pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail [redacted]
Sent via e-mail [redacted]
February 13, 2025

[redacted]
Executive Director
Wyndmoor Assisted Living Company, LLC
551 East Evergreen Avenue
Wyndmoor, Pennsylvania 19038

RE: Springfield Senior Living Community
License #: 14484

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on December 31, 2024 and February 12, 2025 of the above facility, we have determined that your submitted plan of correction for the October 22, 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: *SPRINGFIELD SENIOR LIVING COMMUNITY* **License #:** *14484* **License Expiration:** *02/27/2025*

Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA 19038*

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

Administrator

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

Legal Entity

Name: *WYNDMOOR ASSISTED LIVING COMPANY LLC*

Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA, 19038*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *11/16/1987* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *76* **Waking Staff:** *57*

Inspection Information

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

Reason: *Provisional, Monitoring* **Exit Conference Date:** *10/22/2024*

Inspection Dates and Department Representative

10/22/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *103* **Residents Served:** *53*

Special Care Unit

In Home: *Yes* **Area:** *3rd floor* **Capacity:** *34* **Residents Served:** *16*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *10* **Are 60 Years of Age or Older:** *53*

Diagnosed with Mental Illness: *10* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *23* **Have Physical Disability:** *1*

Inspections / Reviews

10/22/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/15/2024*

Inspections / Reviews *(continued)*

11/26/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/06/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/01/2024*

12/31/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/06/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/06/2025*

02/12/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/06/2025*

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

54a Direct care staff quals

1. Requirements

2800.
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 does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Repeat Violation: 12/22/2023

Plan of Correction ***Directed ([redacted] - 12/31/2024)***

Staff Person A was removed from direct care duties and placed in laundry until qualifications for direct care staff is met. HR or designee will complete an audit of personnel files by 11/29/24 (attached) Any team member that does not meet qualification will be removed from providing direct care duties until qualifications can be met to adhere to 54a. To ensure compliance is maintained, beginning 10/23/24, the Administrator and/or designee will ensure new direct care staff employees meet the qualifications of 54a before their first day of employment.

Proposed Overall Completion Date: 11/29/2024

Directed Plan of Correction:

In addition to the above plan, starting immediately, the administrator shall conduct monthly audits of new employee files for 3 months to ensure that education qualifications are present and appropriate.

Directed Completion Date: *12/31/2024*

81b Resident equip – good repair

2. Requirements

2800.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #1's bed is equipped with a bedside mobility device, which was not attached to the bed frame. The residence used straps to secure the device, which was loose. This type of device can move and create entrapment zones not always present upon inspection. These types of devices are not permitted under any circumstance.

Resident #2's bed is equipped with a bedside mobility device which is 16 inches wide and 6 inches high, which exceeds the FDA guidelines for areas of entrapment. The device was not covered.

Plan of Correction ***Accept ([redacted] - 12/31/2024)***

Resident #1 bedside mobility device was removed by DON on 10/23/24 (see attached). Resident #2 bedside mobility device was covered by DON on 10/23/24 (see attached). To ensure compliance is maintained, the administrator and/or designee will audit apartments monthly times 3 months for mobility devices monthly starting 11/24 and ending 1/25 (attached).

Proposed Overall Completion Date: 12/01/2024

81b Resident equip – good repair *(continued)*

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

85a Sanitary conditions

3. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 10/22/2024 around 02:00 PM, the toilet bowl in resident room #311 was smeared with feces inside and outside.

The bottom of the freezer in the food pantry was covered with brown stained ice and had a small empty box.

The bottom of the freezer section of the stand-alone refrigerator in the residence's Special Care Unit (SCU) was streaked with yellow, pink, and white sticky substance.
The freezer in the 1st floor kitchen had an empty cardboard box with a plastic bag inside sitting on top of another cardboard box.

Repeat Violation: 06/20/2024, 08/20/2024, 05/31/2024, 02/12/2024, 12/22/2023 et al.

Plan of Correction ***Accept ([redacted] - 12/31/2024)***

The toilet bowl was immediately cleaned by housekeeping (see attached). The bottom of the freezer in the food pantry was also cleaned (attached). The refrigerator in the SCU was also immediately cleaned (attached). The cardboard box was also removed, and plastic bag was also removed from the 1st floor kitchen. The Dining Director will re-educate culinary employees on 85a by 11/29/24. To ensure compliance is maintained, beginning 11/15/2024 the Administrator and/or designee will complete random checks of the freezer and refrigerators weekly.

Proposed Overall Completion Date: 12/01/2024

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

Implemented ([redacted] - 02/12/2025)

88a Floors, walls, ceilings, windows, doors

4. 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

On 10/22/24 at 1 PM, the doorknob in the electrical room closet in the residence's SCU was not working properly. The door would not close and inside the closet was glass debris that could potentially hurt the SCU residents.

On 10/22/24 at 1:30pm, there were wires exposed on the wall near the juice table located on the first-floor food pantry.

Repeat Violation: 12/22/2023 et al.

88a Floors, walls, ceilings, windows, doors *(continued)*

Plan of Correction ***Accept ([redacted] - 12/31/2024)***

The doorknob was replaced on 10/22/24 and debris removed (attached). The wires are no longer exposed by juice machine (attached). The Administrator and/or designee will continue to complete an audit of the memory care three times weekly beginning 10/24/24 until 1/31/25 to ensure the electrical closet door is locked (attached). Beginning 10/24/24, the Dining Director and/or designee will ensure no wires are exposed near the juice machine weekly times three months.

Proposed Overall Completion Date: 12/01/2024

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

95 Furniture & Equipment

5. Requirements

2800.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 10/22/24 at 10:45am, the freezer in the food pantry on the first floor was covered with ice on one side of the wall and on the bottom. Per maintenance director, the water drainage was clogged.

Plan of Correction ***Accept ([redacted] - 12/31/2024)***

The freezer was defrosted on 10/23/24 and 11/22/24 (attached). and is on a monthly defrost cycle. The dining director and/or designee will spot check freezer weekly for 3 months beginning 11/22/2024 to ensure compliance. To ensure compliance is maintained, the administrator and/or designee will check freezer monthly for three months beginning 11/24 (attached).

Proposed Overall Completion Date: 12/01/2024

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

Implemented ([redacted] - 02/12/2025)

101j1 Bed/Fire retardant mattress

6. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. An exception will be permitted for residents who wish to provide their own mattresses.

Description of Violation

The mattress on the bed for resident #3 was sagging in the middle.

Repeat Violation: 12/22/2023

Plan of Correction ***Accept ([redacted] - 12/31/2024)***

Resident #3's mattress was replaced on 10/24/24 (attached). The Administrator and/or designee will complete monthly apartment audits times 3 months 11/24 thru 1/25 to ensure mattresses are clean and in good repair. The administrator will remind residents at the11-21-24 Resident council meeting to report if their mattress is not in

101j1 Bed/Fire retardant mattress (continued)

good condition (attached).

Proposed Overall Completion Date: 11/21/2024
Proposed Overall Completion Date: 11/29/2024

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

Implemented ([redacted] - 02/12/2025)

101j7 Lighting/operable lamp

7. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
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.

Repeat Violation: 05/31/2024, 12/22/2023 et al.

Plan of Correction ***Accept ([redacted] - 12/31/2024)***

Resident #4 had a floor lamp next to [redacted] bed which [redacted] moved. As of 10/23/24 resident has a table lamp (attached) and was asked not to move, as it is a DHS regulation. To ensure compliance is maintained the administrator and/or designee will continue to complete apartment audits monthly from 11/24-1/25 to confirm compliance (attached).

Proposed Overall Completion Date: 11/29/2024

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

103e Leftovers

8. Requirements

2800.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There was an unlabeled, undated pitcher of juice in the refrigerator of the residence's Special Care Unit.

Repeat Violation: 12/22/2023

Plan of Correction ***Accept ([redacted] - 12/31/2024)***

The juice was immediately discarded. The wellness team will be re-educated on 103e by the Administrator by 11/29/2024 (attached). To ensure compliance is maintained, the administrator and/or designee will check refrigerator weekly beginning for 3 months beginning 11/18/2024 (attached).

Proposed Overall Completion Date: 11/29/2024

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

103g Storing food

9. Requirements

2800.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

A cup of what looks like water ice in the freezer section of the residence's SCU refrigerator was not covered. Two cups of chocolate Ensure found on the nurse's station desk were not covered.

Repeat Violation: 12/22/2023

Plan of Correction ***Accept (- 12/31/2024)***

The water ice and ensure was immediately removed by administrator on 10/22/2024. The wellness team will be re-educated on 103g by the Administrator by 11/29/2024 (attached). To ensure compliance is maintained, the administrator and/or designee will check freezer weekly for 3 months beginning 11/18/2024.

Proposed Overall Completion Date: 11/29/2024

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

103i Outdated food

10. Requirements

2800.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 10/22/2024 at 10:00 AM, there were unlabeled, undated boxes of sausage patties and chicken patties in the 1st floor kitchen freezer.

On one of the the dry goods shelves, there was a container cake mix which was not in its original container, making it impossible to determine its expiration date.

Repeat Violation: 12/22/2023

Plan of Correction ***Accept (- 12/31/2024)***

The items were immediately removed (attached). The dining director will re-educate culinary team on 103i by 11/29/24 (attached). The Dining Director and/or designee will check freezer and dry foods weekly for 3 months beginning 11/29/2024 to ensure items are labeled and dated (attached). To ensure compliance is maintained, the administrator and/or designee will audit freezer and dry good shelves once a week for 3 months beginning 11/18/24 thru 1/24/25 (attached).

Proposed Overall Completion Date: 11/29/2024

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

Implemented (- 02/12/2025)

144c1 Smoking area guidelines

11. Requirements

2800.
144.c. A residence that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

144c1 Smoking area guidelines *(continued)*

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the residence, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The residence's designated smoking area is near the garden at the back of the residence. There were five wheelchairs which were not fire-proof in the designated smoking area.

Plan of Correction ***Accept (- 12/31/2024)***

Residents were notified by Administrator on 10/23/2024 that wheelchairs could not be placed in the smoking area for additional seating (attached). The wheelchairs have been removed (attached). Housekeeping supervisor and maintenance will be re-educated by the administrator by 11/29/24 that chairs and tables located in the smoking area must be fireproof (attached). Beginning 11/29/2024 the administrator and/or designee will check smoking weekly for 3 months to ensure there are no wheelchairs present.

Proposed Overall Completion Date: 11/29/2024

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

Implemented (- 02/12/2025)

144d Smoking outside

12. Requirements

2800.
144.d. Smoking outside of the smoking room is prohibited.

Description of Violation

On 10/22/2024 at 10:30 AM, resident #5 was smoking right outside of the back exit door of the lobby, which is not the residence's designated smoking area.

Repeat Violation: 08/20/2024, 12/22/2023 et al.

Plan of Correction ***Accept (- 12/31/2024)***

Resident #5 was re-educated by the Administrator on 10/22/2024 on the appropriate smoking area. The Administrator informed Resident#5's responsible party on 10/23/2024 that this was 5th time smoking in an unauthorized area and will be given a 30-day notice if this behavior continues. Responsible party stated would speak with Beginning 11/29/2024 the administrator and/or designee will check courtyard weekly for 3 months to ensure there is no evidence of smoking (cigarette butts, ashes) in the non-smoking courtyard.

Proposed Overall Completion Date: 11/29/2024

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

Implemented (- 02/12/2025)

183d Current medications

13. Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

183d Current medications *(continued)*

Description of Violation

On 10/22/2024, Prednisolone AC 1% eye drop was in the residence's medication cart; however, the medication was prescribed for a resident who no longer resides in the residence.

A glucometer, which belonged to a resident who passed away, was present in the medication cart.

A box of Nicotine Transdermal System Patch (1 patch daily dispensed on 08/26/2024) for resident #1, which was discontinued due to refusal, was present in the medication cart.

Repeat Violation: 08/20/2024, 12/22/2023 et al.

Plan of Correction ***Accept ([redacted] - 12/31/2024)***

The eye drops, glucometer and nicotine patch were immediately removed on 10/22/204 by nursing director. By 11/29/2024 the medication technicians will be re-educated by nursing director on the importance of removing items of residents who are no longer reside in the home or medications which has been discontinued (attached). To ensure compliance the nursing director and/or designee will complete weekly medication cart audits beginning 10/29/2024 through the end of January 2025 (attached).

Proposed Overall Completion Date: 11/29/2024

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

Implemented ([redacted] - 02/12/2025)

183e Storing Medications

14. Requirements

2800.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 10/22/2024 at 01:30 PM, an opened Lantus insulin pen prescribed for resident #6 was in the medication cart without an open/discard after date. According to the manufacturer's instructions, the insulin left in the pen should be discarded 28 days after opening.

A bag of Lorazepam 2 mg/ml prefilled syringes prescribed for resident #7 was in the medication cart, with 'Keep Refrigerated' written on the label.

Repeat Violation: 12/22/2023 et al.

Plan of Correction ***Accept ([redacted] - 12/31/2024)***

The lantus pen was discarded on 10/22/204 by nursing director. Resident also had a vial of lantus which was used instead (attached). The lorazepam was placed in the refrigerator on 10/22/24 by the nursing director (attached). The nursing director will re-educate the medication technicians by 11/29/2024 on the importance of reading and following the manufacturer's storage instructions. To ensure compliance is maintained, the nursing director and/or

183e Storing Medications (continued)

designee will continue to complete weekly medication cart audits 10/29/2024 through 1/31/2025 (attached).

Proposed Overall Completion Date: 11/29/2024

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

184a Resident meds labeled

15. Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
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.

Description of Violation

There was no pharmacy label for resident #1's Lantus insulin pen and a bottle of Tylenol.

Repeat Violation: 12/22/2023 et al.

Plan of Correction ***Accept ([redacted] - 12/31/2024)***

The Nursing Director labeled the Tylenol on 10/22/2024 and the insulin was re-ordered on 11/7/2024 (attached). The Nursing Director will re-educate the medication technicians on ensuring that each medication is labeled properly by 11/29/24. The Nursing Director and/or designee will continue to complete weekly medication cart audits beginning 10/29/2024 through the end of 1/25 (attached). To ensure compliance is maintained, the administrator and/or designee will audit 5 Medication administration records and medications monthly through the end of January 2025 (attached).

Proposed Overall Completion Date: 11/29/2024

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

185a Storage procedures

16. 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 #1's glucometer was not calibrated to correct time. On 10/22/2024 at 02:50 PM, the glucometer displayed 03:14 PM.

Resident #6's glucometer was not calibrated to correct time. On 10/22/2024 at 01:53 PM, the glucometer displayed 01:44 PM.

There was a bag of 30 prefilled Morphine syringes prescribed for resident #7 in the medication cart; however, this medication was not listed on the resident's current medication administration record (MAR).

185a Storage procedures (continued)

Resident #7 is prescribed Lorazepam 2mg/ml every four hours as needed. The resident was administered this medication on 10/17/2024 at 09:00 AM; however, staff B failed to document this on the controlled medication log other than the remaining balance.

Repeat Violation: 12/22/2023 et al.

Plan of Correction ***Accept (- 12/31/2024)***

The glucometer for resident #1 and 6 was recalibrated by nursing director on 10/24/24 (attached). The nursing director will re-educate the medication technicians by 11/29/2024 to ensure the glucometers are calibrated to the correct date and time, medication record is signed appropriately, including narcotic documentation and to notify nursing supervisor if medications are in the medication cart, but not listed on medication record (attached). To ensure compliance is maintained, the nursing director and/or designee will continue to complete weekly medication cart and record audits beginning 10/29/24 through 1/31/2025 to ensure glucometers are calibrated and medication administration records are signed appropriately.

Proposed Overall Completion Date: 11/29/2024

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

Implemented (- 02/12/2025)

187b Date/time of med admin

17. Requirements

2800.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1 is prescribed 20 units of Lantus at bedtime. Resident #1's October medication administration record (MAR) does not include the initials of the staff person who administered it on 10/12/2024 and 10/15/2024 at bedtime.

Resident #7 is prescribed Lorazepam 2mg/ml every four hours as needed. Resident #7's October MAR does not include the initials of staff person B, who administered it on 10/01/24 at 6am, 10/02/24 at 12am, 10/05/24 at 1am, 10/06/24 at 6pm, and 10/07/2024 at 2am.

Repeat Violation: 08/20/2024, 12/22/2023

Plan of Correction ***Accept (- 12/31/2024)***

The nursing director spoke with medication technician responsible for resident #1 insulin administration on 10/12 and 10/15/24. confirmed medication was given. Resident #7 lorazepam was signed out on narcotic log (attached). Nursing Director will re-educate medication technicians by 11/29/2024 on ensuring the medication record is initialed as given after medication administration (attached). The nursing director and/or designee will continue to complete weekly MAR audits beginning 10/29/2024 through 1/31/25 to ensure compliance. To ensure compliance is maintained, the administrator and/or designee will audit 5 Medication administration records and medications monthly beginning 11/15/2024 through the end of January 2025 (attached).

Proposed Overall Completion Date: 11/29/2024

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

187b Date/time of med admin *(continued)*

Implemented (- 02/12/2025)

187d Follow prescriber's orders

18. Requirements

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

Description of Violation

Resident #8, is prescribed the following medications:

- *Metorolol 25mg once per day*
- *Predisone 10mg once per day*
- *Dulera 200/5mcg twice per day*
- *Lidocaine Patch once per day*
- *Budesonide 0.5mg once per day*
- *Gabapentin 300mg once per day*
- *Melatonin 10mg once per day at night*
- *Montelukast 10mg once per day in the evening*
- *Buspirone 5mg (1.5mg tab) three times per day*
- *Aspirin 81mg one per day*
- *Primidone 50mg twice per day*
- *Ezetimibe 10mg once per day at night*
- *Rosuvastatin 40gm once per day*
- *Venlafaxine 75mg once per day*
- *Loratadine 10mg once per day*
- *Multivitamin Tablet once per day*
- *Pantoprazole 40mg twice per day*

The resident was hospitalized on [redacted] returned to the residence late at night on [redacted]. It was found out at the time of the medication cart audit around 02:20 PM on 10/22/2024 that the resident had not been administered any medications since the resident's return to the residence.

Repeat Violation: 12/22/2023

Plan of Correction ***Accept (- 12/31/2024)***

Nursing director re-educated and counseled team member on 10/23/24 (attached). Community completed and submitted reportable incident (attached). The medication technicians will be re-educated by nursing director by 11/29/24 (attached). The nursing director and/or designee will complete weekly MAR audits beginning 10/29/2024 through 1/31/2025. To ensure compliance is maintained, the administrator and/or designee will audit 5 Medication administration records monthly beginning 11/15/2024 through the end of January 2025.

Proposed Overall Completion Date: 11/29/2024

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

187d Follow prescriber's orders *(continued)*

Implemented (- 02/12/2025)

231c1 Preadmit screening

19. Requirements

2800.
231.c.1.i. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.

Description of Violation

Resident #9 was admitted to the SCU on . However, resident #9's written cognitive preadmission screening was completed on

Plan of Correction ***Accept (- 12/31/2024)***

An audit was completed by the administrator on 10/28/24 which confirmed the memory care residents who were admitted before 10/22/2024 pre-admission screening was not compliant. The pre-admission screening could not be corrected as each memory care resident were admitted greater than 72 hours. The Nursing Director and Resident Care Coordinator were re-educated on regulation 231.c.1.i. by the Administrator on 10/23/24 (attached). Beginning 10/23/24, to ensure compliance is maintained, the Administrator and/or designee will review the preadmission screening of each new Memory Care move in 72 hours prior to admission.

Proposed Overall Completion Date: 11/29/2024

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

Implemented (- 02/12/2025)

234a Admission – support plan

20. Requirements

2800.
234.a.1. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the special care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #9 was admitted to the SCU on . However, resident #9's initial support plan was completed on

Plan of Correction ***Accept (- 12/31/2024)***

An audit was completed by the administrator on 10/28/24 which confirmed the memory care residents who were admitted before 10/22/2024 were not compliant with 234.a.1.(attached). The Nursing Director and Resident Care Coordinator were re-educated on regulation 234.a.1. by the Administrator on 10/23/24 (attached). Beginning 10/23/24, to ensure compliance is maintained, the Administrator and/or designee will complete an audit of each new Memory Care move within 48 hours of admission.

Proposed Overall Completion Date: 11/29/2024

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

Implemented (- 02/12/2025)