pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **COLUMBIA HANOVER OPCO, LLC**
LEGAL ENTITY

To operate **THE VERO AT BETHLEHEM**
NAME OF FACILITY OR AGENCY

Located at **4700 BATH PIKE, BETHLEHEM, PA 18017**
(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 **140**
(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 36**

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 15, 2024** until **August 15, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **231630**

ISSUING OFFICER

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 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: August 15, 2024

[redacted]
Columbia Hanover Opco, LLC
[redacted]

RE: The Vero at Bethlehem
4700 Bath Pike
Bethlehem, Pennsylvania 18017
License #: 231630

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on May 8, 2024 and May 9, 2024, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

August 1, 2024

[redacted]
COLUMBIA HANOVER OPCO, LLC
[redacted]

RE: THE VERO AT BETHLEHEM
4700 BATH PIKE
BETHLEHEM, PA, 18017
LICENSE/COC#: 23163

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/08/2024, 05/09/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE VERO AT BETHLEHEM* **License #**: *23163* **License Expiration**: *07/23/2024*

Address: *4700 BATH PIKE, BETHLEHEM, PA 18017*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *COLUMBIA HANOVER OPCO, LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *02/09/2023* **Issued By**: *Hanover Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *159* **Waking Staff**: *119*

Inspection Information

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

Reason: *Provisional, Incident* **Exit Conference Date**: *05/09/2024*

Inspection Dates and Department Representative

05/08/2024 - On-Site: [redacted]

05/09/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *140* **Residents Served**: *118*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *36* **Residents Served**: *33*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *115*

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

Have Mobility Need: *41* **Have Physical Disability**: *1*

Inspections / Reviews

05/08/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/13/2024*

06/20/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/02/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/27/2024*

Inspections / Reviews *(continued)*

07/02/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/02/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/08/2024*

08/01/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *07/02/2024*

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

3c - Post Current License

1. Requirements

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

Description of Violation

Upon conducting the initial walkthrough of the home, it was observed that the Licensing Inspection Summaries for the home were not posted in a conspicuous location.

Repeat violation - 9/12/23

Plan of Correction ***Accept[redacted] 06/20/2024)***

With Respect to the specific deficiency cited:
The former Residence Director failed to post the licensing inspection summaries to maintain compliance with regulatory parameters. The Primary Benefit: Permits residents, families, and visitors to learn about applicable regulations and the regulatory compliance status of the home and the home's plan to correct any violations found.
With Respect to Systemic Measures that have been put into place to address the stated concern:
On 05/20/2024 The current Administrator of the home has verified and placed the LIS in a binder clearly labeled and readily available 24/7, accessible at will and located in the entry lobby of the building. Effective 05/20/2024 The Residence Director will continue to monitor the presence of the LIS weekly to ensure compliance.
With Respect to How the Plan of Corrective Measures will be Monitored:
Effective 05/20/2024 The Residence Director will continue to monitor by physically observing and clarifying the presence of the LIS weekly to ensure compliance.

Licensee's Proposed Overall Completion Date: *06/17/2024*

Update: *06/20/2024*

Please attach picture of binder and audits

Evidence of Completion ***Implemented ([redacted] - 08/01/2024)***

See attached.

Update: *08/01/2024*

Onsite POC Verification 7/16/24 [redacted]

25b - Contract Signatures

2. 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 for resident #3 was not signed by the resident. There is no documentation the resident refused or was unable to sign the contract.

Repeat violation - 12/7/23

25b - Contract Signatures *(continued)*

Plan of Correction ***Accept [redacted] - 06/20/2024)***

With Respect to the specific deficiency cited: Signing the contract constitutes a pledge by both parties to abide by the specified terms. The violation occurred because the prior Residence Director failed to obtain the resident signature in addition to legal representative signature on the resident-home contract.
With Respect to Systemic Measures that have been put into place to address the stated concern The current Residence Director reviewed the resident contract with resident and obtained a signature on 6/3/2024. In addition, a notation was made of any section of the document whereby the resident declined to sign, and the current Residence Director signed the statement as well.
The current Residence Director will review resident-home contract with new residents prior to or within 24 hours of a new admission and obtain resident signature.
With Respect to How the Plan of Corrective Measures will be Monitored: Effective immediately 06.11.2024, the Customer Service Assistant and/or Residence Director will utilize the business file checklist and audit resident business files upon move in for compliance with regulation and ensure proper signatures upon move in.

Licensee's Proposed Overall Completion Date: *06/17/2024*

Update: *06/20/2024*

Please attach resident #3's updated contract, audit tool

Evidence of Completion ***Implemented [redacted] 08/01/2024)***

See attached.

Update: *08/01/2024*

Onsite POC Verification 7/16/24[redacted]

41e - Signed Statement

3. Requirements

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 rights are given to the residents as part of the resident home contract. As Resident #3 did not sign the resident home contract, there is no signed statement acknowledging the resident's receipt of resident rights.

Plan of Correction ***Accept [redacted] 06/20/2024)***

With Respect to the specific deficiency cited:
The Primary Benefit: Protects the home by verifying that residents have been informed of the rights and procedures for filing a complaint. The violation occurred because the prior Residence Director failed to obtain the resident signature on the resident-home contract.
With Respect to Systemic Measures that have been put into place to address the stated concern The New Residence Director reviewed Resident Rights as outlined in resident's contract and signature was obtained by resident # 3 on 6/3/2024.
With Respect to How the Plan of Corrective Measures will be Monitored: Effective immediately 06.11.2024 the Residence Director, Customer Service Assistant and/or designee will audit the resident's business file upon move in for compliance with regulation utilizing the resident business file audit tool to ensure proper signatures are obtained on move in.

41e - Signed Statement (continued)

Licensee's Proposed Overall Completion Date: *06/17/2024*

Update: *06/20/2024*

Please attach resident #3's's updated contract, audit tool

Evidence of Completion ***Implemented [redacted] - 08/01/2024)***

See attached.

Update: *08/01/2024*

Onsite POC Verification 7/16/24 [redacted]

65a - FS Orientation 1st Day

4. 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:

Description of Violation

The home does not have verification that Ancillary Staff Person A hired [redacted] 24 completed orientation in general fire safety and emergency preparedness.

Repeat violation - 9/12/23

Plan of Correction ***Accept [redacted] - 06/20/2024)***

With Respect to the specific deficiency cited: Primary Benefit: Ensures that all staff persons are immediately trained to respond to an emergency situation. The Maintenance Director failed to complete and record the training required to occur on day 1 of onboarding.
With Respect to Systemic Measures that have been put into place to address the stated concern: On March 10th the associate did complete the training for general fire safety and emergency preparedness as is recorded on the Safety Education Checklist and also as noted on his Relias platform transcript.
With Respect to How the Plan of Corrective Measures will be Monitored: Effective immediately 06.11.2024 Both the Residence Director, Customer Service Assistant and/or designee will complete a final review of the associate onboarding training file for compliance with the regulatory requirements using the Associate Management File Checklist and the 8/40 record of training documentation form to ensure proper training is provided and recorded.

Licensee's Proposed Overall Completion Date: *06/17/2024*

Update: *06/20/2024*

Please attach Staff person A's training

Evidence of Completion ***Implemented [redacted] /01/2024)***

See attached.

Update: *08/01/2024*

Onsite POC Verification 7/16/24 [redacted]

65b - Rights/Abuse 40 Hours

5. Requirements

65b - Rights/Abuse 40 Hours *(continued)*

2600.

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

Description of Violation

Ancillary Staff Persons A hired [redacted]/24, E hired [redacted]/24, F hired [redacted]/24, and Direct care staff members B hired [redacted]24, C hired [redacted]/24 , and D hired [redacted]/24 , did not complete initial trainings in Residents Rights, OAPSA, Reportable incidents and conditions, and Emergency medical plan.

Repeat violation - 9/12/23

Plan of Correction ***Do Not Accept [redacted] - 06/20/2024)***

With Respect to the specific deficiency cited: Primary Benefit: Ensures that all staff persons working in the home are familiar with residents' rights, mandated reporting, and the procedures for responding to a medical emergency.
With Respect to Systemic Measures that have been put into place to address the stated concern: While there is a system in place that outlines the onboarding process, The Residence Director/Designee failed to record the training on the facility 8/40 training form.
With Respect to How the Plan of Corrective Measures will be Monitored: Effective immediately 06.11.2024 the Residence Director, Customer Service Assistant and/or designee will audit each associate onboarding training file for compliance with the regulatory requirements using the Associate Management File Checklist and the 8/40 hour record of training documentation form to ensure proper training is provided and recorded.

Licensee's Proposed Overall Completion Date: *06/17/2024*

Update: *06/20/2024*

Please include what was done to correct immediate problem with staff A-D and on what date

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

With Respect to the specific deficiency cited:
The primary benefit: Ensures that all staff persons working in the home are familiar with residents' rights, mandated reporting, and the procedures for responding to a medical emergency.
The supporting documentation will be uploaded and will verify that
Staff Persons A hired [redacted]24 completed the required training on 03.08.2024 & 03.09.2024.
Staff Person E hired [redacted]/24 completed the required training on 04.23.2024 & 04.24.2024.
Staff Person F hired [redacted]7/24 completed the required training on 08.27.2024, 02.28.2024, & 02.29.2024.

Direct care staff members B hired [redacted]/24 completed the required training on 04.24.2024.
Direct care staff member C hired [redacted]/24 completed the required training on 02.27.2024.
Direct care staff member D hired [redacted]4 completed the required training on 04.02.2024.

With Respect to Systemic Measures that have been put into place to address the stated concern:
While there is a system in place that outlines the onboarding process, The former Residence Director/Designee failed to locate the completed 8/40 training forms at time of inspection. on 06.27.2024 the present Residence Director has located the training files that were dispersed in a disorganized manner in other office locations and files.

With Respect to How the Plan of Corrective Measures will be Monitored: Effective immediately 06.11.2024 the

65b - Rights/Abuse 40 Hours (continued)

current Residence Director, Customer Service Assistant and/or designee will audit each associate onboarding training file for compliance with the regulatory requirements using the Associate Management File Checklist and the 8/40 hour record of training documentation form to ensure proper training is provided and recorded.

Licensee's Proposed Overall Completion Date: *06/27/2024*

Update: *07/02/2024*

Reviewed training for above noted staff members

Evidence of Completion ***Implemented [redacted] - 08/01/2024)***

See attached.

Update: *08/01/2024*

Onsite POC Verification 7/16/24[redacted]

65d - Initial Direct Care Training

6. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.

Description of Violation

The home did not have documentation that Direct care staff members B hired [redacted]24, C hired [redacted]/24 , and D hired [redacted]24 , completed a demonstration of job duties, followed by supervised practice.

Plan of Correction ***Do Not Accept[redacted] - 06/20/2024)***

With Respect to the specific deficiency cited: Primary Benefit: Ensures that each individual who provides assistance with ADLs is trained to do so properly.
With Respect to Systemic Measures that have been put into place to address the stated concern: While there is a system in place that outlines the onboarding process to include the first eight and forty hour training process, The Residence Director/Designee failed to record the training on the facility 8/40 training form.
With Respect to How the Plan of Corrective Measures will be Monitored: Effective immediately 06.11.2024 the Residence Director, Customer Service Assistant and/or designee will audit the associate onboarding training file for compliance with the regulatory requirements using the Associate Management File Checklist and the 8/40 record of training documentation form to ensure proper training is provided and recorded.

Licensee's Proposed Overall Completion Date: *06/17/2024*

Update: *06/20/2024*

Please include what was done to correct immediate problem with staff B-D include date

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

With Respect to the specific deficiency cited:
Primary Benefit: Ensures that each individual who provides assistance with ADLs is trained to do so properly.

With Respect to Systemic Measures that have been put into place to address the stated concern:

Direct care staff members B hired [redacted]/24 completed the required training on 04.05.2024.

65d - Initial Direct Care Training (continued)

Direct care staff member C hired [redacted]/24 completed the required training on 02.28.2024.
Direct care staff member D hired [redacted] completed the required training on 04.12.2024.

While there is a system in place that outlines the onboarding process to include the first eight and forty hour training process, The former Residence Director/Designee failed to locate the completed documents.

With Respect to How the Plan of Corrective Measures will be Monitored: Effective immediately 06.11.2024 the Residence Director, Customer Service Assistant and/or designee will audit the associate onboarding training file for compliance with the regulatory requirements using the Associate Management File Checklist and the 8/40 record of training documentation form to ensure proper training is provided and recorded. The new associate management file checklist review will be included in the monthly Quality Management Meeting for the remainder of 2024.

Licensee's Proposed Overall Completion Date: *06/27/2024*

Update: *07/02/2024*

Reviewed above noted training for staff

Evidence of Completion ***Implemented [redacted] 08/01/2024)***

See attached.

Update: *08/01/2024*

Onsite POC Verification 7/16/24[redacted]

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

At time of inspection, there was an approximate an eighth of an inch accumulation of lint in the lint trap of the dryer located in the home's SDCU. There were no clothes in the dryer at the time.

Plan of Correction ***Accept [redacted] - 06/20/2024)***

With Respect to the specific deficiency cited: Primary Benefit: Greatly reduces the chance of fire in the home. Although the signs are present on each dryer indicative that filters must be cleaned after each use, the staff failed to clean the lint out of the dryer after completing laundry service.
With Respect to Systemic Measures that have been put into place to address the stated concern: There are signs present at each of the home's dryers and the Direct Care staff are responsible to clean the lint filter/trap after each use.
With Respect to How the Plan of Corrective Measures will be Monitored: Effective immediately 06.11.2024, The Residence Director will post additional signs in each laundry room to remind staff and residents to maintain the lint filters clean and clear after each use. Beginning 06.11.2024 The Housekeeping staff will conduct daily checks on each dryer and perform any necessary cleaning.

Licensee's Proposed Overall Completion Date: *06/17/2024*

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

Update: *06/20/2024*

Please attach picture of new signs and daily audits

Evidence of Completion ***Implemented [redacted] - 08/01/2024)***

See attached.

Update: *08/01/2024*

Onsite POC Verification 7/16/24 [redacted]

125a - Combustible Storage

8. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

At time of inspection, there was a brown piece of paper towel behind the dryer in the home's SDCU.

A tan washcloth was found behind the dryer in the 2nd floor resident laundry room which posed a potential fire hazard.

Repeat violation - 9/12/23, 12/7/23

Plan of Correction ***Accept [redacted] - 06/20/2024)***

With Respect to the specific deficiency cited: Primary Benefit: Combustible and flammable materials can be ignited by heat sources, leading to explosions and fires. The Maintenance staff failed to perform a routine safety check behind the dryers of the home.
With Respect to Systemic Measures that have been put into place to address the stated concern: Maintenance will perform weekly checks and cleaning behind all laundry equipment.
With Respect to How the Plan of Corrective Measures will be Monitored: Effective immediately 06.11.2024, The Housekeeping staff will conduct daily checks in each laundry room to ensure there are no materials in/on/around/behind the equipment and notify maintenance if any attention is required and Maintenance will perform weekly checks and cleaning behind all laundry equipment and the inspection will be recorded and maintained in the TELS work order software program.

Licensee's Proposed Overall Completion Date: *06/17/2024*

Update: *06/20/2024*

Please attach pictures of area behind dryers, daily and weekly audits

Evidence of Completion ***Implemented [redacted] - 08/01/2024)***

See attached.

Update: *08/01/2024*

Onsite POC Verification 7/16/24 [redacted]

132c - Fire Drill Records

9. Requirements

132c - Fire Drill Records *(continued)*

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 1/25/24 does not include the number of residents in the building, the number of residents evacuated, exit routes used, and any problems encountered.

The fire drill conducted on 2/22/24 does not include the number of residents evacuated, exit routes used, and any problems encountered.

The fire drills conducted on 3/22/24 and 4/30/24 does not include the number of residents in the building, the number of residents evacuated, exit routes used, any problems encountered, and whether the fire alarm or smoke detector was operative.

Repeat violation - 9/12/23

Plan of Correction ***Accept [redacted] 06/20/2024)***

With Respect to the specific deficiency cited:
The home failed to record the information required for fire drills on the dates of 1/25/2024, 2/22/2024, 3/22/2024 & 4/30/2024.
With Respect to Systemic Measures that have been put into place to address the stated concern:
The home trained the Maintenance Director on 5/31/24 regarding Regulation 2600.132c & 2600.132 e; Fire Drill Records, to ensure that they understood the expectations of the regulation. The Maintenance Director will also attend Fire Safety Expert Training with Fire Safety Solutions on 7/17/24, to ensure compliance.
With Respect to How the Plan of Corrective Measures will be Monitored:
The Residence Director will conduct compliance monitoring on Regulation 2600.132c & 2600.132 e Fire Drills & Records, which will be conducted x 2 quarters as part of Quality Assurance meetings. All records will be retained.

Licensee's Proposed Overall Completion Date: *06/17/2024*

Update: *06/20/2024*

Please attach training with staff and fire drill logs since inspection

Evidence of Completion ***Implemented [redacted] - 08/01/2024)***

See attached.

Update: *08/01/2024*

Onsite POC Verification 7/16/24 [redacted]

132e - Fire Drill Sleeping Hours

10. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

132e - Fire Drill Sleeping Hours *(continued)*

Description of Violation

The home conducted an overnight fire drill on 8/31/23, and on 4/30/24, more than 6 months apart.

Plan of Correction ***Accept [redacted] 06/20/2024)***

With Respect to the specific deficiency cited:
The home failed to hold a fire drill during sleeping hours within six months of the prior fire drill.
With Respect to Systemic Measures that have been put into place to address the stated concern:
The Residence Director trained the Maintenance Director on 5/31/2024 regarding Regulation 2600.132e Fire Drill Sleeping Hours, to ensure that he understood the expectations of the regulation. The Maintenance Director will also attend Fire Safety Expert Training with Fire Safety Solutions on 7/17/24, to ensure compliance.
With Respect to How the Plan of Corrective Measures will be Monitored:
The Residence Director will conduct compliance monitoring on Regulation 2600.132c Fire Drill Sleeping Hours, which will be conducted x 2 quarters as part of Quality Assurance meetings. All records will be retained.

Licensee's Proposed Overall Completion Date: *06/17/2024*

Update: *06/20/2024*

Please attach training with staff and fire drill logs since inspection

Evidence of Completion ***Implemented [redacted] - 08/01/2024)***

See attached.

Update: *08/01/2024*

Onsite POC Verification 7/16/24 [redacted]

181c - Self-administration Assessment

11. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #1 is prescribed Sas Azelastine 137mcg .1% nasal spray, Flovent HFA 220 mcg inhaler, Saline Mist .65% nose spray, Striverdi Respimat Inhal Spray and all medications are stored bedside for resident to self-administer. Per Resident #1's medical evaluation dated 3/18/24 and RASP 3/20/24 state resident cannot self-administer medications.

Resident #2 is prescribed Trelegy Ellipta 100-62.5-25 PRN and self-administers this medication. Per Resident #2's assessment and support plan dated 7/10/23, the resident cannot self-administer medications.

Plan of Correction ***Accept [redacted] 06/20/2024)***

With Respect to the specific deficiencies cited:
The Healthcare Director failed to recognize the physicians have assessed the residents as unable to self-administer [redacted] r own medications.
With Respect to Systemic Measures that have been put into place to address the stated concern:
The primary benefit is that it ensures that residents who wish to self-administer medications are able to do so safely. The Healthcare Director did receive for Resident #1 a new DME and also completed a new RASP indicative that [redacted] is able to self-administer. The Healthcare Director did update Resident #2's RASP accordingly to align with [redacted] DME

181c - Self-administration Assessment (continued)

that [redacted] is able to self-administer medications.
With Respect to How the Plan of Corrective Measures will be Monitored:
Effective 06.17.2024The Healthcare Director/Assistant Healthcare Director will complete an audit at the time the RASP are drafted to support alignment with the prescribers orders and reflect with accuracy the residents abilities/limitations/needs. The documents will be provided to the Residence Director for final review and inclusion in the resident chart.

Licensee's Proposed Overall Completion Date: *06/17/2024*

Update: *06/20/2024*

Please attach Resident #1's updated DME, Resident #2's updated RASP

Evidence of Completion ***Implemented [redacted] 08/01/2024)***

See attached.

Update: *08/01/2024*

Onsite POC Verification 7/16/24 [redacted]

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident #4 is prescribed Midodrine 5mg with parameters to hold if the resident's systolic blood pressure was greater than 140 or diastolic blood pressure was greater than 90. On 5/5/24, the resident's blood pressure was 150/92. Per the resident's medication administration record, the medication was administered when it should have been held.

Repeat violation - 9/12/23, 12/7/23

Plan of Correction ***Accept[redacted] 06/20/2024)***

With Respect to the specific deficiencies cited:
The Violation is the home did not support the requirement of the regulation and failed to provide the supply of medication in accordance with the prescribers direction.
With Respect to Systemic Measures that have been put into place to address the stated concern:
A mandatory training for all clinical med techs/nurses was completed by the Healthcare Director on 05.15.2024. The purpose of the training is to review medication administration policies, procedures, interventions and resources and assistance readily available as needed when providing medication administration.
With Respect to How the Plan of Corrective Measures will be Monitored:
To prevent any further occurrence beginning 06.17.2024 the Healthcare Director and Assistant Healthcare Director will complete weekly MAR audits to verify all medications are administered according to physician's orders. The audit information will be reviewed weekly by the Healthcare Director/Assistant Healthcare Director with the Residence Director and will be inclusive in the monthly Quality Management Team meetings as part of the Quality Management Plan for the remainder of 2024.

Licensee's Proposed Overall Completion Date: *06/17/2024*

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

Update: *06/20/2024*

Please attach resident #4's June MAR, training with staff, audits

Evidence of Completion ***Implemented [redacted] - 08/01/2024)***

See attached.

Update: *08/01/2024*

Onsite POC Verification 7/16/24 [redacted]

191 - Resident Right to Refuse

13. 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 #3 did not sign the resident home contract which includes an insert advising of resident rights. There is no documentation that the resident was educated on the right to refuse medication.

Plan of Correction ***Accept[redacted] - 06/20/2024)***

With Respect to the specific deficiencies cited:
Although the legal representative did sign the contract, the violation occurred due to prior Residence Director not reviewing Resident Rights and Right to refuse medication as outlined in Resident's home contract and obtaining signature.
Plan of Correction
•Residence Director reviewed Resident Rights and Right to refuse medication if the resident believes that there may be an error as outlined in resident's contract and signature was obtained on 6/3/24.
•Residence Director will review Residents Rights and Right to Refuse medication as outlined in the homes contract prior to or within 24 hours of admission and obtain resident signature.
•Beginning 06.17.2024 The Customer Service Associate and or Residence Director will audit resident's business file upon move in for compliance that all signatures are present utilizing resident business file audit tool.

Licensee's Proposed Overall Completion Date: *06/17/2024*

Update: *06/20/2024*

Please attach resident #3's updated forms

Evidence of Completion ***Implemented[redacted] - 08/01/2024)***

See attached.

Update: *08/01/2024*

Onsite POC Verification 7/16/24[redacted]

231e - No Objection Statement

14. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

231e - No Objection Statement *(continued)*

Description of Violation

Resident #3 resides in the home's secured dementia unit. The consent to reside in a secured unit is included in the resident's contract. The resident did not sign the resident home contract and there is no documentation the resident has not objected to the resident's admission to the secured unit.

Plan of Correction ***Do Not Accept [redacted] - 06/20/2024)***

With Respect to the specific deficiencies cited:
Although the legal representative did sign the contract, the violation occurred due to prior Residence Director not securing the actual memory care residents signature that they have not objected to the residents admission or transfer to the SDCU.
The Residence Director and/or designee failed to obtain the resident signature.
With Respect to Systemic Measures that have been put into place to address the stated concern & Plan of Correction
•Beginning 06.17.2024 The Customer Service Associate and or Residence Director/Designee will audit the resident's business file upon move in for compliance that there is a notation should the resident decline to sign the contract and to ensure that all signatures are present utilizing the resident move in business file audit tool.

Licensee's Proposed Overall Completion Date: *06/17/2024*

Update: *06/20/2024*

What was done to fix the immediate problem, please include a date

Plan of Correction ***Accept [redacted] - 07/02/2024)***

With Respect to the specific deficiencies cited:

Although the legal representative did sign the contract, the violation occurred due to prior Residence Director not securing the actual memory care residents signature that they have not objected to the residents admission or transfer to the SDCU.
The Residence Director and/or designee failed to obtain the resident signature.

With Respect to Systemic Measures that have been put into place to address the stated concern & Plan of Correction
The current Residence Director did meet with Resident #3 in an effort to review and obtain signatures. On 06.03.2024 the resident did sign page 15 . The resident declined to sign any further and a notation is made accordingly and dated 06.03.2024.

Beginning 06.17.2024 The Customer Service Associate and or Residence Director/Designee will audit the resident's business file upon move in for compliance and also confirm that there is a notation should the resident decline to sign the contract. The newly admitted resident checklist review will be included in the monthly Quality Management Meeting for the remainder of 2024.

Licensee's Proposed Overall Completion Date: *06/27/2024*

Update: *07/02/2024*

Reviewed signature sheets

Evidence of Completion ***Implemented ([redacted] - 08/01/2024)***

See attached.

231e - No Objection Statement *(continued)*

Update: *08/01/2024*

Onsite POC Verification 7/16/24 [redacted]

233c - Key-Locking Devices

15. Requirements

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

Description of Violation

The doors in in the home's secured dementia unit located near room 3 and room 18 were unable to be opened. Staff stated that the keypads were inoperable. Staff members were able to operate the key pads with a fob. However visitors are unable to utilize these doors without asking staff to let them out.

The incorrect code was posted at the exit to the parking lot from the home's courtyard in the secured dementia unit. The gate was unable to be opened with the posted code.

Repeat violation - 9/12/23, 5/17/23

Plan of Correction ***Accept*** [redacted] ***06/20/2024)***

With Respect to the specific deficiencies cited:
The Violation is the home did not support the requirement of the regulation and failed to verify the codes were effective and posted for the doors near room 3, 18, and the MC courtyard exit to the parking lot.
With Respect to Systemic Measures that have been put into place to address the stated concern & Plan of Correction Primary Benefit: Posting the directions for the operation of key-locking devices, electronic cards systems or other devices that prevent immediate egress help to ensure that persons in the secured dementia care unit who do not have an identified need to be in a secured unit can exit the secured unit on their own and at will.
The SDCU remains fully connected to the locking mechanism that is connected to the alarm system/central station. Should the fire alarms sound then the SDCU doors continue to function and automatically unlock allowing safe evacuation in the event of an emergency.
The doors noted near room 3 & 18 also continue to work via key fab.
The Residence Director has contacted the locking mechanism programming representative as well as the PCH building I T department and a new computer will be in place and programming completed for the doors noted on or before June 30th.
With Respect to How the Plan of Corrective Measures will be Monitored:
It is anticipated that the new programmed computer for the locking mechanism will be in place on or before June 30th. The Residence Director will provide an update via e-mail and/or phone to BHSL once the two doors are re-programmed and in full operation.

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

Update: *06/20/2024*

Administrator emailed this writer codes were fixed 6/18/24.

233c - Key-Locking Devices *(continued)*

Evidence of Completion ***Implemented [redacted]/01/2024)***

See attached.

Update: *08/01/2024*

Onsite POC Verification 7/16/24 [redacted]