



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: OCTOBER 4, 2024



VS Wallingford, LLC
2700 Chestnut Parkway
Chester, Pennsylvania 19013

RE: Chestnut Ridge Retirement Living
2700 Chestnut Parkway
Wallingford, Pennsylvania 19086
License #: 141411

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection April 8 and May 8 2024, July 10 and 11, 2024, and August 5, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 141410 dated December 30, 2024 to December 30, 2024 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated December 30, 2024 to December 30, 2024 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 4, 2024 to April 4, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
82c	II	86	\$5	\$430	5 calendar days from mailing date of this letter
185a	II	86	\$5	\$430	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

[REDACTED]

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[REDACTED]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,



Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

[REDACTED]

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

Facility Information

Name: CHESTNUT RIDGE RETIREMENT LIVING License #: 14141 License Expiration: 12/30/2024
Address: 2700 CHESTNUT PARKWAY, CHESTER, PA 19086
County: DELAWARE Region: SOUTHEAST

Administrator

Name: [REDACTED]

Legal Entity

Name: VS WALLINGFORD LLC
Address: 2700 CHESTNUT PARKWAY, CHESTER, PA, 19013
Phone: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 05/19/1997 Issued By: CWOPA L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 117 Waking Staff: 88

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal, Incident Exit Conference Date: 05/09/2024

Inspection Dates and Department Representative

04/08/2024 - On-Site: [REDACTED]
04/08/2024 - On-Site: [REDACTED]
05/08/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 130 Residents Served: 86

Secured Dementia Care Unit

In Home: Yes Area: Memory Care Unit Capacity: 22 Residents Served: 19

Hospice

Current Residents: 4

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 75
Diagnosed with Mental Illness: 5 Diagnosed with Intellectual Disability: 1
Have Mobility Need: 31 Have Physical Disability: 0

Inspections / Reviews

04/08/2024 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *05/20/2024*

05/31/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *06/30/2024*

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *06/03/2024*

06/04/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *06/30/2024*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*

Follow-Up Date: *06/30/2024*

09/05/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *06/30/2024*

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

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

Based on resident 1 and staff member A interviews, on 4/5/2024, resident 1 went to the front desk to ask where the hair salon was, and staff member B, who was sitting at the front desk, took out a can of Lysol and sprayed it on [redacted] face twice. Resident stated staff member B was annoyed and very rude to them. This incident was reported to staff member A on 4/06/2024, approximately at 9:00 a.m. Staff member A reported this to [redacted] supervisor, staff member C, immediately, and staff member C reported to staff member D, who is the Director of Nursing. However, this allegation of abuse was not reported by 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.

Plan of Correction

Accept [redacted] - 05/31/2024)

Executive Director educated Director of Health and Wellness on the policy and procedure for reporting abuse/neglect and incident reporting on 4/10/2024. Director of Health and Wellness will start immediately reporting any and all accusation of abuse/neglect to the Executive Director so that the Executive Director can report and immediately start the investigation. Executive Director will be responsible for the reporting and investigation follow up. In the absence of the Executive Director, the Director of Health and Wellness will be the responsible one to the reporting and investigation and copying the Executive Director. All reportable incidents, including abuse, will be reviewed monthly at the QAPI meetings to ensure ongoing compliance.

R/P Director of Health and Wellness and Executive Director

Proposed Overall Completion Date: 05/16/2024

Licensee's Proposed Overall Completion Date: 05/16/2024

Implemented [redacted] - 08/14/2024)

16b - Incident Policies

2. Requirements

2600.

16.b. The home shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

Description of Violation

On 4/6/2024, at approximately 9:00 am, resident 1 reported an incident of abuse to staff member A. Staff member A reported this to [redacted] supervisor staff member C immediately. Staff member C reported this to staff member D, the Director of Nursing (DON). However, the home did not follow the written policies and procedures on the reporting, notification, and investigation of the incident and conditions.

Plan of Correction

Accept [redacted] - 05/31/2024)

Executive Director educated Director of Health and Wellness on the policy and procedure for reporting abuse/neglect and incident reporting on 4/10/2024. Director of Health and Wellness will start immediately reporting any and all accusation of abuse/neglect to the Executive Director so that the Executive Director can report and immediately

16b - Incident Policies (continued)

start the investigation. Executive Director will be responsible for the reporting and investigation follow up. In the absence of the Executive Director, the Director of Health and Wellness will be the responsible one to the reporting and investigation and copying the Executive Director.

R/P Director of Health and Wellness and Executive Director

Licensee's Proposed Overall Completion Date: 05/16/2024

Implemented [REDACTED] 08/14/2024)

16c - Written Incident Report**3. Requirements**

2600.

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

Description of Violation

Based on resident 1 and staff member A interviews, on 4/5/2024, resident 1 went to the front desk to ask where the hair salon was, and staff member B, who was sitting at the front desk, took out a can of Lysol and sprayed it on [REDACTED] face twice. Staff member B was annoyed and very rude to them. This incident was reported to staff member A on 4/06/2024, approximately at 9:00 a.m. Staff member A reported this to [REDACTED] supervisor, staff member C, immediately, and staff member C reported to staff member D, who is the Director of Nursing. This incident was not reported to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department.

Repeat Violation: 12/14/2023; 2/9/2023, et al; 1/30/2023, et al

Plan of Correction

Accept [REDACTED] 05/31/2024)

Executive Director educated Director of Health and Wellness on the policy and procedure for reporting abuse/neglect and incident reporting on 4/10/2024. Director of Health and Wellness will start immediately reporting any and all accusation of abuse/neglect to the Executive Director so that the Executive Director can report and immediately start the investigation. Executive Director will be responsible for the reporting and investigation follow up. In the absence of the Executive Director, the Director of Health and Wellness will be the responsible one to the reporting and investigation and copying the Executive Director.

R/P Director of Health and Wellness and Executive Director

Licensee's Proposed Overall Completion Date: 05/16/2024

Implemented [REDACTED] - 08/14/2024)

17 - Record Confidentiality**4. 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 April 9, 2024, in Med Cart #2 on the 5th floor, the medication record computer was left unlocked, unattended, and

17 - Record Confidentiality (continued)

accessible so that anyone could access it. When LR walked up to the computer, it was on with a "privacy screen" showing on the screen. When LR pressed the mouse, a resident's MAR was on the screen along with the resident's face sheet.

Plan of Correction

Accept [redacted] - 06/04/2024)

Med techs will be educated by the Memory Care Director on HIPPA and to make sure they lock the screen anytime they walk away from the med cart. This education will be completed by 5/30/2024. Memory Care Director will audit laptops on the med carts once a week for the next 3months starting on 6/6/2024.
R/P Memory Care Director/Designee

Proposed Overall Completion Date: 05/30/2024

Proposed Overall Completion Date: 09/03/2024

Licensee's Proposed Overall Completion Date: 09/03/2024

Implemented [redacted] - 09/11/2024)

18 - Compliance With Laws

5. Requirements

2600.

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

Description of Violation

The home doesn't have a sign at the entrance of the building for non-smoking. The Clean Indoor Air Act requires public places, including personal care homes, to post signs where smoking is regulated by this act. "Smoking" or "No Smoking" signs or the international "No Smoking" symbol shall be posted in each personal care home. The home should display a sign at each entrance to the home specifying whether the home allows smoking or not. If the home does not allow smoking, the home's sign should state, "This is a No Smoking Facility."

Plan of Correction

Accept [redacted] - 05/31/2024)

The sign has been posted on the front door. See photo attached.

Licensee's Proposed Overall Completion Date: 05/16/2024

Implemented [redacted] - 08/14/2024)

41c - Rights Poster

6. Requirements

2600.

41.c. The Department's poster of the list of resident's rights shall be posted in a conspicuous and public place in the home.

Description of Violation

The Department's resident's rights poster is not posted in a conspicuous and public place in the home.

41c - Rights Poster (continued)

Plan of Correction

Accept [REDACTED] - 06/04/2024)

*Resident's Rights has been posted between the elevators in the lobby (see photo attached). Executive Director will audit weekly for the next 3 months to make sure the Resident's Rights are posted. Audits started 5/20/2024.
R/P Executive Director/Designee*

Proposed Overall Completion Date: 08/20/2024

Licensee's Proposed Overall Completion Date: 08/20/2024

Not Implemented [REDACTED] - 09/11/2024)

42c - Treatment of Residents

7. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

Based on resident 1's interview, on 4/5/2024, resident 1 went to the front desk to ask where the hair salon was, and staff member B, who was sitting at the front desk, took out a can of Lysol and sprayed it on [REDACTED]'s face twice. Resident stated "The staff member sitting at the front desk was annoyed and very rude." The resident was not injured.

Plan of Correction

Accept [REDACTED] - 05/31/2024)

Executive Director reeducated the staff member on resident rights and dignity and respect on 5/9/2024. All staff will be educated on resident rights and dignity and respect upon hire. Ed will audit all new hire charts for the next 3 months to make sure all staff are educated.

R/P Executive Director/Designee

Licensee's Proposed Overall Completion Date: 08/20/2024

Not Implemented [REDACTED] - 09/11/2024)

44g - Telephone Number

8. Requirements

2600.

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

Description of Violation

The telephone numbers of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Disability Rights Pennsylvania (DRP), the local law enforcement agency, the Commonwealth Information Center, and the personal care home complaint hotline are not posted in a conspicuous and public place in the home.

44g - Telephone Number (continued)

Plan of Correction

Accept () - 06/04/2024

Poster has been posted at the front desk in the secured glass case. Please see attached photo. Executive Director will audit weekly for the next 3 months to make sure the poster remains in the locked case that is on the wall at the front desk. Audits started 5/20/2024.

R/P Executive Director/designee

Licensee's Proposed Overall Completion Date: 08/20/2024

Not Implemented () - 09/11/2024

51 - Criminal Background Check

9. Requirements

2600.

- 51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff member D, whose date of hire was ()/2024, does not have a criminal history background check available in the employee files.

Staff member E, whose date of hire was ()2020, does not have a criminal history background check available in the employee files.

Plan of Correction

Accept () - 06/04/2024

Staff D and E have had their background checks run. A new Business Office Manager has been hired and will start on 5/21/2024. Executive Director will educate the new BOM on the process of the background checks by 5/30/24. The Business Office Manager is currently auditing all current employees for background checks. These audits will be complete no later than 6/14/2024. The Business Office Manager will audit all new hire's files for completion of the background checks for the next 3 months.

R/P Business Office Manager/Executive Director/ Designee

Proposed Overall Completion Date: 09/09/2024

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

Not Implemented () - 09/11/2024

54a - Direct Care Staff

10. 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 persons E, F and G do not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

54a - Direct Care Staff (continued)

Plan of Correction

Accepted [redacted] - 05/31/2024)

All Direct Care staff persons files will be audited for high school diploma/GED or active registry status on the Pennsylvania nurse aide registry by 6/30/2024 by the BOM. All new hires will have the required documentation prior to the start of their new hire orientation. An audit tool has been created for the Business Office Manager to utilize for all new hires. The Executive Director will conduct random audits of employee hires weekly for 3 months. R/P Business Office Manager/Designee

Proposed Overall Completion Date: 06/30/2024

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

Not Implemented [redacted] - 08/14/2024)

62 - Contact List

11. Requirements

2600.

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

Description of Violation

Staff person H, the administrator, does not maintain a current list of the names, addresses, and telephone numbers of staff members, including substitute personnel and volunteers. The staff list provided included multiple employees listed as active but who are no longer employed at the facility.

Plan of Correction

Accepted [redacted] - 05/31/2024)

A new master list for all employees was created. The Executive Director and Business Office Manager will be trained on how to correctly access this report from the payroll system ADP, so an updated list may be printed at any time. This training will occur by 5/30/24.

Licensee's Proposed Overall Completion Date: 05/30/2024

Implemented [redacted] - 08/14/2024)

65a - FS Orientation 1st Day

12. 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.

65a - FS Orientation 1st Day (continued)

Description of Violation

Staff person D, whose first day of work was [REDACTED] 2024, 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 is 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 the location of smoking areas, if applicable, The location and use of fire extinguishers. Smoke detectors, fire alarms, and Telephone use and notification of emergency services.

Staff person E, whose first day of work was [REDACTED] 2020, 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 is 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 the location of smoking areas, if applicable, The location and use of fire extinguishers. Smoke detectors, fire alarms, and Telephone use and notification of emergency services.

Staff person G, whose first day of work was [REDACTED] 2024, 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 is 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 the location of smoking areas, if applicable, The location and use of fire extinguishers. Smoke detectors, fire alarms, and Telephone use and notification of emergency services.

Plan of Correction

Accept [REDACTED] - 05/31/2024)

A new orientation has been created to include all required training prior to the first day of working on the floors. This new orientation started on 05/13/2024 and will continue with all new hires. BOM will audit all employee files and update all files that are missing any required training documents. This audit will be completed by 6/30/2024.

R/P Business Office Manager/Designee

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

Not Implemented [REDACTED] - 08/14/2024)

65b - Rights/Abuse 40 Hours

13. 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 D completed [REDACTED] 40th scheduled work hour in January 2024. 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) and reporting of reportable

65b - Rights/Abuse 40 Hours (continued)

incidents and conditions.

Staff person E completed [redacted] 40th scheduled work hour in January 2020. 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) and reporting of reportable incidents and conditions.

Staff person G completed [redacted] 40th scheduled work hour in February 2024. 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) and reporting of reportable incidents and conditions.

Plan of Correction

Accept [redacted] - 05/31/2024)

New orientation created to include 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. This new orientation started on 5/13/2024 and will continue with all new hire orientations. BOM will audit all employee files to make sure all required trainings are present in the files. This audit will be completed by 6/30/2024

R/P Business Office Manager/Designee

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

Not Implemented ([redacted] - 08/14/2024)

65c - Ancillary Staff Orientation

14. Requirements

2600.

65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Ancillary staff person I, whose first day of work was [redacted]/2022, did not have a general orientation to [redacted] specific job functions.

Plan of Correction

Accept [redacted] - 05/31/2024)

All ancillary staff persons will have general orientation to their specific job functions prior to working in the capacity. This will be part of the new hire orientation. BOM will audit all ancillary staff members employee files to ensure all required training and documents are in the file. This audit will be completed by 6/30/2024.

R/P Business Office Manager/Designee

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

Implemented [redacted] - 08/14/2024)

65c - Ancillary Staff Orientation (continued)

65d - Initial Direct Care Training

15. 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 E, hired [REDACTED] 2020, began providing unsupervised ADL services on 1/09/2020. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Direct care staff person F, hired on [REDACTED] 2023, began providing unsupervised ADL services on 11/21/2023. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Direct care staff person G, hired on [REDACTED] /2024, began providing unsupervised ADL services on 2/20/2024. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction

Accept [REDACTED] - 05/31/2024)

A new Direct Care staff training has been included in the new hire orientation as of [REDACTED] 2024. New hires will be assigned a mentor to ensure they are properly trained before providing hands on ADL assistance to residents. The BOM will audit all Direct Care staff employee files to ensure every direct care staff member has had the required training and documents are in the employee files. This audit will be completed by 6/30/2024.

R/P Business Office Manager/Designee

65d - Initial Direct Care Training (continued)

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

Not Implemented [REDACTED] 08/14/2024)

65e - 12 Hours Annual Training

16. 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 E received 0 hours of annual training in the training year 2023.

Plan of Correction

Accepted [REDACTED] 05/31/2024)

Direct Care staff training has been included in the new hire orientation as of 5/13/2024. BOM will audit all Direct Care staff employee files to ensure every direct care staff member has had the required training and documents are in the employee files. This audit will be completed by 6/30/2024.

R/P Business Office Manager/Designee

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

Implemented [REDACTED] - 08/14/2024)

65g - Annual Training Content

17. 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 E did not 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 during the training year 2023.

Staff person I, did not 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 during the training year 2023.

65g - Annual Training Content (continued)

Plan of Correction

Accept [redacted] 05/31/2024)

Annual training has been updated to include the areas listed above. These trainings will be added to our monthly town hall meetings that are held on the last Thursday of the month. New BOM will be trained to ensure all regulatory trainings are up to date in employee files.

R/P Business Office Manager/designee

Licensee's Proposed Overall Completion Date: 05/20/2024

[redacted] - 08/14/2024)

66b - Training Plan Content

18. Requirements

2600.

66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

- 1. The name, position and duties of each direct care staff person.
- 2. The required training courses for each staff person.
- 3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home staff training plan for 2024 does not include mandatory reporting, abuse, neglect, or reportable incidents and conditions

Plan of Correction

Accept [redacted] 05/31/2024)

The new training plan has been put into place to include mandatory reporting, abuse, neglect and reportable incidents. Please see attached. These trainings will be included in our Monthly Towne Hall meetings that are held the last Thursday of the month. Training binders will be kept in the BOM office.

R/P Business Office Manager/Designee

Licensee's Proposed Overall Completion Date: 05/20/2024

Implemented [redacted] - 08/14/2024)

82c - Locking Poisonous Materials

19. 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 4/09/2024, a bottle of Head and Shoulders shampoo and a box of alcohol prep pads with a manufacturer's label indicating "Please keep out of reach of children; please contact the poison control center" were unlocked, unattended, and accessible to resident 2 in room [redacted]. Not all the residents of the home, including resident 2, have been assessed as capable of recognizing and using poisons safely.

On 4/09/2024, a can of Right Guard Deodorant and a box of 6 Dove Deodorants with a manufacturer's label indicating "Please keep out of reach of children; please contact the poison control center" were unlocked, unattended, and accessible to resident 3 in room [redacted]. Not all the residents of the home, including resident 3, have been assessed as capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials (continued)

Repeat Violation: 2/21/2024

Plan of Correction

Accept (████) 06/04/2024)

Locks have been added to all the kitchenette cabinets in the memory care units as of 5/16/24. Staff will ensure that all poisonous materials will be locked when staff members are not present to assist with the poisonous materials. Memory Care Director will audit weekly to ensure that all poisonous materials are locked up. These audits began on 5/17/24 and will continue for the next 3 months.

R/P Memory Care Director/Designee

Licensee's Proposed Overall Completion Date: 08/17/2024

Not Implemented (████) - 09/11/2024)

85a - Sanitary Conditions

20. Requirements

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

Description of Violation

On April 8, 2024, the toilet in the lower-level bathroom had brown stains that appeared to be feces all around the toilet lid.

On 4/09/2024, the blanket for resident 1 in room █████ had brown stains that looked like dry blood.

Plan of Correction

Accept (████) 06/04/2024)

On 4/8/2024 the toilet was cleaned by housekeeping staff immediately after they were notified.
On 4/9/2024 resident 1 blanket was cleaned and returned to her bed.
On 4/9/2024 resident 4 trash can was emptied, and extra bags were placed in the bottom of the trash can. Housekeeping Supervisor is conducting audits weekly to ensure all public bathrooms are kept in sanitary conditions. These audits started on 4/23/24.
Direct Care staff has been educated to check apartment trash cans and empty daily and to also replace with new bags. All soiled linens should be washed and returned as soon as they have been laundered. This to also include making the bed. The training was completed on 4/22/2024.
Housekeeping Supervisor/Director of Health and Wellness/ Designee

Licensee's Proposed Overall Completion Date: 07/23/2024

Not Implemented (████) - 08/14/2024)

85e - Trash Outside Home

21. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

85e - Trash Outside Home (continued)

[Redacted content]

86b - Bathroom

22. Requirements

2600.

86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathroom in room 608 belonging to resident 5 does not have an operable window or ventilation fan. The vent is inoperable, and there is no window in the bathroom.

Plan of Correction

Accept [Redacted] - 05/31/2024)

Maintenance Director fixed the fan in 608 bathroom on 4/11/2024. Maintenance Director has added a monthly audit to the TELs system as a reminder to make sure fans are in working order.

R/P Maintenance Director/Designee

Licensee's Proposed Overall Completion Date: 05/20/2024

Implemented [Redacted] - 08/14/2024)

101j3 - Bed/Linens/Pillows/Blankets

24. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 4/09/2024, the bed for resident 1 in room 704 did not have bed sheets. Bedsheets were taken approximately at 7:30 a.m., and at 10:30 a.m., the bed still has no bedsheets. Resident 1 expressed her desire to lay down on the bed.

Plan of Correction

Repeated Violation: 2/9/2023, et al

Accept [Redacted] - 05/31/2024)

Direct care staff person was educated by the Health and Wellness coordinator, on 4/11/2024 to make the beds with fresh clean linens immediately and to take the soiled items to be laundered.

R/P Health and Wellness Coordinator/Designee

Licensee's Proposed Overall Completion Date: 05/20/2024

Not Implemented [Redacted] - 08/14/2024)

101j4 - Bedroom Storage Area

25. 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

Bedroom 404 belonging to resident 3 doesn't have any furniture, including a chest of drawers.

Plan of Correction

Accept [redacted] - 05/31/2024)

All required furniture was placed in the resident's room on 4/10/2024 by the Maintenance Director. All required furniture and supplies will be placed in the resident's rooms prior to moving them or they move in. Maintenance Director will audit all moves and move ins for the next 3 months.

R/P Maintenance Director/Designee

Licensee's Proposed Overall Completion Date: 08/20/2024

Implemented [redacted] - 09/11/2024)

101j5 - Bedside Table/Shelf

26. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

- 5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf beside resident 3's bed in bedroom 404.

Plan of Correction

Accept [redacted] - 05/31/2024)

All required furniture was placed in the resident's room on 4/10/2024 by the Maintenance Director. All required furniture and supplies will be placed in the resident's rooms prior to moving them or they move in. Maintenance Director will audit all moves and move ins for the next 3 months.

R/P Maintenance Director/Designee

Licensee's Proposed Overall Completion Date: 08/20/2024

Not Implemented [redacted] - 09/11/2024)

101j7 - Lighting/Operable Lamp

27. 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.

Description of Violation

Residents 3, 5, and 6 do not have access to a source of light that can be turned on or off at bedside.

Plan of Correction

Accept [redacted] - 05/31/2024)

All required furniture was placed in the resident's room on 4/10/2024 by the Maintenance Director. All required

101j7 - Lighting/Operable Lamp (continued)

furniture and supplies will be placed in the resident's rooms prior to moving them or they move in. Maintenance Director will audit all moves and move ins for the next 3 months.

R/P Maintenance Director/Designee

Licensee's Proposed Overall Completion Date: 08/20/2024

Not Implemented [redacted] - 09/11/2024)

102h - Toilet Paper

28. Requirements

2600.

102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 4/09/2024, there was no toilet paper in the bathroom of room 503 belonging to resident 7.

Plan of Correction

Accept [redacted] - 06/04/2024)

Toilet paper was provided to this resident immediately. Housekeeping Supervisor will do random audits to ensure all residents are provided toilet paper daily and as needed. Random audits will be conducted started the week of 4/08/24 and will continue for the next 3 months.

R/P Housekeeping Supervisor/Designee

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

Implemented [redacted] - 08/14/2024)

103e - Left Overs

29. Requirements

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 4/09/2024, there were six plates of salad in the kitchen refrigerator, unlabeled and undated.

In the main kitchen walk-in freezer, there were a bag of chicken breast, a bag of chicken wings, a bag of crab meat, and two frozen turkeys that were unlabeled and undated.

In the main kitchen area, there were 4 bags of 12 hamburger buns each, 4 bags of 12 hot dog rolls, 11 bags of slice bread, and a bag of mini buns that were unlabeled and undated.

Plan of Correction

Accept [redacted] 06/04/2024)

Dining Director corrected these errors immediately and will conduct weekly audits of food to ensure everything is dated correctly. These audits started the week of 4/15/24 will continue for 3 months.

R/P Dining service Director/Designee

Proposed Overall Completion Date: 07/19/2024

Licensee's Proposed Overall Completion Date: 07/19/2024

Not Implemented [redacted] - 08/14/2024)

103f - Refrigerator/Freezer Temps

30. Requirements

2600.

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

Description of Violation

On 4/09/2024, the temperature in the walk-in freezer at 2:49 p.m. was 30 degrees Fahrenheit, and at 3:30 p.m., it was 10 degrees Fahrenheit.

Plan of Correction

Accept [redacted] - 06/04/2024)

On 4/9/2024 a food order was delivered by Sysco. The dining Service Director was putting food away in the walk in freezer right before the inspection took place. This caused the temperature to drop. The walk in freezer was brought to correct temperature before the surveyor exited the building that day. Dining Service Director is doing weekly audits since this day and will be completed by 5/30/2024. Audits began on 4/09/24

R/P Dining Service Director/Designee

Licensee's Proposed Overall Completion Date: 06/03/2024

Not Implemented [redacted] - 08/14/2024)

105g - Lint Removal and Duct Cleaning

31. 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

On 4/09/2024, there was a large accumulation of lint in the lint trap of the 8th floor laundry room dryer. There were no clothes in the dryer at the time.

Plan of Correction

Accept [redacted] - 05/31/2024)

Lint trap was cleaned immediately, and Audits were put into place to ensure that lint traps are cleaned after every dryer use. These audits will be complete by 5/30/2024.

R/P Maintenance Director/Designee

Licensee's Proposed Overall Completion Date: 05/30/2024

Implemented [redacted] - 08/14/2024)

107b - Emergency Procedures

32. Requirements

2600.

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

1. Contact information for each resident's designated person.
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.

107b - Emergency Procedures (continued)

- 4. Means of transportation in the event that relocation is required.
- 5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.
- 6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

The home written emergency preparedness plan does not include the contact information for each resident's designated person.

Plan of Correction

Accept

and 4th floor

nursing area for anyone to view. The resident's face sheets are kept in a binder in the Director of Health and Wellness and Memory Care Director office for HIPPA privacy.

Licensee's Proposed Overall Completion Date: 05/20/2024

Implemented () 08/14/2024)

123b - Emergency Procedures Posted

33. Requirements

- 2600.
- 123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction

Accept () - 06/04/2024)

The Emergency preparedness plan has been placed at the reception desk and is easily accessible for all to read. Lead concierge will audit weekly starting the week of 6/3/24 and continue for the next 3 months to make sure the binder with the emergency preparedness plan is at the front desk.
R/P Lead Concierge/Designee

Licensee's Proposed Overall Completion Date: 09/06/2024

Implemented () - 09/11/2024)

124 - Notice to Fire Department

34. 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 does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction

Accept () 05/31/2024)

This letter was sent on 4/17/2024 to (). Please see letter attached.

Licensee's Proposed Overall Completion Date: 05/20/2024

124 - Notice to Fire Department (continued)

Implemented [REDACTED] - 08/14/2024)

141a 1-10 Medical Evaluation Information

35. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician’s assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department’s request.

Description of Violation

Resident 3's medical evaluation, dated [REDACTED]/2024, has the special health or dietary needs of the resident as None. Resident 3 resides in the special memory care unit.

Resident 8's medical evaluation, dated [REDACTED] 2023, does not include a medication regimen, contraindicated medications, or medication side effects.

Resident 9's medical evaluation, dated [REDACTED] 023, does not include a medication regimen, contraindicated medications, or medication side effects.

Resident 10's medical evaluation, dated [REDACTED]/2023, does not include the medical information pertinent to a diagnosis and treatment in case of an emergency.

Resident 11's medical evaluation, dated [REDACTED] 024, does not include the medical information pertinent to diagnosis and treatment in case of an emergency, the special health or dietary needs, or the body positioning of the resident.

Resident 12's medical evaluation, dated [REDACTED] 2024, does not include the medical information pertinent to a diagnosis and treatment in case of an emergency.

Resident 13's medical evaluation, dated [REDACTED]/2024, does not include the medical information pertinent to diagnosis and treatment in case of an emergency or the special health or dietary needs.

Plan of Correction

Accept [REDACTED] - 06/04/2024)

An audit tool was created to ensure all medical evaluations are completed correctly. This tool was implemented on 5/20/24. Audits began on 5/20/24. The Director of Health and Wellness and the Director of Memory Care will be responsible for completing these audits. These audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance.

R/P Director of Health and Wellness/Memory Care Director/Designee

141a 1-10 Medical Evaluation Information (continued)

Licensee's Proposed Overall Completion Date: 08/20/2024

Implemented [REDACTED] 09/11/2024)

141b1 - Annual Medical Evaluation

36. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident 8's most recent medical evaluation was not completed as of [REDACTED] 2024. The resident's previous medical evaluation was completed on 3/15/2023.

Plan of Correction

Accept [REDACTED] 06/04/2024)

A tickler system has been created. The Executive Director implemented this system on 5/20/24. The Director of Health and Wellness and the Director of Memory Care will be responsible for completing and updating this ticker system. The Executive Director or designee will complete random DME audits on a bi-weekly basis for 3 months to monitor for ongoing compliance. Audits to start on 6/7/2024.

R/P Director of Health and Wellness/Memory Care Director/Executive Director

Licensee's Proposed Overall Completion Date: 09/06/2024

Not Implemented [REDACTED] 09/11/2024)

181c - Self-administration Assessment

37. 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

On April 9, 2024, there was a bottle of acetaminophen caplets, 500 mg, an extra-strength muscle rub cream, Hydrophilic wound dressing cream, eye drops, and two packs of Tylenol extra-strength on top of a small table in room [REDACTED] belonging to resident 4. Resident 4 states that [REDACTED] does not self-administer medications. Resident 4 has not been assessed by a physician, physician's assistant, or certified registered nurse practitioner regarding his ability to self-administer and the need for medication reminders.

Plan of Correction

Accept [REDACTED] - 06/04/2024)

The Executive Director will be sending out correspondence to families reminding them that all medications need to be brought directly to the nurse's station to safeguard our resident's health. This correspondence will be sent by 06/04/24. Residents will be re-educated at the next Town Hall on 6/11/24 that they are not to have any OTC medications in their rooms if the facility is administering their medications. The Director of Health and Wellness and the Director of Memory Care will conduct random room checks every month to ensure so medications are found in residents' rooms that do not self-administer medications. Audits will start the week of 6/3/24

Licensee's Proposed Overall Completion Date: 09/06/2024

181c - Self-administration Assessment (*continued*)*Not Implemented* [REDACTED] 09/14/2024)

182b - Prescription Medication

38. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On March 3, 2024, staff member J, who is a med tech, administered Ozempic injections to resident 9. The home does not have a waiver for staff member J, who is non-licensed staff and administers this medication.

On March 10 and 24, 2024, staff member K, who is a med tech, administered Ozempic injections to resident 9. The home does not have a waiver for staff member K, who is non-licensed staff and administers this medication.

On March 17, 2024, staff member L, who is a med tech, administered Ozempic injections to resident 9. The home does not have a waiver for staff member L, who is non-licensed staff and administers this medication.

Plan of Correction*Accept* [REDACTED] - 05/31/2024)

On 4/10/24, the Executive Director educated the Director of Health and Wellness and the Director of Memory Care that only licensed nurses were able to administer Ozempic injections. Our LPNs are now the only staff to administer this medication. The Executive Director will be sending out correspondence to families reminding them that all medications need to be brought directly to the nurse's station to safeguard our residents health. This correspondence will be sent by 5/25/24. Residents will be re-educated at the next Town Hall on 6/11/24 that they are not to have any OTC medications in their rooms if the facility is administering their medications. The Director of Health and Wellness and the Director of Memory Care will conduct random room checks every month to ensure so medications are found in residents' rooms that do not self administer medications.

182b - Prescription Medication (continued)

Licensee's Proposed Overall Completion Date: 06/11/2024

Not Implemented [redacted] 08/14/2024)

183b - Meds and Syringes Locked

39. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On April 9, 2024, there was a bottle of acetaminophen caplets, 500 mg, an extra-strength muscle rub cream, Hydrophilic wound dressing cream, eye drops, and two packs of Tylenol extra-strength on top of a small table in room [redacted] unlocked, unattended, and accessible to resident 4.

Plan of Correction

Accept [redacted] - 05/31/2024)

All medication technicians and LPNs will be re-educated on 5/30/24 on proper medication administration and storage of medications by the Director of Health and Wellness. The Director of Health and Wellness and the Director of Memory Care will conduct random resident room checks for medications on a weekly basis for 6 months. They will report their findings to the Executive Director at the monthly QAPI meeting, who will monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: 05/30/2024

Not Implemented [redacted] - 08/14/2024)

183e - Storing Medications

40. Requirements

2600.

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

Lacosamide 100 mg tablet, prescribed for resident 14, was in a blister card. The foil on the back of pill #22 had been torn and taped.

Tramadol HCL 50 mg tablet, prescribed for resident 15, was in a blister card. The foil on the back of pill #14 and #22 has an opening in it.

Diazepam 2 mg tablet, prescribed for resident 15, was in a blister card. The foil on the back of pill #8 has an opening in it.

Oxycodone HCL 5 mg, prescribed for resident 16, was in a blister card. The foil on the back of pill #6 has an opening in it.

Repeated Violation: 12/14/2023

Plan of Correction

Accept [redacted] - 05/31/2024)

The Director of Health & Wellness or designee will conduct weekly medications cart audits. Should any medications be found coming out of the foil - together with another LPN or med tech, that medication will be wasted and documented on the MAR. This audit will be implemented on 5/30/24. These audits will be reviewed monthly at

183e - Storing Medications (continued)

QAPI by the Executive Director to monitor for ongoing compliance

Licensee's Proposed Overall Completion Date: 05/30/2024

Not Implemented [redacted] - 08/14/2024)

185a - Implement Storage Procedures

41. 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 9's glucometer has a reading of 96. However, there was no date, no time on the glucometer, or data on the resident log form.

Resident 17's glucometer has readings of 149, 139, and 203. However, there was no date, no time on the glucometer, or data on the resident log form.

Repeated Violation: 2/9/2023, et al.

Plan of Correction

Accept [redacted] - 05/31/2024)

Medication Technicians will be re-educated on the proper use and documentation of blood sugar checks using glucometers by the Director of Health & Wellness on 5/30/24. The Director of Health and Wellness and the Director of Memory Care will conduct monthly glucometer audits for the next 6 months to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: 05/30/2024

Not Implemented [redacted] - 08/14/2024)

191 - Resident Right to Refuse

42. 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

According to the interview with resident 1, the resident states that [redacted] has been asking the staff members to identify the prescription name that the resident is being administered at the time of administration, however the staff member will not give the resident that information.

Plan of Correction

Accept [redacted] - 05/31/2024)

All medication technicians will be re-educated on 5/30/24 on Resident Rights and their rights with medications, including the right to refuse and they right to be told what medications they were being administered.

Licensee's Proposed Overall Completion Date: 5/30/2024

Implemented [redacted] - 08/14/2024)

224a - Preadmission Screen Form

43. Requirements

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 2 was admitted to the home on [REDACTED]/2023. However, the resident preadmission screening form was completed on 4/26/2023.

Repeat Violation: 2/21/2024, 12/14/2023, 1/30/23, et al

Plan of Correction

Accept [REDACTED] - 06/04/2024)

The Executive Director will be re-educating the Director of Health and Wellness and the Director of Memory Care on the proper completion of required admission paperwork including the prescreen assessment form and the DME. This training will occur on 5/23/24. Director of Health and Wellness and Memory Care Director will audit all new admission for proper completion of required admission paperwork starting with all new admissions for the month of June starting 6/1/24 and continue for the next 3 months.

Licensee's Proposed Overall Completion Date: 09/06/2024

Implemented [REDACTED] - 09/11/2024)

225a - Assessment 15 Days

44. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident 8 was admitted to the home on [REDACTED] 2023. However, the resident's initial assessment was not completed until 4/15/2023.

Plan of Correction

Accept [REDACTED] - 06/04/2024)

The Executive Director will be re-educating the Director of Health and Wellness and the Director of Memory Care on the proper completion and timelines for all new admission. They will audit all new admissions for proper completion of required admission paperwork starting with all new admissions for the month of June starting 6/1/24 and continue for the next 3 months. care plans. This assessment training will take place on 5/23/24.

R/P Director of Health and Wellness and Memory Care Director

Licensee's Proposed Overall Completion Date: 09/06/2024

Implemented [REDACTED] - 09/11/2024)

45. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for resident 10, who was admitted to the home on [REDACTED] 023.

225a - Assessment 15 Days (continued)

Plan of Correction

Directed [redacted] - 06/04/2024)

The Executive Director will be re-educating the Director of Health and Wellness and the Director of Memory Care on the proper completion and timelines for all care plans. This RASP training will take place on 5/23/24. Director of Health and Wellness and Memory Care Director will audit all new admission for proper completion of required admission paperwork starting with all new admissions for the month of June starting 6/1/24 and continue for the next 3 months.

R/P Director of Health and Wellness and Memory Care Director

In addition to the above plan of correction by 6/30/24: An assessment for the resident will be completed. An audit of all residents records will be completed to ensure all residents have a completed assessment [redacted]

Proposed Overall Completion Date: 09/06/2024

Directed Completion Date: 09/06/2024

Implemented [redacted] - 09/11/2024)

46. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident 11's initial assessment is missing the date when it was finalized.

Plan of Correction

Accept [redacted] - 06/04/2024)

The Executive Director will be re-educating the Director of Health and Wellness and the Director of Memory Care on the proper completion and timelines for all care plans. This RASP training will take place on 5/23/24. Director of Health and Wellness and the Director of Memory Care will be auditing all new admissions starting 6/1/24 and continue for the next 3 months.

R/P Director of Health and Wellness/Director of Memory Care

Repeated Violation: 1/30/2023, et al

Licensee's Proposed Overall Completion Date: 09/06/2024

Implemented [redacted] - 09/11/2024)

225c - Additional Assessment

47. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 3's current assessment was completed on [redacted]/2024. However, the resident's previous assessment was completed on 2/05/2022.

225c - Additional Assessment (continued)

Plan of Correction

Accept [REDACTED] /04/2024)

The Executive Director will be re-educating the Director of Health and Wellness and the Director of Memory Care on the proper completion and timelines for all care plans. This RASP training will take place on 5/23/24. Director of Health and Wellness and the Director of Memory Care will be auditing all new admissions starting 6/1/24 and continue for the next 3 months.

R/P Director of Health and Wellness/Director of Memory Care

Licensee's Proposed Overall Completion Date: 09/06/2024

Implemented [REDACTED] - 09/11/2024)

226a - Mobility Assessment

[REDACTED]

Repeated Violation: 1/30/2023, et al

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

227a - Support Plan 30 Days

49. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

227a - Support Plan 30 Days (continued)

Description of Violation

Resident 10's date of admission was [REDACTED] 2023. However, the home did not develop and implement a written support plan within 30 days of admission to the home.

Plan of Correction

Directed ([REDACTED] 06/04/2024)

The Executive Director will be re-educating the Director of Health and Wellness and the Director of Memory Care on the proper completion and timelines for all care plans. This RASP training will take place on 5/23/24. Director of Health and Wellness and the Director of Memory Care will be auditing all new admissions starting 6/1/24 and continue for the next 3 months.

R/P Director of Health and Wellness/Director of Memory Care

In addition to the above plan of correction by 6/30/24: A support plan for the resident will be completed. An audit of all residents records will be completed to ensure all residents have a completed support plan. [REDACTED]

Proposed Overall Completion Date: 09/06/2024

Directed Completion Date: 09/06/2024

Implemented ([REDACTED] - 09/11/2024)

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

227c - Support Plan Revision (continued)*R/P Director of Health and Wellness/Director of Memory Care***Licensee's Proposed Overall Completion Date:** 09/06/2024**Implemented** [REDACTED] - 09/11/2024)**227d - Support Plan Medical/Dental****51. 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

Resident 8's initial assessment, dated 4/15/2023, indicates the resident has a minimal problem with short-term memory. The resident's support plan, dated 4/15/2023, does not document how this need will be met. Resident assessment also specifies that the resident has a moderate problem with turning and positioning; however, the description of the service says it is not applicable.

Resident 11's initial assessment does not include a description of the service need or a plan to meet the service need for securing health care, doing laundry, shopping, managing finances, using the telephone, caring for personal possessions, using a prosthetic device, or hallucinating.

Plan of Correction**Accepted** [REDACTED] - 06/04/2024)

The Executive Director will be re-educating the Director of Health and Wellness and the Director of Memory Care on the proper completion and timelines for all care plans. This RASP training will take place on 5/23/24. The Executive Director will conduct random RASP audits monthly for 6 months to ensure ongoing compliance starting 6/6/24.

Licensee's Proposed Overall Completion Date: 12/06/2024**231b - Medical Evaluation****52. Requirements**

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident 2 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED] 2023; however, the resident medical

231b - Medical Evaluation (continued)

evaluation was completed on 4/27/2023.

Plan of Correction

Accept [redacted] - 05/31/2024)

A tickler system has been created. The Executive Director implemented this system on 5/20/24. The Director of Health and Wellness and the Director of Memory Care will be responsible for completing and updating this ticker system. The Executive Director or designee will complete random DME audits on a bi-weekly basis for 6 months to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: 05/20/2024

Implemented [redacted] - 08/14/2024)

231c - Preadmission Screening

53. Requirements

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident 12 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] 2024. However, the home did not complete a written cognitive preadmission screening in collaboration with a physician or a geriatric assessment team and documented on the department's preadmission screening form within 72 hours prior to the resident's admission to the secured dementia care unit.

Repeat Violation: 2/21/2024

Plan of Correction

Accept [redacted] - 06/04/2024)

The Executive Director will be re-educating the Director of Health and Wellness and the Director of Memory Care on the proper completion of required admission paperwork including the prescreen assessment form and the DME. This training will occur on 5/23/24. They will audit all new admissions for proper completion of required admission paperwork starting with all new admissions for the month of June starting 6/1/24 and continue for the next 3 months. care plans. This assessment training will take place on 5/23/24.

R/P Director of Health and Wellness and Memory Care Director

Licensee's Proposed Overall Completion Date: 09/06/2024

Implemented [redacted] 09/11/2024)

231e - No Objection Statement

54. 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 3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/2024. The home has no documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secure dementia unit.

231e - No Objection Statement (continued)

Plan of Correction

Accept [REDACTED] - 05/31/2024)

The Executive Director will re-educate the Director of Sales and Marketing and the Director of Memory Care on the proper contract addendum that needs to be completed prior to a resident being admitted to the secured memory care unit. This training will be conducted on 5/23/24. The Executive Director will conduct random monthly audits of memory care resident contracts monthly for 6 months to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 05/23/2024

Implemented [REDACTED] - 08/14/2024)

231f - Assessed Annually

55. Requirements

2600.

231.f. In addition to the requirements in § 2600.225 (relating to initial and annual assessment), the resident shall also be assessed annually for the continuing need for the secured dementia care unit.

Description of Violation

Resident 18 was assessed for the need for a Secure Dementia Care Unit (SDCU) on [REDACTED] 2022, and was not assessed again as of today, April 8, 2024.

Plan of Correction

Accept [REDACTED] - 05/31/2024)

An audit tool was created to ensure all medical evaluations are completed correctly. This tool was implemented on 5/20/24. The Director of Health and Wellness and the Director of Memory Care will be responsible for completing these audits. These audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: 05/20/2024

Implemented [REDACTED] 08/16/2024)

234a - Admission Support Plan

56. Requirements

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident 2 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED] 2023. However, the resident's initial support plan was completed on 4/30/2023.

Resident 3 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED] 2024. However, the home did not develop, implement, or document a record for the resident during or within 72 hours.

Resident 12 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED] 2024. However, the home did not develop, implement, or document a record for the resident during or within 72 hours.

234a - Admission Support Plan (continued)

Resident 13 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]/2024. However, the home did not develop, implement, or document a record for the resident during or within 72 hours.

Resident 18 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED], 2022. However, the initial support plan for the resident was completed on August 14, 2022.

Plan of Correction

Accept [REDACTED] - 06/04/2024)

The Executive Director will be re-educating the Director of Health and Wellness and the Director of Memory Care on the proper completion and timelines for all care plans. This RASP training will take place on 5/23/24. The Executive Director will conduct random RASP audits monthly for 6 months to ensure ongoing compliance. Audits will begin 6/6/24

Licensee's Proposed Overall Completion Date: 12/06/2024

234b - Support Plan Needs Elements

57. Requirements

2600.

234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

Resident 2 initial support plan was completed on [REDACTED]/2023. However, the home selected the behavioral or cognitive need and degree as a moderate problem but did not specify the description of the service need or plan to meet the service for irritability, judgement, aggression, hallucinations, understanding instructions, ability to use and avoid poisonous materials, or caring for personal possessions.

Resident 18 initial support plan was completed on [REDACTED]/2022. However, the home did not specify the resident personal care need and degree for agitation, hallucinations, bowel management, or managing health care.

Plan of Correction

Accept [REDACTED] - 06/04/2024)

The Executive Director will be re-educating the Director of Health and Wellness and the Director of Memory Care on the proper completion and timelines for all care plans. This RASP training will take place on 5/23/24. The Executive Director will conduct random RASP audits monthly for 6 months to ensure ongoing compliance. Audits will begin 6/6/24

234d - Support Plan Revision (*continued*)*Implemented* (████) - 08/14/2024)

251b - Record Entries Legible

60. Requirements

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Resident 2's date of admission was █████/2023, and the resident's pre-admission cognitive screening was completed on 4/26/2023. The entries in the resident's cognitive screening dates were overwritten.

Plan of Correction*Accept* (████) - 06/04/2024)

The Executive Director will be re-educating the Director of Health and Wellness and the Director of Memory Care on the proper completion and timelines for all care plans. This RASP training will take place on 5/23/24. The Executive Director will conduct random RASP audits monthly for 6 months to ensure ongoing compliance. Audits will begin 6/6/24

Licensee's Proposed Overall Completion Date: 12/06/2024

252 - Record Content

61. Requirements

2600.

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

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.

252 - Record Content (continued)

- 18. An inventory of the resident’s personal property as voluntarily declared by the resident upon admission and voluntarily updated.
- 19. An inventory of the resident’s property entrusted to the administrator for safekeeping.
- 20. The financial records of residents receiving assistance with financial management.
- 21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
- 22. Copies of transfer and discharge summaries from hospitals, if available.
- 23. If the resident dies in the home, a copy of the official death certificate.
- 24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
- 25. A copy of the resident-home contract.
- 26. A termination notice, if any.

Description of Violation

Resident 3 had an incident on [REDACTED] 2024, where the resident left the facility. However, the copy of the incident report for the individual was not included in the resident's record.

Resident 10 face sheet does not include the color of [REDACTED] hair or eyes.

Plan of Correction

Accepted [REDACTED] - 05/31/2024)

A new admission checklist has been created to ensure all required information is captured in the resident record upon admission. This checklist was implemented 5/20/24 and will be completed by the Director of Health & Wellness and the Director of Memory Care. The Executive Director will review these checklists monthly at QAPI to monitor for ongoing compliance.

Licensee's Proposed Overall Completion Date: 05/20/2024

Not Implemented [REDACTED] - 08/14/2024)

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

Facility Information

Name: *CHESTNUT RIDGE RETIREMENT LIVING* License #: *14141* License Expiration: *12/30/2024*
Address: *2700 CHESTNUT PARKWAY, CHESTER, PA 19086*
County: *DELAWARE* Region: *SOUTHEAST*

Administrator

Name: [REDACTED]

Legal Entity

Name: *VS WALLINGFORD LLC*
Address: *2700 CHESTNUT PARKWAY, CHESTER, PA, 19013*
[REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *10/19/1998* Issued By: *Commonwealth of PA, L&I*
Type: *Other* Date: *10/19/1998* Issued By: *Commonwealth of PA, L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *148* Waking Staff: *111*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Monitoring* Exit Conference Date: *07/11/2024*

Inspection Dates and Department Representative

07/10/2024 - On-Site: [REDACTED]
07/11/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *130* Residents Served: *89*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *50* Residents Served: *35*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *89*
Diagnosed with Mental Illness: *26* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *59* Have Physical Disability: *2*

Inspections / Reviews

07/10/2024 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *08/24/2024*

08/28/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *09/04/2024*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *09/04/2024*

09/05/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *09/04/2024*

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

54a - Direct Care Staff (continued)

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, whose hire date is [REDACTED]/24, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction

Accept [REDACTED] - 08/28/2024)

Executive Director has educated the Business Office Manager on proper documentation needed for new hires on 7/15/2024. The BOM will complete the employee file checklist for every new hire going forward. Business Office Manager and ED will audit all new hire files monthly for accuracy and documentation for the next 6 months starting on 8/21/2024. A new Hire checklist has been added to the employee file. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.

R/P Executive Director/Business Office Manager/Designee

Proposed Overall Completion Date: 01/21/2025

Licensee's Proposed Overall Completion Date: 01/21/2025

64c - Annual Training

4. Requirements

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person C, the home's Administrator/Executive Director, does not have verification of annual training being completed in training year 2023.

Plan of Correction

Accept [REDACTED] - 08/28/2024)

Executive Director was not able to obtain a copy of the trainings from the previous employer. On 04/2024 inspection the surveyor advised that the Executive Director had until December 2024 to obtain the proper training. Executive Director will start working on obtaining the proper training no later than 8/26/2024 and will have completed by 12/31/2024. Executive Director paid for Subscription to CEU academy to start online CEUs no later than 8/26/2024. Please see paid receipt attached.

R/P Executive Director

R/P Executive Director/Designee

Licensee's Proposed Overall Completion Date: 12/31/2024

65a - FS Orientation 1st Day

5. Requirements

2600.

65a - FS Orientation 1st Day (continued)

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]/24, did not receive orientation on the following topics: smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, telephone use and notification of emergency services.

Staff person B, whose first day of work [REDACTED] 24, did not receive orientation on the following topics: smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, telephone use and notification of emergency services.

Staff person D, whose first day of work was [REDACTED]/24, did not receive orientation on the following topics: smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, telephone use and notification of emergency services.

Staff person E, whose first day of work was [REDACTED] 24, did not receive orientation on the following topics: smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, telephone use and notification of emergency services.

Staff person F, whose first day of work was [REDACTED] 24, did not receive orientation on the following topics: smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, telephone use and notification of emergency services.

Plan of Correction

Accepted [REDACTED] - 08/28/2024)

Staff member E is no longer employed here.

Staff persons A,B,D, and F have been trained on 8/22/2024 on the smoking safety procedures, the home's smoking policy and location of smoking areas, telephone use and notification of emergency services, by the Maintenance Director. Maintenance Director will train all new hires on these procedures Within the first 2 days of new hire training. Business Office Manager will audit all new hire files starting on 8/21/2024 and will continue new hire file audits for the next 6 months. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.

R/P Maintenance Director and BOM/Designee

Proposed Overall Completion Date: 01/21/2025

Licensee's Proposed Overall Completion Date: 01/21/2025

82c - Locking Poisonous Materials

6. 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 07/10/24, at 10:46 AM, several items including Listerine Cool Mint Antiseptic and Colgate Anticavity Fluoride Toothpaste, with a manufacture's label indicating "if more than used for (rinsing/brushing) is accidentally swallowed, get medical help or contact a Poison Control Center right away", were unlocked, unattended, and accessible to residents in room 407. Not all the residents of the home, including residents of the 4th floor, which is a memory care unit, have been assessed capable of recognizing and using poisons safely.

On 07/10/24 at 11:00 AM, the laundry room door on the 5th floor, which is also a memory care unit, was propped open with a trash can. Inside the laundry room were industrial laundry detergent and a bottle of Honeywell EyeSaline with a manufacturer's label indicating "If swallowed, get medical help or contact a Poison Control Center right away. Not all the residents of the 5th floor have been assessed capable of recognizing and using poisons safely.

Repeat Violation: 02/21/24.

Plan of Correction

Accept (█) - 08/28/2024)

Memory Care staff will be re-educated on 8/29/2024 at the monthly town hall staff meeting on the importance of poisonous materials being kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials. Memory Care Director will do random weekly audits starting on 8/30/2024 for the next 30 days, biweekly audits for the following 60 days and then monthly audits for 3 months on memory care rooms to make sure there are no poisonous materials left out for any resident to access. Memory Care Director will also do random daily audits to make sure the laundry room doors are closed and locked. These audits will continue for the next 6 months. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.

R/P Memory Care Director/Designee

Proposed Overall Completion Date: 02/26/2025

Licensee's Proposed Overall Completion Date: 02/26/2025

88a - Surfaces

7. 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

Resident #1's bedroom carpet has a stain, possibly from bleach, near the resident's bed. According to the resident, the home placed a carpet (approx. 18" wide x 18" length x 1/4 to 1/2 in tall). Resident #1 stated they have tripped on the carpet at least twice and would like it removed as it can be a tripping hazard.

Plan of Correction

Accept (█) - 08/28/2024)

Housekeepers were educated by the Housekeeping Supervisor on 8/23/2024 not providing any type of throw carpets on the resident's floors, due to the possibility of tripping hazard. Housekeeping Supervisor will do random weekly

88a - Surfaces (continued)

audits on resident rooms to check for any throw rugs for the next 3 months. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.
R/P Housekeeping Supervisor/Designee

Proposed Overall Completion Date: 11/25/2024

Licensee's Proposed Overall Completion Date: 11/25/2024

95 - Furniture and Equipment

8. Requirements

2600.

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

Description of Violation

The closet in resident #1's room is missing a door handle on one side.

Plan of Correction

Accept [redacted] - 08/28/2024)

The closet was fixed on 7/11/2024. Please see attached photo. Maintenance Director will do random weekly audits to rooms to assure there are no missing handles on closet doors. These audits will start on 8/23/2024 and will continue for the next 3 months. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.
R/P Maintenance Director

Proposed Overall Completion Date: 11/23/2024

Licensee's Proposed Overall Completion Date: 11/23/2024

100a - Exterior - Free of Hazards

9. Requirements

2600.

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

Description of Violation

On 07/10/24, at 10:24 AM, the fence on the side of the home, facing the dumpsters, was in disrepair. The fence appears to be stained with a black or brown substance, possibly mildew, and missing fence posts.

Plan of Correction

Accept [redacted] - 08/28/2024)

The fence was cleaned and repaired and cleaned by 8/21/2024. Please see attached photos. Maintenance Director will conduct monthly audits on the ground around the outside of the community to check for disrepair and cleanliness. These audits will be ongoing. These audits will start on 8/23/2024. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.
R/P Maintenance Director

Licensee's Proposed Overall Completion Date: 11/23/2024

101j7 - Lighting/Operable Lamp

10. Requirements

101j7 - Lighting/Operable Lamp (continued)

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.

Description of Violation

The residents in rooms 608 and 718 do not have access to a source of light that can be turned on/off at bedside.

Plan of Correction

Accept [redacted] - 08/28/2024)

Lamp was placed in room on room 718 bedside table and light was placed on the wall at bedside in room 608 on 7/11/2024. Maintenance Director will do random room audits to check to make sure there is accessible lighting by the bedside. These audits will begin on 8/23/2024 and continue for 3 months. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.

R/P Maintenance Director/Designee

Proposed Overall Completion Date: 11/23/2024

Licensee's Proposed Overall Completion Date: 11/23/2024

103f - Refrigerator/Freezer Temps

11. Requirements

2600.

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

Description of Violation

On 7/10/2024 at 2:23 p.m., the temperature in the main kitchen walk-in freezer was 26 degrees Fahrenheit. There was no thermometer inside the freezer; when the culinary director was asked if the thermometer outside was working, [redacted] replied yes. Later that afternoon, the culinary director stated she had found the thermometer under a box and that the outside thermometer was not working properly.

Plan of Correction

Accept [redacted] - 08/28/2024)

The outside thermometer has not worked for some time. This was explained to the surveyor on inspection. The inside thermometer was under a box and not visible. To correct this the outside thermometer was covered and the inside thermometer was secured to the shelf for open visibility, this was corrected on 7/11/2024. Dining Director will conduct daily audits to assure that inside thermometer stays secure. These audits were started on 7/15/2024 and completed on 8/15/2024. Please see attached documents. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.

R/P Dining Director/Designee

Proposed Overall Completion Date: 08/22/2024

Licensee's Proposed Overall Completion Date: 08/22/2024

Not Implemented ([redacted] - 09/05/2024)

103i - Outdated Food

12. Requirements

2600.

103i - Outdated Food (continued)

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

Description of Violation

There were several bags of French Toast unlabeled and undated in the main kitchen freezer.

Plan of Correction

Accepted [redacted] 08/28/2024)

Dining Director educated cook on the policy to date and label all loose food products when they are removed from their original packaging on 8/21/2024. Dining Director will do weekly audits for the next 30 days to verify all loose food products are labeled and dated, starting on 8/23/2024. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.

R/P Dining Director/Designee

Licensee's Proposed Overall Completion Date: 09/23/2024

Implemented [redacted] 10/3/2024)

181c - Self-administration Assessment

13. 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

On 7/10/2024, there were two loose pills, an extra-strength muscle rub cream, Hydrophilic wound dressing cream and eye drops on top of a small table in room [redacted] for resident #2. Resident states they do not self-administer medications. Resident #2 has not been assessed by a physician, physician's assistant, or certified registered nurse practitioner regarding his ability to self-administer and the need for medication reminders.

Plan of Correction

Accepted [redacted] 08/28/2024)

All Medication Techs will be educated by the Director of Health and Wellness on 8/29/2024 at the monthly town hall staff meeting to not leave any medications in a resident's room that has not been assessed for self-medicating. Health and Wellness Coordinator will do random room audits weekly starting on 8/23/2024 to check for any medications including loose pills. These audits will continue for the next 6 months. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.

R/P Health and Wellness Coordinator/Designee.

Licensee's Proposed Overall Completion Date: 01/29/2025

183b - Meds and Syringes Locked

14. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 7/10/2024, there were two loose pills, an extra-strength muscle rub cream, Hydrophilic wound dressing cream, and eye drops, on top of a small table in room 811, unlocked, unattended, and accessible to resident #2.

On 07/10/24, an as needed prescribed medication; PeriGuard ointment, for resident #3 was found inside a cabinet in

183b - Meds and Syringes Locked (continued)

the resident's bedroom. Resident #3 resides in one of the home's memory care units.

Plan of Correction

Accept (████) - 08/28/2024)

All Medication Techs will be educated by the Director of Health and Wellness on 8/29/2024 at the monthly town hall staff meeting to not leave any medications in resident's rooms and all residents, that have not been assessed for self-medicating should take all medication in the presence of the med tech before they leave the resident's room. Health and Wellness Coordinator will do random room audits weekly starting on 8/23/2024 to check for any medications including loose pills. These audits will continue for the next 6 months. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.

R/P Health and Wellness Coordinator/Designee

Licensee's Proposed Overall Completion Date: 01/29/2025

183e - Storing Medications**15. Requirements**

2600.

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

On July 10, 2024, there were 4 different loose pills in the 1st and 2nd drawers of the med cart on the 6th floor.

Repeat Violation: 12/14/23.

Plan of Correction

Accept (████) 08/28/2024)

All Medication Techs will be educated by the Director of Health and Wellness on 8/29/2024 at the monthly town hall staff meeting to check the carts for any loose pills and if a pill falls loose it needs to be disposed of properly. Health and Wellness Coordinator will do weekly cart audits to check for loose pills on all med carts for the next 6 months starting 8/26/2024. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.

R/P Health and Wellness Coordinator/Designee

Proposed Overall Completion Date: 01/27/2025

Licensee's Proposed Overall Completion Date: 01/27/2025

185a - Implement Storage Procedures**16. 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

The following discrepancies were found between resident #4's glucometer readings and information recorded on resident #4's Electronic Medication Administration Record (EMAR):

On 07/06/24, at 3:47 PM, a blood glucose reading of 74 is recorded on the resident's EMAR. This reading is not found on the resident's glucometer.

185a - Implement Storage Procedures (continued)

On 07/07/24, at 4:17 PM, a blood glucose reading of 214 is recorded on the resident's EMAR. This reading is not found on the resident's glucometer.

On 07/08/24, at 12:44 PM, the resident's glucometer had a blood glucose reading of 101. However, this reading was not recorded on the resident's EMAR.

Plan of Correction

Accept [REDACTED] - 08/28/2024)

All Medication Techs will be educated by the Director of Health and Wellness on 8/29/2024 at the monthly town hall staff meeting on proper documentation on glucometers and EMAR. Glucometer and EMAR need to match. Health and Wellness Coordinator, Director of Health and Wellness and Memory Care Director will do weekly glucometer and MAR audits starting on 8/26/2024 to make sure they are documented correctly. These audits will continue for the next 6 months. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.
R/P Director of Health and Wellness/Memory Caree Director/Health and Wellness Coordinator

Licensee's Proposed Overall Completion Date: 01/27/2025

187d - Follow Prescriber's Orders**17. Requirements**

2600.

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

Description of Violation

Resident #4 is prescribed Ozempic, 1 mg, inject 1 mg subcutaneously weekly on Monday. However, resident #4's EMAR does not show this medication as being administered on 06/24/24 at 09:00 AM.

Repeat Violation: 12/14/23.

Plan of Correction

Accept [REDACTED] 08/28/2024)

This medication was actually given but was not signed out. The nurse that gave the medication will be re-educated by the Executive Director on 8/26/2024 on the importance of signing out all medications that were given. Memory Care Director and Director of Health and Wellness will do weekly audits on all MARS to check for any missing documentation starting on 8/27/2024 and will continue for the next 6 months. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.

R/P Director of Health and Wellness and Memory Care Director

Licensee's Proposed Overall Completion Date: 01/24/2025

227g -Support Plan Signatures**18. 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 their support plan on 06/02/24. However, neither staff nor the resident signed the support plan.

227g -Support Plan Signatures (continued)

Resident #6 participated in the development of their support plan on [REDACTED] 24. However, the staff member who prepared the support plan did not sign the support plan.

Resident #7 participated in the development of their support plan on [REDACTED]/23. However, the resident did not sign the support plan.

Repeat Violation: 2/9/23, et al.

Plan of Correction

Accepted [REDACTED] 08/28/2024)

Director of Health and Wellness and Memory Care Director will be educated by the Executive Director on 8/26/2024 on proper signatures on all support plans. Director of Health and Wellness and Memory Care Director will audit all support plans to make sure they are all signed properly. These audits will start on 8/27/2024 and be completed no later than 9/30/2024. Then monthly audits will be done for all new admissions for the next 6 months starting on 10/01/22024. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.

R/P Director of Health and Wellness/Memory Care Director/Designee

Licensee's Proposed Overall Completion Date: 02/28/2025

[REDACTED]

252 - Record Content

20. Requirements

2600.

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

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

252 - Record Content (*continued*)

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

Description of Violation

Resident #6's record does not include the resident's hair color, color of eyes, religious affiliation, if any, identifying marks, the name, address and telephone number of the resident's physician or source of health care, dietary restrictions, and the resident's medical insurance information.

Resident #8's record does not include the resident's hair color, color of eyes, religious affiliation, if any, identifying marks, the name, address and telephone number of the resident's physician or source of health care, dietary restrictions, and the resident's medical insurance information.

Plan of Correction

Accept [REDACTED] - 08/28/2024)

Executive Director will educate the Memory Care Director, Director of Health and Wellness and Health and Wellness Coordinator on 8/26/2024 for proper documentation in the EHR for resident's hair color, color of eyes, religious affiliation, if any, identifying marks, the name, address and telephone number of the resident's physician or source of health care, dietary restrictions, and the resident's medical insurance information. Director of Health and Wellness, Memory Care Director and Health and Wellness Coordinator will audit all resident's files in the EHR to check for all missing information and correct all information. This audit will start on 8/27/2024 and be completed no later than 9/30/2024. Then they will conduct monthly audits on all new admissions for the next 6 months starting on 10/01/2024. The audits will be brought to the monthly QAPI meeting for the Executive Director to monitor for ongoing compliance. The next QAPI meeting is on 8/26/2024 and every 3rd Monday of the month thereafter.

252 - Record Content (continued)

R/P Director of Health and Wellness/Memory Care Director/Health and Wellness Coordinator/Designee

Licensee's Proposed Overall Completion Date: 02/28/2025

Facility Information

Name: CHESTNUT RIDGE RETIREMENT LIVING License #: 14141 License Expiration: 12/30/2024
 Address: 2700 CHESTNUT PARKWAY, CHESTER, PA 19086
 County: DELAWARE Region: SOUTHEAST

Administrator

Name: [REDACTED]

Legal Entity

Name: VS WALLINGFORD LLC
 Address: 2700 CHESTNUT PARKWAY, CHESTER, PA, 19013
 Phone: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 05/19/1997 Issued By: CWOPA L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 126 Waking Staff: 95

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Complaint, Incident Exit Conference Date: 08/05/2024

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 130 Residents Served: 86
 Secured Dementia Care Unit
 In Home: Yes Area: Memory Care Unit Capacity: 50 Residents Served: 33
 Hospice
 Current Residents: 5
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 86
 Diagnosed with Mental Illness: 19 Diagnosed with Intellectual Disability: 1
 Have Mobility Need: 40 Have Physical Disability: 1

Inspections / Reviews

08/05/2024 - Partial
 Lead Inspector: Sandi Wooters Follow-Up Type: POC Submission Follow-Up Date: 08/26/2024

08/29/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 08/30/2024
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 09/03/2024

Inspections / Reviews (*continued*)

09/05/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/30/2024

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 09/11/2024

25b - Contract Signatures

1. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [REDACTED], for resident #1 was not signed by the resident.

Plan of Correction

Accept [REDACTED] - 08/28/2024)

Resident signed the contract on 8/23/24. Executive Director Will audit all new admission files for signatures of residents on all documents that requires a signature, for the next 6 months starting with the next new admission as of 8/23/2024. Audits will be brought to QAPI to monitor for compliance. Monthly QAPI meetings are held on the 3rd Wednesday of every month.

R/P Executive Director/Designee

Licensee's Proposed Overall Completion Date: 02/25/2025

41e - Signed Statement

2. 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 admitted to the home [REDACTED] 2023, 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] - 08/28/2024)

A new Resident's rights form has been added to the admission packet. Resident received the resident' rights and signed the correct document on 8/26/2024. Executive Director Will audit all new admission files for signatures of residents on all documents that requires a signature, for the next 6 months starting with the next new admission as of 8/23/2024. Audits will be brought to QAPI to monitor for compliance. Monthly QAPI meetings are held on the 3rd Wednesday of every month.

R/P Executive Director/Designee

Licensee's Proposed Overall Completion Date: 02/26/2025

42c - Treatment of Residents

3. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

Resident #2 reported that staff person A opened [REDACTED] shower curtain pulled [REDACTED] arm to check the residents

42c - Treatment of Residents (continued)

blood sugar without the residents consent. Resident #2 told the staff person A to come back another time staff replied " I have to do it now". Resident stated this was a invasion of [REDACTED] privacy. Staff person A stated " you lost your right to privacy when you moved in". Resident #2 could not remember specific dates but stated this has happened on multiple occasions.

Plan of Correction

Accept [REDACTED] - 08/28/2024)

Staff member A was given a write up and education on resident rights to privacy and dignity on 8/8/2024. Staff member A was also not allowed to return to resident #2 room. Health and Wellness Coordinator will make sure another med tech is assigned to resident #2 at all times.

R/P Health and Wellness Coordinator/Designee

Licensee's Proposed Overall Completion Date: 08/25/2024

Not Implemented [REDACTED] - 09/11/2024)

42s - Privacy

4. Requirements

2600.

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

Description of Violation

On August 5, 2024, resident #2 reported to the Department that staff person A pulled [REDACTED] to get [REDACTED] blood sugar while the resident was in the shower without consulting with the resident. Resident #2 reported that it has occurred on numerous occasions with other staff members who do not have any consideration for the resident's privacy or dignity. Resident #2 reported that staff person #1 informed the resident that [REDACTED] lost their right to privacy when [REDACTED] moved in the home.

Repeat Violation: 12/14/23

Plan of Correction

Accept [REDACTED] - 08/28/2024)

Staff member A was given a write up and education on resident rights to privacy and dignity on 8/8/2024. Staff member A was also not allowed to return to resident #2 room. Health and Wellness Coordinator will make sure another med tech is assigned to resident #2 at all times.

R/P Health and Wellness Coordinator/Designee

Licensee's Proposed Overall Completion Date: 08/25/2024

Not Implemented [REDACTED] - 10/3/2024)

57d - Waking Hours

5. Requirements

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On July 21, 2024, a total of 126 hours of direct care was required. However, only 109.5 of the required hours, or 68 percent, were provided during waking hours.

57d - Waking Hours (continued)

Plan of Correction

Accept [REDACTED] - 08/28/2024)

Executive Director educated Health and Wellness Coordinator (HWC does the scheduling) to have at least 6 caregivers on every 7am-3pm and 3pm-11pm shifts on 8/6/2024. If there are less than 6 caregivers on the schedule the Health and Wellness Director, Memory Care Director or the Health and Wellness Coordinator must be assigned to an assignment or to pass meds and put a med tech on the caregiver assignment. Executive Director will audit daily schedules weekly to verify compliance for the next 3 months starting on 8/27/2024. Audits will be brought to the monthly QAPI meetings for the to monitor for compliance. Monthly QAPI meetings are held on the 3rd Wednesday of every month.

R/P Executive Director/Health and Wellness Coordinator/Designee

Licensee's Proposed Overall Completion Date: 11/27/2024

60a - [REDACTED]

[REDACTED]

[REDACTED]

101j2 - Bedroom Chairs

7. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

- 2. A chair for each resident that meets the resident's needs.

101j2 - Bedroom Chairs (continued)

Description of Violation

Bedroom 403 is occupied by resident #3; however, the resident did not have a chair in [redacted] bedroom.

Plan of Correction

[redacted] 08/29/2024)

All required furniture was placed in the resident's room on 7/10/2024 by the Maintenance Director. Resident 403 is known to remove furniture from his room. Memory Care Director will do weekly audits to ensure resident has not removed any of his furniture. These audits will start on 8/27/2024 and will continue for the next 3 months. Memory Care Director will also care plan these behaviors on the RASP on 8/27/2024. Audits will be brought to the monthly QAPI meetings for the Executive Director to monitor for compliance. Monthly QAPI meetings are held on the 3rd Wednesday of every month.

R/P Maintenance Director/Designee

Proposed Overall Completion Date: 11/29/2024

Licensee's Proposed Overall Completion Date: 11/29/2024

101j3 - Bed/Linens/Pillows/Blankets

8. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

- 3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

Bedroom 403 is occupied by resident #3. The bed for resident #3, did not have bed linen, a blanket or a pillowcase.

Repeat Violation: 2/9/23, et al.

Plan of Correction

Accept [redacted] - 08/29/2024)

All direct care staff will be educated at the all staff town hall meeting on 8/29/2024 to make the beds with fresh clean linens immediately and to take the soiled items to be laundered. Random weekly audits will be done by the Health and Wellness Coordinator starting on 8/30/2024 and will continue for the next 6 months. Audits will be brought to the monthly QAPI meetings for the Executive Director to monitor for compliance. Monthly QAPI meetings are held on the 3rd Wednesday of every month.

R/P Health and Wellness Coordinator/Designee

Licensee's Proposed Overall Completion Date: 02/28/2025

101j5 - Bedside Table/Shelf

9. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

101j5 - Bedside Table/Shelf (continued)

5. A bedside table or a shelf.

Description of Violation

Bedroom 403 is occupied by resident #3. Resident #3 did not have a bedside table or shelf in [redacted] r bedroom.

Plan of Correction

Accept [redacted] 08/29/2024)

All required furniture was placed in the resident's room on 7/10/2024 by the Maintenance Director. Resident 403 is known to remove furniture from his room. Memory Care Director will do weekly audits to ensure resident has not removed any of his furniture. These audits will start on 8/27/2024 and will continue for the next 3 months. Memory Care Director will also care plan these behaviors on the RASP on 8/27/2024. Audits will be brought to the monthly QAPI meetings for the Executive Director to monitor for compliance. Monthly QAPI meetings are held on the 3rd Wednesday of every month.

R/P Maintenance Director/Designee

Licensee's Proposed Overall Completion Date: 11/29/2024

[Large redacted area]

227g -Support Plan Signatures

11. 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 #3 admitted to the home [redacted], 2024, participated in the development of [redacted] plan on March 29, 2024. However, the resident did not sign the support plan.

Resident #4 admitted to the home [redacted] participated in the development of his/her support plan on

227g -Support Plan Signatures (continued)

██████████ 2023. However, the resident did not sign the support plan.

Repeat Violation: 2/9/23, et al.

Plan of Correction**Accept (██████████ - 08/29/2024)**

Executive Director educated the Memory Care Director on 8/23/2024 on the importance of having all resident's sign their support plans. If a resident is unable to sign, then that needs to be documented. If the resident refuses to sign then documentation of how many attempts were made, including the date and the response from the resident. Memory Care Director will audit all resident support plans and confirm they are all signed or documented. These audits will be completed no later than 9/15/2024 and will continue for the next 6 months on all new admissions. Audits will be brought to the monthly QAPI meetings for the to monitor for compliance. Monthly QAPI meetings are held on the 3rd Wednesday of every month.

R/P Memory Care Director/Designee

Licensee's Proposed Overall Completion Date: 02/27/2025