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

October 25, 2024

[redacted], OWNER
WALDEN CARE LLC
325 NORTH BROADWAY
WIND GAP, PA, 18091

RE: WALDEN III SENIOR LIVING COMMUNITY
325 NORTH BROADWAY
WIND GAP, PA, 18091
LICENSE/COC#: 23072

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *WALDEN III SENIOR LIVING COMMUNITY* **License #**: *23072* **License Expiration**: *05/02/2025*

Address: *325 NORTH BROADWAY, WIND GAP, PA 18091*

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

Administrator

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

Legal Entity

Name: *WALDEN CARE LLC*

Address: *325 NORTH BROADWAY, WIND GAP, PA, 18091*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/28/1994* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *44* **Waking Staff**: *33*

Inspection Information

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

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

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *77* **Residents Served**: *43*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *43*

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

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

07/09/2024 Full

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

08/14/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/15/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/21/2024*

Inspections / Reviews *(continued)*

08/22/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *10/15/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/29/2024*

10/25/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *10/15/2024*

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

3c - Post Current License

1. Requirements

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

Description of Violation

The home did not post a copy of the Department of Public Welfare Chapter 2600 Personal Care Homes regulation book in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 08/22/2024)***

How this happened:
The pink book was displayed on the main dining room bulletin boards. I failed to check on it in my travels to ensure it was still attached to the bulletin board.

Plan of correction:
Another copy was placed in the lobby area and is displayed. The new copy of the Regulations (Pink book) was placed on display on 07/09/2024.

Moving forward:
The administrator and the assistant admin will conduct weekly checks of the front lobby area to ensure the pink box of regulations is securely in place. A checklist will be dated and signed by the administrator and or the assistant admin. This was enacted in our procedures on 07/09/2024

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented [redacted] - 10/16/2024)

26a - Quality Management Plan

2. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home did not have documentation that that an annual quality management plan review had taken place pin the last 12 months.

Plan of Correction ***Accept [redacted] - 08/22/2024)***

How did this happen:
The quality management plan for Walden is due in July. Unfortunately, it was not completed and I, being disorganized, could not locate my 2023 quality management plan.

Plan of correction:
The Administrator and the Administrative Assistant discussed having our quality management meeting in June. That way, we will be sure to have this done by July 30th. The 2024 Quality Management Plan review was completed on 07/26/2024.

Moving forward:
The Administrator and Assistant Admin will move the annual quality management to a calendar year. To be completed moving forward in 2025 in June of 2025

26a Quality Management Plan *(continued)*

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented [redacted] - 10/16/2024)

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 A, whose first day of work was [redacted], did not complete their first day orientation on Evacuation procedures, staff duties and responsibilities during fire drills, designated meeting place, smoking safety procedures/policy, location & use of fire extinguishers, smoke detectors & fire alarms, telephone use & notification of emergency services.

Repeat Violation 6/29/23

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

How did this happen:
The orientation form was two one sided papers instead of a double sided single piece of paper, which allowed one form to become lost. After the surveyor left, the form was found in Staff A's med tech file, which is kept separate from the personnel file. The original date of the training was 10/23.

Plan of correction:
The Administrator re oriented Staff A in the evacuation procedures, staff duties and responsibilities during fire drills, designated meeting place, smoking safety procedures/policy, location & use of fire extinguishers, smoke detectors & fire alarms, telephone use & notification of emergency services. The original date of this training was completed on 10/23/23. (The administrator was unable to complete a new training with Staff Person A, as Staff Person A abandoned her position on 07/10/2024)

Moving forward:
The Administrator drafted a checklist to be attached to every personnel file. Every employee's file will be audited and checked on the front list if something is missing, or if it is complete. This was completed on 07/09/2024

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented ([redacted] - 10/16/2024)

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:
2. Emergency medical plan.

Description of Violation

Staff person A completed their 40th scheduled work hour on [redacted]. However, this staff person did not complete orientation on Emergency Medical Plan.

Repeat Violation 6/29/23

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

How did this happen:
The orientation form was two one-sided papers, instead of a double-sided single piece of paper. This allowed for the one form to become lost. After the surveyor left, the form was found in Staff A's med tech file.

Plan of correction:
The signed form was placed in the correct personnel file of Staff Person A. The form was placed in Staff Person A's file on 07/09/2024. Moving forward Staff Person A, abandoned [redacted] position on [redacted]

Moving forward:
The Administrator drafted an audit form that is attached to all personnel files. The Administrator will conduct a monthly audit of all personnel files to ensure every document and every form is signed and dated. The administrator appointed the Administrative Assistant to do a second audit, to ensure no documents were missed. This audit was begun on All employee files on 07/10/2024

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented [redacted] - 10/16/2024)

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

Description of Violation

The home had no verification that Direct care staff person B, hired on [redacted], completed and passed the Department-approved direct care training course and passed the competency test.

Repeat Violation 6/29/23

Plan of Correction ***Accept ([redacted] - 08/14/2024)***

How did this happen:
Staff person B was hired in 2021. The direct care course was completed in August of 2021. The Administrator did not realize the certificate was missing.

65d Initial Direct Care Training (continued)

Plan of correction:
The administrator set up Staff Person B with the updated version of the Direct Care Staff training. It is in process at this moment. The certificate will be submitted immediately when completed.

Moving forward:
The Administrator drafted an audit form that is attached to all personnel files. The Administrator will conduct a monthly audit of all personnel files to ensure every document and every form is signed and dated. The administrator appointed the Administrative Assistant to do a second audit, to ensure no documents were missed.

Licensee's Proposed Overall Completion Date: *08/12/2024*

Implemented (- 10/16/2024)

65f - Training Topics

6. 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.
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 member C and D did not receive training in medication self administration, DME/RASP, care for residents with dementia and cognitive impairment, personal care service needs of the resident, and care for residents with MH and ID during training year 2023. Direct care staff person B did not receive training in medication self administration, DME/RASP, care for residents with dementia and cognitive impairment, infection control, personal care service needs of the resident, self management techniques, and care for residents with MH and ID during training year 2023.

Repeat Violation 6/29/23

Plan of Correction ***Accept - 08/22/2024)***

1How did this happen:
The surveyor requested the training documents from 2023. Staff Person C and Staff Person D had missed those. Staff Person C and Staff Person D took the training but it was overlooked in the training manual. Their signatures can be observed during the class sign in sheet. Upon further inspection, both Staff Persons had missed the Medication self administration and the Care for residents with MH and ID.

65f - Training Topics (continued)

Plan of correction:
The Administrator retrained both staff persons in the topics of medication self-administration, DME/RASP, care for residents with dementia and cognitive impairment, personal care service needs of the resident, and care for residents with MH and ID.

Moving forward:
The 2024 training is being completed at present. The Administrator will conduct an audit in compilation with the training manual sign-in sheets and the individual personnel files to ensure there are no missed topics required for training as well as no missed signatures of employees.

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented [redacted] - 10/25/2024)

65g - Annual Training Content

7. 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:
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).

Description of Violation

Staff person B did not receive training in emergency preparedness procedures, resident rights, and OAPSA, during training year 2023. Staff person C and D did not receive resident rights during training year 2023.

Repeat Violation 6/29/23

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

How did this happen:
Staff person B had received the emergency preparedness procedures, resident rights, and OAPSA training, but the Administrator (I) failed to date the sheet of the date it was conducted. Staff persons C and D had also received the resident rights training, again I overlooked it when preparing, and the Administrator (I) failed to date the sheet of completion.

Plan of correction:
The Administrator retrained all staff persons B, C, and D, on the topics of resident rights, emergency preparedness procedures, and OAPSA. The retraining in these topics were completed July 11 2024

Moving forward:
The 2024 training is being completed at present. The Administrator will conduct an audit in compilation with the training manual sign-in sheets and the individual personnel files to ensure there are no missed topics required for training as well as no missed signatures of employees. The action plan for audit of the training manual is currently being enacted into Walden procedures 07/12/2024

Licensee's Proposed Overall Completion Date: *08/21/2024*

65g Annual Training Content *(continued)*

Implemented [redacted] - 10/25/2024)

91 Telephone Numbers

8. 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

The required emergency telephone numbers were not posted on or near the landline phone in room #115.

Plan of Correction ***Accept ([redacted] - 08/14/2024)***

How did this happen:
The staff and Administration were unaware of room 115 having a landline. The housekeeping staff and Administrator overlooked this. It was the assumption of Walden that room 115 was using a cell phone.

Plan of correction:
A phone sticker was immediately placed on room 115's landline telephone.

Moving forward:
The Administrator drafted an inventory list of all rooms that have a landline telephone. The Administrator further instructed the Admin Assistant to inspect and chart all rooms with landlines and ensure all landline phones have a sticker of emergency numbers attached.

Licensee's Proposed Overall Completion Date: *08/12/2024*

Implemented ([redacted] - 10/16/2024)

92 Windows

9. Requirements

2600.
92. Windows and Screens Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

The hallway leading to rooms 140 through 150 had 6 windows that were open but did not have screens.

Plan of Correction ***Accept [redacted] - 08/22/2024)***

How did this happen:
In the history of Walden the breezeway leading from the west wing to the NuNu, never had screens. It was never considered so therefore an oversight on the Administrator that no screens were installed.

Plan of correction:

92 Windows (continued)

Of the windows in question in the breezeway from 140 through 150, 10 total were measured and fitted for screens. None are the same size. The sizes were given to the local glass/window repair shop and ordered. A completion picture will be submitted when the screens are installed. 07/31/2024 The administrator put into place an audit of the building to ensure all windows have screens. 10 Screens were ordered, they are being handmade as they are all different sizes, on 07/31/2024.

Moving forward:
The administrator appointed the Maintenance department to inventory and list all the windows within Walden to ensure no screens are missing or broken. An audit will be conducted quarterly to inspect all the windows. The audit of Walden windows has been conducted and determined there are an additional 2 windows that screens are being made for. These screens were ordered on 08/07/2024 from Bangor Glass Works. Final pictures will be sent when delivered and installed.

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented ([redacted] - 10/24/2024)

93a - Handrails

10. Requirements

2600.
93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

The basement has two areas of egress, one that exits to the front of the building and a second that exits to the side of the building The basement is below ground level and both egress routes require ascending a flight of stairs to exit the building. The basement staircase leading to the side exit door, does not have a handrail. Additionally, there is a step down when passing through this exit door. This step does not have a handrail or handle.

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

How did this happen:
The basement stairs are very rarely used. The maintenance department had been working on the sump pump in that area. The administrator overlooked the required hardware such as the handrail, or handle.

Plan of correction:
The Administrator had the maintenance department install the handrail, and door handle and constructed a step outside the exit door. Measurements have been taken and sent to a fabricator to make a handrail that can be cemented in the ground. A picture of the handrail will be submitted when finished. A new handrail was fabricated and installed on 07/11/2024. The concrete step was fabricated on 07/11/2024. The outside handrail was fabricated and installed on 08/10/2024

Moving forward:

93a - Handrails (continued)

The Administrator drafted a log sheet used to recognize all egress, exit, entrance door wares near stairs to ensure they are safe and sturdy, and free of blockages. The Administrator and the Maintenance department will work together to inventory and inspect all egress and railings, stairs and exit doors for any defects. If a repair is noted it will be kept in a maintenance log and the Administrator will follow up with the Maintenance regarding said repairs. A log sheet of all the exits and entrance doors where there are stairs will be kept in the log book.

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented [redacted] - 10/24/2024)

105g - Lint Removal and Duct Cleaning

11. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

A dryer, located in the home's laundry room, was found to be without a lint trap. A lint trap was noted on top of the dryer, broken in half, and missing a filtration screen.

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

How did this happen:
The lint trap on the third dryer had broken. It was not brought to the administrator's attention that it was broken.

Plan of correction:
The Administrator and the Maintenance department inspected the lint screen and discovered it could not be repaired. The dryer was then taken out of commission. The administrator obtained a part number and it is no longer made. The administrator then instructed the Maintenance to remove the dryer from the facility. The Administrator had the dryer placed out of order on 07/09/2024 and it was removed from the facility on 07/10/2024 by the maintenance department.

Moving forward:
The Administrator instructed the Maintenance department and Housekeeping to inspect the dryer every week for any faulty parts. it is further instructed that any washer/dryer with faulty parts be put on "lock out" and the parts be replaced immediately. This inspection will be done with the lint cleaning schedule. The lint cleaning schedule is completed monthly by the maintenance department. The last lint cleaning removal schedule was completed on 08/14/2024.

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented ([redacted] - 10/16/2024)

121a - Unobstructed Egress

12. Requirements

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

121a Unobstructed Egress *(continued)*

Description of Violation

During onsite inspection, a carpet pad was noted on a landing at the top of the basement stairs, in front of the side exiting basement door, obstructing the egress route.

The exit door located in the dining room next to the bird cage would not open without an excessive amount of force, preventing immediate egress in the event of an emergency.

Repeat Violation 6/29/24.

Plan of Correction ***Accept (- 08/22/2024)***

Plan of correction:
The exit door frame has been swollen from the moisture and humidity of the summer weather. The administrator and Maintenance failed to test the door to see for ease of use.

Plan of correction:
A new door and frame has been ordered. This door was ordered on 07/24/2024. It is a steel fire door with a frame. and has yet to be delivered. Once delivered it will be installed by a contractor, with the maintenance department overseeing the construction replacement of the exit door. The door has been ordered to fire and safety specs from the Summitt Door Company of Easton. Delivery is scheduled for 08/30/2024

Moving forward:
The administrator drafted a log sheet for the Maintenance department to inspect all the exit doors within the building to ensure they are functioning properly. Should any be found unsafe they will be replaced immediately. A monthly audit for monitoring the existing exit doors has been put in place by the Administrator and the maintenance department on 07/12/2024

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented (- 10/24/2024)

124 - Notice to Fire Department

13. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home was unable to provide verification of the required Notice to the local Fire Department.

Plan of Correction ***Accept - 08/22/2024)***

Plan of correction:
The administrator was unclear what fire letter was asking for. The administrator thought the surveyor meant the letter from the local fire inspector that shows the allotted time for evacuation. I believe now was asking for the letter that the administrator gave to the local fire chief showing the location of the rooms and those that will need assistance.

124 - Notice to Fire Department (continued)

Plan of correction:
The administrator sent an annual fire packet to the local fire chief with a map of the building outlining the rooms and locations of any residents with disabilities.
This is our annual Emergency Action Plan letter. Please advise if this is not what [redacted] was asking for. The fire packet was received by the WG Fire Company on 07/30/2024

Moving forward:
Every year the local fire department and surrounding companies conduct a supervised fire drill here for our staff, residents, and their firemen. It's practice as well as a learning experience for all. It is also during this drill that our local fire chief fills our fire evacuation time letter that is allowed given our sprinkler, evacuation procedures, and staff to evacuate all residents. The administrator has requested this drill twice a year for all involved. The Fire Chief [redacted] has requested that one of the drills be conducted with the surrounding companies for practice. The administrator agreed this is a good idea for all the companies training as well. The administrator will continue. 07/30/2024

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented ([redacted] - 10/24/2024)

132a - Monthly Fire Drill

14. Requirements

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

Description of Violation

A fire drill record was not maintained for drills held in June 2023 to December 2023. Therefore, it cannot be verified that fire drills were held.

Plan of Correction ***Accept ([redacted] - 08/14/2024)***

How this happened:
The drills are held monthly. The administrator had the fire evacuation chart out for review and due to the disorganization in the office the first half of the fire drill record cannot be located.

Plan of correction:
The Administrator and the Admin Assistant will conduct monthly unannounced fire drills. The administrator has submitted the 2024 schedule of the fire drills.

Moving forward:
The administrator will maintain a fire drill evacuation notebook, with the drill record, notice to the fire department, and the staff sign-in sheets for drill participation.

Licensee's Proposed Overall Completion Date: *08/12/2024*

Implemented ([redacted] - 10/16/2024)

132b - Safety Inspection/Fire Drill

15. Requirements

2600.

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

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

Description of Violation

The last fire safety inspection was completed on 3/16/23. The home did not have a fire safety inspection conducted by a fire safety expert within the past 12 months.

Plan of Correction ***Accept [redacted] - 08/22/2024)***

How this happened:
Waldens last supervised fire drill was conducted on 03/16/2023 by the Wind Gap Fire Company. The administrator lost track of the time frame of the last supervised drill.

Plan of correction:
On July 9th an email and call was made by the administrator to a fire expert to visit Walden to give Walden an accurate evacuation time based on the sprinkler system. This was [redacted]. [redacted] has not returned the call or email.
On 07/10/2024 The administrator then called the fire chief of Wind Gap Volunteer Fire Company to schedule a supervised fire drill with the local fire company. Fire Chief [redacted] has conducted in the previous years supervised fire drill for Walden, at which time he will provide a fire letter of safe evacuation time.

Moving forward:
The administrator will maintain a fire drill evacuation notebook, with the drill record, notice to the fire department, and the staff sign-in sheets for drill participation. The info will be in order of the year. The fire letter will be submitted to DHS upon completion by the Fire Chief [redacted].

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented [redacted] - 10/16/2024)

132d - Evacuation

16. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The last fire safety inspection was completed on 3/16/23 with an evacuation time of 7 minutes and 40 Seconds. The evacuation certification time expired one year from the date of issue and therefore the evacuation time reverted back to the standard evacuation time of 2 minutes and 30 seconds. Every fire drill that was held in 2024 was completed in over 4 minutes and 13 seconds.

Plan of Correction ***Accept [redacted] - 08/22/2024)***

How this happened:
The administrator did not realize the evacuation time reverted to 2 minutes and 30 seconds. This was an error in the judgment of the administrator.

132d - Evacuation (continued)

Plan of correction:
The administrator will continue to hold unannounced fire drills and strive to improve evacuation times. The administrator has placed a call to [redacted] who has been to Walden last spring to give us an evacuation time after inspection. [redacted] has failed to respond back to Walden either by email or call. The administrator will continue to seek out [redacted] experience, as well as that of the fire chief for their safety guidance. The administrator made contact with Fire Chief [redacted] on 07/10/2024. Acting Fire Chief [redacted] returned the call on 07/15/2024, discussed the sprinkler system, and scheduled a supervised drill with surrounding fire companies in September. September 09/09/2024 is the scheduled drill. A sign-in sheet of all staff who participated will be forwarded to DHS. Chief Sinclair stated if they have a cancellation before them he will advise Walden and move forward with the fire drill. In the interim, the administrator will continue to conduct fire drills with the staff. 07/15/2024.

Moving forward:
The administrator will add this paperwork to the fire and evacuation manual. This will add to next year's inspection by being more organized. A log of all drills and staff who participate will be kept in the training log book.

Proposed Overall Completion Date: 08/21/2024

Directed:
The administrator will staff the home to ensure that all residents can be evacuated out of the home in 2 minutes and thirty seconds until a new letter is received from a fire safety expert at which time the home will meet the time specified in writing by the fire safety expert.
The administrator shall monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented ([redacted] - 10/16/2024)

181c - Self-administration Assessment

17. Requirements

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

Description of Violation

Resident #1 is not assessed to self-administer medications. The topical prescription, [redacted], was noted on the resident's nightstand. The resident stated that they apply the cream to their lower extremities, for treatment of eczema rash.

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

How this happened:
The resident has a tube of [redacted] that [redacted] applies to [redacted] arms and [redacted] asks the med techs to help [redacted] apply it to [redacted] back and legs. The administrator has a script stating the resident may keep in [redacted] room. The administrator did not realize this was an error.

Plan of correction:

181c Self administration Assessment (continued)

The administrator addressed the violation with the med tech and the residents and removed the cream till the administrator has received clearance and guidance from the Department of Human Services. The administrator and Med Tech Supervisor looked through Resident 1's medical record and located a copy of the script stating that this resident can have the cream in his room to self administer. The script is uploaded on 07/30/2024. The resident was given a key to securely lock his room when he was not in his room on 07/30/2024.

Moving forward:
The administrator has drafted a log sheet to note all residents who have been declared competent to maintain and apply their medication and creams on their own. The log sheet will be maintained and posted in the med room. The resident was issued a key to securely lock his room when he is not in his room, on 07/30/2024

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented [redacted] - 10/16/2024)

181d -Storing Medication

18. Requirements

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident #2 is assessed to self administer medications independently. Resident #2 stores their medications in two unlocked dresser drawers, located in their room. The resident stated that they do not lock their door when they leave their room.

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

How this happened:
The rooms had new door knob locks installed. The maintenance department and administrator had spare keys made. The administrator did not have enough keys made and has since had more copied.

Plan of correction:
The administrator issued a key to Resident # 2. The administrator had more spare keys made and issued resident #2 [redacted] key on 07/09/2024.

Moving forward:
The administrator drafted a log sheet with the room numbers who have keys to their rooms, on 07/10/2024. The administrator will be more diligent at issuing keys to those residents who have requested one.

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented ([redacted] - 10/16/2024)

183e - Storing Medications

19. Requirements

2600.

183e - Storing Medications *(continued)*

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

Description of Violation

Resident #3 is prescribed [redacted]. The manufacturer's directions indicate it is to be used within 28 days of the pen being opened. The home had initially labelled the pen when the pen was opened but the date rubbed off and it could not be read or verified by staff.

Plan of Correction ***Accept [redacted] - 08/22/2024)***

How this happened:
The pen was opened and dated, the date had worn off from use. When the administrator and med tech supervisor went through the cart, it was overlooked.

Plan of correction:
The administrator and med tech supervisor went through all three carts, on 07/10/2024 to ensure everything was labeled and dated, and discarded any expired medications. The carts were completed on 07/10/2024. The administrator and med tech supervisor will conduct weekly audits on the med carts. All insulin pens are now dated with the opening date and the expiration date effective 07/10/2024

Moving forward:
The administrator and med tech supervisor conduct weekly checks of three med carts to ensure all medications are labeled with the date opened and name of the resident. The insulin pens are also dated with an expiration date of 28 days from opening; effective 07/10/2024.

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented ([redacted] - 10/16/2024)

185a - Implement Storage Procedures

20. Requirements

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

Description of Violation

Resident #3's Medication Administration record noted blood glucose readings of [redacted]. However, there were no corresponding readings logged in the resident's glucometer.

Resident #10's Medication Administration record noted blood glucose readings of [redacted] However, there were no corresponding readings logged in the resident's glucometer.

During medication cart review on [redacted] it was discovered that [redacted] for Residents #5 and #6 was unaccounted for. Resident # 5's bottle was measuring at [redacted] L, but the narcotic control log was indicating that [redacted] should be in the bottle. Resident #6's [redacted] bottle was measuring at [redacted], and the narcotic control log indicated that there should be [redacted] in the bottle. The home was unable to determine what happened to the unaccounted [redacted] from both bottles. Resident #5's [redacted] was last administered on [redacted] according to the narcotic control

185a Implement Storage Procedures (continued)

log and resident #6's [redacted] was last administered on [redacted]. The home failed to follow their controlled substance policy of doing a count of controlled medications at the start and end of each shift on the medication cart.

Plan of Correction ***Accept [redacted] - 08/22/2024)***

How did this happen:
The administrator and med tech supervisor became lax in allowing another med tech to help with monitoring the medications for these and other residents. The med techs are to do narc counts with the outgoing tech and the administrator learned this was not happening. That day the med tech left abruptly and failed to do a narc count with the incoming med tech. During this situation, it was discovered the missing morphine as well. This was a dire error for Walden and the administrator and all the med tech staff.

The administrator noted the inconsistency of the glucometer readings.

Plan of correction:
Immediately upon finding the missing [redacted] the administrator treated this as a possible stolen/misappropriated medication by a med tech.

[redacted] Regional Police were notified and a report was filed with Officer [redacted] on [redacted]. The incident report number is [redacted]
Officer [redacted] conducted an investigation and personally interviewed all the med techs on [redacted] PM.
Officer [redacted] interviewed the day staff on [redacted].
Officer [redacted] and the Administrator pointed out the discrepancy on the narc log for Resident #5 as being written up incorrectly. The narc sheet was written to reflect [redacted] when in actuality the box and bottle of [redacted] was only [redacted] Resident #6 [redacted] count was off by 19 missed doses and it was determined that it was an issue of not being charted. (This has not been a problem or mistake since Staff person A abandoned [redacted] position.)
The administrator is waiting on the finalized report. Report [redacted] dated [redacted] will be submitted upon Walden receiving the report.

All med techs were retrained by [redacted], Train the Trainer RN on [redacted]
The trainer watched all med techs do a med pass and chart appropriately. This training included the proper charting of insulin readings in the proper place in the electronic MAR and on the paper log in the med room. A sign in sheet of all the techs trained was placed in the training log book.
The administrator conducted an internal investigation among the med tech staff on 07/10/2024.
On 07/11/2024 Staff Person #1, a med tech abandoned her position.

The med tech supervisor and the administrator are conducting daily audits of the med carts and counts on all narcs effective 07/09/2024 starting with the PM shift.

The missing morphine counts were reported to The Care Team Hospice company on 07/09/2024. The CAre Team responded with their manager and president and [redacted], RN. Nurse [redacted] wasted the [redacted] in question and ordered new medication for residents #5 & #6. The administrator and the care Team Hospice drafted a waste count sheet to witness the waste and sign off on the wasted products on 07/10/2024.

185a Implement Storage Procedures (continued)

New bottles of [redacted] were ordered by the Care Team and the administrator noted the beginning amounts of the bottle. The new bottles were delivered from WG pharmacy on 07/10/2024.
This was witnessed by the care team, the med tech supervisor, and the administrator.

Moving forward:
The administrator and the med tech supervisor conduct daily audits of the narc control boxes in the carts. This is charted and kept separate from the narc log book, as a backup. The administrator then reinforced the narc control policy with all med techs acknowledging the policy in a retraining conducted on 07/11/2024.

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented [redacted] - 10/16/2024)

187a - Medication Record

21. Requirements

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

Description of Violation

Resident #4 Medication administration record stated that resident takes [redacted] orally 1 tab daily. However, the label on the medication states [redacted] take 2 tabs daily.

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

How this happened:
The med tech supervisor and administrator conduct weekly checks on the med carts to look for expired medications, medications that don't match the label or the E Mar. This was missed in the drawer.

Plan of correction:
On 07/10/2024, The administrator called the pharmacy and asked for a corrected label. CVS could not accommodate this. On 07/10/2024 the Administrator then called [redacted] Pharmacy and asked them to correct the profile in the Quick Mar. Wind Gap Pharmacy profiled the medication according to the label on the bottle. [redacted] Pharmacy needed a new script showing the correction in the profile, the script was received 07/11/2024, the new profile was corrected in the QMar on 07/12/2024

Moving forward:
The administrator and the med tech supervisor will continue to monitor the med carts to ensure accuracy with the med cards matching the Quick Mar. Any inconsistency will be pulled, researched, and forwarded to the Wind Gap Pharmacy to correct errors. This procedure was enacted on 07/11/2024

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented ([redacted] - 10/24/2024)

227d - Support Plan Medical/Dental

22. Requirements

2600.

227d Support Plan Medical/Dental *(continued)*

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

Resident #7, #8, and #9 all utilize bed enabler bars for transfers out of bed and repositioning. However, the residents' charts do not reflect the specific need for the device, the intended use and any associated risks, the residents' ability to use the device safely for the purpose it was intended, and the specific device being used and whether a cover is required to meet FDA guidelines.

Plan of Correction ***Accept (- 08/22/2024)***

How did this happen:
The Med Tech Supervisor does the RASP, support, and Assessment. The supervisor had the information added in the wrong section on the RASP. This was an oversight on behalf of the med tech supervisor and the administrator. The med tech supervisor was taught incorrectly.

Plan of correction:
The Med Tech Supervisor pulled the Resident files for #7, #8, and #9 and corrected the information required for the need for the bed enabler. The resident files and RASP were properly corrected on .

Moving forward:
The administrator and the med tech supervisor will conduct monthly audits of the support and assessments of all residents within the facility. A monthly audit has been put in place to monitor the RASP for any changes that may have occurred with any resident. This has begun on

Licensee's Proposed Overall Completion Date: *08/21/2024*

Implemented (- 10/16/2024)