



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail [REDACTED]

February 21, 2025

[REDACTED]
Administrator
Simpson Meadows
101 Plaza Drive
Downingtown, Pennsylvania 19335

RE: Simpson Meadows
License #: 14118

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on August 16, 2024 and January 16, 2025 of the above facility, we have determined that your submitted plan of correction for the July 22 and 23, 2024 inspection is not fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

[REDACTED]

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *SIMPSON MEADOWS* License #: *14118* License Expiration: *03/01/2025*
Address: *101 PLAZA DRIVE, DOWNINGTOWN, PA 19335*
County: *CHESTER* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *SIMPSON MEADOWS*
Address: *101 PLAZA DRIVE, DOWNINGTOWN, PA, 19335*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *09/11/1998* Issued By: *COPA L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *70* Waking Staff: *53*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *07/23/2024*

Inspection Dates and Department Representative

07/22/2024 - On-Site: [REDACTED]
07/23/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *81* Residents Served: *38*

Special Care Unit

In Home: *Yes* Area: *Memory Care Unit* Capacity: *18* Residents Served: *18*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *38*
Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *32* Have Physical Disability: *0*

Inspections / Reviews

07/22/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/17/2024*

08/16/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/14/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 08/26/2024

02/21/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/26/2024

Reviewer: [REDACTED]

Follow-Up Type: Exception

3d Post license/VR/Regs

1. Requirements

2800.

- 3.d. The assisted living residence shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the assisted living residence.

Description of Violation

On 7/22/2024, the residence's current license inspection summary issued by the Department and a copy of this chapter were not posted in a conspicuous and public place in the residence.

Plan of Correction

Accept (█) - 08/16/2024)

On 8/13/24, the Administrator placed the most recent License Inspection Summary (LIS) from the previous annual relicensing survey, dated 5/22/23, along with subsequent LISs received since the last annual relicensing survey, in a binder labeled "Licensing Inspections." This binder was then placed in a conspicuous location within the front lobby. Beginning 8/20/24, the Administrator or designee will audit the presence and contents of the "Licensing Inspections" binder to ensure it remains in a conspicuous location within the community's front lobby and that the LIS reports are current. The audit schedule is as follows: weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month to validate sustained compliance.

Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented (█) - 01/16/2025)

17 Record confidentiality

2. Requirements

2800.

- 17. Confidentiality of Records - 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 7/23/2024, at 9:22 a.m., the residents records in the memory care unit medication room were unlocked, unattended, and accessible to all residents.

Plan of Correction

Accept (█) - 08/16/2024)

On 7/23/24, the Nurse Manager secured the nurse's office and residents' records by closing and locking the door to the medication room.

On 7/23/24, the Nurse Manager audited the common areas of the community to ensure that confidential records were secured.

On 8/20/24, the Administrator began in-servicing direct care staff on the requirements set forth in regulation 2800.17.

On 7/23/24, the Nurse Manager removed the door stop located within the medication room.

Beginning 8/26/24, the Nurse Manager or designee will audit the medication room doors weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 1 month to validate sustained compliance.

Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

17 Record confidentiality (continued)

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented () - 01/16/2025)

28e Refund - death

3. Requirements

2800.

28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the residence shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The residence shall keep documentation of the refund in the resident's record.

Description of Violation

Various residents of the facility, including resident #1, passed away on [REDACTED]. Resident # 1's personal belongings were removed from [REDACTED] room on [REDACTED]. However, the residence did not refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room was cleared of the resident's personal property. The refund was paid on [REDACTED].

Plan of Correction

Accept () - 08/16/2024)

The community is unable to correct this deficient practice for Resident #1

On 8/12/24, the Administrator audited resident refunds issued in 2024 to identify any additional deficient practices. For identified instances, the Administrator will review potential trends and conduct a root cause analysis to determine the factors contributing to the delayed refunds.

Beginning 8/26/24, the Administrator or designee will audit the refund statuses of recently discharged residents weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 1 month to ensure sustained compliance.

Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented () - 01/16/2025)

28f Refund - within 30 days

4. Requirements

2800.

28.f. Within 30 days of either the termination of service by the residence or the resident's leaving the residence, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the residence by the resident or a refund owed the resident by the residence. Refunds shall be made within 30 days of discharge.

Description of Violation

Various residents of the facility moved out, including resident #2. Resident #2 moved out of the facility on [REDACTED]. However, the residence did not refund the remainder of previously paid charges to the resident's within 30 days from the date the room was cleared of the resident's personal property. The refund was paid on [REDACTED].

Plan of Correction

Accept () - 08/16/2024)

The community is unable to correct this deficient practice for Resident #2

On 8/12/24, the Administrator audited resident refunds issued in 2024 to identify any additional deficient

28f Refund - within 30 days (continued)

practices. For identified instances, the Administrator will review potential trends and conduct a root cause analysis to determine the factors contributing to the delayed refunds.

Beginning 8/26/24, the Administrator or designee will audit the refund statuses of recently discharged residents weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 1 month to ensure sustained compliance.

Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented (█) - 01/16/2025)

42s Privacy - self/possessions

5. Requirements

2800.

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 7/22/2024, there were signs at entrances and around the property that stated, "video monitoring in progress." Staff member A stated, "The video cameras record 3 days' worth of footage and then erase." However, there is nothing listed on the resident's contract stating that the residents are being recorded while on the premises, even if it is only 3 days' worth of footage.

Plan of Correction

Accept (█) - 08/16/2024)

The Administrator will issue a memo to current residents clarifying that common areas of the community and entrances/exits are under video recording, not monitoring.

On 7/31/24, the Administrator ordered new signage reading "Video Recording in Progress" to replace the existing signage that read "Monitored by Video Camera."

On 8/14/24, the Facilities Director removed the old signage and affixed the new signage to the community's entrances and exits.

Beginning 8/26/24, the Administrator or designee will audit the presence of the "Video Recording in Progress" signage weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month to ensure it remains in place.

Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented (█) - 01/16/2025)

51 Criminal background checks

6. Requirements

2800.

51. Criminal background checks

51 Criminal background checks (continued)

- a. 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).
- b. The hiring policies shall be in accordance with the Department of Aging’s Older Adult Protective Services Act policy as posted on the Department of Aging’s web site.

Description of Violation

Staff person B date of hire was [REDACTED]. However staff member B criminal background was completed on 4/4/2024.

Plan of Correction

Accept ([REDACTED] - 08/16/2024)

On 8/9/24, the Administrator educated the Staffing Coordinator on the requirements of regulation 2800.51.
 On 8/9/24, the agency providing contracted staff members submitted background checks for Employee # B and their other employees currently working at the community, in accordance with 2800.51.
 Beginning 8/20/24, the Staffing Coordinator will audit the presence of three agency staff background checks weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 1 month to ensure sustained compliance.
 Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented ([REDACTED] - 01/16/2025)

65a Fire Safety-1st day

7. Requirements

2800.

- 65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
 2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
 3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
 4. Smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable.
 5. The location and use of fire extinguishers.
 6. Smoke detectors and fire alarms.
 7. Telephone use and notification of emergency services.

Description of Violation

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

65a Fire Safety-1st day (continued)

Plan of Correction

Accept () - 08/16/2024

The Administrator will provide Agency Employee #B with orientation in general fire safety and emergency preparedness as outlined in 2800.65(a), items 1 through 7.

On 8/5/24 & 8/6/24, the Staffing Coordinator audited current employee files, including those of contracted employees, to identify any omitted training. For identified instances, the Staffing Coordinator or designee provided the required orientation in general fire safety and emergency preparedness as outlined in 2800.65(a), items 1 through 7.

Beginning 8/26/24, the Staffing Coordinator or designee will audit three new employee files weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month to ensure sustained compliance.

Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented () - 01/16/2025

65e Rights/Abuse 40 Hours

8. Requirements

2800.

65.e. 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.
5. Safe management techniques.
6. Core competency training that includes the following:
 - i. Person-centered care.
 - ii. Communication, problem solving and relationship skills.
 - iii. Nutritional support according to resident preference.

Description of Violation

Staff person B completed 40th scheduled work hour on February 2023. However, this staff person did not complete training in the following topics: Resident rights. Emergency medical plan. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102). Reporting of reportable incidents and conditions. Safe management techniques. Core competency training that includes the following: Person-centered care. Communication, problem solving, and relationship skills. Nutritional support according to resident preference.

Plan of Correction

Accept () - 08/16/2024

The Administrator will provide agency Employee #B with orientation as outlined in 2800.65(e), items 1 through 6. On 8/5/24, the Staffing Coordinator audited current Agency employee files, to identify any omitted training. For identified instances, the Staffing Coordinator or designee provided the required orientation in general fire safety and emergency preparedness as outlined in 2800.65(e), items 1 through 6.

Beginning 8/26/24, the Staffing Coordinator or designee will audit new employee training records weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month to ensure sustained compliance.

Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued

65e Rights/Abuse 40 Hours (continued)

auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented (████) - 01/16/2025)

65i Training topics

9. Requirements

2800.

65.i. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia, cognitive and neurological impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Assisted living service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the residence.

Description of Violation

Direct care staff person C did not receive training in medication self-administration during the 2023 training year.

Plan of Correction

Accept (████) - 08/16/2024)

As of ██████ Employee C is on extended personal leave, so the community cannot fully address this violation until their return.

Upon Employee C's return, they will be receive training in falls and accident prevention or fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert

The Human Resources Manager will audit current employee files to identify additional employees overdue for required annual training. For those identified, the HRM assigned the necessary training and monitored its completion.

Beginning 8/26/24, the HRM or designee will audit three employee annual training completions weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month to ensure sustained compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

65j Annual training content

10. Requirements

2800.

65.j. 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.

65j Annual training content (continued)

- 4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708).
- 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 C did not receive training in falls and accident prevention or fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during the 2023 training year.

Plan of Correction

Accept (█ - 08/16/2024)

As of █, Employee C is on extended personal leave, so the community cannot fully address this violation until their return.

Upon Employee C's return, they will be receive training in falls and accident prevention or fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert

The Human Resources Manager will audit current employee files to identify additional employees overdue for required annual training. For those identified, the HRM assigned the necessary training and monitored its completion.

Beginning 8/26/24, the HRM or designee will audit three employee annual training completions weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month to ensure sustained compliance.

Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

66b Content of training plan

11. Requirements

2800.

66.b. The plan must include training aimed at improving the knowledge and skills of the residence'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 residence's staff training plan for training year 2024 does not include the dates, times, and locations of the scheduled training for each staff person for the upcoming year.

Plan of Correction

Accept (█ - 08/16/2024)

The HRM will document the elements of the home's 2024 and 2025 training plan on an Excel spreadsheet. This spreadsheet details the following:

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

66b Content of training plan (continued)

On 8/13/24, the Administrator will conduct an in-service session with community leadership, including the HRM, to review the requirements set forth in regulation 2800.66b and the community's 2024-2025 staff training plan. The HRM will distribute a copy of the staff training plan to fellow managers by 8/26/24. On 8/13/24, the Administrator created a Microsoft Outlook calendar reminder for mid-2025 to remind the HRM and ED to review regulation 2800.66b when creating the 2026 training plan.

Licensee's Proposed Overall Completion Date: 08/23/2024

82c Locked poisons

13. Requirements

2800.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

Description of Violation

Colgate toothpaste, Periguard Ointment, Dermasil Aloe Lotion, and Sensi Care Skin Barrier Protectant with a manufacturer's label indicating "keep out of reach of children and contact poison control center right away" were unlocked, unattended, and accessible in room 135 in the bathroom vanity drawer. Not all the residents of the residence, including the resident in room 135, have been assessed as capable of recognizing and using poisons safely.

On 7/23/2024 at 9:22 a.m., the medication room door in the memory care unit was opened. A triple antibiotic ointment with a manufacturer's label indicating "keep out of reach of children and contact poison control center right away" was unlocked, unattended, and accessible to the memory care unit residents. Not all the residents of the residence, including the residents in the memory care unit, have been assessed as capable of recognizing and using poisons safely.

Plan of Correction

Accept (█) - 08/16/2024

On 7/23/24, the Nurse Manager secured the memory care medication room door and properly stored the antibiotic ointment.

On 7/23/24, the Nurse Manager audited the community's medication rooms to ensure medications were properly and securely stored when not in use.

On 8/9/24, the Nurse Manager in-serviced licensed nurses and medication technicians on the requirements set forth in regulation 2800.82c.

Beginning 8/20/24, the Nurse Manager or designee will audit the medication rooms for unsecured medications weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month to ensure sustained compliance.

Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented (█) - 01/16/2025

91 Telephone Numbers

14. Requirements

2800.

91 Telephone Numbers (continued)

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

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire Department on or by the telephone in rooms 231 and 239.

Plan of Correction

Accept () - 08/16/2024

On 7/23/2024, the Administrator provided residents occupying apartments #231 and #239 with a list of emergency phone numbers placed within eyesight of their telephones.

On 7/24/2024, the Administrator audited resident apartments to ensure no additional apartments were missing emergency phone numbers near resident phones. No additional instances were identified.

The Administrator will in-service the facility's current direct care, maintenance, therapy, admissions, and housekeeping staff on the requirements set forth in regulation 2800.91

Beginning 8/26/24, the Administrator or designee will audit three resident apartment telephones for posted emergency phone numbers weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month to ensure sustained compliance.

Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented () - 01/16/2025

96b First aid kit- Location

15. Requirements

2800.

96.b. Staff persons shall know the location of the first aid kit.

Description of Violation

Staff person D did not know the location of the first aid kit.

Plan of Correction

Accept () - 08/16/2024

On 7/24/2024, the Administrator informed Employee D about the locations of the community's first aid kits.

On 8/20/24, the Administrator will in-service current direct care and ancillary staff on the locations of the community's first aid kits.

Beginning 8/26/24, the Nurse Manager or designee will ask three community staff members each week for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 1 month about the location of the nearest first aid kit to ensure sustained compliance.

Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

107b Emergency procedures

16. Requirements

2800.

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

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

Description of Violation

The residence’s written emergency procedures do not include the contact information for each resident’s designated person and the contact telephone numbers of local and state emergency management agencies and local resources for housing and emergency care of residents.

Plan of Correction

Accept (█) - 08/16/2024)

On 8/13/24, the Administrator updated the residence’s written emergency procedures to include phone numbers for local and state emergency management agencies, as well as local resources for housing and emergency care of residents.

On 8/13/24, the Administrator created and sent a Microsoft Outlook calendar reminder and invitation to the Administration to prompt the 2025 annual review and revision of the community’s emergency procedures.

Licensee’s Proposed Overall Completion Date: 08/23/2024

Implemented (█) - 01/16/2025)

123b Emerg. procedures posted

17. Requirements

2800.

123.b. Copies of the emergency procedures as specified in § 2800.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the residence and a copy shall be kept.

Description of Violation

The residence’s emergency procedures are not posted in a conspicuous and public place in the residence.

Plan of Correction

Accept (█) - 08/16/2024)

On 8/14/24, the Administrator placed the community’s emergency procedures in a red binder labeled “Emergency Preparedness” in a conspicuous location within the community’s front lobby. The binder includes:

- (1) The emergency preparedness plan for the municipality in which the residence is located.
- (2) Contact telephone numbers for municipal and state emergency management agencies.
- (3) Local resources for housing and emergency care of residents.
- (4) Means of transportation in the event relocation is required.

On 8/20/24, the Administrator will educate staff on the location of the “Emergency Preparedness” binder.

Beginning 8/26/24, the Administrator or designee will audit the presence of the “Emergency Preparedness” binder weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month to ensure it remains stored in a conspicuous location.

Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

123b Emerg. procedures posted (continued)

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented (█) - 01/16/2025)

124 Notice to fire department

18. Requirements

2800.

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

Description of Violation

The residence does not have documentation of written notification to the local fire Department of the address of the residence, location of the living units and bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction

Accept (█) - 08/16/2024)

The Maintenance Director will email the local fire department with the facility's address, the location of the living units and bedrooms, and the assistance needed for evacuation in the event of an emergency, by August 30, 2024.

On 8/14/24, the Administrator in-serviced the facility's Maintenance Director on the requirements set forth in regulation 2800.124.

On 8/13/24, the Administrator sent a Microsoft Outlook calendar reminder for 2025 to the Maintenance Director to prompt the notification to the local fire department regarding the facility's address, the location of the living units and bedrooms, and the assistance needed for evacuation in an emergency.

Proposed Overall Completion Date: 08/23/2024

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented (█) - 01/16/2025)

141a Medical evaluation

19. Requirements

2800.

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.

141a Medical evaluation (continued)

- 10. Mobility assessment, updated annually or at the Department’s request.
- 11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.
- 12. Information about a resident’s day-to-day assisted living service needs.

Description of Violation

The medical evaluation for resident #3, dated [REDACTED] does not include the general physical examination by a physician, physician’s assistant, or nurse practitioner and the medical information pertinent to diagnosis and treatment in case of an emergency. This area of the form is blank.

The medical evaluation for resident #4, dated [REDACTED], does not include the medical information pertinent to diagnosis and treatment in case of an emergency or the medication list, medication regimen, contraindicated medications, or medication side effects.

Repeat Violation - Partial 1/18/2024

Plan of Correction

Accept ([REDACTED]) - 08/16/2024)

A new completed ADME will be provided by the healthcare provider for Resident #3, including Resident #3’s active medication list.

On 7/31/24, the Nurse Manager audited current resident ADMEs to check for omitted medication lists. For any instances identified, a new ADME with an affixed medication list was requested from the medical provider.

Beginning 8/26/24, the Nurse Manager will audit three ADMEs completed and dated after the 7/31/24 comprehensive review, weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month to ensure sustained compliance. (Exhibit 00 – Audit Tool)

Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee’s Proposed Overall Completion Date: 08/23/2024

183e Storing Medications

20. Requirements

2800.

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 7/23/2024, Lorazepam 0.5 mg was in a blister pack for resident #5. However, pill #10 has the back foil open and taped, and pill #1 has an opening on it.

On 7/23/2024, an almost full box of Sureprep protective wipes with an expiration date of 7/2023 was in the med cart in the Memory Care Unit.

Plan of Correction

Accept ([REDACTED]) - 08/16/2024)

On 7/23/24, the Nurse Manager discarded the medications for Resident #5 in accordance with community policy.

On 8/1/24, the Nurse Manager audited the community’s medication carts controlled substance drawers for any

183e Storing Medications (continued)

further instances of compromised blister pack integrity. No additional instances were identified. On 8/9/24, the RDCS and Nurse Manager began in-servicing the home's licensed nurses and medication technicians on the requirements set forth in regulation 2800.183.e. Beginning 8/26/24, the Nurse Manager or designee will audit the home's medication carts controlled substance drawer weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 1 month to ensure sustained compliance. Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

185a Storage procedures

22. Requirements

2800. 185.a. The residence 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 # 6 is prescribed Milk of Magnesia, Kaopectate 262 mg, and Maalox Advanced as needed. On 7/23/2024, these medications were not available in the residence.

Plan of Correction

Accept () - 08/16/2024

On 7/23/24, the healthcare provider discontinued the order for Resident #6's Maalox, Milk of Magnesia and Kaopectate. On 7/24/24, the Nurse Manager audited the medication cart contents to ensure that ordered medications for current residents were present. No additional instances of non-compliance were identified. On 8/9/24, the Nurse Manager conducted an in-service for the community's Licensed Nurses and Medication Technicians on the requirements set forth in regulation 185a. Beginning 8/26/24, the Nurse Manager or designee will audit the medications belonging to 2 residents weekly for 4 weeks, then bi-weekly for 4 weeks, and monthly for 1 month to ensure sustained compliance. Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

187a Medication record

23. Requirements

2800. 187.a. A medication record shall be kept to include the following for each resident for whom medications are administered: 1. Resident's name. 2. Drug allergies. 3. Name of medication. 4. Strength. 5. Dosage form.

187a Medication record (continued)

6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #6 is prescribed Aspirin tablets (81 mg once a day), Loratadine tablets (10 mg once a day), Metformin tablets (500 mg twice a day), Lovastatin tablets (20 mg at bedtime), and Gabapentin capsules (300 mg at bedtime). However, resident #6 medication administration record does not include a diagnosis or purpose for the medications.

Plan of Correction

Accept (█) - 08/16/2024

The Diagnosis or purpose for Aspirin tablets (81 mg once a day), Loratadine tablets (10 mg once a day), Metformin tablets (500 mg twice a day), Lovastatin tablets (20 mg at bedtime), and Gabapentin capsules (300 mg at bedtime) will be added to Medication Administration record for resident #6 by the nurse manager by August 30, 2024. Nurse manager will audit all the remaining Medication Administration Records to identify any other medications that do not include diagnosis, by August 30, 2024. Nurse manager or Administrator will in-service all licensed nursing staff on regulation 2800.187.A Beginning 8/26/24 the Nurse Manager or designee will audit the home's medication administration records weekly for 4 weeks, then bi-weekly for 4 weeks, and monthly for 1 month to ensure sustained compliance.

Proposed Overall Completion Date: 08/23/2024

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented (█) - 01/16/2025

227c Final support plan - revision

24. Requirements

- 2800.
- 227.c. The final support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. The residence shall review each resident's final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

Description of Violation

Resident #3's assessment was completed on █ however, the resident's support plan it does not include the dates was when it was revised.

Plan of Correction

Accept (█) - 08/16/2024

The Nurse Manager will complete a new Assessment and Support Plan (ASP) for Resident #3 by August 30, 2024. The Nurse Manager will audit current residents' ASPs to check for missing completion dates. For any instances identified, the Nurse Manager will create a new ASP for the affected resident. Beginning 8/26/24, the Nurse Manager or designee will audit the ASPs of two residents weekly for 4 weeks,

227c Final support plan - revision (continued)

bi-weekly for 4 weeks, and monthly for 1 month to ensure sustained compliance, starting immediately. Results of the audit will be reviewed during quarterly QI meetings. The QI Committee will decide if continued auditing is necessary based on three consecutive months of compliance.

Proposed Overall Completion Date: 08/23/2024.

Licensee's Proposed Overall Completion Date: 08/23/2024

231c1 Preadmit screening

25. Requirements

2800.

231.c.1. Special care unit for residents with Alzheimer's disease or dementia.

- i. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.
- ii. A geriatric assessment team is a group of multidisciplinary specialists in the care of adults who are older that conducts a multidimensional evaluation of a resident and assists in developing a support plan by working with the resident's physician, designated person and the resident's family to coordinate the resident's care.

Description of Violation

Resident #7's written cognitive preadmission screening, dated [REDACTED], was not completed in collaboration with a physician or a geriatric assessment team.

Repeat Violation - Renewal 5/22/2023

Plan of Correction

Accept [REDACTED] - 08/16/2024)

On 8/13/24, the cognitive preadmission screening for Resident #7 was presented to the resident's physician for signing.

On 8/9/24, the Nurse Manager audited the cognitive screenings for current Special Care Unit (SPU) residents to ensure that physician signatures or those of a geriatric assessment team were documented. Any screenings missing these signatures were resubmitted to the resident's physician(s) with late entry dates.

Beginning 8/26/24, the Nurse Manager or designee will audit cognitive screenings for new SPU residents weekly for 4 weeks, then bi-weekly for 4 weeks, and monthly for 1 month to ensure compliance.

Results of the audit will be reviewed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented [REDACTED] - 01/16/2025)

233c Key-locking devices

26. Requirements

2800.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the residence's locking mechanism are not conspicuously posted near the courtyard in

233c Key-locking devices (continued)

the special care unit.

Repeat Violation - Renewal 5/22/2023

Plan of Correction

Accept () - 08/16/2024

On 7/23/24, the Maintenance Director posted the exit code for the memory care courtyard door in a visible location. On 7/23/24, the Maintenance Director audited locked doors in the Memory Care neighborhood to ensure all had visible exit codes. No additional missing codes were found. On 8/20/24, the Administrator will provide training to direct care staff, housekeeping, maintenance, and therapy teams on the requirements of regulation 2800.233c. Beginning 8/20/24, the Administrator or designee will audit memory care locked doors to ensure they display a visible exit code weekly for 4 weeks, then bi-weekly for 4 weeks, and monthly for 1 month to ensure sustained compliance. Results of the audit will be reviewed during quarterly QI meetings. The QI Committee will decide if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

234a Admission – support plan

27. Requirements

2800.

234.a. Support or rehabilitation plan

- 1. Within 72 hours of the admission, or within 72 hours prior to the resident’s admission to the special care unit, a support plan shall be developed, implemented and documented in the resident record.
2. For individuals being admitted into a special care unit for INRBI, a rehabilitation plan shall be developed, implemented and documented in the resident record. This rehabilitation plan and the individual’s support plan shall be based on the CPB preadmission assessment and other available records and information.

Description of Violation

Resident #3 was admitted to the special care unit on [redacted]. However, the resident’s initial support plan was completed on [redacted]

Plan of Correction

Accept () - 08/16/2024

The community is currently unable to correct the late support plan for Resident #3. On 7/24/24, the Nurse Manager reviewed and confirmed that the support plan for Resident #3 remained appropriate and accurate. On 7/24/24 & 7/25/24, the Nurse Manager reviewed the current support plans for current residents to identify any additional instances of late support plans. Beginning 8/26/24, the Administrator will review the support plans for new residents moving into the SPU weekly for 4 weeks, then bi-weekly for 4 weeks, and monthly for 1 month to ensure sustained compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented () - 01/16/2025

236a Staff training

28. Requirements

236a Staff training (continued)

2800.

236.a. Each direct care staff person working in a special care unit for residents with Alzheimer’s disease or dementia shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to dementia care and services, in addition to the 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

Description of Violation

Direct care staff person B, who works in the special care unit had no hours of training related to dementia care during the 2023 training year.

Plan of Correction

Accept (█ - 08/16/2024)

The Staffing Coordinator, in collaboration with the agency leadership, will ensure that adequate dementia care training hours will be provided by the agency to their staff moving forward.

On 8/1/24, the Staffing Coordinator audited the training records of current direct care agency employees to identify those with less than eight hours of dementia training, either upon hire or annually. For those employees with insufficient training, the Administrator will assign additional training hours to meet the required eight hours. Beginning 8/26/24, the Staffing Coordinator will audit the training records of 3 newly hired/staffed (contracted) employees weekly for 4 weeks, then bi-weekly for 4 weeks, and monthly for 1 month to ensure sustained compliance. Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: 08/23/2024

Implemented (█ - 01/16/2025)