

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

December 3, 2024

[REDACTED], REGIONAL DIRECTOR OF WELLNESS
FIVE STAR QUALITY CARE NS OPERATOR LLC

[REDACTED]
ATTN: LICENSING
NEWTON, MA, 2458

RE: THE DEVON SENIOR LIVING
445 NORTH VALLEY FORGE ROAD
DEVON, PA, 19333
LICENSE/COC#: 13206

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/27/2024, 08/28/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: THE DEVON SENIOR LIVING **License #:** 13206 **License Expiration:** 10/06/2024
Address: 445 NORTH VALLEY FORGE ROAD, DEVON, PA 19333
County: CHESTER **Region:** SOUTHEAST

Administrator

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

Legal Entity

Name: FIVE STAR QUALITY CARE NS OPERATOR LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 08/26/2003 **Issued By:** Commonwealth of PA, L&I

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 72 **Waking Staff:** 54

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Complaint **Exit Conference Date:** 08/28/2024

Inspection Dates and Department Representative

08/27/2024 - On-Site: [REDACTED]
08/28/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
License Capacity: 84 **Residents Served:** 48

Secured Dementia Care Unit
In Home: Yes **Area:** Bridges to Rediscovery **Capacity:** 26 **Residents Served:** 16

Hospice
Current Residents: 3

Number of Residents Who:
Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 48
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 2
Have Mobility Need: 24 **Have Physical Disability:** 0

Inspections / Reviews

08/27/2024 Full
Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 10/06/2024

Inspections / Reviews *(continued)*

12/02/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/02/2024

Reviewer: [REDACTED]

Follow Up Type: *Bypass Document
Submission*

12/03/2024 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/02/2024

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

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.

Repeat Violation: 02/16/24.

Plan of Correction

Accept [REDACTED] - 11/19/2024)

After move-in, a court appointed guardian was put in place (attached). Upon discovery the contract was not signed, the community reviewed the contract with the guardian for signature (attached)

The community completed an audit of all resident contracts on 9/30/24 (attached).

To prevent future occurrence, the Executive Director and Business Office Manager will audit all resident contracts monthly for proper completion of all residents that move in during that month (attached)

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented ([REDACTED] - 12/02/2024)

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

Plan of Correction

Accept [REDACTED] - 11/19/2024)

The Resident Rights and Complaint Procedure are reviewed with the resident as part of the contract, however the contract was not reviewed with resident #1.

The Executive Director received permission from the resident's guardian for signature upon review with the resident (attached)

The Executive Director reviewed the Resident Rights and the Grievance Procedure with resident #1 with signed acknowledgment (attached).

The Community completed an audit of all resident contracts to assure signed acknowledgement of Resident Rights and Grievance Procedure (attached). 9/30/24

The Executive Director and Business Office Manager will review contracts of new residents within the month they arrive to assure signed acknowledgment (attached), starting immediately.

41e Signed Statement (continued)

The Executive Director will continue to review Resident Rights and Grievance Procedure during select resident council meetings.

Proposed Overall Completion Date: 10/07/2024

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented (█) - 12/02/2024)

54a - Direct Care Staff**3. Requirements**

2600.

54.a. Direct care staff persons shall have the following qualifications:

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

Description of Violation

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

Plan of Correction

Accept (█) - 12/02/2024)

The community obtained care staff person A high school diploma for the employee file (attached)

The Business Office Manager completed an audit of all Direct Care staff (attached)

The Executive Director and Business Office Manager will audit the files of all new hires prior to start on a monthly basis (attached)

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented (█) - 12/02/2024)

65b - Rights/Abuse 40 Hours**4. Requirements**

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person B completed their 40th scheduled work hour in June 2024. However, this staff person did not complete training in the following topics: reporting of reportable incidents and conditions.

Staff person C completed their 40th scheduled work hour in May 2024. However, this staff person did not complete

65b Rights/Abuse 40 Hours (continued)

training in the following topics: reporting of reportable incidents and conditions.

Plan of Correction

Accept (████ - 12/02/2024)

Staff person B is no longer employed with the community.

Staff person C was trained in Reporting of reportable incidents and conditions (attached).

Although Reporting of reportable incidents and conditions had been trained as part of orientation, the wording on the orientation form was not specific. The community has adjusted the orientation form for all new hires (attached).

Due to the correction of the orientation form, the community is re training all team members on Reporting of Reportable Incidents and Conditions (attached for resident services). Training of all team members to be completed by 11/1/2024

Licensee's Proposed Overall Completion Date: 11/01/2024

Implemented (████ - 12/02/2024)

65e - 12 Hours Annual Training**5. 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 A received only 11.50 hours of annual training in training year 2023.

Plan of Correction

Directed (████ - 12/02/2024)

During the inspection, the Executive Director failed to submit all of the training completed by staff person A during 2023. The additional training staff person completed to comprise the required 12 hours is attached.

To assure compliance, the Executive Director is now tracking all Direct Care Staff person's training to include completion of required training and total hours. (attached)

Directed Plan of Correction (slw 12/2/24):

- In addition to the steps noted in this Plan of Correction, the following additional steps will be implemented:
- By 12/31/24, them Business Manager will review the staff training hours for all employees to ensure they have completed 12 hours of staff training during the 2024 training year.
- If the staff has not completed 12 hours of training annually, the ED will ensure additional training hours will be scheduled, starting immediately.

Proposed Overall Completion Date: 10/07/2024

Directed Completion Date: 12/10/2024

Implemented (████ - 12/02/2024)

65g - Annual Training Content

6. 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 A 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 training year 2023.

Staff person D 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 training year 2023.

Plan of Correction

Accept [redacted] - 12/02/2024)

Both staff person A and D received Fire Safety training performed by the Executive Director however the Executive Director failed to print his name on the form and instead listed the material utilized. (Training form is attached)

The Executive Director has a been trained by a fire safety expert (attached)

The community has adjusted the new hire orientation form to include the signature of the trainer. (attached)

All future fire safety trainings will include the name of the trainer; to have been trained by a fire safety expert.

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented [redacted] 12/02/2024)

65i - Training Record

7. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff training includes a completed list of "modules" but the list of completed modules for staff person's D and E does not include the length of each course.

Plan of Correction

Directed [redacted] - 12/02/2024)

To accompany the live trainings completed by staff person D and E, the community submitted computer trainings, however did not run the report to include the length of each course.

65i Training Record (continued)

The Executive Director has since consulted with company supports and has learned how to run the report to include the length of the course (example attached)

Any future submissions of computer training completed will include a properly run report to include the length of each course.

Directed Plan of Correction (slw 12/2/24):

- In addition to the steps noted in this Plan of Correction the following steps will be included:
- The Business Manager will be responsible for running staff training document, starting immediately, when requested by the Department.
- The ED will learn how to run the staff training reports by 12/10/24.
- The length of each course and the course instructors will be added to all training documents, by 12/10/24.
- The Business Manager will review all staff training documents bi annually, starting immediately, to ensure the documents reflect the required information.

Proposed Overall Completion Date: 10/07/2024

Directed Completion Date: 12/10/2024

Implemented (████) - 12/02/2024)

81a - Accomodation

8. Requirements

2600.

81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Description of Violation

The home's procedures for bedside mobility devices does not include a periodical assessment for proper installation and maintenance and that the device remains appropriate to the resident's need.

Plan of Correction

Accept (████) - 12/02/2024)

During the inspection, the community did not submit the home's procedures for bedside mobility devices. The procedure is attached.

The community currently has one bedside mobility device. As per the procedures, the assessment of installation and maintenance was completed on 10/4/24 and will be completed pursuant to procedure (attached).

The assessment of appropriateness to the resident's needs was completed on 9/13/24 is attached.

Training on the use and risks of the bedside mobility device was completed on 9/12/24 (attached)

Prior use or need to use a bedside mobility device will be reviewed during the pre admission assessment prior to move in for new residents as well as through assessments completed annually or through significant change.

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented (████) - 12/02/2024)

88a - Surfaces

9. 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

Several walls in resident #1's room are damaged. The resident punched holes in the wall, broke receptacles and ripped fixtures off the wall which the home has not yet finished restoring.

Plan of Correction

Accept ([redacted]) - 12/02/2024)

Resident #1 has created similar damage in the apartment on multiple occasions which had been repaired. Since inspection, the community has repaired all of the new damage and monitors for repair needs daily.

The community completed a audit of all resident apartments for areas requiring repair (attached).

The community will complete an audit of all resident apartments on a monthly basis and repair/correct as needs are discovered.

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented ([redacted]) - 12/02/2024)

95 - Furniture and Equipment

10. Requirements

2600.

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

Description of Violation

Several pieces of furniture in resident #1's room are damaged; doors on bathroom vanity ripped off, broken TV screen, and a broken lamp.

Plan of Correction

Accept ([redacted]) - 12/02/2024)

The broken TV has been removed, the lamp replaced, and the vanity replaced (attached)

The community completed an audit of all apartments on 9/30/24 to review for needed repairs (attached)

The community will continue to review resident #1 apartment daily to review for damage to be repaired and completed an audit of all apartments on a monthly basis.

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented ([redacted]) - 12/02/2024)

101j2 - Bedroom Chairs

11. 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 #13 is occupied by 2 residents; however, there is only 1 (one) chair in this room.

Plan of Correction

Accept ([redacted] - 12/02/2024)

The community has placed a 2nd chair in apartment 13

The Executive Director completed an audit of all SDU and shared apartments on 10/4/24 (attached)

The Bridge to Rediscovery/SDU Director or [redacted] designee will complete a weekly audit of all SDU/shared apartments and submit to the Executive Director for review and, if needed, correction.

Licensee's Proposed Overall Completion Date: 10/14/2024

Implemented ([redacted] - 12/02/2024)

101j7 - Lighting/Operable Lamp

12. 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

Resident #1 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction

Accept ([redacted] - 12/02/2024)

The lamp was replaced for resident #1 bedside table.

The community completed an audit of all apartments on 9/30/24 to include bedside lightsource (attached)

The community completed an audit of all SDU apartments on 10/4/24 to include bedside lightsource (attached)

The maintenance director will complete a monthly audit of all apartments to include bedside lightsource

The Bridget to Rediscovery Director will complete a weekly audit of SDU apartments to include bedside light source.

Licensee's Proposed Overall Completion Date: 10/31/2024

Implemented ([redacted] - 12/02/2024)

102k - No Common Towel

13. Requirements

2600.

102.k. Use of a common towel is prohibited.

Description of Violation

There was a used washcloth in the shared bathroom of room 13.

Plan of Correction

Accept ([redacted] - 12/02/2024)

The washcloth in apartment 13 was removed.

102k - No Common Towel (continued)

An audit of all SDU/shared apartments was completed on 10/4/24 to include no common towels (attached)

The Bridge to Rediscovery Director will complete a weekly audit to include to prevent common towels and submit the Executive Director. (attached)

Direct Care Staff, as part of a pre-scheduled training, will be trained on the prohibition of a common towel on 10/9/24. As the community does not allow the use of common towels, the training will include to assure two sets of common towels for shared apartments are presented on two separate labeled towel bars and that used towels are promptly removed.

Licensee's Proposed Overall Completion Date: 10/09/2024

Implemented (█) - 12/02/2024)

103i - Outdated Food

14. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

The following unlabeled, undated items were found in the home's main kitchen:

- a bag of sirloin patties, a half bag of french fries and a bag of chicken wings in the home's walk-in freezer,
- a container of Ken's Bleu Cheese Dressing, a container of Sysco horseradish, a bag of shredded and a bag of sliced mozzarella cheese in the home's walk-in refrigerator,
- three bags of uncooked Barilla Spaghetti and a box of Gold Medal Yellow Cake Mix in the home's dry goods storage area.

Plan of Correction

Accept (█) - 12/02/2024)

The community completed training on 103.j on 10/1/2024 (attached)

The Executive Director completed an audit of the kitchen to include 103.j on 10/3/24 (attached)

The Culinary Director or his designee will review food on a daily basis to assure compliance with 103.j

The Executive Director will complete a monthly audit of the kitchen to include 103.j

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented (█) - 12/02/2024)

131f - Fire Extinguisher Inspection

15. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the home's 13 passenger van does not have a tag showing it has been inspected by a fire safety expert.

131f Fire Extinguisher Inspection (continued)

Plan of Correction

Accept ([redacted] - 12/02/2024)

The tag of the fire extinguisher was located within the vehicle and returned to the extinguisher.

The maintenance director received training specific to 131.f on 9/30/24 (attached)

The maintenance director completed an audit of extinguishers within the community and vehicle on 9/24/24 (attached).

The maintenance director will review all fire extinguishers within the community and vehicle on a monthly basis and sign off on each tag.

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented [redacted] - 12/02/2024)

141a 1-10 Medical Evaluation Information

16. 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 #1's initial medical evaluation dated [redacted] is incomplete; it did not include the answers to section #9 Health Status.

Repeat Violation: 01/29/24.

Plan of Correction

Accept [redacted] - 12/02/2024)

The medical evaluation for resident#1 was corrected (attached)

The Director of Resident Care received training on medical evaluations and 141.a on 10/3/2024 (attached)

The community completed an audit of all current medical evaluation on 10/3/2024 to assure proper completion (attached)

The Director of Resident Care and Executive Director will review all new medical evaluations on a monthly basis to assure proper completion

141a 1 10 Medical Evaluation Information (continued)

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented ([REDACTED] - 12/02/2024)

141b1 - Annual Medical Evaluation

17. Requirements

2600.

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

Description of Violation

Resident #2's annual medical evaluation dated [REDACTED] is incomplete; it does not include all the answers to section #1 General Physical Examination and section #7 Medications has "See Attached" written in the box; however, no medication list is attached.

Resident #3's most recent medical evaluation was completed on [REDACTED]. The resident's previous medical evaluation was completed on [REDACTED].

Resident #4's most recent medical evaluation was completed on [REDACTED]. The resident's previous medical evaluation was completed on [REDACTED].

Plan of Correction

Accept ([REDACTED] - 12/02/2024)

The medical evaluation for resident #2 was corrected (attached).

The Director of Resident Care was trained on 141b.1 on 10/3/2024 (attached)

The community completed an audit of all medical evaluations on 10/3/2024 (attached).

The Executive Director and Director of Resident Care will review all new medical evaluations monthly (attached). This review will include annual schedule to assure medical evaluations are completed timely and in compliance with 141.b.1

Licensee's Proposed Overall Completion Date: 10/11/2024

Implemented ([REDACTED] - 12/02/2024)

162c - Menus Posted

18. Requirements

2600.

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

Description of Violation

On 08/27/24, the posted menus in the Bridges to Rediscovery (BtR) / secured dementia care unit were for the weeks of June 24th to June 30th, July 01 to July 07, July 08 to July 14th and July 15th to July 21st. The current and following week's menus were not posted.

Plan of Correction

Accept ([REDACTED] - 12/02/2024)

The Culinary Director replaced the menus with current and future week upon discovery.

162c - Menus Posted (continued)

The Culinary Director and chefs were trained on 162.c on 10/1/2024 (attached).

The Culinary Director and Executive Director will inspect weekly to assure future compliance

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented (████) - 12/02/2024)

181f - Record of Medication

19. Requirements

2600.

181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On ██████ resident #5's record did not include the correct dosage of the resident's medications. The list in the resident's record indicates the resident is to administer ██████ tablet twice a day. However, the resident indicates this medication is to be administered three times a day. The resident's assertion was verified with the prescribing physician's order.

Plan of Correction

Accept ██████ - 12/02/2024)

Resident #5 self administers medication and had not alerted the community of the change. The records have been properly adjusted (attached)

The Director of Resident Care received training on 181.f on 10/3/2024 (attached)

The Director of Resident Care will provide education to be documented on progress note to residents who self administer medication on the necessity to immediately communicate changes in prescription, CAM and OTC medications by 10/14/2024.

The Director of Resident Care will audit medications of residents who self administer medications against our records on quartely basis.

Licensee's Proposed Overall Completion Date: 10/14/2024

Implemented (████) - 12/02/2024)

183e - Storing Medications

20. 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

Resident #6 uses two insulin Pens; ██████. Both pens have a manufacturer's recommended expiration date after opening; ██████ - 28 days and ██████ - 56 days. On ██████, during a medication cart audit, it was noted that neither pen is marked with the date the medication was opened making it unable to determine the expiration date.

183e Storing Medications (continued)

Repeat Violation: 07/27/23.

Plan of Correction

Accept ([redacted] - 12/02/2024)

The medication technician failed to write the date opened upon opening the medication. The pens have been replaced.

The Director of Resident Care is providing re training to medication technicians on 10/7/2024

The Director fo Resident Care has completed a full audit of each medication cart. The Director of Resident Care and the Wellness assistant will complete a combined total of 6 cart audits each week beginning the week of 10/7/24 (attached). The schedule of 6 cart audits will continue for 4 weeks. pending review and significant compliance, the audit schedule will reduce to 4 audits per week and titrade down pending the review of the Executive Director and Regional Director of Health and Wellness not to reduce below 2 full cart audits per week.

Licensee's Proposed Overall Completion Date: 11/01/2024

Implemented [redacted] - 12/02/2024)

185a - Implement Storage Procedures

21. Requirements

2600.

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

Description of Violation

On [redacted], the [redacted] blood glucose reading on resident #6's glucometer was [redacted] but documented in the Medication Administration Record (MAR) as [redacted]. On [redacted], resident #6's glucometer displayed a reading of [redacted] at the [redacted] blood glucose testing; however, this reading is not recorded on the MAR.

Resident #6 is prescribed blood sugar testing four (4) times a day; [redacted]. However, resident #6's glucometer does not have a reading for [redacted]

On [redacted], at [redacted], the glucometer for resident #7 displayed the time as [redacted].

Resident #8 is prescribed [redacted] Inhale two puffs every 4 hours as needed. On [redacted] this medication was not available in the home.

Plan of Correction

Accept ([redacted] - 12/02/2024)

The medication technicians will be re trained on 10/7/2024 to include 185.a

The Director fo Resident Care has completed a full audit of each medication cart. The Director of Resident Care and the Wellness assistant will complete a combined total of 6 cart audits each week beginning the week of 10/7/24 (attached). The schedule of 6 cart audits will continue for 4 weeks. pending review and significant compliance, the audit schedule will reduce to 4 audits per week and titrade down pending the review of the Executive Director and Regional Director of Health and Wellness not to reduce below 2 full cart audits per week.

Licensee's Proposed Overall Completion Date: 11/01/2024

185a Implement Storage Procedures (*continued*)

Implemented (████) - 12/03/2024)

185b Medication Procedures

22. Requirements

2600.

185.b. At a minimum, the procedures must include:

Description of Violation

On █████ during a medication cart audit, resident #9's █████ was found among the resident's other medications. █████ is considered a █████ controlled substance due to its potential for abuse and should be stored under a double lock and key such as used for narcotics and other controlled substances.

Plan of Correction

Accept (████) - 12/02/2024)

The █████ was placed securely with controlled substances and controlled count sheet established upon discovery.

All medication technicians will receive re-education specific to 185.b on 10/7/2024

The Director of Resident Care has completed a full audit of each medication cart. The Director of Resident Care and the Wellness assistant will complete a combined total of 6 cart audits each week beginning the week of 10/7/24 (attached). The schedule of 6 cart audits will continue for 4 weeks. pending review and significant compliance, the audit schedule will reduce to 4 audits per week and titrade down pending the review of the Executive Director and Regional Director of Health and Wellness not to reduce below 2 full cart audits per week.

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented (████) - 12/03/2024)

187a Medication Record

23. Requirements

2600.

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.
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.

187a - Medication Record (continued)

Description of Violation

Resident #1 is prescribed [redacted] Tablet, all instructed as take one (1) tablet by mouth one time a day. However, resident's [redacted] medication administration record does not indicate the diagnosis or purpose for the medication.

Resident #9 is prescribed [redacted]. The medication package instructions are [redacted] tablet by mouth every 8 hours. The resident's [redacted] 2024 MAR instructions read [redacted] by mouth every 8 hours. This difference in dosage amounts could lead to medication errors.

Plan of Correction

Accept ([redacted] - 12/02/2024)

The record for resident #1 to include diagnosis is attached

The order for resident#9 was corrected and is attached.

The medication technicians will receive re-training on 10/7/2024 to include 187.a

The Director fo Resident Care has completed a full audit of each medication cart. The Director of Resident Care and the Wellness assistant will complete a combined total of 6 cart audits each week beginning the week of 10/7/24 (attached). The schedule of 6 cart audits will continue for 4 weeks. pending review and significant compliance, the audit schedule will reduce to 4 audits per week and titrade down pending the review of the Executive Director and Regional Director of Health and Wellness not to reduce below 2 full cart audits per week.

Licensee's Proposed Overall Completion Date: 10/11/2024

Implemented ([redacted] 12/02/2024)

187b - Date/Time of Medication Admin.

24. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1 is prescribed [redacted] - give one tablet twice a day as needed for [redacted]. Resident #1's August 2024 medication administration record does not include the initials of the staff person who administered this medication on [redacted] at [redacted]

Resident #10 is prescribed [redacted] - take one tablet by mouth every 4 hours as needed. Resident #10's [redacted] medication administration record does not include the initials of the staff person who administered this medication on [redacted].

Resident #6's [redacted] does not include the initials of the person who administered medication on [redacted] and [redacted]

Plan of Correction

Accept ([redacted] - 12/02/2024)

Medication Technicians will receive re-education on 10/7/2024 to include 187.b

The Director fo Resident Care has completed a full audit of each medication cart and MAR. The Director of Resident Care and the Wellness assistant will complete a combined total of 6 cart and MAR each week beginning the week

187b - Date/Time of Medication Admin. (continued)

of 10/7/24 (attached). The schedule of 6 cart audits will continue for 4 weeks. pending review and significant compliance, the audit schedule will reduce to 4 audits per week and titrade down pending the review of the Executive Director and Regional Director of Health and Wellness not to reduce below 2 full cart audits per week.

Licensee's Proposed Overall Completion Date: 10/31/2024

Implemented () - 12/03/2024)

191 - Resident Right to Refuse**25. Requirements**

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1, admitted () has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction

Accept () - 12/02/2024)

The right to refuse medication if the resident believe that there may be a medicaiton error was reviewed with resident #1 on () (attached).

Resident #1 had not reviewed and signed () contract (guardian has since reviewed and signed), causing the deficiency. The community completed an audit of all resident contracts on () to assure that the right to refuse medication had been reviewed and signed (attached).

The Executive Director and Business Office Manager will review contracts of all new residents monthly to assure the completion of review and signed acknowledgement (attached)

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented () - 12/02/2024)

225c - Additional Assessment**27. 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 #1's assessment, dated () does not include any information regarding recent activities in the home including breaking into rooms, destroying property and other acts of aggression.

Plan of Correction

Accept () - 12/02/2024)

The Assessment for Resident #1 was adjusted on () and reviewed with the guardian (attached)

On 10/2/2024 the Director of Resident Care received training on 225.c (attached)

225c Additional Assessment (continued)

The Director of Resident Care completed a chart audit on [REDACTED] to include current RASP and accuracy (attached)

The Director of Resident Care will complete a monthly review of RASPs of new residents, annual, and significant change on a monthly basis (attached).

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented ([REDACTED] - 12/02/2024)

227d - Support Plan Medical/Dental**28. Requirements**

2600.

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

Description of Violation

The assessment for resident #3, dated [REDACTED] and [REDACTED], are incomplete. Under Section 3: Mental Health, Behavioral Health, and Cognitive Function Needs, the box under Medical Diagnosis Psychological is marked "None". The home did not continue to fill out the remainder of the Assessment which include "Orientation...", "Irritability", "Judgement" et. al. which indicates the home did not assess these conditions even though there are no listed medical diagnoses.

The assessment for resident #11, dated [REDACTED], indicates "C" ([REDACTED]) under the Personal Care Needs and Degree column for "Transferring in/out of bed/chair" and B ([REDACTED]g) under "Turning and positioning in bed/chair"; however, "... uses a bed enabler for safety is listed under "Description of Service Need" and Monitor proper use and repair of bed enabler is written in under the "Plan to Meet Service Need" column.

The Resident Support Plan does not indicate the following:

- The specific need for the device,
- The intended Use,
- Any risks associated with the device,
- The resident's ability to use the device safely for the intended purpose,
- Identification of the specific device to be used,
- If a cover is required to meet FDA guidelines.

Plan of Correction

Accept ([REDACTED] - 12/02/2024)

Resident #11 utilized a bedrail. Upon assessment, it was determined that the resident was not capable of lower or raising the rail. In consultation with the resident, physician, and POA, the rail was removed on 9/14/2024.

A new RASP was completed for resident #11 on [REDACTED] (attached).

The new resident assessment and support plan for resident #3 will be completed by [REDACTED].

The Director of Resident Care was re education on the proper completion of support plans including 227.d on 10/2/2024 (attached).

227d Support Plan Medical/Dental (continued)

The Director of Resident Care will complete an audit of all current RASPs by [REDACTED] to include corrections as needed.

The Director of Resident Care and Executive Director will review RASPs for new move ins, annual, and significant change on a monthly basis to assure compliance

Licensee's Proposed Overall Completion Date: 10/31/2024

Implemented ([REDACTED] - 12/02/2024)

227g -Support Plan Signatures

29. 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 #2's support plans dated [REDACTED] and [REDACTED] are not signed by the staff member who completed the assessment.

Resident #9's support plan dated [REDACTED] is not signed by the resident.

Plan of Correction

Accept ([REDACTED] 12/02/2024)

The Director of Resident Services received re education on the proper completion of support plans to include proper signatures on 10/2/2024 (attached)

The support plan for resident #9 was re reviewed with the resident for signature on [REDACTED] (attached).

The assessor of the support plan for resident #2 is no longer employed. The Executive Director documented and signed off on the document (attached)

The Director of Resident Services will complete a full audit of all current support plans to assure proper signatures and corrections by 10/31/2024

The Director of Resident Services and Executive Director will review the support plans of all new residents, annual, and significant change on a monthly basis for ongoing compliance (attached)

Licensee's Proposed Overall Completion Date: 10/31/2024

Implemented ([REDACTED] - 12/02/2024)

236 - Staff Training

30. Requirements

2600.

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

Description of Violation

236 Staff Training (continued)

Direct care staff person A, who works in the Secure Dementia Care Unit (SDCU) had only 1 hours of training in dementia care during the 2023 training year.

Direct care staff person D works in the Secure Dementia Care Unit (SDCU). Training hours are not listed on the 2023 training provided. Meeting this six (6) hour requirement can not be determined.

Repeat Violation: 07/18/24.

Plan of Correction

Accept (████) - 12/02/2024)

Both team member A & D have completed the minimum requirement of 6 additional hours related to dementia care and services in the 2024 training year.

The Executive Director is currently tracking all training completed to include required training, total hours, and additional required 6 hours of dementia care and services (attached)

The Director of Resident Services and Business Office Manager were re educated on the requirement of 236 on 10/2/2024 (attached).

The Executive Director will update the training tracker on a monthly basis to track progress and assure ongoing compliance

Licensee's Proposed Overall Completion Date: 10/07/2024

Implemented (████) /02/2024)