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 November 1, 2024 and January 21, 2025 of the above facility, we have determined that your submitted plan of correction for the September 4, 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:** *55* **Waking Staff:** *41*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *09/04/2024*

Inspection Dates and Department Representative

09/04/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *81* **Residents Served:** *32*

Special Care Unit

In Home: *Yes* **Area:** *Memory Care Unit* **Capacity:** *18* **Residents Served:** *15*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *32*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *23* **Have Physical Disability:** *0*

Inspections / Reviews

09/04/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/30/2024*

Inspections / Reviews *(continued)*

11/01/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *09/30/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/06/2024*

02/21/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/06/2024*

Reviewer: [redacted] **Follow-Up Type:** *Exception*

65i Training topics

1. 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

The residence annual staff training plan for 2024 does not include instructions on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation, and support plan.

Plan of Correction ***Accept ([redacted] - 11/01/2024)***

By October 9, 2024, the Administrator will update the 2024 Annual Training Plan to include the omitted topic, #2, as required by regulation 2800.65.i, along with a timetable for assigning and completing the training. (Exhibit A1– Revised Annual Training Plan)
By October 9, 2024, the Administrator will provide an in-service to the Human Resource Generalist (HRG) on the revised 2024 Annual Training Plan. (Exhibit – A2 In-service)
Starting October 9, 2024, the HRG or designee will audit the completion of annual training for three employees each week for four weeks. The audit will then occur bi-weekly for the next four weeks and monthly for an additional month to ensure sustained compliance. (Exhibit A3– Audit Tool)
Audit results will be reviewed during quarterly QI meetings. The QI Committee will assess whether continued auditing is necessary based on three consecutive months of compliance.

Proposed Overall Completion Date: 10/09/2024

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

65j Annual training content

2. 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.
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

The residence annual staff training plan for 2024 does not include the Older Adult Protective Services Act (35 P.S. § §

65j Annual training content (continued)

10225.101—10225.708). Falls and accident prevention and the new population groups that are being served at the home that were not previously served.

Plan of Correction ***Accept ([redacted] - 11/01/2024)***

By October 9, 2024, the Administrator will update the 2024 Annual Training Plan to include training for the omitted areas under regulation 2800.65.j (#4, #5, #6), along with a timetable for their assignment and completion. (Exhibit B1– Revised 2024 Annual Training Plan)
By October 9, 2024, the Administrator will provide an in-service to the HRG on the updated 2024 Annual Training Plan requirements outlined in regulation 2800.65.j. (Exhibit B2– In-service)
Starting October 9, 2024, the HRG or designee will audit the completion of annual training for three employees each week for four weeks, then bi-weekly for another four weeks, and finally, monthly for one month to ensure ongoing compliance. (Exhibit B3– Audit Tool)
The results of these audits will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will decide if further audits are needed based on three consecutive months of compliance.

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

88a Floors, walls, ceilings, windows, doors

3. Requirements

2800.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

Two ceiling tiles are missing on the second floor near room 239, and numerous other ceiling tiles have water stains on them.

Plan of Correction ***Accept ([redacted] - 11/01/2024)***

On September 6, 2024, the Facilities Director replaced the two missing ceiling tiles near room 239 and inspected the integrity of all ceiling tiles in the community, replacing any with water stains. (Exhibit C1– Photo of Replaced Ceiling Tiles)
By October 9, 2024, the Administrator will provide an in-service to the Facilities Director on the requirements outlined in regulation 2800.88a. (Exhibit C2– In-service)
Starting October 9, 2024, the Facilities Director or designee will inspect the community's ceiling tiles for any disrepair or stains. This audit will occur weekly for four weeks, then bi-weekly for another four weeks, and monthly for an additional month to ensure sustained compliance. (Exhibit C3– Audit Tool)
The audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will decide whether ongoing audits are necessary based on three consecutive months of compliance.

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

Implemented ([redacted] - 01/21/2025)

141a Medical evaluation

4. 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.

141a Medical evaluation *(continued)*

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.
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 #1, dated [redacted], does not include the immunizations and tuberculosis testing and the mobility assessment. This area of the form is blank.

The medical evaluation for resident #2, dated [redacted], does not include if the resident can self-administer. This area of the form is blank.

Repeat Violation: 1/18/2024

Plan of Correction ***Accept ([redacted] - 11/01/2024)***

On September 6, 2024, the Nurse Manager, a Registered Professional Nurse, amended the medical evaluation for Resident #1 to include immunizations, tuberculosis testing, and a mobility assessment. (Exhibit D1– Amended Medical Evaluation)
On September 6, 2024, the Nurse Manager updated the medical evaluation for Resident #2 to include the resident's self-administration status. (Exhibit D2 – Amended Medical Evaluation)
By October 9, 2024, the Nurse Manager will audit the medical evaluations of all current residents to identify any additional instances of missing required information. (Exhibit D3– Audit Tool)
Starting October 9, 2024, the Nurse Manager or designee will audit the medical evaluations of newly admitted residents weekly for four weeks, bi-weekly for another four weeks, and monthly for an additional month to ensure sustained compliance. (Exhibit D4– Audit Tool)
Audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will decide whether further audits are necessary based on three consecutive months of compliance.

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

141b2 Medical evaluation changes

5. Requirements

2800.
141.b. A resident shall have a medical evaluation:
2. If the medical condition of the resident changes prior to the annual medical evaluation.

141b2 Medical evaluation changes *(continued)*

Description of Violation

Resident #3's medical condition changed on [redacted], and [redacted] was admitted to Hospice. However, the home failed to have a medical evaluation conducted prior to the annual medical evaluation. The most recent medical evaluation was completed on [redacted] No medical evaluation related to his declining medical status for admission to HOSPICE on [redacted] was completed.

Plan of Correction ***Accept ([redacted] - 11/01/2024)***

On September 17, 2024, Resident #3's physician completed a new medical evaluation, documenting Resident #3's need for hospice services. (Exhibit E1– Amended Medical Evaluation)
By October 9, 2024, the Nurse Manager will audit the medical evaluations for residents receiving hospice services, noting the completion date of each evaluation. If it is found that a new "significant change" medical evaluation was not completed before or on the day hospice services began, the Nurse Manager, in collaboration with the resident's physician, will amend the resident's current medical evaluation to reflect end-of-life services. (Exhibit E2– Audit Tool)
Starting October 9, 2024, the Nurse Manager or designee will audit the medical evaluations of residents who have initiated hospice or palliative care to confirm that a "significant change" medical evaluation was completed before the start of services. This audit will occur weekly for four weeks, then bi-weekly for four weeks, and monthly for an additional month to ensure sustained compliance. (Exhibit E3– Audit Tool)
The audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will determine if further auditing is required based on three consecutive months of compliance.

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

Implemented ([redacted] - 01/21/2025)

183e Storing Medications

6. 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

Resident #4 is prescribed a Lantus U-100 insulin pen. The medication was opened on 8/01/2024, and it continued to be used and administered until 09/04/2024. According to the manufacturer's instructions, this medication has to be discarded 28 days after opening.

Plan of Correction ***Accept ([redacted] - 11/01/2024)***

On September 4, 2024, the Nurse Manager discarded Resident #4's Lantus U-100 insulin pen, which had been opened on August 1, 2024.
On September 5, 2024, the Nurse Manager audited current residents' insulin pens to identify any being used past the manufacturer's specified discard date. No additional instances of non-compliance were found.
By October 9, 2024, the Nurse Manager will provide an in-service to currently employed licensed nurses and medication technicians on the requirements of regulation 2800.183.e. (Exhibit F1– In-service Documentation)
Starting October 9, 2024, the Nurse Manager or designee will audit the insulin belonging to current residents weekly for four weeks, then bi-weekly for another four weeks, and monthly for an additional month to ensure sustained compliance. (Exhibit F2– Audit Tool)
The audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will

183e Storing Medications (continued)

decide whether ongoing auditing is needed based on three consecutive months of compliance.

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

185a Storage procedures

7. 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 #4 has various glucometer readings that do not match the EMAR readings documented.
On 9/02/2024, at 7:31 am, resident #4 glucometer has a reading of 385. However, the reading on the EMAR was 285.
On 9/03/2024, at 4:27 pm, resident #4 glucometer has a reading of 198. However, the reading on the EMAR was 197.
On 9/04/2024, at 7:37 am, resident #4 glucometer has a reading of 287. However, the reading on the EMAR was 286.

Resident #4 glucometer was not calibrated; on 9/03/2024, the time on the glucometer was 4:27 p.m. and the time on the EMAR was 4:16 p.m.

Plan of Correction ***Accept ([redacted] - 11/01/2024)***

On September 5, 2024, the Nurse Manager reported the medication error associated with the transcription error above that resulted in a medication error (9/2/2024, 7:31am) for Resident #4 to the resident, their physician, their responsible party, and the Department. (Exhibit G1– Reportable Incident)
On September 5, 2024, the Nurse Manager audited the glucometer readings of current residents who are ordered blood glucose finger sticks for the preceding 20 days, along with the corresponding Medication Administration Record (MAR) entries, to ensure the readings matched the transcriptions. Additional errors were identified and reported to the affected residents, their designated persons, the prescribers, and the Department.
By October 9, 2024, the Nurse Manager educated currently employed licensed nurses and diabetic-trained medication technicians on the requirements of regulation 2800.185.a. Additionally, effective immediately, the following best practice was implemented: staff must have a witness when reading glucometers, transcribing blood glucose values, and determining the number of insulin units to be administered, to ensure accuracy. (Exhibit G2– In-service Documentation)
Starting October 9, 2024, the Nurse Manager or designee will audit residents' glucometer readings and the corresponding MAR entries weekly for four weeks, then bi-weekly for another four weeks, and monthly for an additional month to ensure sustained compliance. (Exhibit G3 – Audit Tool)
The audit results will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will decide whether continued auditing is needed based on three consecutive months of compliance.

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

187d Follow prescriber's orders

8. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #3 was not administered the prescribed Seroquel 50 mg at bedtime from 8/24/24 to 8/31/24. The Medication Administration Record indicates the medication was not available.

187d Follow prescriber's orders (continued)

Resident #4 is prescribed Lantus U-100 insulin. However, starting 8/16/2024, the directions change from 40 units to 36 units in am at breakfast. The change in directions was not updated on the medication package.

Resident #4 is prescribed Novolog Flex Pen U-100 Insulin. However, starting 8/16/2024, the directions change from a standing order of 14 units before breakfast, 8 units before lunch, and 16 units before dinner plus a sliding scale that is above 150 to a standing order of 8 units before breakfast, 6 units before lunch, and 10 units before dinner plus a sliding scale that is above 150. The change in directions was not updated on the medication package.

On 9/02/2024, at 7:31 am, resident #4 glucometer has a reading of 385. However, the reading on the EMAR was 285. Resident #4 was administered 6 units instead of 10 units per sliding scale.

Plan of Correction ***Accept ([redacted] - 11/01/2024)***

On September 26, 2024, the Nurse Manager notified Resident #3, their responsible party, and their physician of the missed Seroquel doses between August 24, 2024, and August 31, 2024.
On September 26, 2024, the Nurse Manager self-reported this medication error to the Department. (Exhibit H1– Reportable Incident)
On September 26, 2024, , the Nurse Manager confirmed the community had received Resident #3's Seroquel 50mg tablets from the pharmacy on [Date].
On September 26, 2024,, the Nurse Manager audited the Medication Administration Records (MAR) for current residents to identify any additional instances of unavailable medications. No further instances were identified.
On September 26, 2024,, the Nurse Manager placed a "Directions Changed, See MAR" sticker on Resident #4's Lantus U-100 insulin package and Novolog Flex Pen U-100 insulin package.
On September 26, 2024, the Nurse Manager audited the current MAR instructions for residents, comparing them to the medication packaging. When discrepancies were found between the MAR and the label, a "Directions Changed, See MAR" sticker was placed on the medication packaging.
On September 26, 2024, the Nurse Manager issued a formal disciplinary action to the licensed nurse who incorrectly documented a blood sugar reading of "285" instead of "385," resulting in the administration of 6 units of insulin instead of the ordered 10 units.
On September 26, 2024, the Nurse Manager informed Resident #4, their responsible party, and their physician of the insulin administration error (6 units instead of 10 units as per the sliding scale order).
On September 26, 2024, the Nurse Manager self-reported Resident #4's medication error to the Department. (Exhibit H2– Reportable Incident)
On September 5, 2024, the Nurse Manager educated currently employed licensed nurses and diabetic-trained medication technicians on the requirements of regulation 2800.185.d. The following best practice was implemented effective immediately: staff are required to obtain a witness for glucometer readings, transcription of blood glucose values, and the number of insulin units administered to ensure accuracy. (Exhibit H3 – In-service Documentation)
On September 5, 2024, the Nurse Manager audited the glucometer readings for current residents from the preceding 10 days, along with their corresponding MAR entries, to ensure that readings matched transcriptions. Additional errors were identified and reported to the affected residents, their designated persons, prescribers, and the Department.
Beginning October 9, 2024, the Nurse Manager or designee will audit residents' glucometer readings and corresponding MAR entries weekly for four weeks, then bi-weekly for four weeks, and monthly for one month to ensure sustained compliance. (Exhibit H4– Audit Tool)

187d Follow prescriber's orders (continued)

Beginning October 9, 2024, the Nurse Manager or designee will run the Matrixcare Medication Administration Compliance report to ensure that ordered medications are readily available, weekly for four weeks, then bi-weekly for four weeks, and monthly for one month to ensure sustained compliance. (Exhibit H5– Audit Tool)
The results of the audits will be reviewed during quarterly Quality Improvement (QI) meetings. The QI Committee will determine whether continued auditing is necessary based on three consecutive months of compliance.

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

Implemented (- 01/21/2025)

188b Medication error reporting

9. Requirements

2800.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #4 is prescribed Novolog U-100 Insulin. However, resident #4 was administered 6 units of insulin on 9/02/2024, at 7:31 am instead of 10 units per sliding scale. The medication error was not reported to the resident, the resident's designated person, or the prescriber.

Plan of Correction ***Accept (- 11/01/2024)***

On September 5, 2024, the Nurse Manager notified Resident #4, their responsible party, and their physician of the insulin administration of 6 units instead of the 10 units as per their sliding scale order.
On September 5, 2024, the Nurse Manager self-reported Resident #4's medication error to the Department. (Exhibit I1– Reportable Incident)
On September 5, 2024, the Nurse Manager audited the glucometer readings of current residents for the preceding 10 days and the associated Medication Administration Record (MAR) entries to verify that readings matched the transcriptions. Additional errors were identified and reported to the resident, their designated person, the prescriber, and the Department.
On September 23, 2024, the Nurse Manager educated licensed nurses and medication technicians on the requirements outlined in regulation 2800.188.b. (Exhibit I2 – In-service Documentation)
Beginning October 9, 2024, the Nurse Manager will audit medication error incident reports weekly for four weeks, then bi-weekly for four weeks, and monthly for one month to ensure documentation reflects that the involved resident, their designated person, and the prescriber were immediately notified. (Exhibit I3– Audit Tool)
The results of the audits will be reviewed during quarterly Quality Improvement (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: *10/09/2024*

Implemented (- 01/21/2025)

202 Prohibitions

10. Requirements

2800.
202. The following procedures are prohibited:

202 Prohibitions *(continued)*

1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2800.231 (relating to admission).
2. Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.
3. Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.
4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.
5. A mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device or the resident or his designee understands the need for the device and consents to its use.
6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

On 8/2/2024, at 12:05 am, resident #3 was administered Ativan 1 mg PRN for being very agitated. The medication is prescribed for anxiety. On 8/18/24, at 05:44 am and 11:46 pm, the resident was administered Ativan 1 mg and Morphine Concentrate 10 mg for restlessness and anxiety. Morphine is to be administered for pain and shortness of breath. No nonpharmacological interventions were employed.

Plan of Correction ***Accept ([redacted] - 11/01/2024)***

The community is unable to address this deficient practice concerning Resident #3.
By October 9, 2024, the Nurse Manager will educate currently employed licensed nurses on the requirements set forth in regulation 2800.202, including appropriate non-pharmacological interventions to be implemented prior to administering a PRN psychotropic or controlled medication. (Exhibit J1 – In-service Documentation)
By October 9, 2024, the Nurse Manager will conduct an audit of current residents prescribed psychotropic and controlled medications to ensure these medications have appropriate indications for use and administration. If any inappropriate indications for use or administration are identified, the Nurse Manager will notify the resident's prescriber to seek clarification and, if necessary, review regulation 2800.202 (#4) with the prescriber, documenting the outcome.
Beginning October 9, 2024, the Nurse Manager or designee will audit the administration notes for PRN psychotropic and controlled medications weekly for four weeks, then bi-weekly for four weeks, and finally monthly for one month to ensure these medications are administered according to their indications for use. (Exhibit J2– Audit Tool)
The results of the audits will be discussed during quarterly Quality Improvement (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: *10/09/2024*

Implemented ([redacted] - 01/21/2025)

224a2 30 days prior to admission

11. Requirements

2800.
224.a.2. An individual shall have a written initial assessment that is documented on the Department's assessment form within 30 days prior to admission unless one of the conditions contained in paragraph (3) apply.

224a2 30 days prior to admission *(continued)*

Description of Violation

Resident #5 was admitted on [redacted]. The resident's initial assessment was not completed until [redacted]

Resident #6 was admitted on [redacted]. The resident's initial assessment was not completed until [redacted]

Plan of Correction ***Accept ([redacted] - 11/01/2024)***

On September 5, 2024, the Nurse Manager reviewed the initial assessments for Residents #5 and #6 to ensure they accurately reflect the residents' care needs and preferences. No revisions or amendments were deemed necessary at this time.

On September 26, 2024, the Regional Director of Clinical Services (RDCS) provided in-service training to the Nurse Manager and Assisted Living Administrator regarding the date requirements outlined in regulation 2800.224.a.2. (Exhibit K1– In-service Documentation)

Beginning October 9, 2024, the Nursing Manager or designee will audit the initial assessments of newly admitted residents weekly for four weeks, then bi-weekly for four weeks, and finally monthly for one month to ensure sustained compliance. (Exhibit K2– Audit Tool)

The results of the audits will be discussed during quarterly Quality Improvement (QI) meetings. The QI Committee will determine whether continued auditing is necessary based on three consecutive months of compliance.

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

Implemented ([redacted] - 01/21/2025)

225a2 Assessment – significant change

12. Requirements

2800.

225.a.2. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

On [redacted] resident #3 was admitted to Hospice. Resident #3's assessment, dated [redacted] does not include the significant change. An additional written assessment and support was not completed and developed.

Plan of Correction ***Accept ([redacted] - 11/01/2024)***

On September 16, 2024, the Nurse Manager developed and completed an Assessment and Support Plan (ASP) for Resident #3, noting the resident's need for hospice services. (Exhibit L1– ASP)

By October 9, 2024, the Nurse Manager will audit the ASPs for residents receiving hospice services, documenting the completion date for each. If instances are identified where a "significant change" ASP was not completed prior to or on the day hospice services were initiated, the Nurse Manager will create and complete a new ASP. (Exhibit L2 – Audit Tool)

Beginning October 9, 2024, the Nurse Manager or designee will audit the ASPs of residents who have started

225a2 Assessment – significant change (continued)

hospice or palliative care to ensure that a "significant change" ASP was completed before or on the start date of services. This audit will occur weekly for four weeks, bi-weekly for four weeks, and then monthly for one month to ensure sustained compliance. (Exhibit L3 – Audit Tool)
The results of the audits will be discussed during quarterly Quality Improvement (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: *10/09/2024*

Implemented ([redacted] - 01/21/2025)

227a Final support plan – 30 days

13. Requirements

2800.
227.a. Each resident requiring services shall have a written final support plan developed and implemented within 30 days after admission to the residence. The final support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1's assessment was completed on [redacted]; however, the resident's support plan does not include the dates when it was revised.
Resident #5 assessment was completed on [redacted] however, the resident's support plan does not include the dates when it was revised.
Resident #6 assessment was completed on [redacted]; however, the resident's support plan does not include the dates when it was revised.

Repeat Violation: 1/18/2024

Plan of Correction ***Accept ([redacted] - 11/01/2024)***

On September 5, 2024, the Nurse Manager documented the completion date for late entry in the support plans for Resident #5
On September 11, 2024, the Nurse Manager documented the completion date for late entry in support plan Resident #6
On September 30, 2024, the Nurse Manager documented the completion date for late entry in support plan Resident #1
On [Date], the Regional Director of Clinical Services (RDCS) provided in-service training to the Nurse Manager and Administrator on the requirements outlined in regulation 2800.227.a. (Exhibit – In-service)
Beginning October 9, 2024, the Administrator or designee will audit the support plans of newly admitted residents weekly for four weeks, bi-weekly for four weeks, and then monthly for one month to ensure sustained compliance. (Exhibit – Audit Tool)
The results of the audits will be discussed during quarterly Quality Improvement (QI) meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Proposed Overall Completion Date: 10/09/2024

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

227a Final support plan – 30 days *(continued)*

Implemented (- 01/21/2025)

227h Support plan – refusal sign

14. Requirements

2800.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #6 participated in the development of support plan on The resident did not sign the support plan. The residence did not make a notation regarding the resident's refusal or inability to sign.

Repeat Violation: 5/22/23, 1/18/2024

Plan of Correction ***Accept (- 11/01/2024)***

On September 24, 2024, the Administrator offered Resident #6 the opportunity to sign their support plan. Following the resident's refusal, the Administrator made a notation regarding this refusal. (Exhibit N1 – Signature page of ASP with Administrator's notation)
By October 9, 2024, the Administrator or designee will audit current resident support plans for the presence of resident signatures. For any additional instances of omitted signatures, the Administrator will review the support plan with the resident and present it for signing. If the resident declines to sign or is physically unable to do so, the Administrator will document this on the support plan.
Beginning October 9, 2024, the Administrator or designee will audit newly completed resident support plans weekly for four weeks, then bi-weekly for four weeks, and finally monthly for one month to ensure sustained compliance. (Exhibit N2 – Audit Tool)
The results of the audit will be discussed during quarterly Quality Improvement (QI) meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Proposed Overall Completion Date: 10/09/2024

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

Implemented (- 01/21/2025)

252 Records – content

15. Requirements

2800.
252. Content of Resident Records - Each resident's record must include the following information:
1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. A language, speech, hearing or vision need which requires accommodation or awareness of during oral or written communication.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.

252 Records – content *(continued)*

7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the residence, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the residence, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2800.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.
27. A record relating to any exception request under § 2800.229 (relating to excludable conditions; exceptions).
28. Ongoing resident progress notes.

Description of Violation

Residents #2, 5, and 6 records do not include color of hair or color of eyes.

Repeat Violation: 1/18/2024

Plan of Correction ***Accept ([redacted] - 11/01/2024)***

On 9/26/24, the Administrator updated Residents #2, #5, and #6 records with their corresponding hair and eye color. (Exhibit O1- Updated face sheets)

By October 9, 2024, the Administrator or designee will audit current resident face sheets to confirm that the color of residents' hair and eyes is documented. For any additional instances where hair and eye color are omitted, the Administrator will update the face sheets accordingly.

Beginning October 9, 2024, the Administrator or designee will audit the face sheets of newly admitted residents weekly for four weeks, then bi-weekly for four weeks, and finally monthly for one month to ensure sustained compliance. (Exhibit O2– Audit Tool)

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

Proposed Overall Completion Date: 10/09/2024

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

252 Records – content *(continued)*

Implemented (- 01/21/2025)