pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **GREENFIELD OF PERKIOMEN VALLEY LLC**
LEGAL ENTITY

To operate **GREENFIELD OF PERKIOMEN VALLEY**
NAME OF FACILITY OR AGENCY

Located at **300 PERKIOMEN AVENUE, SCHWENKSVILLE, PA 19473**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **90**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 44**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **March 21, 2025** until **September 21, 2025**, unless sooner revoked for non-compliance with applicable laws and regulations.

No: **137352**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MARCH 21, 2025

[redacted]
Executive Director
Greenfield of Perkiomen Valley, LLC
[redacted]

RE: Greenfield of Perkiomen Valley
300 Perkiomen Avenue
Schwenksville, Pennsylvania 19473
License #: 137352

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection September 11, 2024, October 16, 2024, and November 13 and 14, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from March 21, 2025 to September 21, 2025.

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

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)

[redacted]

65f	III	37	$3	$111	15 calendar days from mailing date of this letter
65g	III	37	$3	$111	15 calendar days from mailing date of this letter
85e	III	37	$3	$111	15 calendar days from mailing date of this letter
101o	III	37	$3	$111	15 calendar days from mailing date of this letter
185a	II	37	$5	$185	5 calendar days from mailing date of this letter
187b	II	37	$5	$185	5 calendar days from mailing date of this letter
236	III	37	$3	$111	15 calendar days from mailing date of this letter

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

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

Your facility's SECOND PROVISIONAL license will expire on 09/21/2025. Pursuant to 55 Pa. Code § 20.54, a maximum of four consecutive provisional certificates of compliance may be issued to the legal entity for each specific facility or agency (1 Pa. Code. Part II).

[redacted]

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

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

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[redacted]

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

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *GREENFIELD OF PERKIOMEN VALLEY* **License #**: *13735* **License Expiration**: *01/02/2025*

Address: *300 PERKIOMEN AVENUE, SCHWENKSVILLE, PA 19473*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *GREENFIELD OF PERKIOMEN VALLEY LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/23/2012* **Issued By**: *Borough of Schwenksville*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *60* **Waking Staff**: *45*

Inspection Information

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

Reason: *Complaint, Incident, Monitoring* **Exit Conference Date**: *09/11/2024*

Inspection Dates and Department Representative

09/11/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served**: *41*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *44* **Residents Served**: *5*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *41*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *19* **Have Physical Disability**: *1*

Inspections / Reviews

09/11/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/10/2024*

Inspections / Reviews *(continued)*

10/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/15/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/21/2024*

10/31/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/15/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/15/2024*

03/04/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/15/2024*

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

3c - Post Current License

1. Requirements

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

Description of Violation

The home has not posted the most recent license inspection summary. The home has a license inspection summary dated 6/8/23 posted. The most recent license inspection summary is 3/5/24.

Plan of Correction ***Accept (- 10/16/2024)***

Administrator Posted the most recent license inspection of 7/18/2024 on 9/11/2024. Administrator posted the most recent license inspection summary which is 9/11/2024, on 9/30/2024. Administrator will start weekly checks of Current licensure postage starting on 10/14/2024 for 4 weeks, and continue for 2 months after.

Proposed Overall Completion Date: 11/01/2024

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

Implemented (- 03/04/2025)

54a - Direct Care Staff

2. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct Care Staff Person A, hired does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept (- 10/16/2024)***

Direct Care staff A was Terminated on Administrator will re-educate business office director on 10/15/2024 regarding the direct care staff qualifications. For future new hires, prior to onboarding for the specified job, barring any new regulation or requirement, the business office director will collect a high school degree, GED and pull active Pennsylvania aide certification/license from the registry. The business office director will continue monthly audits for high school diplomas for direct care staff employees starting 10/2024 and provide documentation of the audit to the administrator.

Proposed Overall Completion Date: 11/01/2024

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

Implemented (- 03/04/2025)

[redacted]

WITHDRAWN 3/14/25

[redacted]

85e - Trash Outside Home

4. Requirements

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

Description of Violation

The outdoor courtyard outside of the memory care unit has two bags of trash located on the walking

path. Repeat Violation: 10/31/23 et. al

Plan of Correction ***Accept ([redacted] - 10/16/2024)***

On 9/11/2024 Administrator removed trash bags from memory care unit. Starting 10/14/2024, Memory Care Coordinator will do daily checks for trash in courtyard for 1 month and continue weekly trash checks for 2 months thereafter. Administrator will hold training on 10/24/2024 covering the topic of disposing of trash, the locations of the dumpsters and the importance of trash storage in covered receptacles

Proposed Overall Completion Date: 11/01/2024

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

Not Implemented ([redacted] - 02/18/2025)

100a - Exterior - Free of Hazards

5. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The outdoor courtyard outside of the memory care unit is unable to be used safely. The landscaping is overgrown ; dried leaves, overgrown bushes and trees were present covering the walking path, causing tripping hazards.

100a - Exterior - Free of Hazards (continued)

The walking path is also cracked and elevated from a tree root growing underneath. The cracked path and overgrown landscaping provide a tripping hazard and make it unsafe for use.

Repeat Violation: 10/31/23 et. al

Plan of Correction ***Accept (- 10/16/2024)***

On 10/2/2024, the maintenance director repaired the cracked and elevated walking path. On 10/4/2024, the administrator approved for landscaping to be completed by 11/1/2024. will pull weeds, trim bushes, trees and lay mulch to provide a safe path for residents to walk. Starting 11/1/2024 Maintenance director will do weekly checks for 8 weeks in courtyard do make sure the path is clear of any debris or tripping hazards.

Proposed Overall Completion Date: 11/01/2024

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

Implemented (- 03/04/2025)

105g - Lint Removal and Duct Cleaning

6. Requirements

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

Description of Violation

On 9/11/24, there was an accumulation of lint in the lint trap of the Amana dryer # 2 in the PC area of the 3rd floor. There were no clothes in the dryer at the time.

Repeat Violation: 10/31/23 et. al

Plan of Correction ***Accept (- 10/31/2024)***

On 9/19/2024 the Administrator held an educational meeting with all staff on the importance of cleaning out lint traps after each use. Starting 10/14/2024, the care staff will sign off lint trap checks twice a day for am and pm shifts. These checks will continue for 4 months, and documentation will be given to the administrator at the end of each month, to be saved for department's review.

Proposed Overall Completion Date: 11/01/2024

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

Not Implemented (- 03/04/2025)

141b1 - Annual Medical Evaluation

7. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident # 1's most recent medical evaluation was completed on The resident's previous medical evaluation was completed on

141b1 - Annual Medical Evaluation (continued)

Resident # 2's most recent medical evaluation was completed on [redacted] The residents previous medical evaluation was completed on [redacted]

Repeat Violation: 1/23/24, 3/5/24 et. al

Plan of Correction ***Accept ([redacted] - 10/31/2024)***

Director of nursing will start Annual Medical Evaluation audit on 10/14/2024 and have completed by 11/1/2024. Director of nursing will continue medical evaluation audits monthly for 6 months, in order to maintain compliance in accordance with regulation 141b1.

Proposed Overall Completion Date: 11/01/2024

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

Implemented ([redacted] - 03/04/2025)

182c - Medication Administration

8. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

Resident # 2 is prescribed the following medications:
1. Azelastine Nasal Spray twice daily at 9:00 A.M. and 9:00 P.M.
2. Valsartan 40 mg 1 tablet once daily
3. Tamulosin 0.4 mg 2 tablets once daily
4. Symbicort inhale 2 puffs twice daily at 9:00 A.M. and 9:00 P.M.
5. Mucinex 1200 mg 1 tablet twice daily at 9:00 A.M. and 9:00 P.M.
6. Fluocinonide Ointment apply topically to the affected area twice daily at 9:00 A.M. and 9:00 P.M.
7. Eliquis 5mg 1 tablet by mouth twice daily at 9:00 A.M. and 9:00 P.M.
8. Calcium 600 mg 1 tablet by mouth twice daily at 9:00 A.M. and 9:00 P.M.
9. Betameth Dip Cream apply a thin layer to elbows twice daily at 9:00 A.M. and 9:00 P.M.

These medications were administered on 9/9/24 at 9:00 P.M.; however, the staff person did not document the administration of the medications on the Medication Administration Record (MAR).

Plan of Correction ***Accept ([redacted] - 10/31/2024)***

Director of nursing will hold training on medication administration documentation on 10/31/2024 with med techs at the wellness meeting. Director of nursing will monitor Care stream program daily for medication signatures starting 10/14/2024, for 8 weeks. Documentation will be signed off weekly by the Executive Director, and documentation will be held for department review

Proposed Overall Completion Date: 11/01/2024

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

Not Implemented ([redacted] - 02/18/2025)

[redacted]

WITHDRAWN 3/14/25

[redacted]

225c - Additional Assessment

10. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident # 1's current assessment was completed on [redacted] However, the resident's previous assessment was completed on [redacted]. The current assessment did not indicate their need for agitation or aggression following a resident to resident altercation on 8/23/24 in which the resident threatened to hit resident # 2.

Resident # 2' s current assessment was completed on [redacted] However, the resident's previous assessment was completed on [redacted] The current assessment does not include their need for agitation or aggression following a resident to resident altercation on 8/23/24 in which Resident # 2 grabbed Resident # 1's wrist.

Repeat Violation: 1/23/24; 3/5/24 et al.

Plan of Correction ***Accept ([redacted] - 10/31/2024)***

Director of nursing will complete updated assessments for resident 1 and 2, to include agitation/aggression by 10/25/2024. Director will hold education with med tech/care staff on the importance of notes/communication with RCC for behavior changes on 10/31/2024. Director of nursing will complete chart audit including audit of assessments monthly starting 10/2024 for 3 months to ensure compliance.

Proposed Overall Completion Date: 11/01/2024

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

Not Implemented ([redacted] - 03/04/2025)

232a - Exercise Indoor/Outdoor

11. Requirements

2600.
232.a. The home shall provide exercise space, both indoor and outdoor.

Description of Violation

Residents of the home do not have access to outdoor recreation space. The home has an outdoor courtyard dedicated for use of residents in the secured dementia care unit. The home currently does not allow the residents to use this area due to the tripping hazards.

Plan of Correction ***Accept (- 10/16/2024)***

On 10/2/2024, the maintenance director repaired the cracked and elevated walking path. On 10/4/2024, the administrator approved for landscaping to be completed by 11/1/2024. will pull weeds, trim bushes, trees and lay mulch to provide a safe path for residents to walk. Starting 11/1/2024 Maintenance director will do weekly checks for 8 weeks in courtyard do make sure the path is clear of any debris or tripping hazards.

Proposed Overall Completion Date: 11/01/2024

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

Not Implemented (- 03/04/2025)

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

Facility Information

Name: *GREENFIELD OF PERKIOMEN VALLEY* **License #:** *13735* **License Expiration:** *01/02/2025*

Address: *300 PERKIOMEN AVENUE, SCHWENKSVILLE, PA 19473*

County: *MONTGOMERY* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *GREENFIELD OF PERKIOMEN VALLEY LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff:** *59* **Waking Staff:** *44*

Inspection Information

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

Reason: *Incident* **Exit Conference Date:** *10/16/2024*

Inspection Dates and Department Representative

10/16/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served:** *40*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Willow* **Capacity:** *22* **Residents Served:** *6*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *40*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *19* **Have Physical Disability:** *0*

Inspections / Reviews

10/16/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/18/2024*

Inspections / Reviews *(continued)*

11/19/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/09/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/24/2024*

12/03/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/09/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/09/2024*

03/04/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/09/2024*

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

15c - Supervision

1. Requirements

2600.
15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

Description of Violation

On October 5, 2024, resident #1 reported an incident between resident #2 and resident #3 to staff person A. On [redacted], staff person A was suspended. The home concluded an internal investigation on [redacted] at which time, Staff person A returned to work. However the home did not submit a plan of supervison to the Department.

Plan of Correction ***Accept ([redacted] - 12/03/2024)***

Executive Director will provide copies of the initial and final state reportable that included the suspension of staff member A that occurred on [redacted] Moving forward executive director will submit the supervision of any suspended staff to the department to review within the 24 hour timeline. Executive Director will educate directors within the home the suspension policy for internal investigations and abuse reporting timeliness on 11/27/2024.

Proposed Overall Completion Date: 12/01/2024

Licensee's Proposed Overall Completion Date: *12/01/2024*

Implemented ([redacted] - 03/04/2025)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On October 5, 2024, an incident occurred between resident #2 and resident #3. The home did not report this incident to the Department until October 8, 2024.

Plan of Correction ***Accept ([redacted] - 11/19/2024)***

Executive Director will educate all staff on 11/21/2024, about abuse reporting timeliness, and who to report to. Executive Director will hold random weekly questionnaires for 3 staff per week, for 8 weeks covering abuse reporting. Executive Director will hold documentation for department review.

Proposed Overall Completion Date: 12/01/2024

Licensee's Proposed Overall Completion Date: *12/01/2024*

Not Implemented ([redacted] - 03/04/2025)

23a - Activities of Daily Living Assistance

3. Requirements

23a - Activities of Daily Living Assistance *(continued)*

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan dated [redacted] for resident #4 indicates the resident requires assistance with bladder management. On October 15, 2024, the resident did not receive this assistance as required.

The assessment and support plan dated [redacted], for resident #5 indicates the resident requires assistances with transferring from wheelchair to the bed. On October 15, 2024, the resident did not receive the assistances from the home as required.

Repeat Violation: 10/31/2023 et al.; 3/5/2024, et al

Plan of Correction ***Accept ([redacted] - 11/19/2024)***

Director of nursing will audit ADL's for all residents starting 11/25/2024. Director of nursing will continue audits for 8 weeks. Director of nursing will educate direct care staff on 11/20/2024 on transfers and bladder/incontinence management. Director of nursing will have weekly random questioners for 3 people, and continue for 6 weeks on ADL's and bladder management.

Proposed Overall Completion Date: 12/01/2024

Licensee's Proposed Overall Completion Date: *12/01/2024*

Not Implemented ([redacted] - 03/04/2025)

42b - Abuse

4. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On October 15, 2024, resident #4, requested assistance with bladder management. The resident rang the call bell 21 times to request assistance. The call bell report shows that the resident rung the call bell at 7:15 pm and as of 9:00pm it was not answered. On October 15, 2024, the resident completed their own bladder management.

Resident #5 requires occasional assistance with transferring as described in [redacted] support plan dated [redacted]. On October 15, 2024, Resident #4, [redacted] resident #5, who also requires assistance with personal care needs, assisted the resident with the transfer when staff did not answer the repeated call bell requests, putting both residents at risk of injury.

Repeat Violation: 7/8/2024, et al.; 3/5/24 et al.

Plan of Correction ***Accept ([redacted] - 11/19/2024)***

Director of nursing will audit ADL's for all residents starting 11/25/2024. Director of nursing will continue audits for 8 weeks. Director of nursing will educate direct care staff on 11/20/2024 on transfers and bladder/incontinence

42b - Abuse (continued)

management. Director of nursing will have weekly random questioners for 3 people, and continue for 6 weeks on ADL's and bladder management.

Proposed Overall Completion Date: 12/01/2024

Licensee's Proposed Overall Completion Date: *12/01/2024*

Not Implemented (- 03/04/2025)

[redacted]

Vio n Withdrawn

[redacted] 3/5/2025

[redacted]

Vio n Withdrawn

[redacted] 3/5/2025

[redacted]

Vio[redacted] Withdrawn

Date: 3/5/2025

[redacted])

65g - Annual Training Content

7. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

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 complete the following trainings for 2023

1.) Resident rights.

2.) The Older Adult Protective Services Act

3.) Falls and accident prevention.

Repeat Violation: 3/5/2024 et al.; 7/8/2024, et al

Plan of Correction ***Accept ([redacted] - 11/19/2024)***

Director of nursing will educate direct care staff of resident rights, the older adult protective services act. and falls and accident prevention on 11/20/2024. Director of nursing will hold weekly random questionnaires for 3 random staff members, on these topics for 8 weeks. Documentation will be held by executive director for department review.

Proposed Overall Completion Date: 12/01/2024

Licensee's Proposed Overall Completion Date: *12/01/2024*

Not Implemented ([redacted] - 03/04/2025)

[redacted]

[redacted]

Vio[redacted]n Withdrawn

3/5/2025

[redacted]

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

On October 16, 2024, the 1st floor carpet in the entrance of the dining area and the hallway near the dining room is not secured to the floor and is unraveling causing a tripping hazard.

Plan of Correction ***Accept ([redacted] - 11/19/2024)***

Director or Maintenance will have carpet repaired, replaced by 12/31/24 in the hallway near the dining room and hallway entrance. Director Of Maintenance will do carpet checks for any tares in the carpet starting 11/25/2024 and continue for 6 weeks thereafter. Executive director will keep carpet audit for department review.

Proposed Overall Completion Date: 12/01/2024

Licensee's Proposed Overall Completion Date: *12/01/2024*

Not Implemented ([redacted] - 02/18/2025)

100a - Exterior - Free of Hazards

10. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The landscaping in the personal care courtyard is overgrown blocking the walkway, causing tripping hazards.

100a - Exterior - Free of Hazards *(continued)*

Plan of Correction ***Accept (- 11/19/2024)***

Director of Maintenance will have contracted landscaper complete landscaping in personal care courtyard by 12/31/2024. Director of Maintenance will clear overgrown weeds etc that are blocking the walkway on 11/22/2024. Director of Maintenance will do weekly checks on the personal care courtyard to make sure the walkway is free of hazards starting 11/25/2024. The Director of Maintenance will continue weekly checks for 6 weeks.

Proposed Overall Completion Date: 12/01/2024

Licensee's Proposed Overall Completion Date: *12/01/2024*

Implemented (- 03/04/2025)

101o - Walls, Floors, Ceilings

11. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On October 16, 2024, room 110 had a hole in the wall the size of a baseball behind the recliner chair.

Repeated Violation: 3/5/24 et al.; 10/31/23 et al.

Plan of Correction ***Accept (- 12/03/2024)***

Maintenance Director repaired wall behind residents' room 110 on 10/17/2024. Executive Director will educate residents at resident council on 11/27/2024 on issuing work order/Maintenance request for any needs within their rooms. Maintenance Director will educate all new residents that move in starting 12/1/2024, on how to properly submit work orders for repairs in their rooms. Maintenance director will start monthly room checks with all current residents starting 12/2024 and continue for 4 months thereafter.

Proposed Overall Completion Date: 12/01/2024

Licensee's Proposed Overall Completion Date: *12/01/2024*

Not Implemented (- 03/04/2025)

141b1 - Annual Medical Evaluation

12. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's most recent medical evaluation was completed on The resident's previous medical evaluation was completed on .

Repeat Violation: 1/23/24, 3/5/24,7/8/2024, et al

141b1 - Annual Medical Evaluation *(continued)*

Plan of Correction ***Accept (- 12/03/2024)***

Director of nursing will create annual assessment chart audit that will start 11/25/2024 and be updated monthly to make sure all annual assessments are within the annual timeline. Director of nursing will check the YARDI(Assessment/service plan program) weekly to assess whose annual assessment is coming to a renewal period starting 11/25/2024 for 6 weeks and continue monthly for 6 months thereafter. Executive director will sign off weekly checks to assure we are in compliance, and the documentation will be held for department review by the executive director.

Proposed Overall Completion Date: 12/01/2024

Licensee's Proposed Overall Completion Date: *12/01/2024*

Implemented (- 03/04/2025)

201 - Positive Interventions

13. Requirements

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident #3 had two incidents involving resident to resident altercation. One of the incidents occurred on August 23, 2024, resident #3 grabbed resident #7 by the arm and twisted. On October 5, 2024, resident #3 called resident #2 "fatty" and "obese" in the dining room. The home has not implemented positive interventions to modify or eliminate these behaviors.

Plan of Correction ***Accept (- 11/19/2024)***

Executive director will educate Director of nursing and RCC on 11/22/2024 on positive intervention for residents, such as helping with positive intervention to modify or eliminate behaviors. Resident Care Coordinator Called MD associates for a Psych Evaluation on 11/11/2024, and was scheduled for

Proposed Overall Completion Date: 12/01/2024

Licensee's Proposed Overall Completion Date: *12/01/2024*

Implemented (- 03/04/2025)

[redacted]

[redacted] **Withdrawn**

Date: 3/5/2025

[redacted]

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

Facility Information

Name: *GREENFIELD OF PERKIOMEN VALLEY* **License #**: *13735* **License Expiration**: *01/02/2025*

Address: *300 PERKIOMEN AVENUE, SCHWENKSVILLE, PA 19473*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *GREENFIELD OF PERKIOMEN VALLEY LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/23/2012* **Issued By**: *Borough of Schwenksville*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *55* **Waking Staff**: *41*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *11/14/2024*

Inspection Dates and Department Representative

11/13/2024 - On-Site: [redacted]

11/14/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served**: *37*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *The Willow* **Capacity**: *44* **Residents Served**: *6*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *37*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *18* **Have Physical Disability**: *1*

Inspections / Reviews

11/13/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/07/2024*

12/17/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/10/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/22/2024*

01/08/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/10/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/10/2025*

03/04/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/10/2025*

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

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: 03/05/2024 et al., 10/31/2023 et al.

Plan of Correction ***Accept ([redacted] - 01/08/2025)***

Executive Director Updated Resident #1 Contract with "Unable to sign". Executive director and POA tried to have [redacted] sign, while [redacted] moved to Memory care, and [redacted] was unable to sign. Executive Director will audit all current resident-home contracts for resident signatures starting 12/9/2024. Executive Director will continue the resident home contract audits monthly for 4 months starting 12/23/2024. Executive Director will make sure that all residents signatures are in place on lease agreements for any new resident moving in after 12/20/2024, and if they are unable to sign, Executive Director will have the POA witness and document "Unable to Sign".

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

Implemented ([redacted] - 02/18/2025)

28e - Death of a Resident

2. Requirements

2600.
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 home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident #2 passed away on [redacted] Resident #2's personal belongings were removed on [redacted]; however, the resident's estate has not received the refund in the amount of $2999.06.

Plan of Correction ***Accept ([redacted] - 01/08/2025)***

[redacted] our Corporate accountant sent check on 11/19/2024 to [redacted] for $2999.06. Executive Director will attach document showing the $2999.06 refund was received on 12/1/2024. Executive Director will educate the Business office manager on 12/13/2024 for proper refund practices after resident has passed. Business office director will audit all residents' files for 2024 of residents who have passed, and make sure they have the proper documentation for any refund on 12/13/2024.

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

Implemented ([redacted] - 02/18/2025)

[redacted]

42s - Privacy

4. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 10/16/2024 at 01:05 AM, staff A was observed on resident-owned video footage going through resident #3's refrigerator and kitchen cabinets looking for and consuming the resident's food.

Plan of Correction ***Accept (- 01/08/2025)***

Staff A was terminated on for going through resident 3# refrigerator and consuming the resident's food without permission from the residents. Director of nursing will educate Care staff/Med techs on the right of privacy of self and possessions on 12/11/2024. Director of Nursing will hold random questionnaires with 3 staff members weekly for 6 weeks covering right of possessions and privacy. Executive Director will Sign off weekly checks for 6 weeks and hold for department review. Business office director will communicate with families for any instances moving forward of refunds for any stolen items starting 12/23/2024. Business office manager will communicate with our corporate accountant so send refunds within a weeks' notice of a missing item.

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

Not Implemented (- 02/18/2025)

63a - First Aid/CPR Training

5. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 11/4/24, 11/9/24, and 11/12/24, there were 37 residents present in the home. However, from 5:00 PM to 7:00 AM next morning, there was no staff person trained in first aid/CPR on duty.

63a - First Aid/CPR Training *(continued)*

Plan of Correction ***Accept (- 12/17/2024)***

Director of Nursing will audit all current staff members with current first aid/CPR certifications on 12/13/2024. Director of nursing will continue this audit for 6 months starting on 12/13/2024. Executive director will have a first aid/CPR course to re-certified all direct care staff/Med Techs by 12/31/2024. Executive Director will educate the Resident care coordinator on the homes requirements for CPR/first aide coverage on 12/16/2024. Executive Director will review weekly schedules starting 12/16/2024, to make sure the home has the proper staffing with first aid/CPR training 24/7, and continue for 6 weeks.

Proposed Overall Completion Date: 01/01/2025

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

Not Implemented (- 02/18/2025)

65f - Training Topics

6. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
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. Personal care service needs of the resident.

Description of Violation

Direct care staff person A and B did not receive training in the following topics during training year 2023:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
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. Personal care service needs of the resident.

Repeat Violation: 01/23/2024, 03/05/2024 et al., 7/8/2024

Plan of Correction ***Accept (- 12/17/2024)***

Staff Member A was terminated on . Director of nursing will hold education for direct care staff members on 12/11/2024, covering all of the above topics. Director of nursing will audit all direct care staff's trainings for 2024 on 12/16/2024, to ensure we have covered all topics for annual training, and continue the audit for 6 weeks. The director of nursing will hold random questionnaires for 6 weeks starting 12/16/2024, for 3 staff members each week covering the above topics.

Proposed Overall Completion Date: 01/01/2025

65f - Training Topics *(continued)*

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

Not Implemented ([redacted] - 02/18/2025)

65g - Annual Training Content

7. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
5. Falls and accident prevention.

Description of Violation

Staff person A and B did not receive training in falls and accident prevention during training year 2023.

Repeat Violation: 7/8/24 et al.; 03/05/2024 et al.

Plan of Correction ***Accept ([redacted] - 01/08/2025)***

Resident care coordinator educated Staff member B on 10/16/2024 on falls and accident prevention for our annual training. Director of nursing will audit all training in falls and accident prevention for the 2024 training year to ensure we are in compliance with regulation 2600.65g. Executive director will hold another training on falls and accident prevention on 12/19/2024 for all direct care staff. The director of nursing will hold random questionnaires weekly for 6 weeks starting 12/16/2024, for 3 staff members each week covering falls and accident prevention. Executive director will sign off the weekly checks and hold for the departments review. RCC will educate all new direct care staff hired after 12/20/2024 on slip and fall prevention during the 1st day of initial trainings. Executive Director will keep all of the direct staff slip and fall prevention trainings for department review.

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

Not Implemented ([redacted] - 02/18/2025)

101j7 - Lighting/Operable Lamp

8. 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 #4 does not have access to a source of light that can be turned on/off at bedside.

Repeated Violation: 10/31/2023 et al.

Plan of Correction ***Accept ([redacted] - 01/08/2025)***

Executive director was educated by the ombudsman on 11/14/2024 during the exit process with the state surveyors, that is the residents right to re-arrange their room to their liking. Executive director spoke with resident #4 on 12/7/2024, and [redacted] said that [redacted] does not want a bedside lamp or other source of lighting at bedside. Executive director noted this in the Yardi system under resident #4 file. Maintenance director will audit all current residents' rooms on 12/23/2024 to make sure there is a bedside light source and continue audit for 3 months thereafter. Maintenance Director will install wall mounted light next to resident #4's bedside on 12/23/2024.

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

101j7 - Lighting/Operable Lamp *(continued)*

Not Implemented (- 02/18/2025)

103g - Storing Food

9. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 11/13/2024, an opened and unsealed bag of frozen diced eggs was found in freezer #2 in the main kitchen.

Repeated Violation: 10/31/23 et al.

Plan of Correction ***Accept (- 12/17/2024)***

On 11/13/2024 director of dining disposed the unsealed bag of frozen diced eggs. Director of dining will hold education for all dietary staff on 12/26/2024 explaining the importance of proper food storage. Director of dining will do weekly checks for proper food storage starting 12/16/2024 for 6 weeks and continue for 3 months after.

Proposed Overall Completion Date: 01/01/2025

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

Not Implemented (- 02/18/2025)

[redacted]

WITHDRAWN 13/14/25

[redacted]

132d - Evacuation

11. Requirements

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

132d - Evacuation *(continued)*

Description of Violation

The home's maximum safe evacuation time is 15 minutes according to the annual fire safety inspection letters dated 03/20/2023 and 03/11/2024. The home exceeded this evacuation time of 15 minutes during the fire drill on 02/03/2024 at 05:11 AM (30 minutes and 20 seconds) and on 08/19/2024 at 06:34 AM (19 minutes and 36 seconds).

Plan of Correction ***Accept (- 01/08/2025)***

Executive director will provide copy of re-do fire drill on 8/26/2024 to prove compliance of the fire drill that was performed. Maintenance Director will educate all staff on 12/19/2024 on the proper fire drill procedures and evacuating the residents within a timely matter. Executive Director will provide more walkie talkies to kitchen staff and housekeeping staff by 1/1/2024, to provide better communication between departments. Maintenance Director will hold in house fire drill education monthly for all staff starting 1/23/2025 and continue monthly for 6 months.

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

Implemented (- 02/18/2025)

141b1 - Annual Medical Evaluation

12. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #5's most recent medical evaluation was completed on The resident's previous medical evaluation was completed on

Repeat Violation: 01/23/2024, 03/05/2024 et al., 7/8/2024

Plan of Correction ***Accept (- 12/17/2024)***

Director of nursing will create annual assessment chart audit that will start 12/16/2024 and be updated monthly to make sure all annual assessments are within the annual timeline. Director of nursing will check YARDI(Assessment/service plan program) weekly to assess whose annual assessments are coming to into a renewal period starting 12/16/2024 for 6 weeks and continue monthly for 6 weeks thereafter. Executive director will sign off weekly checks to assure we are in compliance, and documentation will be held for department review by the executive director.

Proposed Overall Completion Date: 01/01/2025

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

Implemented (- 02/18/2025)

181d -Storing Medication

13. Requirements

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

181d -Storing Medication *(continued)*

Description of Violation

Resident #6 self-administers medications and stores medications in [redacted] room. On 11/13/2024 at 01:50 PM, there was a weekly pill organizer on top of the resident's bedroom dresser with pills in it. The resident stated that [redacted] does not lock the door when leaving the room.

Repeated Violation: 10/31/2023 et al.

Plan of Correction ***Accept ([redacted] - 01/08/2025)***

Director of nursing spoke with resident #6 on 11/14/2024 about keeping [redacted] medication locked and in a secure location. Executive director will educate residents who attend resident council on 12/18/2024, about proper storage of medications in their rooms. Director of nursing will educate the direct care staff/med techs on 12/11/2024 covering residents who self-administer/storage of medicine. Director of nursing will audit residents' rooms on 12/23/2024 that self-administer to see if they have their medications properly stored. Director of nursing will continue this audit weekly for 6 weeks starting 12/23/2024.

Proposed Overall Completion Date: 01/01/2025

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

Not Implemented ([redacted] - 02/18/2025)

183d - Prescription Current

14. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 11/14/2024, Imodium 2 mg prescribed for resident #7 was in the home's medication cart; however, the medication was not listed on the resident's current medication order.

Repeated Violation: 10/31/2023 et al.

Plan of Correction ***Accept ([redacted] - 01/08/2025)***

Resident #7 Imodium 2mg was discarded from the med cart on 11/14/2024 by the Director of nursing, because there is no current order for Imodium. Director of nursing start medication cart audits on 12/16/2024 weekly for 6 weeks and continue monthly for 6 months thereafter. Director nursing will educate the med techs on 12/11/2024 on the 5 rights of administration.

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

Not Implemented ([redacted] - 02/18/2025)

183e - Storing Medications

15. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

183e - Storing Medications *(continued)*

Description of Violation

On 11/14/2024, an opened Levemir insulin pen belonging to resident #7 was not marked with open/discard after date. According to the manufacturer's instructions, the insulin pen should be discarded 42 days after opening.

Repeated Violation: 10/31/2023 et al.

Plan of Correction ***Accept (- 01/08/2025)***

Director of nursing discarded the Levemir insulin pen on 11/14/2024. Director of nursing start medication cart audits on 12/16/2024 weekly for 6 weeks and continue monthly for 6 months thereafter. Director of nursing will educate the med techs on 12/11/2024 on the 5 rights of administration, and how to properly dispose of expired medications. Director of nursing will hold random questionnaires for 3 staff members weekly for 6 weeks on the 5 rights of medication administration.

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

Not Implemented (- 02/18/2025)

184a - Resident's Meds Labeled

16. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #8 is prescribed Tramadol 50 mg twice a day and every 8 hours as needed. The pharmacy label for resident #8's Tramadol 50 mg read every 8 hours as needed.

Repeat Violation: 03/05/2024 et al., 10/31/2023 et al.

Plan of Correction ***Accept (- 01/08/2025)***

Resident #8's prn was discontinued on 11/18/2024.Director of nursing will educate med techs on 12/11/2024 on proper prescription renewals and access to prescribed medications including a direction change sticker. Director of nursing start medication cart audits on 12/16/2024 weekly for 6 weeks and continue monthly for 6 months thereafter.

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

Not Implemented (- 02/18/2025)

184c - Sample Prescription Meds.

17. Requirements

2600.
184.c. Sample prescription medications shall have written instructions from the prescriber that include the components specified in subsection (a).

Description of Violation

Four boxes of Vraylar 3 mg capsules with "Professional Sample-Not For Sale" printed on the boxes that were present in the medication cart. They belong to resident #9, whose current order for this medication is 6 mg. The sample boxes do not have written instructions from the prescriber that include:

184c - Sample Prescription Meds. (continued)

1. The resident's name
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber

Plan of Correction ***Accept ([redacted] - 01/08/2025)***

Residents' family provides the Vraylor 3 mg for resident # 9 because of the cost of the medication being so high. RCC reached out onto the family on 12/20/2024 to see if there is a generic version of vraylor, that we can administer to resident #9 that includes the written instructions from the provider. Director of nursing start medication cart audits on 12/16/2024 weekly for 6 weeks and continue monthly for 6 months thereafter.
Prescription to be obtained by 12/31/24 for Resident to self administer Vraylor. Medication removed from medication cart for immediate reaction.

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

Not Implemented ([redacted] - 02/18/2025)

185a - Implement Storage Procedures

18. Requirements

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

Description of Violation

Resident 10's is prescribed blood glucose readings four times per day at 7:00AM, 11:00 AM, 4:00 PM, and 9:00 PM. On glucometer was calibrated to correct date and time. However, the history on the machine did not match the log. The history log on the machine is descending order and the 1st number was 199 on 11/14/2024 at 08:00 AM, which was logged correctly. The 2nd number was 295 on 11/14/2024 at 10:34 AM, which was logged as 182. The 3rd number was 180 on 11/14/2024 at 05:32 AM, the 4th number 187 on 11/14/2024 at 12:21 AM, the 5th number 179 on 11/13/2024 at 11:09 PM, and the 6th number 167 on 11/13/2024 at 09:53 AM. Of the most recent six numbers on the machine, only two numbers 199 and 179 (for 07:00 AM reading on 11/13/2024) were recorded on resident #10's November medication administration record.

Repeat Violation: 03/05/2024 et al.

Plan of Correction ***Accept ([redacted] - 12/17/2024)***

Director of nursing re-calibrated all glucose monitoring equipment on 11/15/2024 to the correct date and time. Director of nursing will educate all med techs on 12/11/2024 on proper glucose monitoring reading and re-calibrations. Director of nursing will complete weekly glucose monitoring checks/calibrations starting 12/16/2024 for 6 weeks.

Proposed Overall Completion Date: 01/01/2025

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

Not Implemented ([redacted] - 02/18/2025)

19. 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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #7 is prescribed Zilactin-B gel 10% as needed. On 11/14/2024, this medication was not available in the home.

Repeated Violation: 10/31/23 et al.

Plan of Correction ***Accept ([redacted] - 12/17/2024)***

Director of nursing called pharmacy for a renewal of the prescribed Zilactin-B gel 10% on 11/14/2024. Director of nursing start medication cart audits on 12/16/2024 for 6 weeks and continue for 6 months thereafter. Director of nursing will educate med techs on 12/11/2024 on proper prescription renewals and access to prescribed medications.

Proposed Overall Completion Date: 01/01/2025

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

Not Implemented ([redacted] - 02/18/2025)

20. Requirements

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

Description of Violation

Resident #11 is prescribed Tramadol 50 mg once at bedtime: however, the medication was signed out on the narcotic control log twice on 11/02/2024 at 08:00 AM and 08:00 PM without any discrepancy in the count. The home could not explain why it was signed out twice and could not account for the pill that was signed out at 08:00 AM on 11/02/2024.

Plan of Correction ***Accept ([redacted] - 01/08/2025)***

Director of nursing verified that the medication was administered only 1 time, but was not signed out incorrectly by the med tech on 11/02/2024. Director if nursing will educate all med techs on medication administration and documentation on 12/11/2024. Director of nursing will start weekly med cart/narcotic binder audit on 12/16/2024 and continue for 6 weeks, then 3 months thereafter. Director of nursing will hold random question with 3 med techs weekly for 6 weeks about the medication administration documentation process.

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

Not Implemented ([redacted] - 02/18/2025)

187b - Date/Time of Medication Admin.

21. 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 #7 is prescribed Oxycodone 5 mg every six hours as needed. Resident #7's November medication administration record does not include the initials of the staff person who administered it on 11/10/2024 at 12:00 AM, 11/11/2024 at 12:45 AM, 11/13/2024 at 04:00 PM, and 11/14/2024 at 12:00 AM.

Repeat Violation: 03/05/2024 et al.

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

Plan of Correction ***Accept (- 01/08/2025)***

Director of nursing verified that the medication was administered but was not signed out by the med tech on 11/14/2024. Director if nursing will educate all med techs on medication administration and documentation on 12/11/2024. Director of nursing will start weekly med cart/narcotic binder audit on 12/16/2024 and continue for 6 weeks, then monthly for 3 months thereafter. Director of nursing will hold random questionnaires with 3 med techs weekly for 6 weeks about the medication administration documentation process.

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

Not Implemented (- 03/04/2025)

231c - Preadmission Screening

22. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secured Dementia Care Unit (SDCU) on [redacted] However, the resident's written cognitive preadmission screening was completed on [redacted]

Plan of Correction ***Accept (- 01/08/2025)***

Executive director will educate director of nursing on the preadmission screening process on 12/20/2024 that includes written cognitive preadmission screening to be completed in collaboration with a physician or a geriatric assessment team within 72 hours prior to admission to a secured dementia care unit. Director of nursing will audit all residents who currently reside in the secured dementia care unit for the preadmission screening on 12/13/2024, and continue audit monthly for 3 months. Director of nursing will audit preadmission paperwork for new move ins within 72 hours prior to physical move in date.

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

Implemented (- 03/04/2025)

234a - Admission Support Plan

23. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #1 was admitted to the Secured Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was completed on [redacted]

Repeat Violation: 03/05/2024 et al.

Plan of Correction ***Accept (- 01/08/2025)***

Executive director will educate director of nursing on the admission support plan process for residents moving into a secured dementia care unit on 12/13/2024.Director of nursing will create annual assessment chart audit that will start 12/16/2024 and be updated monthly to make sure all annual assessments are within the annual timeline.

234a - Admission Support Plan (continued)

Director of nursing will check YARDI(Assessment/service plan program) weekly to assess whose annual assessments are coming to into a renewal period starting 12/16/2024 weekly for 6 weeks and continue monthly for 6 months thereafter. Executive director will sign weekly checks for 6 weeks and 6 months thereafter to assure we are in compliance, and documentation will be held for department review by the executive director.

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

Implemented (- 03/04/2025)

236 - Staff Training

24. 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

Direct care staff person B, hired , who works in the Secured Dementia Care Unit (SDCU), did not receive any training in dementia care during training year 2023.

Repeat Violation: 7/8/2024, 3/05/2024 et al.

Plan of Correction ***Accept (- 01/08/2025)***

Direct care staff will have their 6 hours of annual dementia training on 1/08/2025 and 1/09/2024 held by hospice. Director of nursing will audit all direct care staffs annual 6 hour Dementia training for 2024 on 12/23/2024, and continue audits monthly for 6 months.

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

Not Implemented (- 03/04/2025)

251c - Standardized Forms

25. Requirements

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

Resident #5's support plan, dated , was not completed on the Department's current Personal Care Home form. It was completed on the Department's Assisted Living form.

Plan of Correction ***Accept (- 01/08/2025)***

Executive director will education director of nursing and Resident care coordinator on the proper current personal care home support plan form on 12/16/2024. Director of nursing will audit all current support plans weekly for 6 weeks starting 12/23/2024, and continue monthly for 4 months after, to ensure that the support plans are completed on the current personal care home form.

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

Not Implemented (- 03/04/2025)

[redacted]

254b - Policy and Procedures

27. Requirements

2600.
254.b. Each home shall develop and implement policy and procedures addressing record accessibility, security, storage, authorized use and release and who is responsible for the records.

Description of Violation

The home does not have policies and procedures for managing records including record accessibility, security, storage, authorized use and release and who is responsible for the records.

Plan of Correction ***Accept ([redacted] - 12/17/2024)***

The executive director will develop policies and procedure for managing records including record accessibility, security, storage, authorized use and release and who is responsible for the records on 12/16/2024. After the policy and procedure is created, the executive director will educate the Director of nursing and resident care coordinator on this procedure on 12/17/2024.

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

Implemented ([redacted] - 03/04/2025)