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

September 20, 2024

[redacted], REGIONAL DIRECTOR OF OPERATIONS - PENNSYLVANIA
COLUMBIA/WEGMAN SOUTHAMPTON,LLC
[redacted]

RE: THE PROVINCE OF SOUTHAMPTON
1160 STREET ROAD
SOUTHAMPTON, PA, 18966
LICENSE/COC#: 14538

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/08/2024, 07/09/2024 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 PROVINCE OF SOUTHAMPTON* **License #**: *14538* **License Expiration**: *07/17/2024*

Address: *1160 STREET ROAD, SOUTHAMPTON, PA 18966*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *COLUMBIA/WEGMAN SOUTHAMPTON,LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *10/10/2019* **Issued By**: *Upper Southampton Township*

Type: *I-2* **Date**: *10/10/2019* **Issued By**: *Upper Southampton Township*

Type: *Other* **Date**: *10/10/2019* **Issued By**: *Upper Southampton Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *111* **Waking Staff**: *83*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *07/09/2024*

Inspection Dates and Department Representative

07/08/2024 - On-Site: [redacted]

07/09/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *106* **Residents Served**: *65*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *36* **Residents Served**: *19*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *64*

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

Have Mobility Need: *46* **Have Physical Disability**: *3*

Inspections / Reviews

07/08/2024 Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/15/2024*

08/21/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/14/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/15/2024*

09/20/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *09/14/2024*

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

17 - Record Confidentiality

1. 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 [redacted], at [redacted], the door to the home's "Chart Room" was propped open leaving approximately 45 resident medical records as well as a whiteboard with resident's first name, room number, bathing schedule, escort need, dressing assistance need, incontinence care and specialized need unlocked, unattended, and accessible to the public. The Chart Room is located behind the "Medication Administration" room which was also open and unattended; however, no medications were present.

Plan of Correction ***Accept ([redacted] - 08/21/2024)***

The chart room door is secured using a keypad locking system. The home failed to keep the door closed to ensure the contents of the chart room during the medical provider's visit to the house.

On 7/08/24, the Healthcare Director corrected the door by closing and securing it.

On 8/14/24, the Healthcare Director/Assistant Healthcare Director re-educated the current direct care staff on Regulation 2600.17, Record Confidentiality. This training included the following: Resident Records shall be confidential and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person (POA of health care proxy), staff persons to provide services to residents, agents of the department, and the long-term care ombudsmen.
Starting from 08/15/24, the Healthcare Director will be responsible for the routine monitoring of the doors on weekdays to ensure compliance with security measures. On weekends and holidays, this responsibility will be seamlessly transferred to the Manager on Duty, who will ensure compliance during community walk-throughs and document these checks on the Manager on Duty Checklist.
Starting from 08/15/24, the Administrator will play a crucial role in ensuring compliance with security measures. They will personally oversee this during their routine community walk-throughs and review the Manager on Duty Checklist to ensure compliance during monthly Quality Assurance meetings. This ongoing commitment is a critical step in ensuring the safety of our residents, and comprehensive documentation of these meetings will be maintained for reference.

Proposed Overall Completion Date: 08/31/2024

Licensee's Proposed Overall Completion Date: *08/31/2024*

Implemented [redacted] - 09/20/2024)

23a - Activities of Daily Living Assistance

2. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

23a Activities of Daily Living Assistance *(continued)*

Description of Violation

The "AL NIGHT SHIFT TASK ASSIGNMENT" for RA#1 lists the following for two resident rooms; "INCONTINENT PLEASE CHANGE THROUGH NIGHT. CHECK AT 11, CHANGE AT 3AM, 6AM". Per resident #1's spouse, resident #1, had not been receiving this care on a consistent basis prior to being sent to the hospital on [redacted].

Plan of Correction ***Accept ([redacted] - 08/21/2024)***

The home failed to consistently follow task sheets outlining the care needs of resident #1 regarding the overnight incontinence check schedule as outlined on the task sheet.

On 8/14/24, the Healthcare Director/Assistant Healthcare Director re educated the current direct care staff on Regulation 2600.23a, Activities of Daily Living. During this training, they reviewed and educated nursing staff on assignment task sheets and procedures put in place for all task sheets to be reviewed by med techs at the end of the shift and turned in for Healthcare Director and Assistant Healthcare Director to review the following day.

Beginning 08/15/24, the Medication Technician will collect, review, and approve task sheets at the end of their shift. They will then submit them to the Healthcare Director and/or Assistant Healthcare Director for final review and signature. This new process empowers the Medication Technicians and underscores their crucial role in our operations.

Beginning 08/15/24, the Healthcare Director/Assistant Healthcare Director and/or designee will review and sign off on task sheets daily and provide re education to comply with Regulation 2600.23a, Activities of Daily Living. Task sheets will be retained for thirty days.

Proposed Overall Completion Date: 08/31/2024

Licensee's Proposed Overall Completion Date: *08/31/2024*

Implemented [redacted] 09/20/2024)

25b - Contract Signatures

3. 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 Residency Agreement, dated [redacted], for resident #1 was not signed by the resident.

Plan of Correction ***Accept [redacted] - 08/21/2024)***

This Customer Service Associate and Administrator failed to obtain the resident's signature on the resident home contract at the time of resident #1 physical move in.

On 8/14/24, the Administrator educated the new Customer Service Assistant on Regulation 2600.25b, Contract Signatures, utilizing the resident business file audit tool.

On 8/15/24, the Administrator reviewed the residency contract with resident #1 and obtained signatures.

On 08/15/24 the Administrator and Customer Service Associate audited all resident contracts, and no further

25b - Contract Signatures (continued)

errors were noted.

Beginning 8/15/24 the Administrator will review the resident-home contract with new residents before or within 24 hours of a new admission and obtain a resident signature.

Beginning 08/15/24 and ongoing, the Administrator/designee shall review all new admission files within 30 days of admission to ensure compliance with Regulation 2600.25b, Contract Signatures. Ongoing compliance will be maintained, and documentation will be retained.

Proposed Overall Completion Date: 08/31/2024

Licensee's Proposed Overall Completion Date: *08/31/2024*

Implemented [redacted] - 09/20/2024)

41e - Signed Statement

4. 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 #1's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept ([redacted] - 08/21/2024)***

The Customer Service Associate and Administrator failed to review Resident Rights and Complaint Procedures within the resident-home contract at the time of Resident #1 physical move-in.

On 8/14/24, the Administrator educated the new Customer Service Associate on Regulation 2600.41e, Signed Statement, utilizing the resident business file audit tool.

On 8/15/24, the Administrator reviewed the residency contract with resident #1 and obtained signatures.

On 8/15/24, the Administrator and Customer Service Associate audited all resident contracts, and no further errors were noted.

Beginning 8/15/24, the Administrator will review the resident-home contract with new residents before or within 24 hours of a new admission and obtain a resident signature.

Beginning 08/15/24 and ongoing, 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. Ongoing compliance will be maintained, and documentation will be retained.

41e - Signed Statement (continued)

Proposed Overall Completion Date: 08/31/2024

Licensee's Proposed Overall Completion Date: *08/31/2024*

Implemented ([redacted] - 09/20/2024)

42p - Restraints

5. Requirements

2600.
42.p. A resident shall be free from restraints.

Description of Violation

On [redacted] at approximately [redacted] resident #2 was being physically restrained to their bed by a wooden chair and a large pillow that ran the full length of one side of the bed. The other side of the bed is against a wall.

Plan of Correction ***Accept ([redacted] - 08/21/2024)***

At the time of discovery on [redacted] the Assistant Healthcare Director and Healthcare Director were notified immediately. They removed the wooden chair and large pillow. The Assistant Healthcare Director and Healthcare Director immediately educated associates regarding furniture placement related to 2600.42.p. Training records shall be retained.

On 8/14/24, the Healthcare Director and Assistant Healthcare Director educated current staff regarding Regulation 2600.42p, Restraints, as outlined in the RCG. They also provided information regarding best practices to protect residents' right to liberty and dignified treatment. The administrator will give additional reeducation at the next all-staff meeting on 8/27/24. Training records shall be retained.

All Residents are regularly informed of their rights (upon admission and during resident council). Residents are and will continue to be encouraged to report if someone is allegedly mistreating or restraining them promptly.

For four weeks beginning 8/15/24, Med-Techs will round the SDCU once per shift to ensure residents are not restricted in movement per regulation 2600.42p. They will record rounds and findings on the SDCU rounds log for compliance and provide reeducation as needed.

For four weeks beginning 8/15/24, the Assistant Healthcare Director/Designee/Manager on Duty will round the SDCU 1x per shift to ensure no resident is being restricted in movement per regulation 2600.42p and record rounds and findings on SDCU rounds log for compliance and provide reeducation as needed.

Beginning on 8/19/24, the Administrator will review the SDCU round log weekly for compliance and provide re-education as needed. Records will be retained as part of the monthly Quality Assurance meetings.

Proposed Overall Completion Date: 09/15/2024

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented ([redacted] - 09/20/2024)

60a - Staff/Support Plan

6. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

According to Resident Council minutes staff do not respond to call bells in a timely manner and management knows this to be a problem. The home does not maintain a call bell response time policy. When asked, staff person A, stated an acceptable call bell response time, based on experience, is eight (8) minutes.
Licensing representative requested a copy of the call bell report for the period of June 01 through June 07, 2024. There are many response times exceeding the suggested 8 minutes, including:

- [redacted] *Pull Switch in M.C. apartment 1 - Response Time: 1h 6m 26s,*
- *Pendant pressed in apartment 222 - Response Time: 2h 37m 47s,*
- *Pull Switch: & 29 bathroom in M.C. apartment 28 - Response Time; 44m 20s,*
- *Pendant pressed in apartment 204 - Response Time: 44m 33s,*
- *Pull Switch in M.C. apartment 1 - Response Time: 40m 37s,*
- *Pull Switch: Bathroom in M.C. apartment 24 - Response Time: 1h 30m 33s,*
- *Pendant pressed in apartment 217 - Response Time: 21m 42s.*

Plan of Correction ***Accept [redacted] - 08/21/2024)***

During June 1st and 7th, many call bell response times exceeded the suggested 8 minutes. The home failed to consistently review call bell logs to address timely responses with direct care staff.

On 8/14/24, the Administrator educated all Front Desk staff that any call exceeding the suggested 8 minutes should call out all call bell alerts over the walkie-talkie to shorten the call bell response times during front desk coverage between 8 a.m. and 8 p.m. The Front Desk staff were also instructed to alert the Healthcare Director, Assistant Healthcare Director, and/or Administrator if a call bell exceeds the desired call bell response time of 8 minutes.

On 8/14/24, the Healthcare Director educated all Med Techs that any call exceeding the suggested 8 minutes to call out over the walkie-all call bell alerts between 8 pm-8 am when Front Desk staff is not on duty and to aid in responding to call bells to ensure a timely response.

The Healthcare Director educated direct care staff on 8/14/24 on the appropriate response time for call bell alerts.

Beginning 8/12/24, the Healthcare Director, Assistant Healthcare Director, and Administrator will review the Call bell report daily, Monday through Friday, at the home's collaborative care meeting.

Beginning 8/12/24, the Healthcare Director and Assistant Healthcare Director will review with direct care staff at the daily shift huddle any call bell alerts that exceed the desired time frame of 8 minutes to keep it top of mind regarding timely answering of call bell alerts.

Adherence to 2600.60a, Staff/Support Plan, will be rigorously monitored during our regularly scheduled Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

Proposed Overall Completion Date: 08/31/2024

Licensee's Proposed Overall Completion Date: *08/31/2024*

60a - Staff/Support Plan *(continued)*

Implemented [redacted] - 09/20/2024)

91 - Telephone Numbers

7. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

Resident #3 has a cell phone in [redacted] apartment. There are no emergency telephone numbers to include the nearest hospital and fire Department in apartment [redacted]

Plan of Correction ***Accept ([redacted] - 08/21/2024)***

The home was unaware that Resident #3 had a cell phone in the apartment. The emergency telephone numbers, including the nearest hospital and fire department, were unavailable.

On 7/8/24, the Administrator promptly corrected this deficiency by proactively posting the emergency telephone numbers, including the nearest hospital and fire department, thereby resolving the issue.

On 8/13/24, The Administrator emailed residents and POAs to inform them to notify the home if and when they provide phone service to residents so that we can ensure emergency numbers are posted according to regulation.

An audit, a crucial step in ensuring compliance with regulations and the safety of our residents, was completed on 8/15/24. Emergency phone numbers were posted in every occupied apartment, providing a secure environment for our residents.

On 8/14/24, the Administrator educated Housekeeping staff on Regulation 2600.91, Telephone Numbers, regarding the requirement to post these numbers. This facilitates a quick response from the appropriate agency in an emergency and allows staff and residents to contact the Department to report complaints in privacy. Housekeepers were given a small supply of emergency phone number tags to place during weekly cleaning if unavailable.

Adherence to 2600.91, Telephone Numbers, will be rigorously monitored during our regularly scheduled Quality Assurance meetings. This unwavering commitment to compliance and safety is a critical step in ensuring the well-being of our residents. Comprehensive documentation of these meetings will be maintained for reference.

Proposed Overall Completion Date: 08/31/2024

Licensee's Proposed Overall Completion Date: *08/31/2024*

Implemented [redacted] - 09/20/2024)

101j7 - Lighting/Operable Lamp

8. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

101j7 - Lighting/Operable Lamp *(continued)*

Description of Violation

Resident #4 does not have access to a source of light that can be turned on/off at bedside. The floor lamp next to resident #4's bed was not plugged in and had the cord wrapped around the base of the lamp.

Plan of Correction ***Accept (- 08/21/2024)***

Resident #4, who lives in our has a bedside light. However, unplugs the light to use radio and clock at the bedside. During the inspection on 7/8/24, the Maintenance Director corrected this deficiency and plugged in the bedside light.

On 8/14/24, the Administrator purchased battery-operated touch lights and installed a tap light at Resident #4's bedside if the table lamp is unplugged.

On 8/14/24, the Administrator educated current direct care staff on Regulation 2600.101j7, Lighting/Operable Lamp, ensuring that all residents have an operable bedside light in place. The Administrator will provide additional reeducation at the next all-staff meeting on 8/27/24. Training records shall be retained.

By 8/31/24, all occupied apartments in Memory Care will have a tap light installed at the bedside.

Beginning on 8/15/24, Med Techs will round the SDCU once per shift to ensure that bedside lights are operable. They will record rounds and findings on the SDCU rounds log for compliance, and provide re-education as needed.

Beginning on 8/15/24, the Administrator will review the SDCU round Log 1x weekly for compliance and provide re-education as needed, records to be retained.

Proposed Overall Completion Date: 09/01/2024

Licensee's Proposed Overall Completion Date: *09/01/2024*

Implemented (- 09/20/2024)

141b2 - Medical Evaluation Changes

9. Requirements

2600.
141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

Resident #1's Documentation of Medical Evaluation (DME), dated , includes a special diet need of an ". This dietary need is not included in the resident's support plan. Staff A and B were questioned and responded the resident denied the need for the fluid restriction on (documented in the "Resident Notes") and had the restriction removed by the issuing physician. Other than the resident's denial, there is no documentation removing this restriction. This change should have been documented on a new DME and signed off by the resident's primary physician.

Plan of Correction ***Accept - 08/21/2024)***

Resident #1's Documentation of Medical Evaluation (DME), dated , includes a particular diet need for an ".” This dietary need was not included in the resident's support plan. Staff A and B were questioned and responded that the resident denied the need for the fluid restriction on (documented in the

141b2 - Medical Evaluation Changes (continued)

"Resident Notes") and had the restriction removed by the issuing physician. The former Healthcare Director failed to obtain a new Document of Medical Evaluation (DME) or physician's order removing the [redacted] fluid restriction before resident #1's physical move-in so that it would have been reflected accurately on the resident's support plan.

The Healthcare Director will conduct a reassessment of the resident prior to her return to the community, obtain a new Document of Medical Evaluation, and complete a new Resident Assessment and Support Plan (RASP) upon the resident's return from an SNF admission.

Beginning on 8/15/24, the Healthcare Director and Assistant Healthcare Director will review all Documents of Medical Evaluation (DMEs) prior to the resident move-in and ensure information regarding the resident's needs is documented accurately on the Resident Assessment and Support Plan.

Beginning on 8/15/24 and ongoing, the Administrator or designee shall review all new admission files within 30 days of admission to ensure compliance with Regulation 2600.1e, Signed Statement. Ongoing compliance will be maintained, and documentation will be retained.

Proposed Overall Completion Date: 08/31/2024

Licensee's Proposed Overall Completion Date: *08/31/2024*

Implemented [redacted] - 09/20/2024)

191 - Resident Right to Refuse

10. 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 #1, admitted [redacted] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept [redacted] - 08/21/2024)***

Residents have the right to refuse medication if they believe there may be a medication error, which is reviewed upon admission in the residency agreement. The home obtained the signature on the residency agreement from the POA on [redacted] Still, it failed to have the resident sign it because the resident took physical possession of it later after the financial move-in.

On 8/14/24, the Administrator educated the Customer Service Assistant on Regulation 2600.191, Resident Right to Refuse, utilizing the home's resident business file audit tool.

Beginning on 8/15/24, the Customer Service Associate and/or Residence Director will audit the resident's business file upon move-in to ensure compliance with regulation, utilizing the resident business file audit tool.

Beginning on 8/15/24, the Administrator will review the Residents' Rights and Right to Refuse medication as outlined in the home contract before or within 24 hours of admission and obtain residents' signatures.

191 Resident Right to Refuse (continued)

Beginning 8/15/24 and ongoing, the Administrator or designee shall review all new admission files within 30 days of admission to ensure compliance with Regulation 2600.191, Resident Right to Refuse. Ongoing compliance will be maintained, and documentation will be retained.

Proposed Overall Completion Date: 08/31/2024

Licensee's Proposed Overall Completion Date: *08/31/2024*

Implemented ([redacted] - 09/20/2024)

202 - Prohibitions

11. Requirements

2600.
202. The following procedures are prohibited:

1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2600.231 (relating to admission).
2. Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.
3. Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.
4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.
5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.
6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

On [redacted] at approximately [redacted] resident #2 was restricted to their bed by a wooden chair and a large pillow on one side and a wall on the other side. No staff were present in the room when this was observed.

Plan of Correction ***Accept ([redacted] - 08/21/2024)***

At the time of discovery on 7/8/24, the Assistant Healthcare Director and Healthcare Director were notified immediately. They removed the wooden chair and large pillow. The Assistant Healthcare Director and Healthcare Director immediately educated the staff regarding positioning of furniture related to 2600.202. Training records shall be retained.

On 8/14/24, the Healthcare Director and Assistant Healthcare Director educated current staff regarding Regulation 2600.202, Prohibitions, as outlined in the RCG. They also provided information regarding best practices to protect residents' right to liberty and dignified treatment. The administrator will give additional reeducation at the next all staff meeting on 8/27/24. Training records shall be retained.

All Residents are regularly informed of their rights (upon admission and during resident council). Residents are and will continue to be encouraged to report if someone is allegedly mistreating or restraining them promptly. The

202 Prohibitions (continued)

Assistant Healthcare Director will also conduct random interviews with staff and residents in memory care regarding restraints twice weekly for twelve weeks beginning 8/19/24. Documentation shall be retained.

For four weeks beginning 8/15/24, Med Techs will round the SDCU once per shift to ensure residents are not restricted in movement per regulation 2600.202. They will record rounds and findings on the SDCU rounds log for compliance and provide reeducation as needed.

For four weeks beginning 8/15/24, the Assistant Healthcare Director/Designee/Manager on Duty will round the SDCU 1x per shift to ensure no resident is being restricted in movement per regulation 2600.202 and record rounds and findings on SDCU rounds log for compliance and provide reeducation as needed.

Beginning on 8/19/24, the Administrator will review the SDCU round log weekly for compliance and provide re education as needed. Records will be retained as part of the monthly Quality Assurance meetings.

Proposed Overall Completion Date: 09/15/2024

Licensee's Proposed Overall Completion Date: *09/15/2024*

Implemented [redacted] - 09/20/2024)

227d - Support Plan Medical/Dental

12. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The home uses assignment sheets to indicate resident needs to staff. The "AL NIGHT SHIFT TASK ASSIGNMENT" for RA#1 indicates resident #1 (by room number) requires the following care; "INCONTINENT PLEA(S)E CHANGE THROUGH NIGHT. CHECK AT 11, CHANGE AT 3AM, 6AM. This information is not included in the resident's assessment and support plan.

Plan of Correction ***Accept ([redacted] - 08/21/2024)***

The home uses assignment sheets to indicate resident needs to staff. The "AL NIGHT SHIFT TASK ASSIGNMENT" for RA#1 indicates resident #1 (by room number) requires the following care: "INCONTINENT PLEASE CHANGE THROUGH NIGHT. CHECK AT 11, CHANGE AT 3 AM, 6 AM. The former Healthcare Director failed to include this specific care need in the resident's assessment and support plan.

On [redacted] Resident #1 was out of the community at a [redacted] facility. As of [redacted], the Resident is still out of the community. The Healthcare Director will assess Resident #1 prior to discharge from the skilled nursing facility, obtain a new Document of Medical Evaluation, complete a new assessment and resident assessment support plan (RASP), and update the assignment sheets to reflect the care needs outlined on the resident assessment support plan.

227d - Support Plan Medical/Dental (continued)

On 8/12/24, the Administrator educated both the Healthcare Director and Assistant Healthcare Director on Regulation 2600.227d, Support Plan Medical/Dental, that the Residents' needs on the task sheets must also be outlined on the Residents' Assessment and Support Plan.

Beginning 8/15/24, the Healthcare Director and Assistant Healthcare Director will audit task sheets to ensure they match the care needs outlined on the Resident Assessment and Support Plan. The audit will be completed by 8/31/24.

Beginning 8/15/24 and continuing, the Administrator or designee shall review all new admission files within 30 days of admission to ensure compliance with Regulation 2600.227d, Support Plan Medical/Dental. Ongoing compliance will be maintained, and documentation will be retained.

Proposed Overall Completion Date: 09/01/2024

Licensee's Proposed Overall Completion Date: *09/01/2024*

Implemented (- 09/20/2024)

231e - No Objection Statement

13. 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.

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on .
Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on .
The home has no documentation that these residents and the residents' designated persons have not objected to the admission.

Plan of Correction ***Accept - 08/21/2024)***

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on . The home has no documentation that these residents and the residents' designated persons have not objected to the admission.

Residents #2 and #4 were admitted to the home under the prior management company, and it was unknown to current management and the Administrator that the prior management group's residency agreement did not contain a "No Objection" statement.

New residency agreements were prepared under the new/current management group, which contain a "No Objection" statement. They were reviewed with Residents #2 and #4, and their signatures were received on the residency agreement on 8/14/24.

Beginning on 8/15/24, the Administrator and Customer Service Associate will audit all resident business files for residents residing in the home's secure dementia unit to ensure all residents have residency agreements with the "No Objection" statement. The audit of all resident residency agreements in the home's secure dementia unit will be complete by 8/23/24.

231e - No Objection Statement (continued)

Beginning on 8/15/24, the home will only accept an updated residency agreement that includes the "No Objections" Statement for admission to its secure dementia unit.

Beginning on 8/15/24 and ongoing, the Administrator/designee shall review all new admission files within 30 days of admission to ensure compliance with Regulation 2600.231e, No Objection Statement. Ongoing compliance will be maintained, and documentation will be retained.

Licensee's Proposed Overall Completion Date: *08/31/2024*

Implemented [redacted] 09/20/2024)