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

September 12, 2024

[redacted] ADMINISTRATOR
KENDAL-CROSSLANDS COMMUNITIES, INC.
P.O. BOX 100
KENNETT SQUARE, PA, 19348

RE: KENDAL AT LONGWOOD
P.O. BOX 100, CUMBERLAND HOUSE
KENNETT SQUARE, PA, 19348
LICENSE/COC#: 18573

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/05/2024, 06/06/2024 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: *KENDAL AT LONGWOOD* **License #:** *18573* **License Expiration:** *10/01/2024*

Address: *P.O. BOX 100, CUMBERLAND HOUSE, KENNETT SQUARE, PA 19348*

County: *CHESTER* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *KENDAL-CROSSLANDS COMMUNITIES, INC.*

Address: *P.O. BOX 100, KENNETT SQUARE, PA, 19348*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/17/1997* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *45* **Waking Staff:** *34*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *06/06/2024*

Inspection Dates and Department Representative

06/05/2024 - On-Site: [redacted]

06/06/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *54* **Residents Served:** *45*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *45*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability:** *0*

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

Inspections / Reviews

06/05/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/01/2024*

07/05/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/31/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/10/2024*

Inspections / Reviews *(continued)*

07/10/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/31/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/31/2024*

09/12/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/31/2024*

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

16c - Written Incident Report

1. Requirements

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

Description of Violation

On 6/03/2024, the home shared resident 1's glucometer with resident 2. The home did not report this incident of medication error to the Department.

Plan of Correction ***Accept (- 07/03/2024)***

An incident report related to the medication error that occurred on 6/3/2024 was sent to DHS on 6/11/24. The medication error was reported to the physician, to resident#2 and the power of attorney for #3. An incident report was completed in the electronic medical record on 6/24/204.
The medication administration policy (policy 12.01), Blood Glucose monitoring and management policy (policy 4.01) and Med errors policy (policy 12.24) were updated on 6/24/2024.
An individual counseling for the nurse who committed the error was completed on 6/25/2024 by [redacted] NM and [redacted] Rn Staff educator to ensure understanding of our practices regarding glucometers and to ensure understanding of medication errors. This nurse was counseled on the DHS reportable incidents. All other nurses will receive a refresher education on glucometers, medication errors and DHS reportable incidents by 7.31.24

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 09/12/2024)

17 - Record Confidentiality

2. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 6/6/2024, during an inspection, staff member A left the medication cart (med cart) with the residents medications and information unlocked, unattended, and accessible.

On 6/6/2024, at 9:03 am, the Med Cart in front of the 2nd floor lounge has the laptop screen open with resident records visible. The screen was only partially closed, and at 10:16 am, the Med Cart on the first floor across from resident storage locker area was left unattended. The computer screen was partially closed, but resident records were accessible and open. The staff member was in a room with a resident with the door closed.

Plan of Correction ***Accept (- 07/03/2024)***

Education for all nursing staff who access medical records electronically began on 6.6.24 by [redacted] Nurse manager, LPN to ensure that they utilize the "walk away" button embedded in the electronic record before walking away from their computer to provide medications or treatments. utilizing this button removes resident information from the screen. The education will be completed by 7.31.24 and will be conducted by [redacted] LPN, Nurse

17 - Record Confidentiality (continued)

manager and/or [redacted] Rn Staff Educator.
The medication policy was revised to reflect this practice on 6.24.24 by [redacted] DON and will be used in the education noted above.
During medication passes, [redacted] LPN, Nurse manager and/or the nursing supervisors will do routine checks to see if med techs/nurses are using the walk away button. This will be observed daily for 1 month, then weekly for 2 months, then Quarterly to ensure that the "walk away" button is activated. These audits will begin 7.1.2024 and continue for 4 quarters. The results of these audits will be reported to QAPI quarterly, beginning with the July 16th, 2024, meeting.

Education will provide to all nurses and med tech reviewing the proper procedure for not leaving med carts unlocked, unattended and accessible. This education will be completed by 7.31.24 by [redacted] RN nurse educator.

Proposed Overall Completion Date: 07/17/2025

Licensee's Proposed Overall Completion Date: *07/17/2025*

Implemented ([redacted] - 09/12/2024)

18 - Compliance With Laws

3. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The entrance of the building does not have a non-smoking sign. The Clean Air Act stated, "The CIAA requires that no smoking signs or the international no smoking symbol, which consists of a pictorial representation of a burning cigarette in a circle with a bar across it, must be prominently posted and properly maintained where smoking is not permitted." There is only a sign listing as this is a non-smoking community that is hard to see at the campus entrance.

Plan of Correction ***Accept ([redacted] - 07/03/2024)***

Although there is a sign at the entrance to the campus noting that the entire campus (inclusive of grounds, gardens and all buildings) is smoke free, a decal recording this fact was added to the front door on 6.27.24.

Licensee's Proposed Overall Completion Date: *06/28/2024*

Implemented ([redacted] - 09/12/2024)

42s - Privacy

4. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 6/05/2024, there were no signs stating that video cameras were recording. Cameras were located in the common areas above the ATM and by the front door.

42s - Privacy *(continued)*

Plan of Correction ***Accept (- 07/10/2024)***

The scale was moved on 7.8.24 and a sign describing video surveillance was placed next to the ATM machine.
The sign related to video surveillance which was positioned on the post on the walkway leading to the Main Entrance was removed and a decal was placed on the sliding glass door at the Main Entrance.
Signs will be monitored weekly by the Administrator [redacted] and reported on at QAPI beginning on 7/16/24.
This will continue indefinitely.

Licensee's Proposed Overall Completion Date: *07/17/2025*

Implemented (- 09/12/2024)

44g - Telephone Number

5. Requirements

2600.
44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

The telephone numbers of the local law enforcement agency are not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (- 07/03/2024)***

A temporary sign was posted on the bulletin board with the local law enforcement agency, but we purchased new signs for varies areas located in the personal care home. They were purchased on 6/27/24 and will be put in place once the arrive.

Licensee's Proposed Overall Completion Date: *06/28/2024*

Implemented (- 09/12/2024)

62 - Contact List

6. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person A, originally did not have a staff list with all staff persons listed. It did not include all direct care or ancillary workers. Multiple staff persons were on the schedule but not on the staff list

62 - Contact List *(continued)*

Plan of Correction ***Accept (- 07/03/2024)***

The staff list maintained by the personal care administrator was updated by this administrator on 6.28.24 An audit of staff listing will be completed monthly by the PCH Administrator and will be reported at the quarterly QAPI meetings beginning 7.16.24

Licensee's Proposed Overall Completion Date: *07/17/2025*

Implemented (- 09/12/2024)

65i - Training Record

7. 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 staff person B's training record for onsite fire safety at the home only lists May 2023 as the completion date.

Plan of Correction ***Accept (- 07/03/2024)***

A new training record sheet was initiated on 7.1.24 by , LPN, nurse manager. This new record sheet includes the date and the time of the training, as well as the place of training. This new record will be in place indefinitely.

Licensee's Proposed Overall Completion Date: *06/28/2024*

Implemented (- 09/12/2024)

66b - Training Plan Content

8. Requirements

2600.
66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:
1. The name, position and duties of each direct care staff person.
2. The required training courses for each staff person.
3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home's staff training plan does not include the dates, times, and locations of the scheduled training for each staff person for the upcoming year.

Plan of Correction ***Accept (- 07/03/2024)***

The training plan record maintained by , the personal care manager, was updated to include the dates, times and location of each training for each staff member in the coming year by on 6.28.24
This new plan will be in place indefinitely.

Licensee's Proposed Overall Completion Date: *06/28/2024*

Implemented (- 09/12/2024)

66b - Training Plan Content *(continued)*

85a - Sanitary Conditions

9. Requirements

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

Description of Violation

On 6/03/2024, the home shared resident 1's glucometer with resident 2.

A uncovered urinal container that was nearly full was observed on the bedside table nearest to the window in resident 3's bedroom on June 6, 2024, at 9:50 a.m.

Plan of Correction ***Accept (- 07/10/2024)***

Nurses received refresher education on glucometers, medication errors and DHS reportables by 7.31.24 in training conducted by RN Staff Educator and LPN to ensure that glucometers are not used on more than one resident. Resident was supplied with a new glucometer.

Although the resident is independent with the use of urinal the RASP for Resident #1 was updated to reflect not only desire to manage own urinal but also capability to manage this. At the time of the survey, resident's was not yet up so Resident #1 had not yet disturbed to empty urinal from bedside. In addition, a prompt will be entered into Resident #1's eMAR prompting the nurse to ensure that the urinal is emptied after Resident #1's gets up late morning.

This will be indefinite.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 09/12/2024)

100a - Exterior - Free of Hazards

10. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 6/06/2024, there was a bucket of water next to the door and a large plexiglass behind a deck box outside the lounge on the first floor.

Plan of Correction ***Accept (- 07/03/2024)***

The bucket of water and the piece of plexiglass were removed on 6/6/24. On the 3-11 shift, a Campus Responder locks the door leading to this patio and checking for any trash or debris (and disposing of it) was added to his checklist beginning 7.1.24.
This will be indefinite.

Licensee's Proposed Overall Completion Date: *06/28/2024*

Implemented (- 09/12/2024)

103f - Refrigerator/Freezer Temps

11. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 6/05/2024, and 6/06/2024, at 9:39 am, the temperature in the freezer in the lounge kitchen was 4 degrees Fahrenheit.

On 6/06/2024, the temperature in the freezer of the main kitchen was 10 degrees at 10:09 am.

Plan of Correction ***Accept (- 07/05/2024)***

A repair order was placed with Facilities Services for the freezer in question by , NHA on 6.24.24. Checks of this freezer nightly on 11-7 have not revealed temperatures above 0 degrees in the last three months.

Freezer in Cumberland kitchen - Note during the inspection the freezer door had been open due to service. It was checked and found to be more than 0 degrees. It has and will be monitored twice a day with temperatures recorded in the equipment log to ensure ongoing compliance. Culinary staff education will be completed by 7/12/24 by , Culinary manager. Culinary service will report this to the quarterly QAPI meeting starting July 16th, 2024, for 4 quarters.

Licensee's Proposed Overall Completion Date: *07/17/2025*

Implemented (- 09/12/2024)

103g - Storing Food

12. Requirements

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

Description of Violation

There was an ice cream container in the main kitchen freezer that was opened and unsealed.

Plan of Correction ***Accept (- 07/05/2024)***

Replacement Plastic lids will be ordered for ice cream lid. Staff will be educated that ice cream must covered with lids that are sealed when not in use. Supervisor will make daily check to ensure compliance is maintained. Culinary staff education will be completed by , Culinary manager by completed by 7/12/24. Culinary service will report this to the quarterly QAPI meeting starting July 16th, 2024, for 4 quarters.

Licensee's Proposed Overall Completion Date: *07/12/2024*

Implemented (- 09/12/2024)

103i - Outdated Food

13. Requirements

2600.

103i - Outdated Food *(continued)*

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

Description of Violation

There was a bottle of lemon juice sitting on the table, open half full, warm to the touch, with instructions to refrigerate after opening.

Plan of Correction ***Accept ([redacted] - 07/05/2024)***

Culinary staff will be educated on the need to refrigerator food that need to be refrigerated items between uses. The supervisor will make daily check to ensure compliance is maintained. Culinary staff education by [redacted] Culinary manager and completed by 7/12/24. Culinary service will report this to the quarterly QAPI meeting starting July 16th, 2024, for 4 quarters.

Licensee's Proposed Overall Completion Date: *07/12/2024*

Implemented ([redacted] - 09/12/2024)

107b - Emergency Procedures

14. Requirements

2600.
107.b. The home shall have written emergency procedures that include the following:

1. Contact information for each resident's designated person.
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.
5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.
6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

The home's written emergency procedures do not include the contact information for each resident's designated person.

Plan of Correction ***Accept ([redacted] - 07/05/2024)***

The KCC Emergency Procedure Manual and information on each resident's emergency contact were maintained in 2 separate binders, each easily accessible. On 6.5.24, at the direction of DHS surveyors, the information from one binder was placed within the other binder so that they were in 1 binder. Moving forward, only one binder will be maintained containing Emergency Procedures and resident contact information.
This will be indefinite.

Licensee's Proposed Overall Completion Date: *06/28/2024*

Implemented ([redacted] - 09/12/2024)

131f - Fire Extinguisher Inspection

15. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

131f - Fire Extinguisher Inspection *(continued)*

Description of Violation

The fire extinguisher in the kitchen has not been inspected by a fire safety expert since 4/2023.

Plan of Correction ***Accept (- 07/10/2024)***

On July 3, 2024, a new Kitchen rated fire extinguisher, K, Potassium, Citrate/Acetate was received via Grainger and placed in the Cumberland Kitchen.

The Preventative Work Order System has been changed to establish a monthly work request inspection of this kitchen fire extinguisher by the Facilities staff and to correct any deficiencies. This change will be implemented starting July 2024 and will continue until June 2025. These inspections will be documented in the Work Order System. The documented inspections will be used to capture inspection compliance and corrective actions taken related to any deficiencies identified during the inspections. This information will be compiled in a quarterly Quality Control Report illustrating inspection compliance rate and deficiency count verses correction. The Facilities Assistant Director will monitor and provide oversight to ensure the inspections are being conducted and deficiencies are corrected. This information will be included in the Facility Section of the Quarterly Quality Assurance Meeting Report by the Facilities Manager or designee.

Licensee's Proposed Overall Completion Date: *06/30/2025*

Implemented (- 09/12/2024)

141a 1-10 Medical Evaluation Information

16. 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.

Description of Violation

Resident 4's medical evaluation dated did not include the medical information pertinent to diagnosis and treatment in case of an emergency.

Plan of Correction ***Accept (- 07/05/2024)***

At the direction of a prior DHS surveyor, Section 3 (if applicable) was not completed by our Personal Care Manager or designee when completing these evaluations. Moving forward and at the direction of current surveyors, this section will be completed. Starting 6/10/2024 Section 3 will be completed. the PCH Administrator and will be reporting on at quarterly QAPI meetings, beginning on 7.16.24.

Licensee's Proposed Overall Completion Date: *07/17/2025*

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

Implemented (- 09/12/2024)

181f - Record of Medication

17. Requirements

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

Description of Violation

On 6/06/2024, resident 3, who self-administers stated that was no longer taking certain medications and they were not in medication box. stated that stopped taking them 6 months to a year ago. The medications were Potassium Chloride ER 10 vial take once a day with Furosemide, (Lasix) Lasix 20 mg tablet take daily as needed with potassium, and Triamcinolone Acetonide 0.1% as a layer twice a day is needed. These medications were listed on resident 3's June 2024 medication administration record (MAR).

Plan of Correction ***Accept (- 07/05/2024)***

Resident #3's Medication Administration record did not match the contents of medication storage box. Resident reported that upon the advice of outside physician, had stopped taking certain medications but had not informed our nursing staff. At this time, and with express consent, Resident #3 is no longer self-administering medications due to a lack of coordination between outside physician and our staff.
All other residents who self-administer are to be reeducated about the parameters of self-administration by LPN or designee by 7.31.24. Quarterly – rather than annual - audits of the medications of those who self-administer will commence in July of 2024 and will be conducted by , LPN or designee.
This will be completed for 4 quarters.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 09/12/2024)

183d - Prescription Current

18. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 6/06/2024, Lidocaine patches were observed unlocked in the bathroom cabinet for resident 5; however, the medication is not part of the resident 5 medication list.

Plan of Correction ***Accept (- 07/05/2024)***

A prescription for Lidocaine patches for Resident #5 was obtained from physician on 6.14.24 and these are being administered by Nursing staff as of 6.15.24.
All Cumberland staff were educated by , LPN and , RN by 7.31.24 to report any medications that appear to be in a resident's possession outside of the self-administration program.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 09/12/2024)

184b - Labeling OTC/CAM

19. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 6/06/2024, an OTC milk of magnesia 400 mg, acetaminophen 325 mg, and Robafen DM 100-10 mg was administered to resident 2 from the stock medications and was not labeled with the resident's name.

Plan of Correction ***Accept (- 07/05/2024)***

OTC medications: Nurses or MedTech's will be education on the process of attempting to place the residents name on the bottle of the stock med if a resident uses the stock medication. If there is not enough room on the bottle, we will place the bottle in a plastic bag and type up each resident s name. This education will be completed by 7.31.204 and the process of the nurses and med tech adding names will begin 7.1.2024

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 09/12/2024)

188b - Medication Error Reporting

20. Requirements

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

Description of Violation

On 6/03/2024, the home shared resident 1's glucometer with resident 2. The home did not report this medication error immediately to the resident, the resident's designated person, and the prescriber.

Plan of Correction ***Accept (- 07/10/2024)***

Once this error was brought to our attention, we notified the resident, physician and POA and DHS. Staff Education will be provided to all nurses and med tech regarding medication errors and the process for reporting the error. The importance of reporting a medication error immediately to the nursing supervisor so they can start the correct process. Resident was supplied with a new glucometer. This education will be completed by 7.31.2024.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 09/12/2024)

188c - Medication Error Documentation

21. Requirements

2600.
188.c. Documentation of medication errors and the prescriber's response shall be kept in the resident's record.

Description of Violation

On 6/03/2024, the home shared resident 1's glucometer with resident 2. There is no documentation of the error in the resident's record.

188c - Medication Error Documentation (continued)

Plan of Correction ***Accept (- 07/10/2024)***

Since this error was not reported it was not able to be in the chart. After the error was found Nurse manager reported the incident to DHS and added an incident in the eMAR. A copy of the DHS reportable incident was placed in the paper chart. Nurse Manager will complete and audit monthly on reportable incidents to make sure the incidents are placed in the resident records. This audit will be for 4 quarters and reported to QAPI starting 7.16.2024
Resident was supplied with a new glucometer.
Education on this violation will be completed by 7.31.24.

Licensee's Proposed Overall Completion Date: *07/17/2025*

Implemented (- 09/12/2024)

252 - Record Content

22. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).

252 - Record Content *(continued)*

25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

None of the resident records, including resident 1, includes a photograph of the resident that is no more than 2 years old.

Plan of Correction ***Accept (- 07/05/2024)***

Photographs are in the eMar but were not placed in the paper record. Photographs of residents were added to the paper records maintained for each resident on 6.5.24 in addition to maintaining them in the electronic health record which is used to administer medications, treatments and other care. These were added by Night shift supervisor and will be maintained by unit secretary. This will be updated on admission and annually. Education will be completed by 7.31.2024 This is indefinite.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 09/12/2024)