pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **DRESHER CARE GROUP LLC**
LEGAL ENTITY

To operate **WOODLAND CREEK ALZHEIMER'S SPECIAL CARE CENTER**
NAME OF FACILITY OR AGENCY

Located at **1424 DRESHERTOWN ROAD, DRESHER, PA 19025**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

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

The total number of persons which may be cared for at one time may not exceed **66** (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 66**

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

No: **146052**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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

Manager
Dresher Care Group, LLC

RE: Woodland Creek Alzheimer's Special Care Center
1424 Dreshertown Road
Dresher, Pennsylvania 19025
License #: 146052

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection March 18 and 19, 2024 and May 2, 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 September 6, 2024 to March 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.

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
82c	II	34	$5	$170	5 calendar days from mailing date of this letter
85d	III	34	$3	$102	15 calendar days from mailing date of this letter

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

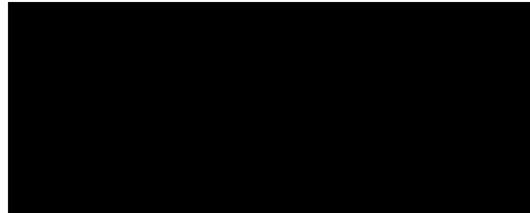
No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain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

If you disagree with the decision to issue a 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:

, Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120

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.



Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: , Office of General Counsel
, Director, Human Services Licensing
, Director of Operations
, Regional Director, Human Services Licensing

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

Facility Information

Name: *WOODLAND CREEK ALZHEIMER'S SPECIAL CARE CENTER* **License #**: *14605* **License Expiration**: *04/24/2024*

Address: *1424 DRESHERTOWN ROAD, DRESHER, PA 19025*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *DRESHER CARE GROUP LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *12/19/2019* **Issued By**: *Township of Dublin*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date**: *03/19/2024*

Inspection Dates and Department Representative

03/18/2024 - On-Site:

03/19/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served**: *36*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire building* **Capacity**: *66* **Residents Served**: *36*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *36*

Diagnosed with Mental Illness: *10* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *36* **Have Physical Disability**: *0*

Inspections / Reviews

03/18/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/11/2024*

04/12/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/01/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/16/2024*

04/18/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/01/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/01/2024*

05/16/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *05/01/2024*

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

16f - Copy of Reportable Incident or Condition

1. Requirements

2600.
16.f. The home shall keep a copy of the report of the reportable incident or condition.

Description of Violation

The home has not retained copies of the reportable incidents between November 2023 and January 2024.

Plan of Correction ***Accept (- 04/18/2024)***

Audit completed by Resident Care Director of submitted reports 3.18.24
Starting 3.18.24 Resident Care Director or designee will audit reportable submissions monthly and ensure they are included in both the resident record and reportable binder this will continue for 6 months
Ongoing reportables will be reviewed quarterly by the management team at the quality meeting to ensure they are part of the resident record 6.30.24

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 05/16/2024)

18 - Compliance With Laws

2. 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 PA Department of Agriculture Food Employee Certification Act, 3 Pa C.S.A. 6501 – 6510, effective January 22, 2011, requires one employee per licensed food facility to obtain a nationally recognized food manager certification. National exam programs are those that have been approved by ANSI using the Conference of Food Protection certified food protection manager standards. The Food Employee Certification Act requires one supervisory employee per food facility to obtain a food safety certification by taking an ANSI-CFP nationally recognized food safety class.

On staff A was working as cook in the home's kitchen. However, staff A's ServSafe certificate expired and the home currently has no one who is certified in Servsafe.

Plan of Correction ***Accept (- 04/18/2024)***

On 3.18.24 Regional Dining Director came to the community to oversee the kitchen operations and educate the staff
Regional Dining Director completed training for ED 3.18.24
New Dining Director started 3.28.24, Serv Safe certification valid
Dining Director will ensure cooks are taking Serv Safe training online by 4.30.24
Dining Director or designee will audit certificates quarterly based on calendar year, next audit will be completed by 6.30.24, updated Serv Safe certifications in place by 4.30.24
Ongoing this will be reviewed by management team at quarterly meeting 6.30.24

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

18 - Compliance With Laws *(continued)*

Implemented (CM - 05/16/2024)

51 - Criminal Background Check

3. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies 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).

Description of Violation

The home did not have an ePatch for staff B (date of hire [redacted] and C (date of hire [redacted]). The one for staff D (date of hire [redacted] and 1st day onsite 02/27/2024) was dated 02/28/2024.

Plan of Correction ***Accept ([redacted] - 04/18/2024)***

Audit completed by Business Office Manager on all employee files 3.22.24
Missing background checks run by Business Office Manager 3.22.24
Business Office Manager or designee will audit 10% of employee charts quarterly to ensure continued compliance. This will be reviewed during quality meeting on a calendar year by 6.30.24. Audits of all employee files were completed by the Business Office Manager 3.22.24
Business Office Manager or designee will audit all employee files annually to ensure background checks are present 12.31.24

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

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

63a - First Aid/CPR Training

4. Requirements

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

Description of Violation

The home has only three staff members who are trained in 1st aid and certified in CPR. The home currently has 36 residents and requires at least 1 staff who is 1st aid trained and CPR certified at all time. Most days, including 03/10/2024, no staff meeting the requirements was present for the entire day.

Plan of Correction ***Accept [redacted] - 04/18/2024)***

Email sent by Executive Director to set up CPR training 3.18.24.
Audit completed by Resident Care Director of CPR training records 3.18.24.
CPR training confirmed by Business Office Manager for 4.10.24
Audit completed quarterly based on a calendar year by Business Office Manager or designee and will be reviewed by management team during quality meeting by 6.30.24
Business Office Manager or designee will audit all files annually to ensure CPR certs are current and present in all employee records 12.31.24

63a - First Aid/CPR Training (continued)

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (CM - 05/16/2024)

65i - Training Record

5. 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 access to the annual training record of direct care staff E.

Plan of Correction ***Accept (- 04/18/2024)***

Due to change in ownership to Viva Senior Living the community was unsuccessful in obtaining Relias training records from Sunshine Retirement Living
Effective1.1.24 Executive Director had put 2024 training record in place for mandatory hours
Effective 3.18.24 All community trainings will be in person and onsite. The Executive Director is responsible for coordinating with trainers to provide and implement all required and necessary trainings. Executive Director will utilize Regional staff from Viva Senior Living, Fox Rehab, Accent Care Hospice and Nursing, and Angelic Health Palliative Care. Paid trainers for certifications will also be utilized.

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (05/16/2024)

82c - Locking Poisonous Materials

6. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On around the home's salon door was unlocked, leaving the salon unattended and accessible to residents. In the salon was found Loreal Paris Advanced Hairstyle spray with warning label: "Keep out of reach of children. Intentional misuse by deliberately concentrating and inhaling can be harmful or fatal." Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Repeated Violation: 4/3/23 et al, 5/16/23 et al, 7/12/23 et al

82c - Locking Poisonous Materials *(continued)*

Plan of Correction ***Accept - 04/18/2024)***

Salon was secured immediately by Maintenance Director during walkthrough 3.18.24
Audit of the locked drawers in all rooms completed and ensured all chemicals away and secured by care team and med techs 3.18.24
Executive Director re-educated staff on regulation 82c and stressed concern for safety in ensuring chemicals are secured 3.22.24
Effective 3.18.24 Resident Care Director or designee will conduct random daily walkthroughs to ensure compliance. This will be a sampling of several resident rooms. If there is an unlocked drawer or chemical out, Resident Care Director or designee will pull caregiver for 1:1 additional education. This will continue for 4 weeks. That caregiver will then be spot checked over the next week starting 3.18.24.
This will be evaluated on a quarterly basis by the management team at the quality meeting which occurs on a calendar quarterly basis. Next quality meeting will be prior to 6.30.24

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Not Implemented - 05/16/2024)

85d - Trash Receptacles

7. 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 03/18/2024 at 09:35 AM, the trash cans in the kitchen had no lids on.

Repeated Violation: 4/3/23 et al

Plan of Correction ***Accept - 04/18/2024)***

Maintenance Director placed lids on trashcan immediately 3.18.24
Regional Dining Director inserviced staff on regulation 85d 3.18.24
Effective 3.18.24 daily kitchen and sanitation compliance audit tool introduced by Regional Dining Director for compliance. This will be utilized daily by kitchen team members and monitored on a weekly basis by Dining Director or designee ongoing.
Effective 3.18.24 compliance tool utilized weekly by kitchen team members and monitored by Dining Director ongoing
Effective 4.30.24 compliance tool audited monthly by Dining Director and reviewed by management team quarterly at quality meeting ongoing

Licensee's Proposed Overall Completion Date: *04/30/2024*

Not Implemented (- 05/16/2024)

103d - Storing Food Off Floor

8. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 03/18/2024 at 10:35 AM, a box of frozen sweet potatoes was stored on the floor in the walk-in freezer.

Plan of Correction ***Accept (- 04/18/2024)***

Food was discarded by Regional Dining Director 3.18.24
Food was labeled by kitchen team 3.18.24
Regional Dining Director inserviced staff on Regulation 103cd, 3.18.24
Food labels were ordered by Executive Director 3.20.24 for consistency in labeling of items 3.20.24
Effective 3.18.24 daily kitchen and sanitation compliance audit tool introduced by Regional Dining Director for compliance to be utilized daily by kitchen team
Compliance tool utilized daily by kitchen team and monitored weekly by Dining Director or designee effective 4.1.24
Compliance tool audited monthly by Dining Director or designee and reviewed quarterly by management team at quality meeting which occurs on a calendar basis.

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Not Implemented (- 05/16/2024)

103e - Left Overs

9. Requirements

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

Description of Violation

There was an unlabeled, undated bowl of ice cream in the freezer. There were unlabeled, undated containers with left over cantaloup, green beans, rice in the refrigerator.

Plan of Correction ***Accept (- 04/18/2024)***

Food was discarded by Regional Dining Director 3.18.24
Food was labeled by kitchen team 3.18.24
Regional Dining Director inserviced staff on Regulation 103cd, 3.18.24
Food labels were ordered by Executive Director 3.20.24 for consistency in labeling of items 3.20.24
Effective 3.18.24 daily kitchen and sanitation compliance audit tool introduced by Regional Dining Director for compliance to be utilized daily by kitchen team
Compliance tool utilized daily by kitchen team and monitored weekly by Dining Director or designee effective 4.1.24
Compliance tool audited monthly by Dining Director or designee and reviewed quarterly by management team at quality meeting which occurs on a calendar basis.

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Not Implemented (- 05/16/2024)

103g - Storing Food

10. Requirements

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

Description of Violation

The following items were opened and unsealed
- *a piece of meat (that looked freezer burned) in the freezer*
- *a bag of frozen chicken tenders in the freezer*
- *a bag of tortilla chips on dry goods shelves*
- *a bag of pasta on the dry goods shelf.*

Plan of Correction ***Accept (- 04/18/2024)***

Food was discarded by Regional Dining Director 3.18.24
Food was labeled by kitchen team 3.18.24
Regional Dining Director inserviced staff on Regulation 103cd, 3.18.24
Food labels were ordered by Executive Director 3.20.24 for consistency in labeling of items 3.20.24
Effective 3.18.24 daily kitchen and sanitation compliance audit tool introduced by Regional Dining Director for compliance to be utilized daily by kitchen team
Compliance tool utilized daily by kitchen team and monitored weekly by Dining Director or designee effective 4.1.24
Compliance tool audited monthly by Dining Director or designee and reviewed quarterly by management team at quality meeting which occurs on a calendar basis.

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Not Implemented (- 05/16/2024)

107c - Food/Water 3 Day Supply

11. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 03/18/2024, the home served 36 residents. The home did not have a 3-day supply of emergency food. Some of the emergency food are opened and used and some expired.

Plan of Correction ***Accept - 04/18/2024)***

Regional Director inserviced staff 3.18.24 on regulation 107c
Emergency food order placed by Regional Dining Director 3.18.24, there is enough food in-house for 7 days
3 day emergency food supply delivered and labeled by kitchen team 3.20.24
3 day emergency food supply will be monitored weekly for 4 weeks by Dining Director or designee. This will move to monthly following the 4 weeks 3.29.24
3 day emergency supply will be rotated quarterly to comply with expiration dates by dining director or designee 6.30.24

107c - Food/Water 3 Day Supply (continued)

Proposed Overall Completion Date: 06/30/2024
Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (05/16/2024)

132a - Monthly Fire Drill

12. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The home could not provide documentation showing that an unannounced fire drill was held during the month of October 2023, December 2023, and January 2024.

Plan of Correction ***Accept 04/18/2024)***

Executive Director and Maintenance Director re-educated on regulation 132a by Executive Director 4.2.24
Effective 3.18.24 monthly fire drills being completed by Maintenance Director or designee in accordance with regulation 132a
Effective 3.31.24 monthly fire drill records being maintained by Maintenance Director or designee
Effective 4.1.24 compliance audited monthly by Maintenance Director or designee and will be reviewed quarterly by management company for compliance at the quarterly quality meeting. Quarter is based on a calendar year and will be reviewed by 6.30.24

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 05/16/2024)

132b - Safety Inspection/Fire Drill

13. Requirements

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

Description of Violation

The last safety inspection and fire drill observed by a fire safety expert was conducted on 05/18/2022.

Plan of Correction ***Accept (- 04/12/2024)***

Executive Director and Maintenance Director re-educated on regulation 132b by Executive Director 4.2.24
Executive Director reached out on 3.18.24 via email to previous provider Bob Mueller, there was no response
Maintenance Director reached out to Croker Fire to schedule a Fire Safety Inspection and Drill to complete by 4.30.24
Maintenance Director or designee will ensure annual training with Provider moving forward

Proposed Overall Completion Date: 04/30/2024

132b - Safety Inspection/Fire Drill *(continued)*

Licensee's Proposed Overall Completion Date: *04/30/2024*

Not Implemented (CM - 05/16/2024)

132c - Fire Drill Records

14. Requirements

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

Description of Violation

The fire drill record for the drill conducted on 02/05/2024 does not include exit routes used.

The fire drill record for the drill conducted on 11/13/2023 does not include the time and the exit route used.

Plan of Correction ***Accept (CM - 04/18/2024)***

Executive Director and Maintenance Director re-educated on regulation 132c by Executive Director 4.2.24

Effective 3.18.24 monthly fire drills being completed by Maintenance Director or designee in accordance with regulation 132c to include state approved documentation sheets

Effective 3.31.24 monthly fire drill records being maintained by Maintenance Director or designee

Effective 4.1.24 compliance audited monthly by Maintenance Director or designee and will be reviewed quarterly by management company for compliance at the quarterly quality meeting. Quarter is based on a calendar year and will be reviewed by 6.30.24

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented ██ - 05/16/2024)

141a 1-10 Medical Evaluation Information

15. Requirements

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

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

141a 1-10 Medical Evaluation Information *(continued)*

Description of Violation

The medical evaluation dated 02/05/2024 for resident #1 did not include (7) medication list and (9) cognitive functioning.

Plan of Correction ***Accept (04/18/2024)***

Resident Care Director in serviced by Regional Nurse 3.20.24
DMEs audited by Resident Care Director for completion 3.28.24
3.28.24 and ongoing Resident Care Director will have Executive Director and wellness nurse or designee review DME prior to admission to ensure document is completed in entirety
10% of resident charts will be reviewed quarterly by resident Care Director or designee and discussed at the quality meeting to ensure continued compliance 6.30.24
DME audit completed 3.13.24
RCD inserviced by Regional Nurse 3.20.24
3.21.24 DME's completed by practitioner to gain compliance with regulation 2600.141b
DME tracker implemented (?)
10% of charts pulled quarterly by RCD or designee and to be reviewed at quality meeting 6.30.24

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented - 05/16/2024)

183e - Storing Medications

16. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On , blister pack prescribed for resident #2 was torn at the back in slot 1.

Repeated Violation: 4/3/23 et al

Plan of Correction ***Accept - 04/12/2024)***

Executive Director and Resident Care Director disposed of medication in presence of inspector 3.18.24
Resident Care Director called the pharmacy to inquire about thicker packing for the blister medications 3.19.24
Regional Nurse and Resident Care Director completed cart audits to inspect all blister packs 3.20.24
Resident Care Director or designee will conduct weekly checks of the blister packs for 4 weeks. This will move to monthly following the 4 weeks. This will be part of the monthly cart audit. 4.30.24

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

183e - Storing Medications *(continued)*

Implemented [redacted] - 05/16/2024)

185a - Implement Storage Procedures

17. Requirements

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

Description of Violation

Resident #3 is prescribed [redacted], [redacted] as needed. On [redacted], these medications were not available in the home.

Resident #4 is prescribed [redacted] as needed. On [redacted], these medications were not available in the home.

Repeated Violation: 5/16/23 et al

Plan of Correction ***Accept ([redacted] - 04/12/2024)***

Resident Care Director followed up on missing PRN medications with pharmacy 3.19.24.
Resident Care Director had a meeting with Hospice team 3.19.24. regarding missing/expired PRN medications and outlined a process with them
Regional Nurse re-educated nursing team to regulation 185a to ensure understanding of procedures for safe storage access, security, distribution, and use of medications and medical equipment by trained staff persons
weekly cart audit completed by med tech or designee for 4 weeks and monthly after to ensure compliance. This will be reviewed quarterly at quality and will be evaluated at the end of the year for continued need 4.30.24

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented [redacted] - 05/16/2024)

186c - Change in Medications

18. 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 #3's order for Lorazepam 0.5 mg as needed was discontinued and order for Gabapentin 300 mg changed from 3 times a day to once a day. However, the resident’s medication record was not updated when the home received written notice of the change.

Plan of Correction ***Accept (CM - 04/18/2024)***

Regional Nurse educated Resident Care Director on regulation 186c 3.20.24

186c - Change in Medications (continued)

Cart audit completed by Regional Nurse and Resident Care Director 3.22.24
Resident Care Director or designee will conduct a weekly cart audit for 4 weeks and monthly after to ensure compliance.
10% of resident records will be reviewed quarterly by Resident Care Director or designee. This will be reviewed at the quality meeting quarterly 6.30.24

Proposed Overall Completion Date: 06/30/2024
Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented - 05/16/2024)

187a - Medication Record

19. Requirements

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

Description of Violation

Resident #2 is prescribed once daily twice a day, three times per day and at bedtime, and twice daily for 30 days.. However, the resident's March medication administration record (MAR) does not indicate the diagnoses or purpose of the medications.

Repeated Violation: 11/15/2023

Plan of Correction ***Accept - 04/18/2024)***

Regional Nurse re-educated staff on regulation 187a 3.22.24
Cart audit completed by Regional Nurse and Resident Care Director 3.22.24
Resident Care Director or designee will conduct a weekly cart audit for 4 weeks and monthly after to ensure compliance.
Resident Care Director updated Resident #2 MAR.
Resident Care Director confirmed all MAR's included diagnosis and purpose of medication. Missing information was completed at that time.
10% of resident records will be reviewed quarterly by Resident Care Director or designee. This will be reviewed at the quality meeting quarterly 6.30.24

Proposed Overall Completion Date: 06/30/2024
Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented - 05/16/2024)

187b - Date/Time of Medication Admin.

20. Requirements

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

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

Description of Violation

Resident #2 is prescribed two tabs at bedtime. This medication was not available in the home between the evening of . However, the resident's March MAR was initialed as administered on at .

Repeated Violation: 5/16/23 et al, 11/15/23

Plan of Correction ***Accept (- 04/18/2024)***

Regional Nurse re-educated nursing team on regulation 187b 3.22.24
3.22.24 and ongoing peer to peer review during cart changeover to check for documentation. Resident Care Director and nurse spoke with staff on expected communication during med count and ensuring the documentation is completed. Med techs and staff passing medications including nurse and Resident Care Director would participate in communication.
3.29.24 10% of MARS will be audited weekly by Resident Care Director or designee for the next 4 weeks. The audit will move to monthly following the 4 weeks. This will be evaluated on a quarterly basis at the quality meeting 6.30.24

Proposed Overall Completion Date: 06/30/2024
Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 05/16/2024)

187d - Follow Prescriber's Orders

21. Requirements

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

Description of Violation

Resident #2 is prescribed three times a day at at and 2 tabs at However, this medication was not administered to the resident at , at on 03/04, 08/2024, and at 08:00 PM on 03/01 and 03/04 because the medication was not available in the home.

Repeated Violation: 5/16/23 et al, 7/12/23 et al, 11/15/23

Plan of Correction ***Accept (- 04/18/2024)***

Resident Care Director confirmed Resident #2 medications were present in the home 3.19.24
Resident Care Director confirmed Resident #3 medications were present in the home 3.20.24
Regional Nurse re-educated med techs on following prescribers instructions and documenting the administration

187d - Follow Prescriber's Orders (continued)

of the medication. They were re-educated by the nurse who expressed proper administration along with proper documentation 3.20.24
Cart audit completed by Regional Nurse and Resident Care Director 3.22.24
10% of MARS will be audited weekly for the next 4 weeks by the Resident Care Director or designee. The audit will move to monthly following the 4 weeks. This will be evaluated on a quarterly basis at the quality meeting. 3.29.24

Proposed Overall Completion Date: 06/30/2024
Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 05/16/2024)

22. Requirements

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

Description of Violation

Resident #2 is prescribed). However, the resident was not administered these medications on

Repeat Violation: 5/16/23 et al, 7/12/23 et al, 11/15/23

Plan of Correction ***Accept (- 04/18/2024)***

Resident Care Director confirmed Resident #2 medications were present in the home 3.19.24
Resident Care Director confirmed Resident #3 medications were present in the home 3.20.24
Regional Nurse re-educated med techs on following prescribers instructions and documenting the administration of the medication. They were re-educated by the nurse who expressed proper administration along with proper documentation 3.20.24
Cart audit completed by Regional Nurse and Resident Care Director 3.22.24
10% of MARS will be audited weekly for the next 4 weeks by the Resident Care Director or designee. The audit will move to monthly following the 4 weeks. This will be evaluated on a quarterly basis at the quality meeting. 3.29.24

Proposed Overall Completion Date: 06/30/2024
Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented - 05/16/2024)

190c - Record of Training

23. 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 E does not include the name of the trainer and documentation that the course was successfully completed.

Plan of Correction ***Accept (- 04/18/2024)***

Med Observer on record as of November 16, 2023
Resident Care Director updated training documents for staff person E from trainer 3.22.24
Regional Nurse educated Resident Care Director to regulation 190c 3.22.24
Resident Care Director audited med certification book for any additional discrepancies 3.22.24
Med certification book will be reviewed by Resident Care Director or designee monthly to ensure compliance 3.22.24.
This will be reviewed at the quarterly quality meeting 6.30.24

Proposed Overall Completion Date: 06/30/2024
Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 05/16/2024)

225c - Additional Assessment

24. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #2's most recent assessment was completed on

Plan of Correction ***Accept (- 04/18/2024)***

Executive Director re-educated Resident Care Director on regulation 225c 3.19.24
Resident Care Director auditing resident record for missing support plans 3.31.24
Resident Care Director updating support plan for all resident 4.30.24
Resident Care Director or designee will audit 10% of resident charts monthly 4.30.24
6.30.24 and ongoing quarterly process will be reviewed at quality meeting

Proposed Overall Completion Date: 06/30/2024
Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 05/16/2024)

227h - Support Plan Refuse Sign

25. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

227h - Support Plan Refuse Sign *(continued)*

Description of Violation

The support plan for Resident #1 dated [redacted] and the one for resident #5 dated [redacted] did not make a notation regarding the resident's inability/refusal to participate/sign.

Repeated Violation: 12/11/2023

Plan of Correction ***Accept ([redacted] - 04/18/2024)***

Executive Director re-educated Resident Care Director on regulation 227h 3.19.24
Resident Care Director auditing resident record for missing support plans 3.31.24
Resident Care Director updating support plan for all residents to include when the resident is unable to sign 4.30.24
Resident Care Director or designee will audit 10% of resident charts monthly 4.30.24
6.30.24 and ongoing quarterly process will be reviewed at quality meeting

Proposed Overall Completion Date: 06/30/2024
Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

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

234d - Support Plan Revision

26. Requirements

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

Description of Violation

The most recent support plan for resident #2 was completed on [redacted]

Repeated Violation: 7/12/23 et al

Plan of Correction ***Accept ([redacted] - 04/18/2024)***

3.19.24 pre screen completed for resident
3.20.24 Executive Director educated Resident Care Director and wellness nurse to regulation 234d
Resident Care Director audited resident charts for support plans to be compliant with regulation 234d 3.25.24
10% of charts will be reviewed monthly by Resident Care Director or designee to ensure completed and updated RASP is present 6.30.24 this will be discussed at quarterly quality meeting

Proposed Overall Completion Date: 06/30/2024
Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

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

252 - Record Content

27. Requirements

2600.

252 - Record Content *(continued)*

252. Content of Resident Records - Each resident's record must include the following information:
    13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.

Description of Violation

Resident #4's record does not include the preadmission screening and initial intake assessment.

Plan of Correction ***Accept (- 04/18/2024)***

Resident Care Director printed incident reports and added them to the corresponding resident chart 3.19.24

Executive Director re-educated Resident Care Director to regulation 252 3.19.24

Resident Care Director or designee will audit reportable binder monthly to ensure reports are appropriately placed in resident record 3.13.24

Reportable incidents will be reviewed quarterly at quality meeting 6.30.24

Proposed Overall Completion Date: 06/30/2024

Proposed Overall Completion Date: 04/30/2024

Licensee's Proposed Overall Completion Date: *04/30/2024*

Implemented (- 05/16/2024)

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

Facility Information

Name: *WOODLAND CREEK ALZHEIMER'S SPECIAL CARE CENTER* **License #**: *14605* **License Expiration**: *04/24/2024*

Address: *1424 DRESHERTOWN ROAD, DRESHER, PA 19025*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *DRESHER CARE GROUP LLC*

Address:

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *68* **Waking Staff**: *51*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *05/02/2024*

Inspection Dates and Department Representative

05/02/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served**: *34*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire home* **Capacity**: *66* **Residents Served**: *34*

Hospice

Current Residents: *x*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *34*

Diagnosed with Mental Illness: *7* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *34* **Have Physical Disability**: *3*

Inspections / Reviews

05/02/2024 - Partial

Lead Inspector: *Youn Hie Chung* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/26/2024*

Inspections / Reviews *(continued)*

05/30/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/19/2024*

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

06/05/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/19/2024*

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

07/24/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *06/19/2024*

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

82c - Locking Poisonous Materials

1. 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

Colgate toothpaste, with a manufacture's label indicating "If more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible in the bathroom of resident room #3. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Repeat Violation: 4/3/23 et al, 5/16/23 et al, 7/12/23 et al

Plan of Correction ***Accept (- 05/30/2024)***

Toothpaste was secured immediately for resident #3 by caregiver 5.2.24
Audit of the locked drawers in all rooms completed and ensured all chemicals away and secured by care team and med techs 5.2.24
Executive Director re-educated Resident Care Director on regulation 82c and stressed concern for safety in ensuring chemicals are secured 5.20.24
Week of 5.31.24 staff training on regulation 82c will be completed by Resident Care Director, any staff on vacation will have training completed upon return.
Starting 5.20.24 an audit will be completed daily by Resident Care Director or designee for 2 weeks. This will move to a weekly audit for 2 weeks and followed by a monthly audit for 2 months. Weekly audits will be submitted to Executive Director and Regional Director of Clinical weekly for 4 weeks.
Once these audits have been completed 10% of resident rooms will be audited monthly ongoing.
Residents are assessed upon admission, as needed for changes, and annually this assessment includes capabilities of utilizing poisons safely
Starting June 2024 the quality assurance committee will review the audits for further recommendations monthly and ongoing. Next Quality meeting will be June 2024.

Proposed Overall Completion Date: 06/30/2024

Licensee's Proposed Overall Completion Date: *06/30/2024*

Not Implemented (- 07/22/2024)

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

On 05/02/2024 around 10:30 AM, the floor of the walk-in freezer in the kitchen was observed with a large red stain the size of a round placemat.

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Accept (█ - 05/30/2024)***

VP of Dietary and Food Service provided a Teams Training to re-educate the Dining Director on regulation 85a, daily audit tool, and review sanitation policy on 5.20.24
Dining Director re-educated cooks and dietary staff to regulation 85a and daily audit tool 5.21.24
Starting 5.20.24 daily audit tool will be completed by the Dining Director or designee daily for 14 days. This will move to weekly for 2 weeks. Following the four weeks the daily audit tool will be submitted to the Executive Director and VP of Dietary and Food Service monthly for 2 months. This will continue as needed ongoing.
Starting June 2024 the quality assurance committee will review the audits for further recommendations monthly and ongoing. Next Quality meeting will be June 2024.

Proposed Overall Completion Date: 06/30/2024

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (█ - 07/22/2024)

103i - Outdated Food

3. Requirements

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

Description of Violation

On 05/02/2024 around 10:30 AM, there was an unlabeled, undated plastic container of cooked potato and an unlabeled, undated half ham in the walk-in refrigerator. There was an unlabeled, undated bag of breaded fish in the walk-in freezer.

Plan of Correction ***Accept (█ - 05/30/2024)***

VP of Dietary and Food Service provided a Teams Training to re-educate the Dining Director on regulation 103i, daily audit tool, and review of proper food labeling on 5.20.24
Dining Director re-educated cooks and dietary staff to regulation 103i and daily audit tool 5.21.24
Starting 5.20.24 daily audit tool will be completed by the Dining Director or designee daily for 14 days. This will move to weekly for 2 weeks. Following the two weeks the daily audit tool will be submitted to the Executive Director and VP of Dietary and Food Service monthly for 2 months. This will continue as needed ongoing.
Starting June 2024 the quality assurance committee will review the audits for further recommendations monthly and ongoing. Next Quality meeting will be June 2024.

Proposed Overall Completion Date: 06/30/2024

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (█ - 07/22/2024)

183e - Storing Medications

4. Requirements

2600.

183e - Storing Medications *(continued)*

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

Description of Violation

On [redacted] blister pack prescribed for resident #1 was torn at the back in slot 9.

Plan of Correction ***Accept ([redacted] - 05/30/2024)***

Executive Director and Resident Care Director disposed of Lorazepam medication 5.2.24
Med Tech completed a PRN audit on 5.2.24 and Resident Care Director completed a cart audit on 5.10.24
Regional Nurse re-educated Resident Care Director 5.20.24 on regulation 183e and reviewed medication policy
Resident Care Director is re-educating Med Techs to regulation 183e this will be completed by week of 5.31.24
Starting 5.20.24 an audit will be completed weekly by Resident Care Director or designee for 4 weeks. This will move to a monthly audit for 2 months. Weekly audits will be submitted to Executive Director and Regional Director of Clinical weekly for 4 weeks.
In addition to the weekly audit completed by the Resident Care Director, the Executive Director will audit a few random MAR/cart audit for four weeks. This started 5.17.24
Once these audits have been completed 10% of resident blister packs will be audited monthly by the Resident Care Director or designee ongoing.
Starting June 2024 the quality assurance committee will review the audits for further recommendations monthly and ongoing. Next Quality meeting will be June 2024.

Proposed Overall Completion Date: 06/30/2024

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] - 07/24/2024)

184a - Resident's Meds Labeled

5. Requirements

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

1. The resident's name.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The current order of resident #2's [redacted] is once daily while the bottle says twice a day.
[redacted] prescribed for resident #3 had no pharmacy label on the box.

Repeat Violation: 11/15/2023

Plan of Correction ***Accept ([redacted] - 05/30/2024)***

Resident Care Director placed a change of direction sticker on resident #2 Quetiapine on 5.2.24.
Resident Care Director placed a label on resident #3 Balmex cream on 5.2.24.
Regional Nurse re-educated Resident Care Director 5.20.24 on regulation 184a and reviewed medication policy
Resident Care Director is re-educating Med Techs to regulation 184a this will be completed by week of 5.31.24

184a - Resident's Meds Labeled (continued)

Starting 5.20.24 an audit will be completed weekly by Resident Care Director or designee for 4 weeks. This will move to a monthly audit for 2 months. Weekly audits will be submitted to Executive Director and Regional Director of Clinical weekly for 4 weeks.
In addition to the weekly audit completed by the Resident Care Director, the Executive Director will audit a few random MAR/cart audit for four weeks. This started 5.17.24
Once these audits have been completed 10% of resident MARs will be audited monthly by the Resident Care Director or designee ongoing.
Starting June 2024 the quality assurance committee will review the audits for further recommendations monthly and ongoing. Next Quality meeting will be June 2024.

Proposed Overall Completion Date: 06/30/2024

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented - 07/24/2024)

185a - Implement Storage Procedures

6. Requirements

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

Description of Violation

Resident #4 is prescribed , , as needed. On these medications were not available in the home.

Plan of Correction ***Accept - 05/30/2024)***

Resident Care Director completed a cart audit on 5.10.24
Executive Director completed a cart audit on 5.17.24 and found that medications were still needed from Hospice. Per audit, meds were rectified and available on 5.20.24
Regional Nurse re-educated Resident Care Director 5.20.24 on regulation 185a and reviewed medication policy
Resident Care Director is re-educating Med Techs to regulation 185a this will be completed by week of 5.31.24
Starting 5.20.24 an audit will be completed weekly by Resident Care Director or designee for 4 weeks. This will move to a monthly audit for 2 months. Weekly audits will be submitted to Executive Director and Regional Director of Clinical weekly for 4 weeks.
In addition to the weekly audit completed by the Resident Care Director, the Executive Director will audit a few random MAR/cart audit for four weeks. This started 5.17.24
Once these audits have been completed 10% of resident MARs will be audited monthly by the Resident Care Director or designee ongoing.
Starting June 2024 the quality assurance committee will review the audits for further recommendations monthly and ongoing. Next Quality meeting will be June 2024.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (- 07/24/2024)

187b - Date/Time of Medication Admin.

7. Requirements

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

Description of Violation

Resident #2 is prescribed [redacted] as needed. The resident's [redacted] medication administration record (MAR) includes only two staff initials as administered while the controlled medication log indicates 18 pills were signed out in [redacted].

Resident #3 is prescribed [redacted] at bed time and 1 tab [redacted]. The medication is not available at the home but there is staff initials present on [redacted] at bedtime as administered.

Repeat Violation: 5/16/23 et al, 11/15/23

Plan of Correction ***Accept [redacted] - 05/30/2024)***

Executive Director completed a cart audit on 5.17.24 as part of ongoing POC
Executive Director completed training for Med Techs on medication errors and reporting and how to complete a cart audit on 5.17.24
Executive Director counseled Med Tech [redacted] and removed [redacted] from administering medications until further training is completed 5.20.24. Training with Resident Care Director to take place on 5.22.24.
Regional Nurse re-educated Resident Care Director 5.20.24 on regulation 187b and reviewed medication policy
Resident Care Director is re-educating Med Techs to regulation 187b this will be completed by week of 5.31.24
Starting 5.20.24 an audit will be completed weekly by Resident Care Director or designee for 4 weeks. This will move to a monthly audit for 2 months. Weekly audits will be submitted to Executive Director and Regional Director of Clinical weekly for 4 weeks.
In addition to the weekly audit completed by the Resident Care Director, the Executive Director will audit a few random MAR/cart audit for four weeks. This started 5.17.24
Once these audits have been completed 10% of resident MARs will be audited monthly by the Resident Care Director or designee ongoing.
Starting June 2024 the quality assurance committee will review the audits for further recommendations monthly and ongoing. Next Quality meeting will be June 2024.

Proposed Overall Completion Date: 06/30/2024

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] - 07/24/2024)

187d - Follow Prescriber's Orders

8. Requirements

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

Description of Violation

Resident #3 was prescribed [redacted] at bed time and 1 tab in the morning on [redacted] However, this medication has not been administered to the resident since [redacted] because the medication was not available in the home.

Repeat Violation: 5/16/23 et al, 7/12/23 et al, 11/15/23

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction ***Accept - 05/30/2024)***

Executive Director completed a cart audit on 5.17.24 as part of ongoing POC
Executive Director completed training for Med Techs on medication errors due to medications not available and reporting and how to complete a cart audit on 5.17.24
Regional Nurse re-educated Resident Care Director 5.20.24 on regulation 187d and reviewed medication policy
Resident Care Director is re-educating Med Techs to regulation 187d this will be completed by week of 5.31.24
Starting 5.20.24 an audit will be completed weekly by Resident Care Director or designee for 4 weeks. This will move to a monthly audit for 2 months. Weekly audits will be submitted to Executive Director and Regional Director of Clinical weekly for 4 weeks.
In addition to the weekly audit completed by the Resident Care Director, the Executive Director will audit a few random MAR/cart audit for four weeks. This started 5.17.24
Once these audits have been completed 10% of resident MARs will be audited monthly by the Resident Care Director or designee ongoing.
Starting June 2024 the quality assurance committee will review the audits for further recommendations monthly and ongoing. Next Quality meeting will be June 2024.

Proposed Overall Completion Date: 06/30/2024

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented - 07/24/2024)

190a - Completion Medication Course

9. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person A, who completed the discontinued paper course on rather than the new Department-approved online medication administration course, administered medications to residents on between next day.

Repeat Violation: 05/16/2023 et al

Plan of Correction ***Accept - 05/30/2024)***

Staff person A was pulled from administering medications effective
Resident Care Director completed a review of remaining Med Tech credentials for compliance with regulation 190a and all 7 were found to be compliant
Regional Nurse re-educated Resident Care Director 5.20.24 on regulation 190a and reviewed medication policy
Executive Director familiarized to the new approved department online medication administration course by Regional Clinical Director and peer PA Executive Director 5.22.24
Executive Director located a department approved Medication Trainer to support the community 5.21.24. The trainer is on vacation until week of 5.27.24. Executive Director will work to set up approved Medication Training in the community as needed moving forward.

190a - Completion Medication Course (continued)

Starting June 2024 the quality assurance committee will review the audits for further recommendations monthly and ongoing. Next Quality meeting will be June 2024.

Proposed Overall Completion Date: 06/30/2024

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented - 07/24/2024)

231c - Preadmission Screening

10. Requirements

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

Description of Violation

Resident #5 was admitted to the Secured Dementia Care Unit (SDCU) on However, the resident's written cognitive preadmission screening was not completed.

Repeat Violation: 07/12/2023

Plan of Correction ***Accept (- 06/05/2024)***

Resident Care Director updated cognitive preadmission screening of resident #5 on
Resident Care Director will have a chart audit completed by week of 5.27.24 to ensure all preadmission screenings are fully completed present and compliant
Regional Nurse re-educated Resident Care Director and Executive Director 5.20.24 on regulation 231c and reviewed admission policy
Effective July 2024 Resident Care Director or designee will audit 10% of resident charts monthly for 3 months to include but not limited to cognitive preadmission screening following full audit. This will be reviewed monthly by the quality assurance committee ongoing for continued compliance.
Starting June 2024 the quality assurance committee will review the audits for further recommendations monthly and ongoing. Next Quality meeting will be June 2024.

Proposed Overall Completion Date: 06/30/2024

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (- 07/24/2024)