Care Director on incident reporting to DHS within the appropriate time frame on 02/21/2024. Residence Director will continue to educate Health Care Director and Assistant health care director on incident reporting to DHS within 24 hours. The Health Care Director or Assistant Health Care Director shall review all incident reports daily for the next four weeks and ongoing, assuring that incidents are being reported correctly and in a timely manner. Going forward, summaries from reports shall be reviewed monthly at QMPI meetings by Health Care director and re-evaluated for further monitoring. Next QMPI meeting will be on 3/27/2024.

Licensee's Proposed Overall Completion Date: *03/27/2024*

Implemented [redacted] - 04/19/2024)

16c - Written Incident Report

2. Requirements

2600.

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

Description of Violation

The following incidents were not immediately reported to the department's regional office as required:

On 12/5/23 resident #1 pushed resident #2 to the floor. The incident was not reported until 12/21/23.

Also, during a record review it was determined that resident #1 pushed and/or punched residents on the following dates:

4/27/23, 7/15/23, 8/8/23. All three incidents were not reported to the department's regional office.

Also, on 10/17/23 resident #1 eloped from the secure dementia unit and was later found in the parking lot area when a staff member was arriving for work. The home did not report the elopement to the department as required.

Plan of Correction ***Accept [redacted] - 03/11/2024)***

16c Health Care Director and Assistant Health Care Director were re-educated by the Resident Director on 02/28/2024 on the Incidents that are required to be reported to the department's regional office and the time frame in which these incidents need to be reported. The Health Care Director and/or Assistant Health Care Director will

16c - Written Incident Report (continued)

review all incident reports daily for the next four weeks and ongoing, and will reevaluate additional monitoring if needed. Going forward, summaries from reports shall be reviewed monthly at QMPI meetings by Health Care director and re-evaluated for further monitoring. Next QMPI meeting will be on 3/27/2024.

Licensee's Proposed Overall Completion Date: *03/27/2024*

Not Implemented [redacted] - 04/19/2024)

182c - Medication Administration

3. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.
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).
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

Through review of resident record, it was determined that on [redacted]/24 family member of secure dementia unit resident #3 arrived at the home around 9am and found a cup of medications on a table next to the resident's bed. The family member took a photo of the medications and reported it to staff.

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

All med techs will be re-educated on proper administration of medications by the Health Care Director and the Assistant Health Care Director by 3/1/2024. Med techs will be required to demonstrate how to properly administer medications and witness the consumption of medication by residents with the Health Care Director. After the re-education has been provided, Med Techs will be required to have one additional med pass observed with either the Health Care Director or designee. Moving forward med techs with be required to have a Random medication administration pass with Health Care Director monthly, to assure proper medication administration, and consumption of medication.

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

Not Implemented [redacted] - 04/19/2024)

201 - Positive Interventions

4. Requirements

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident #1 was admitted to the home's secure dementia unit on [redacted]22. Resident #1 engaged in several acts of aggression towards other residents on the following dates:
4/27/23—Resident #1 punched another resident in the chin

201 - Positive Interventions (continued)

[redacted]*—Resident #1 pushed another resident to the floor*
Resident #1 pushed another resident to the floor
Resident #1 pinned another resident to the wall
—Resident #1 hit another resident with a water bottle
—Resident #1 pushed another resident to the floor.

It was determined that the home did not implement a plan to address resident #1's aggression towards other residents in a timely manner.

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

Health Care Director and Assistant Health Care Director will re-educate med techs, resident assistants, and life enrichment staff on ways to promote positive interventions and behaviors for Memory Care Residents by 3/4/2024. Monthly education to be provided on different topics to help and support the staff with challenges that may occur during their shift by the Health Care Director and the Assistant Health Care Director and or designee. Educating staff will be ongoing with new staff hires and as needed with memory care resident changes.

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

Implemented [redacted] - 04/19/2024)

234a - Admission Support Plan

5. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #3 was admitted to the home's secure dementia unit on [redacted]/23. The home did not complete an assessment of the resident's needs until 7/11/23.
Resident #4 was admitted to the home's secure dementia unit on [redacted]23. The home did not complete an assessment of the resident's needs until 12/27/23.

Plan of Correction ***Accept [redacted] - 03/11/2024)***

234a Health Care Director, Assistant Health Care director and or designee will create all support plans within 72 hours of admission into the secured dementia unit. The reviewer will make sure the support plans identify the resident's physical, medical, social, cognitive and behavioral needs. Health Care Director and Assistant Health Care Director will be responsible for monitoring ongoing compliance of all current and new secured dementia unit residents to assure the support plans are accurate and up to date by 3/8/2024.

Licensee's Proposed Overall Completion Date: *03/08/2024*

Implemented [redacted] - 04/19/2024)

234b - Support Plan Needs Elements

6. Requirements

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

234b - Support Plan Needs Elements *(continued)*

Description of Violation

Resident #1's support plan dated [redacted]/22 was not updated to reflect that resident #1 had frequent acts of aggression towards staff and residents until 9/28/23. Resident #1 had four incidents of aggression towards residents prior to 9/28/23.

Plan of Correction ***Accept [redacted] - 03/11/2024)***

234b. Health Care Director and/or Assistant Health Care director will continue to create and review support plans within 72 hours of admission into the secured dementia unit. The reviewer will make sure the support plans identify the resident's physical, medical, social, cognitive and behavioral needs. Health care director and assistant health care director will ensure support plans meet the needs of the resident including behaviors. The Health Care Director and the Assistant Health Care Director will be responsible for monitoring ongoing compliance with all current and new secured Dementia unit residents to assure the support plans are accurate and up to date by 3/8/2024.

Licensee's Proposed Overall Completion Date: *03/08/2024*

Implemented [redacted] - 04/19/2024)

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

Facility Information

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF ALLENTOWN* **License #**: *23139* **License Expiration**: *12/01/2023*

Address: *6043 LOWER MACUNGIE ROAD, MACUNGIE, PA 18062*

County: *LEHIGH* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *LW ALLENTOWN OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *07/15/2018* **Issued By**: *Lower Macungie Twp*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *85* **Waking Staff**: *64*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *12/26/2023*

Inspection Dates and Department Representative

12/13/2023 - On- [redacted]
12/14/2023 - On- [redacted]
12/19/2023 - Off- [redacted]
12/26/2023 - Off- [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *83*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *30* **Residents Served**: *28*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *83*

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

Have Mobility Need: *2* **Have Physical Disability**: *0*

Inspections / Reviews

12/13/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/26/2024*

02/06/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/20/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/13/2024*

02/13/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/20/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/20/2024*

05/28/2024 - Document Submission

Submitted By: [redacted] *ins* **Date Submitted**: *02/20/2024*

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

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

The licensing inspection summaries dated 6/28/23, 9/5/23 and 2/15/23 were not posted in a public conspicuous area of the home.

Plan of Correction ***Accept [redacted] - 02/13/2024)***

Licensing inspection summaries dated 6/28/23, 9/5/23 and 2/15/23 have been posted in a conspicuous and public place as required by the Residence Director on 1/26/2024. Residence Director and or designee will post all future licensing inspection summaries when received within 24 hours of receipt. RD. HCD, and or designee will monitor this process monthly.

Licensee's Proposed Overall Completion Date: *02/12/2024*

Implemented [redacted] - 05/16/2024)

16c - Written Incident Report

2. Requirements

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

Description of Violation

Resident #13 was out of the facility during the day on [redacted]/23 and therefore missed [redacted] 2pm dose of Gabapentin 400mg, 12pm Diclofenac Sodium 1% gel, and 8am daily weight. The home did not report this missed medication error to the Department.

Plan of Correction ***Accept [redacted] 02/13/2024)***

Incident report for identified resident #13 submitted per requirements on 12/14/2023 by Health Care Director. Health Care Director and Assistant Health Care Director shall re-educate associates that administer medications regarding documentation protocol for residents who are out of the residence by 2/2/2024. The Incident report for identified resident #13 was submitted per requirements on 12/14/2023 by Health Care Director. Health Care Director and Assistant Health Care Director shall re-educate associates that administer medications regarding documentation protocol for residents who are out of the residence by 2/2/2024. Health Care Director or Assistant Health Care Director shall review medication reports for missed medications daily for the next Four weeks and ongoing and also investigate medications that are not signed as administered. Going forward, summaries from reports shall be reported at monthly QMPI meetings by Health Care director and re-evaluated for further monitoring.

Licensee's Proposed Overall Completion Date: *02/12/2024*

Not Implemented [redacted] - 05/16/2024)

23a - Activities of Daily Living Assistance

3. Requirements

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

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

Description of Violation

The assessment and support plan dated [redacted]/23 for Resident #9 indicates the resident requires assistance with bladder and bowel management, including incontinence care. Per staff interviews and documentation of shift reports, the resident's incontinence briefs were found to be soaked through to[redacted] clothes on multiple occasions because staff were unable to change them due to [redacted]r resistance to care.

Plan of Correction ***Accept [redacted] - 02/13/2024)***

Health Care Director and Assistant Health Care Director Initiated incontinence care log on 12/1/2023 for resident #9. Health Care Director, Assistant Health care Director or designee, shall continue to review and re-evaluate if further monitoring is needed. Clinical associates have been re-educated on how to approach resistant residents for incontinence care. Resident Assessment and Support plan has been updated to reflect the current needs of the resident by the Health Care Director and Assistant Health Care Director. Audit for RASP's of current residents was completed on 2/1/2024 by the Health care director and Assistant Health care director. Health care Director and Assistant health care director will continue to review accuracy with new and recuring assessments.

Licensee's Proposed Overall Completion Date: *02/12/2024*

Not Implemented ([redacted] - 05/16/2024)

26b - Quality Management Plan Content

5. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:

Description of Violation

The home's quality management plan states that quality management meetings will be conducted monthly to review the topics required by this regulation. The home is not currently conducting monthly meetings that review the topics required by this regulation.

Plan of Correction ***Accept [redacted] - 02/13/2024)***

Residence Director and or designee will conduct monthly Quality management meetings with department heads which includes reportable incidents and condition reporting procedures, complaint procedures, staff person training, licensing violations and plans of corrections. Residence Director has held regular monthly meetings with department heads since September 2023. Going forward, Residence Director, Health care Director or designee will continue to hold QMPI monthly meetings to review outcomes of previous issues/discussions in addition to addressing new concerns. Next meeting will be held on 2/29/2024.

Licensee's Proposed Overall Completion Date: *02/12/2024*

Implemented [redacted] - 05/16/2024)

28f - Resident's Funds and 30-day Refund

6. Requirements

2600.
28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

28f - Resident's Funds and 30-day Refund *(continued)*

Description of Violation

Resident #7's estate was not sent an accurate itemized written account of the resident's funds upon the resident's discharge. The itemized account contained inaccurate information regarding the resident's monthly apartment rate and monthly care fee, and the amount refunded to the estate was not itemized.

Plan of Correction ***Directed [redacted] - 02/13/2024)***

Refund had no discrepancies and check was submitted per Legend invoice # 5944 on October 12th 2023 by Accounting department and family had no concerns regarding issued refund. Resident Director and Customer Service Associate or designee will continue to monitor and review itemized accounts sent to residents/POAs for accuracy.

Proposed Overall Completion Date: 02/12/2024

The home will issue the required itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home, to Resident #7.

The administrator will develop a tracking system to ensure that all discharged residents receive the required account and/or refund within 30 days of discharge.

Directed Completion Date: *02/20/2024*

Implemented [redacted] /11/2024)

57c - 2 Hours/Day

7. 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 12/1/23, 12/2/23, and 12/3/23, there were 83 residents in the home, including 30 residents with mobility needs, requiring a total minimum of 113 hours of direct care service. On 12/3/23 date, only 110.78 hours of direct care staffing was provided.

Plan of Correction ***Accept [redacted] 02/13/2024)***

Residence Director and Health Care Director reviewed the schedule immediately and found it to be in compliance on 12/13/2023. Residence Director and Health care director will ensure direct care hours will meet the minimum

57c - 2 Hours/Day (continued)

requirements according to mobility and care needs to meet the minimum standard. One Month schedule will be posted in advance and Residence Director and Health Care Director will calculate hours daily and ongoing to ensure we meet the needs of the residents beginning on 12.14.2023 and will add staff as needed to the schedule based on resident mobility and care needs.

Licensee's Proposed Overall Completion Date: *02/12/2024*

Implemented [redacted] - 03/11/2024)

60a - Staff/Support Plan

8. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

Per staff interviews, the mobility needs of the resident's of the home was assessed as the following: 5 residents in the home require assist of 1 staff person into a wheelchair and need to be propelled by a staff person to safety; and 4 residents in the home require assist of 2 into a wheelchair and need to be propelled by a staff person to safety in the event of an emergency. 2 of these resident require the use of a Hoyer lift for transfers.

On the following dates, the home only had 3 staff present in the home from 10p-6a, which based on the home's mobility needs was deemed to be not enough staff to ensure safe evacuation of all residents in the event of an emergency: 11/20/23, 11/22/23, 11/30/23, 12/2/23, 12/3/23, and 12/5/23.

Plan of Correction ***Accept [redacted] - 02/13/2024)***

Upon exit, staffing was adjusted to add one additional FTE on 10p-6a shift which is reflective in the staffing schedule by Residence Director and Health care Director. Direct care hours will meet the minimum requirements according to mobility and care needs to meet the minimum standard. Four-week schedule posted in advance by Residence Director and Health Care Director or designee. The Residence Director and Health Care Director will calculate hours daily and ongoing to meet the needs of the residents beginning on 12.14.2023 and will add staff as needed to schedule based on resident mobility and care needs.

Licensee's Proposed Overall Completion Date: *02/12/2024*

Implemented [redacted] - 03/11/2024)

63a - First Aid/CPR Training

9. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

The home serves 83 residents and is required to have 2 staff persons present in the home at all times certified in First Aid and CPR. On 12/1/23 from 10p-6a only one staff person was certified in First Aid.

Plan of Correction ***Accept [redacted] - 02/13/2024)***

The schedule was reviewed and validated that the requirements are met for 1:50 First Aid/CPR trained associate to

63a - First Aid/CPR Training (continued)

resident ratio by Residence Director and Health Care Director. Missing certifications were obtained and validated by Health Care Director, that compliance is met. First aid/CPR training to occur on 2/29/2024 to train additional associates on first aid/CPR. Health Care Director and Resident Director, to review schedule a week in advance weekly for 4 weeks and update the schedule to have 1:50 associate to resident ratio for First Aid/CPR trained per requirement. The Residence Director and Health Care Director to re-evaluate if further monitoring is needed in advance and make changes to meet 1:50 CPR/first aide associate requirement. Going forward, CPR/FA training will be conducted each quarter for new hires and renewals.

Licensee's Proposed Overall Completion Date: *02/12/2024*

Implemented (05/16/2024)

65b - Rights/Abuse 40 Hours

10. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Staff person A hired , Staff person B hired 3, Staff person C hired , Staff person D hired Staff person E hired Staff person F hired and Staff person G hired did not receive training in The Older Adults Protective Services Act, reporting of reportable incidents and conditions and emergency medical plan.

Plan of Correction ***Accept - 02/13/2024)***

Customer Service Associate (CSA) completed audit of current associates on 1/26/2024. Associates without documentation of completed rights/abuse training received education on 2/2/2024, and all new hires will need to complete training prior to working on the floor independently. Customer Service Associate will be responsible for employee file audits and new hire training. All current employees have completed the Older Adults rights/Abuse training as of 2/2/2024. Moving forward, RD and Customer service Associate will monitor for compliance and keep record of this training.

Licensee's Proposed Overall Completion Date: *02/12/2024*

Implemented - 05/16/2024)

103e - Left Overs

11. 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

The main kitchen walk-in refrigerator had the following items that was not labeled and dated when opened: 5 pounds of shredded cheese, shredded lettuce, and a pan of cooked carrots.

The main walk-in refrigerator had a 5-pound cooked pork roast that was not labeled and dated when prepared and served.

103e - Left Overs *(continued)*

Plan of Correction ***Accept (RY - 02/13/2024)***

The unlabeled/dated food items were immediately discarded as soon as reported by the Chef on 12/13/2023. Chef/kitchen associates were reeducated by the Residence Director on labeling opened food items in the refrigerator on 12/14/2023. Chef/cook initiated food storage area review on 12/14/2023 and corrected food storage items identified immediately. Moving forward, refrigerator audits to be performed daily by Chef, Cook, RD and or designee identifying any other unable food items and offer any reeducation for kitchen associates as indicated.

Licensee's Proposed Overall Completion Date: *02/12/2024*

Implemented ([redacted] - 05/16/2024)

132d - Evacuation

12. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

On 3/31/23 at 11:05 PM the home conducted an overnight fire drill that was over the allowable evacuation time given by the fire safety expert. The home has an allowable evacuation time of 15 minutes, and the fire drill was documented to take 19 minutes.

Plan of Correction ***Accept [redacted] - 02/06/2024)***

Subsequent fire drills have been in the time frame designated for safety since 4/31/2023. RD shall reeducate MD by 1/30/2023 that fire drills that are over the time frame shall initiate immediate reeducation of associates on shift and another fire drill on the same shift. Maintenance Director, or designee, shall audit fire drills monthly; fire drills that are over the time frame shall initiate immediate reeducation of associates on shift and another fire drill on the same shift. Monthly results reviewed at quality meeting and re-evaluated if further monitoring is needed.

Licensee's Proposed Overall Completion Date: *01/30/2024*

Implemented [redacted] - 03/11/2024)

141a - Medical Evaluation

13. Requirements

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

Description of Violation

Resident #1 was admitted to the home on [redacted]/23. Resident #1's DME was completed 4/20/23, outside of timeframe required by this regulation.

Resident #11's medical evaluation (DME) dated 10/12/23 was written on in blue pen after the form was completed and returned by the qualified medical professional in the "Date Resident Evaluated" field. There was no documentation to verify that this alteration to the form was approved by a qualified medical professional.

141a - Medical Evaluation (continued)

Resident #14's DME dated 9/14/23 is missing documentation regarding the resident's ability to self-administer medications.

Plan of Correction ***Accept [redacted] - 02/06/2024)***

DMEs for Residents #1, #11 and #14 shall be corrected by 2/2/2024. HCD and AHCD reeducated on the requirements for DMEs by the RD on 1/29/2024. Current resident DMEs shall reviewed and corrected, as indicated, by 2/2/2024 by HCD and AHCD. HCD, or designee, shall review new resident DMEs upon move in and contact provider for clarification and updates as indicated.

Licensee's Proposed Overall Completion Date: *02/02/2024*

Implemented [redacted] - 03/11/2024)

162c - Menus Posted

14. 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

At time of inspection, the home did not have their menus posted for the present week of 12/10/23 through 12/16/23, or the upcoming week of 12/17/23 through 12/23/23.

Plan of Correction ***Accept [redacted] - 02/06/2024)***

Menus posted for the present and upcoming week by the Chef as of 12/13/23. Chef reeducated on 12/13/2023 by RD on posting menus. Chef, or designee, shall audit for accurate posted menus weekly and then reevaluate if further monitoring is needed.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented [redacted] 05/16/2024)

162e - Menu Changes

15. Requirements

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

Description of Violation

On the date of inspection 12/13/23 the home changed the lunch time meal with the main course and did not give residents advanced notice. The home's original planned entrée was salisbury steak and turkey. The home changed the menu choices to turkey and fish without advanced notice.

Plan of Correction ***Accept [redacted] - 02/13/2024)***

Substitution logs have been provided to the chef for future use as of 12/13/2023 by the Administrator. In the future if there is a substitution, the chef will notify residents in advance of the meal by publicly posting substitution outside of the Dining area. The chef will put a menu change on each dining room table as well. The Resident Director, Chef and or designee to audit daily times 4 weeks and on ongoing as needed.

Proposed Overall Completion Date: 02/12/2024

162e - Menu Changes *(continued)*

Licensee's Proposed Overall Completion Date: *02/12/2024*

Implemented [redacted] - 03/11/2024)

183d - Prescription Current

16. 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

Resident #2's Basaglar Kwikpen insulin pen was opened 10/25/23 and expired 28 days after it was opened, on 11/22/23. Resident #3's Lantus Solostar insulin pen was opened 9/18/23 and expired 28 days after it was opened, on 10/16/23. Both expired medications were still present in the medication cart.

Plan of Correction ***Accept [redacted] - 02/06/2024)***

Resident #2 and Resident #3 identified medications were discarded immediately. Associates managing medication storage shall be reeducated to expiration dates by 2/2/2024 by HCD, or designee. Multidose medications were audited for open date and expiration, medications identified were discarded and replaced by 2/2/2024 by HCD. HCD, or designee, shall audit multidose medications for open date and expiration weekly starting 2/2/2024 for 4 weeks and reevaluate if further monitoring is indicated.

Licensee's Proposed Overall Completion Date: *02/02/2024*

Implemented [redacted] 03/11/2024)

185a - Implement Storage Procedures

17. Requirements

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

Description of Violation

Resident #1 has an order for blood glucose readings 4 times daily. On 12/11/23 at 4p the Medication Administration Record (MAR) indicated a reading of 335, the glucometer had a reading of 329. On 12/8/23 at 8pm the MAR indicated a reading of 226, the glucometer had a reading of 228.

Resident #12's Blood glucose readings on the following dates were not documented correctly: 12/10/23 at 4:00PM Resident #12's glucometer had a blood glucose reading of 178 and the home documented a blood glucose reading of 221. On 12/11/23 Resident #12's glucometer blood glucose reading for 4:00PM had a reading of 354 and the home documented a blood glucose reading of 345.
Repeat Violation: 6/8/23

Plan of Correction ***Accept [redacted] - 02/06/2024)***

Med techs reeducated on reading and recording glucometer readings by 2/2/2024 by HCD, designee. HCD to complete daily audit for 1 week, if Med Techs will complete weekly glucometer audits. Once we are 100% complaint, audits will be moved to monthly and reviewed by HCD.

Licensee's Proposed Overall Completion Date: *02/02/2024*

Not Implemented [redacted] - 03/11/2024)

187a - Medication Record

18. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #5 is prescribed Systane eye drops 5x daily. On 12/3/23, 12/8/23, and 12/11/23, the resident's medication administration record (MAR) was not documented that the medication was administered.

Plan of Correction ***Accept [redacted] - 02/13/2024)***

Health Care Director reeducated Medication technicians on medication administration, documentation and ordering protocols as of 2/2/2024. Health Care Director and Assistant Health Care Director shall review medication reports for missed medications daily and investigate medications that are not signed as administered. Going forward, Health Care Director and Assistant Health Care Director to monitor daily report summaries and weekly cart audits and then reevaluate if further monitoring and education is needed.

Licensee's Proposed Overall Completion Date: *02/12/2024*

Implemented [redacted] - 03/11/2024)

187d - Follow Prescriber's Orders

19. Requirements

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

Description of Violation

Resident #4 is prescribed Metoprolol 25mg. On 12/7/23 at 8am, the medication was not administered because the medication was not present in the home.

Resident #6 is prescribed Claravis 20mg. On 12/9/23, 12/10/23, and 12/11/23, the medication was not administered because the medication was not present in the home.

Resident #13 was out of the facility during the day on 12/11/23 and therefore missed his/her 2pm dose of Gabapentin 400mg, 12pm Diclofenac Sodium 1% gel, and 8am daily weight.

Repeat Violation: 6/8/23

Plan of Correction ***Accept [redacted] - 02/13/2024)***

Health Care Director reeducated Medication technicians on medication administration, documentation and ordering protocols and following the direction of the prescriber as of 2/2/2024. Health Care Director and Assistant Health Care Director shall review medication reports for missed medications daily and investigate medications that are not signed as administered. Going forward, Health Care Director and Assistant Health Care Director to monitor daily report summaries and weekly cart audits and then coach and counsel and reevaluate if further monitoring and education is required.

Licensee's Proposed Overall Completion Date: *02/12/2024*

Not Implemented ([redacted] - 05/16/2024)

188b - Medication Error Reporting

20. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #13 was out of the facility during the day on 12/11/23 and therefore missed [redacted]r 2pm dose of Gabapentin 400mg, 12pm Diclofenac Sodium 1% gel, and 8am daily weight. The resident's designated person and prescriber were not notified of the missed medications/treatments.

Plan of Correction ***Accept [redacted] - 02/06/2024)***

Resident #13 missed mediations reported per mediation reporting on DATE by HCD. HCD reeducated on missed medication reporting requirements on 1/26/2024 by RHCD. HCD to monitor daily report audits, investigate medications not documented on and report per reporting requirements as indicated.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented [redacted] - 03/11/2024)

224a - Preadmission Screen Form

21. Requirements

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

Description of Violation

Resident #8's preadmission screening form, dated [redacted]3, does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept ([redacted] - 02/13/2024)***

Prescreen for resident #8, dated [redacted]/2023 was updated for completion on 1/26/2024 by Health Care Director and Assistant Health Care director. Going forward, prescreens will be reviewed prior to move in for accuracy by Health Care Director, Assistant health Care Director and or designee. Health Care Director and Assistant Health care director completed an audit of current prescreens for discrepancy on 2/2/2024.

Licensee's Proposed Overall Completion Date: *02/12/2024*

Implemented [redacted] - 05/16/2024)

227d - Support Plan Medical/Dental

23. Requirements

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

Description of Violation

Resident #1 utilizes a bedside mobility device. The resident's RASP dated 10/19/23 does not include the required

227d - Support Plan Medical/Dental (continued)

verbiage regarding use of the enabler bar, including:

- *The specific need for the device*
- *The intended use*
- *Any risks associated with the device*
- *The resident's ability to use the device safely for the intended purpose*
- *Identification of the specific device to be used*
- *If a cover is required to meet FDA guidelines*

Repeat Violation: 9/5/23

Plan of Correction ***Accept [redacted] - 02/13/2024)***

Resident #1 and [redacted] were educated on bed enablers by Health Care Director and Assistant Health Care Director on 12/26/2023 for their use, safety, can cognition ability to use them safely for bed mobility and or transfers. Health care Director and or Assistant Health Care Director will review current residents and or any new residents with requests of bed enabler devices and update RASPs per requirement as of 2/2/2024. Going forward if applicable the criteria will be detailed in the RASP.

Proposed Overall Completion Date: 02/12/2024

Licensee's Proposed Overall Completion Date: *02/12/2024*

Implemented ([redacted] - 05/16/2024)