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

September 12, 2024

[redacted], GENESIS HC
600 PAOLI POINTE DRIVE OPERATIONS LLC
600 PAOLI POINTE DRIVE
PAOLI, PA, 19301

RE: HIGHGATE AT PAOLI POINTE
600 PAOLI POINTE DRIVE
PAOLI, PA, 19301
LICENSE/COC#: 13610

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/02/2024, 07/10/2024, 07/11/2024 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: *HIGHGATE AT PAOLI POINTE* **License #**: *13610* **License Expiration**: *10/02/2024*

Address: *600 PAOLI POINTE DRIVE, PAOLI, PA 19301*

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

Administrator

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

Legal Entity

Name: *600 PAOLI POINTE DRIVE OPERATIONS LLC*

Address: *600 PAOLI POINTE DRIVE, PAOLI, PA, 19301*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/15/1966* **Issued By**: *Dept of L & I*

Staffing Hours

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

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *07/11/2024*

Inspection Dates and Department Representative

07/02/2024 - On-Site: [redacted]

07/10/2024 - Off-Site: [redacted]

07/11/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *124* **Residents Served**: *47*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Homestead* **Capacity**: *30* **Residents Served**: *17*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *47*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *42* **Have Physical Disability**: *2*

Inspections / Reviews

07/02/2024 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/01/2024*

Inspections / Reviews *(continued)*

08/08/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/26/2024*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *08/13/2024*

08/13/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/26/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *09/13/2024*

08/22/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/26/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *09/13/2024*

09/12/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/26/2024*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted], resident 1 hit resident 2 in the mouth causing him/her to bleed. Resident 2 then pushed resident 1 to the floor. This incident was observed by a staff person. This incident was reported to staff person A on [redacted]. However, this allegation of abuse was not reported to the local area agency on aging.

Plan of Correction ***Accept ([redacted] - 08/13/2024)***

Act 13 was copleted and reported to local Area of Agency on Aging on 7/3/2023 Audit completed by Administrator on 7/4/2024 on reportable incidents that require
Act 13 that has occurred since 5/25/2024. No other deficient practices noted. DWH will
be educated by Administrator by 7/4/2024 on completing Act 13. Administrator/Designee
will audit reportable incidents that require Act 13 starting 7/22/24 for three months or until compliance is determined. Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented ([redacted] - 08/22/2024)

54a - Direct Care Staff

2. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person B, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept [redacted] - 08/13/2024)***

Staff Person B, Notarized High School Diploma is in staff person b employee file as of [redacted] BOM/HR and DHW will be educated by Administrator by [redacted] High School Diploma waivers
Audit will start by 7/25/2024 on High School waivers. Any concerns will be addressed immediately.
BOM/HR/Designee will audit waivers for three months or until compliance is determined. Findings will be reported to QAPI

54a Direct Care Staff *(continued)*

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented [redacted] - 09/12/2024)

65a - FS Orientation 1st Day

3. Requirements

2600.

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

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

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

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

Repeat Violation date 11/27/2023.

Plan of Correction ***Accept ([redacted] - 08/13/2024)***

Staff person B, completed orientation [redacted] on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during
emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency. BOM/HR and Maintenance Director will be educated by Administrator by 7/10/2024 for Completing Safety Orientation in a timely manner.
Audit will start by 7/11/2024 Safety Orientation. Any concerns will addressed immediately. BOM/HR/Designee will audit Safety
Orientation for three months or until compliance is determined. Findings will be reported to QAPI

65a - FS Orientation 1st Day (continued)

Staff person C is no longer with the company as o

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented (- 09/12/2024)

65b - Rights/Abuse 40 Hours

4. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person B completed his/her 40th scheduled work hour on However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Repeat Violation date 11/27/2023.

Plan of Correction ***Accept (- 08/13/2024)***

Staff person B, completed orientation on the following topics: complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions. BOM/HR, DHW, Memory Care Director, Activity Director will be educated by
Administrator by 7/10/2024 for Completing Orientation in a timely manner.
Audit will start by 7/11/2024 Safety Orientation. Any concerns will be addressed immediately.
BOM/HR/Designee will audit Orientation training for three months or until compliance is determined. Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented (- 09/12/2024)

65d - Initial Direct Care Training

5. 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.

65d - Initial Direct Care Training *(continued)*

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person B, hired on [redacted], began providing unsupervised ADL services on or before [redacted]. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test until [redacted]

Plan of Correction ***Accept ([redacted] - 08/13/2024)***

Staff person B, completed and passed the Department-approved direct care training course and pass the competency test on
7/3/2024. Audit will be start by BOM/HR by 7/11/1/2024 Any concerns will be immediately addressed. BOM/HR and DHW will be re- educated by
Administrator by 7/8/24 on Department-approved direct care training course and pass the competency test. Audit for three months or until compliance is determined. Findings will be reported to QAPI Findings will be reported to QAPI.

Licensee's Proposed Overall Completion Date: *09/08/2024*

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

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.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   i. Safe management techniques.
   ii. ADLs and IADLs
   iii. Personal hygiene.
   iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   vi. Implementation of the initial assessment, annual assessment and support plan.
   vii. Nutrition, food handling and sanitation.
   viii. Recreation, socialization, community resources, social services and activities in the community.
   ix. Gerontology.
   x. Staff person supervision, if applicable.
   xi. Care and needs of residents with special emphasis on the residents being served in the home.
   xii. Safety management and hazard prevention.
   xiii. Universal precautions.
   xiv. The requirements of this chapter.
   xv. Infection control.
   xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person B, hired on [redacted], began providing unsupervised ADL services on or before [redacted]

65d - Initial Direct Care Training (continued)

. However, the staff person did not complete training that included a demonstration of job duties, followed by supervised practice.

Plan of Correction ***Accept (- 08/13/2024)***

Staff person B, completed and passed the Department-approved direct care training course and pass the competency test on .

BOM/HR and DHW will be re- educated by Administrator by 7/8/2024 on Department approved direct care training course and pass the competency test.

Audit will be completed by Administrator/Designee by 7/11/2024. Any concerns will be immediately. Audit for three months or until compliance is determined. Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented (- 09/12/2024)

65e - 12 Hours Annual Training

7. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person D received no hours of annual training in training year 2023.

Plan of Correction ***Accept - 08/13/2024)***

To ensure policy consistency and accountability in training completion across all departments, the following measures will be enforced:

All Direct care staff will receive mandatory 12 hour annual training by Administrator/Deisgnee.

BOM/HR and DHW will be re- educated by Administrator by 7/8/2024 on ensuring staff completes annual training in a timely manner.

Audits conducted by Administrator/ Designee started 7/11/2024 and will continue for three months or until compliance is determined. Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented (- 09/12/2024)

65f - Training Topics

8. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.

65f Training Topics *(continued)*

4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

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

Plan of Correction ***Accept [redacted] - 08/13/2024)***

To ensure policy consistency and accountability in training completion all director care staff personal will complete the following training:
in medication self administration , instruction on meeting the
needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques , care for residents with mental illness or an intellectual disability, or both, if the population is served
within our community. Trained by Administator/ Deisgnee. BOM/HR and DHW will be re educated by Administrator by 7/8/2024 on ensuring staff completes annual training in a timely manner. Audit will start 7/11/2024 and continue for three months or until compliance is determined. Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented [redacted] - 09/12/2024)

65g - Annual Training Content

9. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a

65g Annual Training Content (continued)

fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102), falls and accident prevention, new population groups that are being served at the home that were not previously served, if applicable during training year 1/1/2023 to 12/31/2023.

Plan of Correction ***Accept (- 08/13/2024)***

To ensure policy consistency and accountability in training completion across all departments, the following measures will be enforced: All staff will receive
receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101 10225.5102), falls and accident prevention. Training by Administrator/Deisgnee. BOM/HR and DHW will be re educated by Administrator by 7/8/2024
Audit will start 7/11/2024 and will continue for three months or until compliance is determined. Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented (- 09/12/2024)

82c - Locking Poisonous Materials

10. 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 7/2/2024 Clorox disinfecting wipes with manufacturer's label indicating "Hazards to human and domestic animals, call poison control for treatment advice", was unlocked, unattended, and accessible to residents in the memory care kitchen. Not all the residents of the home, including those in memory care, have been assessed as capable of recognizing and using poisons safely.

On 7/2/2024 OdorShield Spray with manufacturer's label indicating "keep out of reach of children, wash hands thoroughly after handling, get medical advice/treatment if you feel unwell.", was unlocked, unattended, and accessible to residents in the memory care kitchen. Not all the residents of the home, including those in memory care, have been assessed as capable of recognizing and using poisons safely.

On 7/2/2024 Sure Scents Spray with manufacturer's label indicating "keep out of reach of children and pets", was unlocked, unattended, and accessible to residents in room 325 located in the memory care unit. Not all the residents of the home, including those in memory care, have been assessed as capable of recognizing and using poisons safely.

Repeat violation: 2/27/2023.

Plan of Correction ***Accept (- 08/13/2024)***

Corrected while surveryor was on site for initial visit on 7/2/2024. Clorox disinfecting wipes,OdorShield Spray and

82c - Locking Poisonous Materials (continued)

Sure Scents Spray with manufacturer's label was removed immediately. The Memory Care Director will start an audit by 7/12/2024. Community staff will be re-educated by Menory Care Director by 7/3/2024 on poisonous materials. New hires will be educated during orientation on poisonous materials. The Memory Care Director/ Designee will audit poisonous materials for three months or until compliance is determined. Findings will be reported to QAPI.

Licensee's Proposed Overall Completion Date: *09/08/2024*

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

85a - Sanitary Conditions

11. Requirements

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

Description of Violation

On 7/2/2024 at 10:27am the smell of feces and urine inside room 325 was eye-watering. At approximately 11:36am The hallway outside of room 325 still smelled heavily of urine and feces.

There was no method to dry hands in rooms 325, 304, or 303.

Staff person E stated that he/she is only washing the hands of residents in memory care in the mornings and not again prior to other meals.

Plan of Correction ***Accept ([redacted] - 08/13/2024)***

Room 325 mattress was replaced on 7/15/204 and room cleaning schedule has been increased from once a weekly to daily.
Rooms 325,304 and303, as well other rooms on Memory Care, Hand towels were placed in the bathrooms on 7/2/2024 as a method to dry hands. Memory Care hand towel audit started on 7/3/2024. Audit is completed daily after meals. Any areas of concern will be immediately corrected.
Staff person E was re-educated on 7/4/24on ADL/Resident handwashing by Administrator. Method:- Conduct random observations of residents during peak activity hours, (AM/PM care, Walk to Hand-Wash & Dine Program.
- Utilize a checklist to document handwashing practices (Sing-Happy Birthdayx2, use soap) .
- Interview residents to assess their understanding and compliance with hygiene protocols.
Start Date: 7/4/2024
Frequency: Weekly
Duration: 3 month (June 4 to Oct 8, 2024)
Responsible Person:
- Title: Memory Care Director, Designee
Community staff will be educated by DHW starting 7/4/2024. New hires will be educated during orientation on the hand towel drying method and resident handwashing. Memory Care Director/Designee will audit hand towel drying method daily after meals for hand towels for three months or until compliance is determined.

85a Sanitary Conditions (continued)

Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented [redacted] - 09/12/2024)

88a - Surfaces

12. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 7/2/2024, at 9:33am there was a ceiling tile missing outside the private dining room. The ceiling and the floor underneath it was wet. There was an open trashcan located under the tile to collect water.

On 7/2/2024 throughout the building, multiple areas of the ceiling were missing including in the main dining room on the bottom level and the Paoli Local Bistro on the first floor. There was also water damaged observed through the building, including in the women's public bathrooms on the bottom level, the activity room on the 2nd floor, and in the hallways.

Staff member F, the maintenance director, stated the leaks started over a month ago before he/she began working there. They were caused by issues with the cooling system and there was still 7 active leaks.

Plan of Correction ***Accept [redacted] - 08/13/2024)***

Ceiling tiles were replaced in the main dining room, Paoli Local Bistro, Women's bathroom, 1 floor Activity room and hallways on 7/15/2024 location T level & 1st floor. The remaining community ceiling tile audits will start 7/5/2024. The Maintenance Director/ Designee will audits for ceiling tile water damage weekly for three months or until compliance is determined. Frequency of Audits: weekly
Start Date 7/25/24
The audits will be conducted monthly to ensure timely and thorough monitoring of the condition of water damage ceiling towels. Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

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

95 - Furniture and Equipment

13. Requirements

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

Description of Violation

On 7/2/2024, The homes cooling system was not working properly causing 7 active leaks throughout the building. Staff member F stated that over a month ago the system had broken down forcing 200 degree water to run throughout the system and melting the cooling pipes.

95 Furniture and Equipment *(continued)*

Plan of Correction ***Accept ([redacted] - 08/13/2024)***

Documentation was offered to surveyor during initial visit on 7/2/2024, however it was refused. Leaks were repaired 7/5/2024. Any areas of concern were immediately corrected. The Maintenance Director/ Designee will audit the cooling system for three months or until compliance is determined. Frequency of Audits: biweelky Start Date: 7/25/2024
The audits will be conducted monthly to ensure timely and thorough monitoring of the condition of water damage ceiling towels. Findings will
be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

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

101j4 - Bedroom Storage Area

14. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
4. A storage area for clothing that includes a chest of drawers and a closet or wardrobe space with clothing racks or shelves accessible to the resident.

Description of Violation

Resident 3 does not have access to a closet or wardrobe with clothing racks or shelves in the bedroom. The resident instead puts his/her clothes in the kitchen cabinets.

Plan of Correction ***Accept ([redacted] - 08/13/2024)***

Resident 3 has access to a closet with clothing racks and shelves. Community families, POA's and responsible parties were educated during a family council meeting held on 7/12/2024. Community staff will be re educated by Memory Care Director by 8/5/2024.
New hires will be educated during orientation on residents' closets. The Memory Care Director/ Designee will audit the closet
Frequency of Audits: Weekly Start Date: 8/6/2024

The audits will be conducted monthly to ensure timely and thorough monitoring of the condition of water damage ceiling towels. for three months or until compliance is determined. Findings will be reported to QAPIpe text here

Audit will audit the shared closet shpace for three months or until compliance is determined. Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented ([redacted] 09/12/2024)

121a - Unobstructed Egress

15. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 7/2/2024 at 10:38 am, patio chairs blocked egress from the home's private dining room.

Plan of Correction ***Accept (- 08/13/2024)***

Patio chair was removed from the egress immediately 7/3/2024. Any areas of concern were immediately corrected. Activity Director was re-educated on 7/4/2024. Community staff will be re-educated by Activity Director 7/24/2024 on keeping egress unobstructed. New hires will be educated during orientation on keeping egress unobstructed. The Maintenance Director/ Designee will
audit the egresses Frequency of Audits: weekly
Start Date: 7/25/2024
The audits will be conducted monthly to ensure timely and thorough monitoring of the condition of water damage ceiling towels. for three months or until compliance is determined. Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented (- 09/12/2024)

162c - Menus Posted

16. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menu for the week of 6/30/24-7/6/2024 was posted in the memory care unit twice. However, the next week's menu was not posted.

Repeat Violation date 2/26/2024.

Plan of Correction ***Accept (- 08/13/2024)***

Corrected while surveyor was on site for initial visit on 7/2/2024. Current week's menu and the one week in advance menu
was posted by the resident's dining room. The Dietary Director will re-educate and start an audit by 7/7/2024. Community staff will be re-educated
by Dietary Director on the posting of one week in advance menus. New hires will be educated during orientation on posting menus. The Dietary
Director/ Designee will audit the menu Frequency of Audits: weekly
The audits will be conducted monthly to ensure timely and thorough monitoring of the condition of water damage ceiling towels. for the next three months or until compliance is determined findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented (- 08/22/2024)

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

On [redacted] Resident 4 has an order for compression socks to be put on in the morning, and removed at night. This order is on resident 4's medication administration record. Staff member G stated they are in charge of putting on resident 4's compression socks in the mornings. Staff member G stated night staff is in charge of taking off resident 4's socks in the evening and washing them. Staff member G stated that he/she does not initial the medication administration record after placing resident's socks on, as he/she is not a med tech and does not have access to the MAR. Resident's MAR has been initialed every morning by a staff member who is not performing task of placing the compression socks on the resident.

Plan of Correction ***Accept [redacted] - 08/13/2024)***

Staff member G was educated and given access on 7/3/2024 to flow sheet documentation. Staff member G, completed ted socks tasks documentation for resident 4 on 7/3/2024. Community staff will be educated on ted socks by DHW by 7/15/2024 DHW will start an audit on ted sock
by 7/25/24. Any areas of concern will be immediately corrected.
New hires will be educated during orientation on ted socks flow sheet documentation. The DHW/ Designee will audit the following of doctor's orders and signing off of flowsheets and MAR/TAR by the correct team members. Frequency of Audits: daily starting: 7/4/2024
for three months or until compliance is determined. Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented ([redacted] 09/12/2024)

187d - Follow Prescriber's Orders

18. Requirements

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

Description of Violation

Resident 4 has an order that compression socks must be put on him/her in the mornings and removed in the evenings. However, staff member G stated that resident 4's compression socks are regularly not removed in the evenings, including the evening of [redacted].

Repeat Violation date 11/27/2023 and 6/07/2023.

Plan of Correction ***Accept [redacted] - 08/13/2024)***

Staff member G, was educated on 7/3/2024 following doctors ordres. Community staff will be educated by DHW by 7/4-8/2024 on the importance
of following resident's doctor's orders. New hires
will be educated during orientation on the importance of following resident's doctor's orders. DHW/ Designee will audit the following
residents' doctor's MAR/TAR orders. Frequency of Audits: weelky starting: 7/4/2024 for three months or until

187d Follow Prescriber's Orders (continued)

compliance is determined. Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented [redacted] - 09/12/2024)

227g -Support Plan Signatures

19. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident 5 participated in the development of his/her support plan on [redacted] However, the accessor did not sign the support plan.

Resident 6 participated in the development of his/her support plan on [redacted]. However, the resident and the accessor did not sign the support plan.

Plan of Correction ***Accept [redacted] - 08/13/2024)***

Resident 5, support plan was signed on [redacted] . DHW will start the audit by [redacted]. Any areas of concern will be immediately
corrected. Community staff will be educated by DHW by [redacted] on signing support plans. New hires will be educated during orientation on singing support
plans. The DHW/ Designee will audit support plans for accessor signature Frequency of Audits: bi weekly starting: 7/17/2024 for three months or until compliance is determined. Findings will be
reported to QAPI
Resident 6, support plan was signed by resident 6 and accessor on 7/12/24 . DHW will start the audit by 7/17/24. Any areas of
concern will be immediately corrected.
Community staff will be educated by DHW by 7/16//24 on signing support plans. New hires will be educated during orientation on singing
support plans. The DHW/ Designee will audit support plans for accessor signature Frequency of Audits: bi weekly starting: 7/17/2024 for three months or until compliance is determined. Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented [redacted] - 09/12/2024)

233c - Key-Locking Devices

20. 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.

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

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near any of the 3 doors to the stairwells in the Secure Dementia Care Unit (SDCU).

Plan of Correction ***Accept (- 08/13/2024)***

3rd fl. code posting was corrected while surveyor was on site for initial visit on 7/2/2024. The Maintenance Director will re-educate community staff and starting an audit by 7/3/2024. Any areas of concern will be immediately corrected. New hires will be educated during orientation on posting 3rd floor door codes.
The Memory Care Director/ Designee will audit the code posting for 3dr floor locking mechanism Frequency of Audits: daily starting: 7/4/2024for three months or until compliance is determined.
Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented - 09/12/2024)

236 - Staff Training

21. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person D, who works in the Secure Dementia Care Unit (SDCU) had no hours of training in dementia care during the training year.

Plan of Correction ***Accept (- 08/13/2024)***

To ensure policy consistency and accountability in training completion all director care staff personal who works in the Secure Dementia Care Unit (SDCU) will complete the following training: dementia care
Trained by Administrator/ Designee. Memory Care Director and DHW will be re- educated by Administrator by 7/8/2024 on ensuring staff completes training and annual training in a timely manner. Audit will start 7/11/2024 audit frequency weekly and continue for three months or until compliance is determined. Findings will be reported to QAPI

Licensee's Proposed Overall Completion Date: *09/08/2024*

Implemented 09/12/2024)