



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **LOGAN OPERATOR LLC**
LEGAL ENTITY

To operate **LOGAN SQUARE ENHANCED SENIOR LIVING**
NAME OF FACILITY OR AGENCY

Located at **2 FRANKLIN TOWN BOULEVARD, PHILADELPHIA, PA 19013**
(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 **101**
(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 14**

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 **August 6, 2024** until **February 6, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **149632**

Janette Biderup
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.



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: AUGUST 6, 2024

[REDACTED]
Logan Operator, LLC
[REDACTED]

RE: Logan Square Enhanced Senior Living
License #: 149632

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection February 5 and 6, 2024 and April 29 and 30, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from August 6, 2024 to February 6, 2025.

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

If you disagree with the decision to issue a SECOND PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

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

[REDACTED]

[REDACTED]

Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

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

Sincerely,



Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

[REDACTED]

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

Facility Information

Name: *LOGAN SQUARE ENHANCED SENIOR LIVING* License #: *14963* License Expiration: *04/06/2024*
Address: *2 FRANKLIN TOWN BOULEVARD, PHILADELPHIA, PA 19013*
County: *PHILADELPHIA* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *LOGAN OPERATOR LLC*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *Other* Date: *04/13/1984* Issued By: *City of Philadelphia, L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *105* Waking Staff: *79*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Provisional* Exit Conference Date: *02/06/2024*

Inspection Dates and Department Representative

02/05/2024 - On-Site: [REDACTED]
02/06/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *101* Residents Served: *67*

Secured Dementia Care Unit

In Home: *Yes* Area: *The Gardens* Capacity: *14* Residents Served: *8*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *67*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *38* Have Physical Disability: *0*

Inspections / Reviews

02/05/2024 - Full

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

03/08/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/01/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 03/13/2024

03/08/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/08/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission

Follow-Up Date: 04/11/2024

07/09/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/09/2024

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

On 02/05/24 and 02/06/24 the home's current violation report dated 11/30/23, and a copy of 55 PA. Code Chapter 2600, were not posted in a conspicuous and public place in the home.

Repeat Violation : 9/22/23

Plan of Correction

Accept [REDACTED] 03/07/2024)

- 1. The Executive Director immediately placed copies of the current violation report and copies of 55 PA. Code Chapter 2600 in the 1st floor lobby, the 5th floor elevator lobby and the 3rd floor Memory Care entrance.
- 2. The Administrator, front desk personnel, and security staff were educated on posting requirements by the Executive Director starting on 2/6/24 and completed on 2/8/24.
- 3. The Administrator or Designee will conduct random audits 3x per week for 2 months of the main lobby, 3rd floor memory care, and 5th floor elevator lobby, beginning 2/8/24 to ensure the home's current violation report and a copy of 55 PA. Code Chapter 2600 are posted. To be completed by 4/10/24.
- 4. The Administrator will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

Proposed Overall Completion Date: 04/10/2024

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

Not Implemented [REDACTED] /16/2024)

5a1 - DHS Access

2. Requirements

2600.

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

- 1. Agents of the Department.

Description of Violation

On 02/05/23, at approximately 9:30 AM during the day 1 entrance conference, agents of the Department requested access to a staff list including ancillary staff. Staff person A was unable to provide a listing of ancillary staff until after 2:30 PM.

Plan of Correction

Accept [REDACTED] - 03/07/2024)

- 1. Staff person A was terminated on [REDACTED] 24.
- 2. All department heads and the incumbent Administrator were educated on immediate access to the home, residents, and records to agents of the Department on 2/6/24 by the Executive Director.
- 3. The Executive Director or designee will randomly interview 3 Department Heads 1x weekly for 2 months to ensure understanding of providing access to agents of the Department. To be completed by 4/10/24.
- 4. The Administrator will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

5a1 - DHS Access (continued)

Proposed Overall Completion Date: 04/10/2024

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

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

18 - Compliance With Laws

3. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Carbon Monoxide detector for the kitchen was within 15 feet of the gas appliances. Per the Care Facility Carbon Monoxide Alarms Standards Act of Jun. 23, 2016; Carbon Monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance.

Plan of Correction

Accept [REDACTED] - 03/07/2024)

1. The Maintenance Supervisor purchased a new carbon monoxide detector on 2/6/24 and it was immediately placed in the kitchen not closer than 15 ft from the gas source.
2. Maintenance Supervisor immediately audited all other areas of the community that required a carbon monoxide detector to be in place. All other areas carbon monoxide detectors were located and in working order. This was completed on 2/6/24 by Maintenance supervisor.
3. Executive Director provided re-education to Maintenance Supervisor and Executive Chef on requirements for carbon monoxide detectors on 2/6/24.
4. On 2/28/24, The Maintenance Supervisor updated the facility maintenance task management system (TELS) to create a monthly maintenance check to assure carbon monoxide detectors are in place and in working order.
5. The Maintenance Director or designee will assure random audits are performed 1x each week for 2 months to determine that reeducation has been effective in assuring that the carbon monoxide detectors are in place. To be completed by 4/10/24.
6. Maintenance Supervisor will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

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

25a - Written Contract and Review

4. Requirements

2600.

- 25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

The contract for Resident #1 is signed; however, the contract is not dated. There is no way to determine when the contract was reviewed or signed.

25a - Written Contract and Review (continued)

Plan of Correction

Accept [redacted] - 03/08/2024)

- 1. Resident #1 expired on [redacted] 24.
- 2. All resident contracts were audited on 2/9/24 by the business office manager to ensure they were signed and dated.
- 3. On 2/10/24, a resident file check list was created to place in all future resident files.
- 4. Members of the Sales Team and the Business Office Manager were educated by the Executive Director on 2/9/24 to ensure all resident contracts are reviewed, signed and dated by the resident and the resident's designated person if any. And that the check list is completed.
- 5. The Executive Director or designee will conduct an audit on all new admissions weekly for the next 2 months to be completed by 4/10/24.
- 6. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

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

25b - Contract Signatures

5. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted]/23, for resident #2 was not signed by the resident.

Plan of Correction

Accept [redacted]/08/2024)

- 1. The Executive Director reviewed the contract with Resident #2 on 2/7/24, who then signed a the contract on 2/7/24.
- 2. All resident contracts were audited on 2/9/24 by the business office manager to ensure they were signed and dated appropriately.
- 3. On 2/10/24, a resident file check list was created to place in all future resident files.
- 4. Members of the Sales Team and the Business Office Manager were educated by the Executive Director to ensure all resident contracts are reviewed, signed and dated by the resident and the resident's designated person if any. And that the check list is completed.
- 5. The Executive Director or designee will conduct an audit on all new admissions weekly for the next 2 months to be completed by 4/10/24.
- 7. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

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

41e - Signed Statement

6. Requirements

41e - Signed Statement (*continued*)

2600.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #2's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. *The Executive Director reviewed the resident rights and complaint procedures with Resident #2 on 2/7/24, and the resident signed acknowledgement of their residents rights and complaint procedures on 2/7/24.*
2. *All resident files were audited by the Business Office Manager on 2/9/24 to ensure each contained record of receipt of resident rights and complain procedures.*
3. *Executive Director educated Sales Team Members and Business Office manager on obtaining acknowledgement of receipt of a copy of the resident rights and complaint procedures for the resident file on 2/9/24.*
4. *The Executive Director or designee will conduct an audit on all new admissions weekly for the next 2 months to be completed by 4/10/24.*
5. *The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.*

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

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

52 - Hiring Staff

7. Requirements

2600.

52. Staff Hiring, Retention and Utilization - Hiring, retention and utilization of staff persons shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults) and other applicable regulations.

Description of Violation

Staff member B's date of hire is [REDACTED]/23, staff member B's criminal background check request was not completed until 06/16/23.

Staff member C's date of hire is [REDACTED]/00, staff member C's criminal background check request was not completed.

Staff member D's date of hire is [REDACTED]01, staff member D's criminal background check request was not completed.

Staff member E's date of hire is [REDACTED]20, staff member E's criminal background check request was not completed until 09/26/22.

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. *Employees C through E were hired prior to the change of ownership, under the former operator's license. The prior operator removed all employee files at time of change of ownership, so the original background checks could not be located. Logan Enhanced Senior Living ran background checks on employees C through E on 9/26/23, which was prior to change of ownership. Employee B is no longer an active employee as of [REDACTED]/23, which was their last working day.*
2. *The Human Resources Director or designee will audit all current employee files by 3/15/24 to ensure*

52 - Hiring Staff (continued)

background checks were completed timely.

3. The Human Resources Director and Human Resources Assistant were educated by the Executive Director on 2/7/24 regarding mandatory background checks for all employees prior to starting.

4. The Executive Director or designee will conduct audits of all new employees weekly for 2 months to ensure background checks are completed timely. To be completed by 4/10/24.

5. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

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

64c - Annual Training**8. Requirements**

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person A, [REDACTED], completed only 23 hours of Department-approved training in training year 2023.

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. Staff person A was terminated on [REDACTED] 24. The current administrator's education was audited by the Executive Director on 2/9/24 to ensure compliance with 64c.

2. The Executive Director was educated on 2/7/24 by the VP of Senior Living to ensure the Administrator of record has at least 24 hours of annual training relating to the job duties.

3. The Executive Director will request CEU credits as obtained for the Administrator's file and audit once monthly for 2 months, to be completed by 4/10/24.

4. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

Not Implemented [REDACTED] 05/16/2024)

65a - FS Orientation 1st Day**9. Requirements**

2600.

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

1. Evacuation procedures.

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

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

3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, whose first day of work was [REDACTED] 23, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services. The home could not provide documentation.

Staff person F, whose first day of work was [REDACTED] 23, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services. The home could not provide documentation.

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. Staff person B's last day worked was [REDACTED] 23 and is no longer employed. Staff person F was educated on general fire safety and emergency preparedness on 10/18/23.
2. HR Director and HR Assistant were educated on 2/7/24 by the Executive Director on 65a.
3. A new hire check list was created on 2/7/24 to ensure compliance with 65a.
4. All current employee files will be audited by 3/15/24 by the HR director or designee to ensure each employee had completed FS orientation.
5. All new hire employee files will be audited by the Executive Director or designee weekly for 2 months to ensure general fire safety and emergency preparedness education was completed. To be completed by 4/10/24.
6. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

Not Implemented ([REDACTED]) - 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:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

65b - Rights/Abuse 40 Hours (continued)

4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person B completed their 40th scheduled work hour in June 2023. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, and reporting of reportable incidents and conditions. The home could not provide documentation.

Staff person F completed their 40th scheduled work hour in October 2023. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), and reporting of reportable incidents and conditions. The home could not provide documentation.

Plan of Correction

Accept [REDACTED] 03/08/2024)

1. Staff Person B's last working day was [REDACTED]/23 and is no longer employed. Staff Person F completed general orientation on 2/28/24 and 2/29/24. Orientation contained training in the following areas: resident rights, emergency medical plan, and reporting of reportable incidents and conditions.
2. HR Director and HR Assistant were educated by the Executive Director on 2/7/24 regarding required training topics within 40 working hours for all direct care staff, ancillary staff, substitute personnel and volunteers.
3. A new hire check list was implemented on 2/7/24 and all current employee files will be audited by 3/15/24 by the HR Director or designee to ensure mandatory training topics were reviewed.
4. The Executive Director or designee will audit all new hires weekly for 2 months to ensure all training topics are covered within 40 working hours for direct care staff, ancillary staff, substitute personnel and volunteers. To be completed by 4/10/24.
5. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

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

65e - 12 Hours Annual Training

11. Requirements

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person D received only 2 hours of annual training in training year 2023.

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. Direct Care person D will complete 12 hours of annual training by 3/15/24.
2. The HR Director and HR Assistant were educated by the Executive Director on 2/7/24 regarding the requirement for 12 hours of annual training for direct care staff relating to their job duties.
3. All direct care staff were educated to ensure completion of their 12 hours of annual training related to their job duties by the Administrator on 2/12/24.
4. 3 random employee files will be audited by the Executive Director or Designee weekly for 2 months to ensure their education is completed according to the annual training calendar. To be completed by 4/10/24.
5. The Executive Director will report audit findings at the Quality Management Review Meeting for additional

65e - 12 Hours Annual Training (continued)

recommendations as needed.

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

Not Implemented (█ - 05/16/2024)

65f - Training Topics**12. Requirements**

2600.

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

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

Description of Violation

Direct care staff person C did not receive training on instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2023. The home could not provide documentation.

Direct care staff person D did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, or safe management techniques during training year 2023. The home could not provide documentation.

Plan of Correction

Accept (█ - 03/08/2024)

1. *Staff Person C received education on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan on 2/14/24. On 2/14/24, Staff person D received education on medication self-administration training instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, or safe management techniques.*
2. *The HR Director or Designee will audit all current direct care employee files by 3/15/24 to ensure completion of annual training topics for direct care staff are completed.*
3. *The Executive Director or designee will audit 2 random employee files of direct care staff weekly for 2 months to ensure completion of annual training for direct care staff persons. To be completed by 4/10/24.*
4. *The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.*

65f - Training Topics (continued)

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

Implemented [REDACTED] - 05/16/2024)

65g - Annual Training Content

13. Requirements

2600.

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

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

Description of Violation

Staff person C did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, during training year 2023. The home could not provide documentation.

Staff person D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), during training year 2023. The home could not provide documentation.

Staff person E did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention during training year 2023. The home could not provide documentation.

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. Staff Person C, D and E will receive training by a fire safety expert by 3/15/24. Staff persons D & E will also receive training on resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101 —10225.5102) by 3/15/24. Staff person E will also receive training on emergency preparedness procedures and recognition and response to crises and emergency situations, falls and accident prevention by 3/15/24.
2. The HR Director or Designee will audit all employee files to ensure annual training has been completed by 3/15/24.
3. The Executive Director or designee will complete a weekly audit of 3 employees, 1 time per week for 2 months to ensure Staff Training Plan is followed as scheduled. To be completed by 4/10/24.
4. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

65g - Annual Training Content (*continued*)

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

Implemented [REDACTED] - 05/16/2024)

65i - Training Record

14. 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.

Description of Violation

The home does not have a record of training for staff member E.

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. A training record for Employee E will be completed by 3/15/24.
2. The HR Director and HR Assistant were educated by the Executive Director on 2/7/24 regarding keeping a record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received.
3. The HR Director will complete an audit of all employee files to ensure that each contains a training record, to be completed by 3/15/24.
4. The Executive Director or designee will complete a weekly audit of 3 employees, 1 time per week for 2 months to ensure training records are maintained. To be completed by 4/10/24.
5. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

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

66b - Training Plan Content

15. Requirements

2600.

66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

1. The name, position and duties of each direct care staff person.
2. The required training courses for each staff person.
3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home's staff training plan does not include the name, position and duties of each direct care staff person, the required training courses for each staff person, the dates, times and locations of the scheduled training for each staff person for the upcoming year.

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. The Staff Training Plan was updated on 2/12/24 by the Executive Director to include the name, position, and duties of each direct care staff person and the dates, times, and locations of the scheduled training for each staff person for the upcoming year .
2. Newly hired employees are provided training during orientation and are assigned according to the Staff Training Plan.

66b - Training Plan Content (continued)

3. Department Directors were educated on the home's Staff Training Plan by the Executive Director on 2/14/24.
4. The Human Resources Director or designee will complete a weekly audit of three employees 1 time per week for 2 months to ensure Staff Training Plan is followed as scheduled. To be completed by 4/10/24.
5. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

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

81a - Accommodation**16. Requirements**

2600.

- 81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Description of Violation

The home's procedures for bedside mobility devices does not include a periodical assessment for proper installation and maintenance and that the device remains appropriate to the resident's need.

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. By 3/15/24 The Maintenance Director or designee will update the facility maintenance task management system (TELS) to create a monthly maintenance check to assure bedside mobility devices are properly installed. By 3/15/24, the Administrator or designee will complete a safety/assistive device evaluation for all residents with bedside mobility devices, which will trigger quarterly thereafter.
2. All residents with bedside mobility devices will be assessed by 3/15/24 to ensure proper installation and maintenance and that the device remains appropriate to the resident's need by the maintenance director or designee and the administrator or designee.
3. The Administrator or designee will educate all licensed staff on the procedures for periodical assessment to ensure the device remains appropriate to the resident's need by 3/15/24. The Administrator or designee will also educate the maintenance staff on the periodical assessment for proper installation and maintenance by 3/15/24
4. The Administrator or designee will audit all residents requiring mobility devices one time monthly for 2 months to ensure assessment for proper installation and maintenance, and that the device remains appropriate for the resident's need. To be completed by 4/10/24.
5. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

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

81b - Resident Personal Equipment**17. Requirements**

2600.

- 81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

81b - Resident Personal Equipment (continued)

Description of Violation

Resident #3 has two bedside mobility devices on their bed. These devices are not securely attached to the bedframe. One device is covered. The other device has an uncovered opening measuring 12 inches by 5.5 inches. This does not adhere to the FDA guidelines which states "If any openings within the device exceed 120 mm (4 3/4 inches), a cover that allows for safe gripping and use of the device for its intended purpose must be in place".

Resident #4 also has a bedside mobility device on their bed. This device is not securely attached to the bedframe. The device has an uncovered opening measuring 12 inches by 15 inches. This does not adhere to the FDA guidelines which states "If any openings within the device exceed 120 mm (4 3/4 inches), a cover that allows for safe gripping and use of the device for its intended purpose must be in place."

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. Resident #3 and #4's bedside mobility devices were removed by the maintenance director on 2/6/24.
2. The Administrator audited all residents with beside mobility devices on 2/9/24 to ensure they were securely attached to the bedframe and covered if required.
3. The Administrator educated all direct care staff and maintenance staff starting on 2/9/24 and completed on 2/16/24 to ensure that all bedside mobility devices are securely attached to the bedframe and covered if needed.
4. The Administrator or designee will audit all residents with bedside mobility devices once weekly for 2 months to ensure they are properly mounted and covered if required. To be completed by 4/10/24.
5. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

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

82c - Locking Poisonous Materials

18. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Spring Rain Antibacterial Hand Soap, with a manufacture's label indicating "Keep out of reach of children. If swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to resident #5. Not all the residents of the home, including residents in the memory care unit ("The Gardens"), have been assessed capable of recognizing and using poisons safely.

A tube of Crest toothpaste, with a manufacture's label indicating "Keep out of reach of children under 6 years of age. If more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to resident #5. Not all the residents of the home, including residents in the memory care unit ("The Gardens"), have been assessed capable of recognizing and using poisons safely.

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. The Spring Rain Antibacterial Hand Soap and Crest toothpaste was removed immediately from resident #5's access by staff person A.
2. All direct care staff were educated on 82c by the Administrator by 2/14/24.

82c - Locking Poisonous Materials (continued)

- 3. The Administrator or designee will audit 5 random resident rooms once weekly for 2 months to ensure all poisonous materials are locked and inaccessible to residents.
- 4. The Executive Director or designee will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

Not Implemented [REDACTED] 05/16/2024)

85d - Trash Receptacles

19. Requirements

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

Description of Violation

On 02/05/24, at 9:54 AM, there was an uncovered trash can in the 5th floor guest bathroom.

Repeat Violation : 9/22/23

Plan of Correction

Accept [REDACTED] - 03/08/2024)

- 1. A lid was placed on the trash can in the 5th floor guest bathroom on 2/6/24 by the housekeeping director.
- 2. All housekeepers were educated by the Housekeeping Director on 2/8/24 to ensure call trash cans are kept covered to prevent the penetration of insects and rodents.
- 3. The Housekeeping Director or designee will audit all kitchen areas and bathrooms to ensure trash cans are covered. To be completed by 3/5/24.
- 4. The Housekeeping Director or designee will conduct an audit of 5 random rooms, 3 times per week for 2 months to ensure all trash cans are covered. To be completed by 4/10/24.
- 5. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

Implemented [REDACTED] - 05/16/2024)

95 - Furniture and Equipment

20. Requirements

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

Description of Violation

The heater in resident #6's bathroom is dirty, damaged and uncovered leaving the heating coils exposed.

Plan of Correction

Accept [REDACTED] - 03/08/2024)

- 1. The heater in resident #6's bathroom was cleaned, repaired and covered on 2/6/24 by the maintenance director.
- 2. The Maintenance staff were educated on ensuring that furniture and equipment are in good repair, clean and free of hazards by the Executive Director on 2/8/24.
- 3. The Maintenance director will audit all resident rooms to ensure each have heaters in good repair, clean and free

95 - Furniture and Equipment (continued)

of hazards, to be completed by 3/15/24.

4. By 3/15//24, the Maintenance Director updated the facility maintenance task management system (TELS) to create a monthly maintenance check to assure heating units are in good repair, clean and free of hazards.

5. The Maintenance Director or designee will audit 3 random resident rooms 3 times weekly for 2 months to ensure heaters are in good repair, clean and free of hazards. To be completed by 4/10/24.

6. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

Implemented () - 05/16/2024)

101j7 - Lighting/Operable Lamp**22. Requirements**

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #3 does not have access to a source of light that can be turned on/off at bedside.

Resident #7 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction

Accepted () - 03/08/2024)

1. A light source was added to resident #3 and Resident #7's bedside on 2/6/24.

2. The Executive Director educated the maintenance director and maintenance staff to ensure all residents have access to an operable lamp or other source of lighting at bedside on 2/8/24.

3. The maintenance director or designee will complete an audit of all resident rooms to ensure each had an operable lamp or light source at bedside on 3/15/24.

4. The maintenance director or designee will complete a random audit of 3 resident rooms once per week for 2 months to ensure that all residents have operable lamps or light sources at bedside. To be completed by 4/10/24.

5. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

Implemented () - 05/16/2024)

103i - Outdated Food**24. Requirements**

2600.

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

Description of Violation

There was an unlabeled, undated styrofoam container of food in the refrigerator and something wrapped in paper towels, also unlabeled and undated, in the ice of the freezer of the Memory Care kitchen.

103i - Outdated Food (continued)

Plan of Correction

Accept [redacted] - 03/08/2024)

1. The food located in the memory care kitchen refrigerator was removed immediately by the Food Service Director.
2. The Executive Director Educated the food service staff and all staff working in memory care regarding the need to ensure all food is labeled, dated and appropriately covered for storage on 2/8/24.
3. The Food Service Director audited all refrigerators on 2/8/24 to ensure all food is labeled, dated and covered for storage.
4. The Food Service Director or designee will conduct a random audit of refrigerators in the home three times weekly for 2 months to ensure all food is labeled, dated, and covered. To be completed by 4/10/24.
5. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

Not Implemented [redacted] /16/2024)

105g - Lint Removal and Duct Cleaning

25. Requirements

2600.

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

Description of Violation

On 02/05/24, there was an excessive amount of lint in the lint trap of the 5th floor dryer.

On 02/05/24, the lint trap in the 8th floor dryer was broken allowing lint to spread into the internal components of the dryer.

Plan of Correction

Accept [redacted] - 03/08/2024)

1. The lint trap of the 5th floor dryer was cleaned on 2/5/24 by the housekeeping director. The lint trap on the 8th floor was replaced on 2/8/24 by the maintenance director.
2. The housekeeping staff were in serviced by the Executive Director on 2/12/24 to ensure that lint traps are free from lint and in good repair.
3. The housekeeping director conducted an audit of all lint traps on 2/12/24 to ensure that lint traps are free from lint and in good repair.
4. The housekeeping director or designee will conduct a random audit of 3 lint traps, 3 times per week for 2 months to ensure that lint traps are free from lint and in good repair. To be completed by 4/10/24.
5. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

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

107d - Procedure Emergency Management Agency Submission

26. Requirements

107d - Procedure Emergency Management Agency Submission (continued)

2600.

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

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency management agency since 01/18/23. The home has been undergoing several renovations since that time.

Plan of Correction

Accept [redacted] - 03/08/2024)

1. The Administrator delivered the Emergency Procedure manual to the local emergency management agency on 3/1/24 for review. Renovations have been strictly cosmetic.
2. The Executive Director educated the Maintenance Director on the annual submission of the emergency procedure manual to the local emergency management agency on 2/12/24.
3. The Administrator or designee will obtain proof of receipt and review of the emergency management procedures by the local emergency management agency and add it to the survey binder annually.
4. The Executive Director or designee will conduct and audit once weekly for 2 months to ensure the emergency procedures have been reviewed annually. To be completed by 4/10/24.
5. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

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

130a - Smoke Detector 15 ft Bedroom

27. Requirements

2600.

130.a. There shall be an operable automatic smoke detector located within 15 feet of each bedroom door.

Description of Violation

On 02/05/24, renovations to resident rooms on floors 7 and 8 were being completed by construction workers. Due to dust and debris being created from the work, the workers covered the smoke detectors with blue "painters" tape so the alarms would not set off a false alarm. However, this also interferes with the intended purpose of detecting smoke leaving floors 7 and 8 without operable smoke detectors. These floors are also occupied by residents. Further, staff A, the Administrator, stated the smoke detectors are disabled on floors 5, 6, 7, and 8.

On 02/06/24, tape was not present on smoke detectors. However, the home had contacted their alarm company and had the fire alarm system put on test mode rendering the alarms inoperable. Staff H, Director of Plant Operations, stated this is done daily while renovations are being completed.

Fire watch procedures were not being completed or documented.

Plan of Correction

Accept ([redacted] 03/08/2024)

1. On 2/5/24 The Maintenance Director had the blue painters tape removed from the smoke detectors on floors 7 and 8, and Fire Watch was implemented by the Maintenance Director on 2/5/24 at 11:30AM. The system was back online on 2/5/24 3:30pm and fire watch ended.
2. The Maintenance Director completed an audit of all smoke detectors on 2/6/24 to ensure all coverings were removed.

130a - Smoke Detector 15 ft Bedroom (continued)

3. The Executive Director educated the Maintenance Director and Renovation Team on 2/12/24 to ensure fire watch is initiated if the smoke detectors are disabled or covered.
4. The Maintenance Director will conduct an audit of 3 random floors, 3 times per week for 2 months to ensure smoke detectors are not covered, and if the system is offline due to renovations, fire watch is enacted.
5. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

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

131f - Fire Extinguisher Inspection**28. Requirements**

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the home's bus does not have an inspection tag to determine when it was last inspected by a fire safety expert.

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. The fire extinguisher in the bus was replaced on 2/6/24 with a brand-new extinguisher by the Maintenance Director.
2. The Maintenance Director will conduct an audit of all fire extinguishers in the home to ensure each have been inspected annually by a fire safety expert with the date of inspection by 3/5/24.
3. On 2/12/24, the Executive Director educated the Maintenance Director to ensure all fire extinguishers are inspected annually and have the date of the annual inspection on the extinguisher.
4. The Maintenance Director will audit 3 random extinguishers weekly to ensure all have been inspected annually by a fire safety expert, with the date of the inspection listed.
5. The Executive Director will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

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

181d - Storing Medication**29. Requirements**

2600.

181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident #7 self-administers medications and stores medications in their room. On 02/06/24, at approximately 11:40 AM, there were several unlocked, unattended medications in resident #7's bedroom. The door to the room was unlocked and no one was present in the room.

181d - Storing Medication (continued)

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. Resident #7 educated/ reminded on regulation 181.d to self-administer medications. By Administrator on 2/8/24. Resident verbalized their understanding of need to keep medications in a secure, locked location and the need to keep apartment door locked.
2. All residents who self-administer medications will be educated/ reminded of regulation 181.d and the importance of adherence to regulation by 3/15/24 by the Administrator or designee.
3. All health and wellness staff will be educated on 181.d by the Administrator or designee by 3/15/24, training to include room observations for medications, staff will report any findings to Health and Wellness Director, Administrator, or ED.
4. Administrator or designee will audit 3 random resident rooms weekly for two months for compliance with proper storing of medications for residents who self-administer medications.
5. The Administrator or designee will report audit findings at the Quality Management review meeting for additional recommendations

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

Not Implemented [REDACTED] 05/16/2024)

183d - Prescription Current

31. Requirements

2600.

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

Description of Violation

On 02/06/24, Senna 8.6 MG Tabs prescribed for individual #10, was in the home's medication cart; however, the medication had a "Discard By:" date of 01/04/24.

Plan of Correction

Accept [REDACTED] 03/08/2024)

1. Expired Senna 8.6 mg tabs immediately removed from medication storage area by Administrator/ Staff person A on 2/6/24.
2. All medications audited for expiration dates by Administrator on 2/8/24.
3. All medication technicians and LPNs will be educated on regulation 183d by 3/15/24 by the administrator or designee.
4. 10 Random resident medication audits will be conducted weekly for 2 months by Administrator or designee.
5. Administrator or designee will report audit findings at the Quality Management review meeting for additional recommendations.

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

Not Implemented [REDACTED] 05/16/2024)

184a - Resident's Meds Labeled

32. Requirements

2600.

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

184a - Resident's Meds Labeled (*continued*)**Description of Violation**

On 02/06/24 at 11:41 AM, an unlabeled container of Latanoprost Ophthalmic Solution 125mcg/2.5mL was found in resident #11's medication bin.

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. Unlabeled Latanoprost Ophthalmic Solution was removed and discarded immediately by Administrator/ Staff person A on 2/6/24.
2. All medications will be audited for proper labeling by Administrator by 3/15/24.
3. All medication technicians and LPNs will be educated on regulation 184a by 3/15/24 by Administrator or designee.
4. 10 random resident medications audits will be conducted weekly for 2 months by Administrator or designee.
5. Administrator or designee will report audit findings at the Quality Management review meeting for additional recommendations.

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

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

185a - Implement Storage Procedures

33. 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 #12 is prescribed Melatonin as needed. On 02/06/24 this medication was not available in the home.

Resident #13 is prescribed K-phos 500 as needed. On 02/06/24 this medication was not available in the home.

Plan of Correction

Accept [REDACTED] 03/08/2024)

1. Missing Melatonin and K-phos 500 immediately ordered from pharmacy by Administrator on 2/6/24.
2. All resident "as needed" medications will be audited for availability by Administrator or designee by 3/15/24.
6. All medication technicians and LPNs will be educated on regulation 185a by 3/15/24 by Administrator or designee.
3. 10 random resident medications audits will be conducted weekly for 2 months by Administrator or designee.
4. Administrator or designee will report findings at the Quality Management review meeting for additional recommendations.

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

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

190c - Record of Training

34. Requirements

2600.

190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

190c - Record of Training (continued)

Description of Violation

The home's medication administration training record for staff person C does not include any training prior to staff person C's Initial medication administration training completed on 01/11/24. Staff person C administered medications in December 2023. The home does not have the previous medication administration training records.

Five other staff members completed their "initial" medication administration training in January 2024. Per staff member's A and G, the previous records are not available.

Plan of Correction

Accept [REDACTED] 03/08/2024)

1. All current medication technicians attended an initial medication training on 2/29/24 by Regional Director of Clinical/ Train the Trainer. Initial medication observations of all medication technicians completed on 2/29/24.
2. Administrator and ED educated on regulation 182b on 2/29/24 by Regional Clinician.
3. Administrator or designee will audit medication technician trainings monthly for 2 months to ensure observations and MAR reviews are in compliance to be completed by 4/10/24.
4. Administrator or designee will report audit findings at the Quality Management review meeting for additional recommendations.

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

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

191 - Resident Right to Refuse

35. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #2, admitted [REDACTED]/23, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error. The home could not provide documentation.

Plan of Correction

Accept [REDACTED] 03/08/2024)

1. Resident #2 was educated on the right to refuse medication on 2/7/24 by the Administrator, which has been documented.
2. The business office manager audited all resident files on 2/9/24 to ensure each received a copy of their residents' rights, with the right to question or refuse a medication if the resident believes there may be a medication error.
3. On 2/9/24, the sales team and business office manager were educated by the Executive Director to ensure residents are notified of their right to refuse prior to or at time of move-in.
4. The business office manager or designee will audit all new resident files weekly for 2 months to ensure residents receive notification of their right to refuse and it is documented in the resident file.
5. The Business office manager or designee will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

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

224a - Preadmission Screen Form

36. 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 #14 was admitted to the home on [REDACTED]/23; however, the resident's preadmission screening form was completed on 01/31/24.

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. Administrator or designee will complete full audit of all residents newly admitted to the community since 1/1/24 to verify accuracy of Preadmission Screening Form completed by 3/15/24.
2. Executive Director will conduct training on the Pre-Admission Screening form to the Administrator and sales team completed on 3/15/24.
3. Executive Director or designee will audit new admissions on or prior to date of physical admission for the next 2 months to assure complete and accurate documentation, and assure prospective resident is appropriate for personal care, to be completed by 4/10/24.
4. The Executive Director or designee will report audit findings at the Quality Management Review Meeting for additional recommendations as needed

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

Implemented [REDACTED] 05/16/2024)

227d - Support Plan Medical/Dental

37. Requirements

2600.

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

Description of Violation

The assessment for resident #3, dated [REDACTED] 23, indicates A (Independent) under the Personal Care Needs and Degree column for Transferring in/out of bed/chair and Turning and positioning in bed/chair. The support plan does not indicate a need for a bedside mobility device.

The assessment for resident #4, dated [REDACTED]/23, indicates A (Independent) under the Personal Care Needs and Degree column for Transferring in/out of bed/chair and Turning and positioning in bed/chair. The support plan does not indicate a need for a bedside mobility device.

The assessment for resident #6, dated [REDACTED]/23, indicates D (Total Physical Assistance) under the Personal Care Needs and Degree column for Transferring in/out of bed/chair and A (Independent) for Turning and positioning in bed/chair. However, the support plan does not indicate a need for a bedside mobility device.

When such devices are in use, the resident's support plan must reflect:

- The specific need for the device,

227d - Support Plan Medical/Dental (continued)

- 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.

Plan of Correction

Accept [REDACTED] 03/08/2024)

1. The RASP for resident #3, #4 and #6 were updated by the Administrator on 3/1/2024 to reflect an accurate assessment of the resident's mobility status and to reflect the need for a bedside mobility device, the intended use, any risks associated with the device, resident's ability to use device for intended purposes, identification of the specific device resident is using and if a cover is required.
2. Residents with bed mobility devices RASPs will be audited and updated by 3/15/24 by the Administrator or designee to reflect an accurate assessment of the resident's mobility status and to reflect the need for a bedside mobility device, the intended use, any risks associated with the device, resident's ability to use device for intended purposes, identification of the specific device resident is using and if a cover is required.
3. Health and Wellness staff will be educated on regulation 227d by 3/15/24 by the Administrator or designee.
4. RASPs will be audited by the Administrator or designee weekly for 2 months for proper documentation, to be completed by 4/10/24.
5. The Executive Director or designee will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

Not Implemented [REDACTED] 05/16/2024)

227g -Support Plan Signatures**38. Requirements**

2600.

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

Description of Violation

Resident #15 participated in the development of [REDACTED]'s support plan on [REDACTED]/23. However, the resident did not sign the support plan.

Plan of Correction

Accept [REDACTED] - 03/08/2024)

1. The Administrator reviewed the resident's support plan with Resident #15 on 2/29/24 and the resident signed and dated the plan.
2. The Executive Director educated the Administrator on 227g on 2/29/24.
3. The Administrator or designee will audit any residents with support plan reviews dating back to 1/1/24 to ensure all have been reviewed with the resident, signed and dated. To be completed by 3/15/24.
4. RASPs will be audited by the Administrator or designee weekly for 2 months for proper documentation, to be completed by 4/10/24.
5. The Executive Director or designee will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

227g - Support Plan Signatures (*continued*)

Implemented [REDACTED] - 05/16/2024)

234b - Support Plan Needs Elements

39. Requirements

2600.

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

Description of Violation

The support plan, dated [REDACTED]/23, for resident #1 does not address the resident's Behavioral or Cognitive Needs (pgs. 10 and 11 of RASP).

Plan of Correction

Accepted [REDACTED] 03/08/2024)

1. Resident #1 expired on [REDACTED]/24.
2. The Executive Director educated the Administrator on 234b on 2/29/24.
3. The Administrator or designee will audit all support plans going back to 1/1/24 to ensure they address the resident's physical, medical, social, cognitive and safety needs by 3/15/24.
4. The Administrator or designee will audit 3 support plans weekly for 2 months, to be completed by 4/10/24.
5. The Executive Director or designee will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

Implemented [REDACTED] - 05/16/2024)

252 - Record Content

40. Requirements

2600.

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

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.

252 - Record Content *(continued)*

17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident #14's record does not include race, color of hair, color of eyes, religious affiliation, if any, and identifying marks or a photograph of the resident that is no more than 2 years old.

Plan of Correction

Accept [REDACTED] **03/08/2024)**

1. Resident #14's record was updated to include race, color of hair, color of eyes, religious affiliation, if any, and identifying marks or a photograph of the resident that is no more than 2 years old on 2/29/24 by the Administrator.
2. On 2/29/24, The Executive Director educated the sales team and Administrator on 252.
3. The Administrator or designee will audit all resident files by 3/15/24.
4. The Administrator or designee will conduct an audit of all new residents weekly for 2 months, to be completed by 4/10/24.
5. The Executive Director or designee will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

Implemented [REDACTED] **05/16/2024)**

253c - Records Log

41. Requirements

2600.

253.c. The home shall keep a log of resident records destroyed on or after October 24, 2005. This log must include the resident's name, record number, birth date, admission date and discharge date.

Description of Violation

Based on an interview with staff member A, [REDACTED], the home does not keep a record of destroyed records.

Plan of Correction

Accept [REDACTED] **- 03/08/2024)**

1. The community had a change of ownership on 11/4/22. There have been no records that were destroyed since that time, therefore there was no current record of destroyed records.
2. The community established a log on 2/11/24 by the Business Office Manager to be used for any records destroyed in the future.
3. The Business Office manager was educated by the Executive director on 2/29/24 on 253c.
4. The Business Office Manager or designee will audit once monthly for two months to ensure a log of resident records destroyed in maintained, to be completed by 4/10/24.
5. The Executive Director or designee will report audit findings at the Quality Management Review Meeting for

253c - Records Log (continued)

additional recommendations as needed.

6. The Executive Director or designee will report audit findings at the Quality Management Review Meeting for additional recommendations as needed.

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

Implemented [REDACTED] /16/2024)

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

Facility Information

Name: *LOGAN SQUARE ENHANCED SENIOR LIVING* License #: *14963* License Expiration: *04/06/2024*
Address: *2 FRANKLIN TOWN BOULEVARD, PHILADELPHIA, PA 19013*
County: *PHILADELPHIA* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *LOGAN OPERATOR LLC*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *Other* Date: *04/13/1984* Issued By: *City of Philadelphia, L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *89* Waking Staff: *67*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Monitoring* Exit Conference Date: *04/30/2024*

Inspection Dates and Department Representative

04/29/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *101* Residents Served: *61*

Secured Dementia Care Unit

In Home: *Yes* Area: *The Gardens* Capacity: *14* Residents Served: *8*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *61*
Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *28* Have Physical Disability: *1*

Inspections / Reviews

04/29/2024 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *05/17/2024*

06/14/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 05/25/2024

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 07/08/2024

08/02/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/08/2024

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

42s - Privacy

1. Requirements

2600.

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

Description of Violation

On 04/29/24, at approximately 9:00 AM, video recording devices were identified in the home's main lobby. The home does not have a sign posted in this area indicating images are being recorded.

Plan of Correction

Accept [REDACTED] 06/07/2024)

1. Cameras were reviewed on 4/30/2024 by our VP of Plant Operations to identify all areas where cameras are recording.
2. Signage was ordered on 4/30/2024 by the Vice President of Plant Operations.
3. On 5/6/2024 signage was placed in our 2 lobbies, 1st & 5th floor Elevator lounge & 5th Floor medication room by our Director of Plant Operations.
4. Education on 42s was provided to the Executive Director & Director of Plant Ops on 5/1/2024 by the Vice President of Senior Living
5. All areas being recorded will be audited 3 x week beginning on 5/6/2024 by the Executive Director or designee for 2 months to ensure proper signage is posted.
6. The Executive Director or designee will report audit findings at the Quality Management Review Meeting, that is tentatively scheduled for 5/30/24, for additional recommendations as needed.

Proposed Overall Completion Date: 07/08/2024

Licensee's Proposed Overall Completion Date: 07/08/2024

Implemented [REDACTED] - 07/25/2024)

62 - Contact List

2. Requirements

2600.

62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Neither staff person A, [REDACTED], or staff person B, [REDACTED], could provide an accurate list of staff persons.

Plan of Correction

Accept [REDACTED] - 06/10/2024)

1. A current staff list was obtained by the HR Director on 5/1/2024 to include all shared staff between Personal Care & Independent Living.
2. Education was provided to the HR Director & Executive Director on 5/1/2024 by the Vice President of Senior Living on the importance of maintaining a current employee list to include shared staff.
3. As of 5/1/2024 the Executive Director or designee will audit the staff list weekly for two months to ensure all staff working in the personal care home are reflected on the list.
4. The Executive Director or designee will report audit findings at the Quality Management Review Meeting, that is tentatively scheduled for 5/30/24, for additional recommendations as needed.

62 - Contact List (continued)

Proposed Overall Completion Date: 07/08/2024

Licensee's Proposed Overall Completion Date: 07/08/2024

Implemented [REDACTED] - 07/25/2024)

81b - Resident Personal Equipment

3. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #1 has a bedside mobility device that is not attached to the bed frame but slides under the resident's mattress. Bedside mobility devices that slide under the mattress and are not securely attached to the structure of the bed can move and create entrapment zones not always present upon inspection. These types of devices are not permitted under any circumstance.

Plan of Correction

Accept [REDACTED] - 06/07/2024)

1. Enabler for resident #1 was replaced with a Halo Safety Ring with cover on 5/16/2024 and installed according to manufacturer guidelines by maintenance team.
2. The Executive Director audited all resident apartments with beside mobility devices on 5/6/24 to ensure they were securely attached to the bedframe and covered if required.
3. The Health & Wellness Director educated all direct care staff and maintenance staff starting on 5/6/24 and completed on 5/25/24 to ensure that all bedside mobility devices are securely attached to the bedframe and covered if needed.
4. Beginning on 5/13/2024 the Executive Director or designee will audit all residents with bedside mobility devices once weekly for 2 months to ensure they are securely attached to the bedframe and covered if required.
5. The Executive Director or designee will report audit findings at the Quality Management Review Meeting, that is tentatively scheduled for 5/30/24, for additional recommendations as needed.

Proposed Overall Completion Date: 07/08/2024

Licensee's Proposed Overall Completion Date: 07/08/2024

Not Implemented [REDACTED] - 07/25/2024)

82c - Locking Poisonous Materials

4. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Several products including; Medline Barrier Cream, Listerine Mouthwash, Premium Hand Sanitizer and Fabuloso Multi-Purpose Cleaner, with a manufacture's label indicating seek medical help or contact a Poison Control Center if ingested were found unlocked, unattended, and accessible to residents of the home's secured dementia care unit (The Gardens). Not all the residents of The Gardens have been assessed capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials (continued)

Plan of Correction

Accept [redacted] - 06/07/2024)

1. All storage boxes in SDU (The gardens) apartments were locked immediately on 4/30/2024 by Health & Wellness Director.
2. All resident apartments in the SDU were audited on 5/1/2024 by the Executive Director to ensure all boxes were locked. Findings revealed several locks needing replacement. All locks were replaced on 5/1/2024.
3. All direct care staff were educated on 82c by the Health & Wellness Director starting on 5/6/2024 and completed by 5/25/2024
4. Beginning on 5/6/2024 all SDU apartments will be audited 3 x week by the Executive Director or designee for 2 months to ensure all storage boxes are locked.
5. The Executive Director or designee will report audit findings at the Quality Management Review Meeting, that is tentatively scheduled for 5/30/24, for additional recommendations as needed.

Proposed Overall Completion Date: 07/08/2024

Licensee's Proposed Overall Completion Date: 07/08/2024

Not Implemented [redacted] - 07/25/2024)

88a - Surfaces

6. Requirements

2600.

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

Description of Violation

On 04/30/24, at 1:31 PM, the paint on the wall in the sixth floor hallway, near room 603, was damaged as if a fixture had been removed. The home states the walls are being wall papered and this was part of the preparation. However, the "spot" on the wall had paint bubbling up and peeling away from the wall.

Plan of Correction

Accept [redacted] - 06/07/2024)

1. On 5/1/2024 the contractors returned to work after their religious holiday and the wall was repaired by the contractors.
2. On 5/1/2024 all floors were audited by the Plant Ops Director to ensure all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards.
3. Education was provided to all Maintenance Staff on 88a beginning on 5/6/2024 and completed on 5/8/2024 by Executive Director.
4. Beginning on 5/6/2024 The Plant Ops Director or designee will audit all floors 1 x week to ensure all floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards.
5. The Executive Director or designee will report audit findings at the Quality Management Review Meeting, that is tentatively scheduled for 5/30/24, for additional recommendations as needed.

Proposed Overall Completion Date: 07/08/2024

Licensee's Proposed Overall Completion Date: 07/08/2024

Implemented [redacted] - 07/25/2024)

105g - Lint Removal and Duct Cleaning

7. Requirements

2600.

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

Description of Violation

On 04/30/24, at 1:54 PM, there was an accumulation of lint in the lint trap of the dryer next to the trashcan in the eighth floor laundry room. There were no clothes in the dryer at the time.

Plan of Correction

Accept (████) 06/14/2024)

1. The lint trap of the 8th floor dryer was cleaned on 4/30/2024 by the housekeeping director.
2. The Executive Director or designee will report audit findings at the Quality Management Review Meeting, that is tentatively scheduled for 5/30/24, for additional recommendations as needed.
3. Signage for the dryers was ordered on 5/2/2024 to remind all staff & residents to clean the lint traps before and after each use. Signage received and placed on dryers on 5/7/2024.
4. All housekeepers & direct care staff were educated by the Executive Director starting on 5/1/2024 and completed on 5/25/2024 to ensure that lint traps are free from lint.
5. All residents that clean their own laundry were educated on 5/2/2024 by the Health & Wellness Director to ensure that lint traps are free from lint.
6. Beginning on 5/6/2024 the housekeeping director or designee will conduct audits of all dryers daily for 2 months to ensure that lint traps are free from lint.
7. The Executive Director or designee will report audit findings at the Quality Management Review Meeting, that is tentatively scheduled for 5/30/24, for additional recommendations as needed.

Proposed Overall Completion Date: 07/08/2024

Licensee's Proposed Overall Completion Date: 07/08/2024

Not Implemented (████) - 07/25/2024)

182b - Prescription Medication

8. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 04/30/24, at 9:00 AM, staff person C administered medications to residents to include the following; Sertraline 50 MG Tabs to resident #4. Staff person C is not a staff person who has completed the medication administration

182b - Prescription Medication (continued)

training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies. Staff person C completed the modified medication administration course on 10/24/23 but this course stopped being a valid alternative after 07/31/22 and required passing the standard course by 06/30/23.

On 04/29/24, at 9:00 AM, staff person D administered medications to residents to include the following; Quetiapine 25 MG Tab to resident #4. Staff person D is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies. Staff person D completed the modified medication administration course on 02/25/24 but this course stopped being a valid alternative after 07/31/22 and required passing the standard course by 06/30/23.

On 04/21/24, at 9:00 AM, staff person E administered medications to residents to include the following; Aspirin 81 MG Tablet to resident #4. Staff person E is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies. Staff person E completed the medication administration paper course which was discontinued after 12/31/23. Starting January 01, 2024, the updated medication administration training course is required to be completed online and the previous versions are no longer valid.

Plan of Correction

Accept (████) - 06/07/2024)

1. All Medication Technicians not in compliance were removed of medication administration duties as of 4/30/2024.
2. All current medication technicians completed the online medication administration course through the Office of Developmental Programs by 5/9/2024.
3. Initial medication observations of all medication technicians were completed by 5/9/24.
4. Health & Wellness Director, Wellness Coordinator and Executive Director were educated on regulation 182b on 5/1/2024 by Vice President of Senior Living.
5. Beginning on 5/15/2024 Executive Director or designee will audit medication technician trainings monthly x 2 months to ensure observations and MAR reviews are in compliance.
6. The Executive Director or designee will report audit findings at the Quality Management Review Meeting, that is tentatively scheduled for 5/30/24, for additional recommendations as needed.

Licensee's Proposed Overall Completion Date: 07/08/2024

Implemented (████) - 07/25/2024)

184b - Labeling OTC/CAM**10. Requirements**

2600.

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

Description of Violation

On 04/30/24, a package of Bayer low dose aspirin belonging to resident #2 was in the resident's medication cabinet and was not labeled with the resident's name.

Plan of Correction

Accept (████) - 06/07/2024)

1. Resident #2's medications audited on 4/30/2024 by Health and Wellness Director for proper labeling.

184b - Labeling OTC/CAM (continued)

2. All medications removed from resident medication cabinet and placed in medication cart on 5/15/2024.
3. All LPNs and Medication Technicians educated on 184b by Health and Wellness Director starting on 5/6/2024 and completed on 5/15/2024
4. Beginning 5/6/2024 Health and Wellness Director or designee will audit 5 random resident medications to ensure proper labeling.
5. The Executive Director or designee will report audit findings at the Quality Management Review Meeting, that is tentatively scheduled for 5/30/24, for additional recommendations as needed

Proposed Overall Completion Date: 07/08/2024

Licensee's Proposed Overall Completion Date: 07/08/2024

Implemented [REDACTED] 07/25/2024)

185a - Implement Storage Procedures**11. Requirements**

2600.

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

Description of Violation

Resident #3 is prescribed Quetiapine 25 MG Tab as needed. On 04/30/24 this medication was not available in the home.

Plan of Correction

Accept [REDACTED] - 06/07/2024)

1. Missing quetiapine was immediately ordered from the Pharmacy on 5/1/2024 by Health & Wellness Coordinator.
2. An audit of all PRN Medications was conducted on 5/1/2024 to ensure availability.
3. All LPN's and Medication Technicians educated on 185a by Health & Wellness Director starting on 5/6/2024 and completed on 5/15/2024.
4. Beginning on 5/6/2024 The Health & Wellness Director or designee will audit 5 random resident PRN medications weekly x 2 months to ensure availability of PRN medications.
5. The Executive Director or designee will report audit finding at the Quality Management Review Meeting, that is tentatively scheduled for 5/30/2024 for additional recommendations as needed.

Licensee's Proposed Overall Completion Date: 07/08/2024

Not Implemented [REDACTED] - 07/25/2024)

186c - Change in Medications**12. Requirements**

2600.

186.c. Changes in medication may only be made in writing by the prescriber, or in the case of an emergency, an alternate prescriber, except for circumstances in which oral orders may be accepted by nurses in accordance with regulations of the Department of State. The resident's medication record shall be updated as soon as the home receives written notice of the change.

Description of Violation

Resident #2's physician order form, dated 0 [REDACTED] /24, has a prescription for Rexulti 0.5 MG Tab-Take one tablet by

186c - Change in Medications (continued)

mouth in the evening. This order was changed on the physician order form from two tablets to one tablet on 04/22/24. Resident #2's MAR lists this most recent prescription as discontinued (D/c) on 04/25/24. This medication is listed two additional times on the MAR with dates of 04/11/24 and 04/18/24. When asked why there are so many changes on the MAR, staff person A stated the resident's [REDACTED] is a physician and makes changes to the medications. Staff person A also stated the resident's spouse D/c'd the medication on 04/25/24. The resident's spouse is not the prescribing physician.

Plan of Correction**Accept [REDACTED] 06/07/2024)**

1. Resident #2's medications were audited on 5/1/2024 by Health and Wellness Director to ensure any change in medications were prescribed by the resident's provider.
2. Residents primary care physician re-wrote all prescriptions in questions on 5/1/2024.
3. All medications were removed from resident medication cabinet and placed in the medication cart on 5/15/2024.
4. Resident's spouse was educated on 186c on 5/1/2024 via phone by Health & Wellness Director.
5. All LPNs and Medication Technicians educated on 186c by Health and Wellness Director starting on 5/6/2024 and completed on 5/15/2024.
6. Beginning 5/6/2024, Health and Wellness Director or designee will audit 5 random resident medications to ensure prescription are written by the resident's provider.
7. The Executive Director or designee will report audit findings at the Quality Management Review Meeting, that is tentatively scheduled for 5/30/24, for additional recommendations as needed.

Licensee's Proposed Overall Completion Date: 07/08/2024

Implemented [REDACTED] - 07/25/2024)**187d - Follow Prescriber's Orders****13. Requirements**

2600.

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

Description of Violation

Resident #2 is prescribed Melatonin 10 MG Tab-Take one tablet by mouth at bedtime with a 9:00 PM administration time. However, resident #2 was administered Ocmelatonin 5 MG Tab-Take one tablet by mouth at bedtime on 05/27/24, 05/28/24, 05/29/24 at 7:30 PM.

Plan of Correction**Accept [REDACTED] - 06/07/2024)**

1. Resident #2's medications were audited and compared to current physicians' orders on 4/30/24 by the Health and Wellness Director.
2. All medications were removed from resident medication cabinet and placed in the medication cart on 5/15/2024.
3. All LPN's and Medication Technicians educated on 187d by Health and Wellness Director beginning on 5/6/2024

187d - Follow Prescriber's Orders (continued)

and completed on 5/15/2024.

4. Beginning 5/6/2024, Health and Wellness Director or designee will audit 5 random resident medications weekly to ensure compliance with current physicians' orders x 2 months.

5. The Executive Director or designee will report audit findings at the Quality Management Review Meeting, that is tentatively scheduled for 5/30/24, for additional recommendations as needed.

Proposed Overall Completion Date: 07/08/2024

Licensee's Proposed Overall Completion Date: 07/08/2024

Implemented [REDACTED] - 07/25/2024)

227d - Support Plan Medical/Dental**14. 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 has a "RASP Updates and Changes" form dated [REDACTED]/24 indicating a need for a bedside mobility device. This update does not include the following: the specific need for the device, identification of the specific device to be used and If a cover is required to meet FDA guidelines. Further, this update is not signed by staff or the resident.

Resident #2 has a Resident Assessment and Support Plan (RASP) dated [REDACTED] 24. This date is for both the assessment and the finalization of the support plan. The assessment indicates A (Independent) under the Personal Care Needs and Degree column for Turning and positioning in bed/chair; however, "Uses enabler to position/turn in bed" is hand written in the Description of Service Need and Plan to Meet Service Need columns. A second hand written line is present but is not legible. Resident #2 also has a "RASP Updates and Changes" form dated 03/01/24 (prior to RASP) indicating a need for a bedside mobility device. This update has the word "independently" crossed out and "w/assist of aide" and "uses enabler to move/position in bed" hand written on the document. This update does not include the identification of the specific device to be used and If a cover is required to meet FDA guidelines. Further, this update is not signed by staff (The RASP indicates the resident is unable to participate). Finally, neither the RASP or the Update include the use of a Hoyer Lift which is prescribed for the resident and present in his/her room.

Resident #4 has a "RASP Updates and Changes" form dated [REDACTED] 24 indicating a need for a bedside mobility device. This update does not include the following: the specific need for the device, identification of the specific device to be used and If a cover is required to meet FDA guidelines. Further, this update is not signed by staff or the resident.

During the entrance conference on 04/30/24, Licensing Representative asked staff persons A and B the names of residents who self administer medications. Four names were provided including resident #5. In an interview with resident #5, the resident could not identify what medications were prescribed or why. A review of the residents medical file shows that the resident's last two Medical evaluations, dated [REDACTED] and the resident's last two RASPs, dated [REDACTED] indicate the resident had been assessed as not being able to self-administer medications.

227d - Support Plan Medical/Dental (*continued*)**Plan of Correction****Accept** [REDACTED] - 06/07/2024)

1. On 5/1/2024 Resident # 1, #2, #4 & #5 RASPS & addendums were reviewed. New RASPS were completed & signed by Health & Wellness Director and resident to reflect current resident status and needs.
2. An audit of all residents that require the use of an enabler bar was conducted on 5/3/2024 to ensure the specific need for the device, identification of the specific device to be used and if a cover is required to meet FDA guidelines by Health & Wellness Director.
3. An audit of all resident DME's that self-administer medications was conducted on 5/2/2024 by the Executive Director to ensure DME's reflect resident's ability to administer their own medications.
4. An audit of all RASPS was conducted on 5/3/2024 by the Health & Wellness Director & Wellness Coordinator to ensure all RASPS accurately reflect residents' status and needs and are signed by resident & staff.
5. A Medication Self-Administration Safety Screen was conducted on all residents who self-administer medications on 5/2/2024 by the Health & Wellness Director and will continue to be completed quarterly.
6. Education was provided to the Health & Wellness Director, Wellness Coordinator and LPN's on 227d by the Executive Director beginning on 5/6/2024 and completed on 5/25/2024
7. Beginning on 5/6/2024, Health & Wellness Director or designee will audit 5 random resident charts to ensure all RASPS & DME's accurately reflect residents needs and RASPS are signed by resident & staff.
8. Executive Director or designee will report audit findings at the Quality Management Review Meeting, that is tentatively scheduled for 5/30/24, for additional recommendations as needed.

Licensee's Proposed Overall Completion Date: 07/08/2024

Not Implemented [REDACTED] /25/2024)