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

April 14, 2025

[REDACTED], REGIONAL DIRECTOR OF OPERATIONS
CA SENIOR VALLEY FORGE OPERATOR LLC
[REDACTED]

RE: ANTHOLOGY OF KING OF PRUSSIA
350 GUTHRIE ROAD
KING OF PRUSSIA, PA, 19406
LICENSE/COC#: 14788

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/28/2024, 10/29/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ANTHOLOGY OF KING OF PRUSSIA* **License #**: *14788* **License Expiration**: *01/16/2025*

Address: *350 GUTHRIE ROAD, KING OF PRUSSIA, PA 19406*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *CA SENIOR VALLEY FORGE OPERATOR LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/08/2020* **Issued By**: *Upper Merion Township*
Type: *I-2* **Date**: *12/08/2020* **Issued By**: *Upper Merion Township*
Type: *Other* **Date**: *12/08/2020* **Issued By**: *Upper Merion Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *83* **Waking Staff**: *62*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *10/29/2024*

Inspection Dates and Department Representative

10/28/2024 - On-Site:
10/29/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *128* **Residents Served**: *54*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Virtue* **Capacity**: *28* **Residents Served**: *24*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *54*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *29* **Have Physical Disability**: *0*

Inspections / Reviews

10/28/2024 - Full

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

Inspections / Reviews *(continued)*

11/21/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *01/15/2025*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *11/26/2024*

11/25/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *01/15/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *12/09/2024*

04/14/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *01/15/2025*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Influenza Awareness Act (NH 1785) requires that Personal Care Homes must post the required influenza information in a public place in the residence year-round. On 10/28/24, the home did not have the required influenza information posted in a public place within the home.

CARE FACILITY CARBON MONOXIDE ALARMS STANDARDS ACT - ENACTMENT Act of Jun. 23, 2016 requires that Carbon monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance. On 10/29/24, a carbon monoxide detector could not be located in the area of the main kitchen's gas stove.

Plan of Correction ***Accept (- 11/25/2024)***

A CO2 detector was purchased and installed immediately; the home already had such a detector in place at the time of inspection, but staff were not aware of its location. An audit of the kitchen was conducted, it was found that a CO2 detector was already in place, staff is aware of the location. Director Of Culinary and Director of Plant Operation will monitor during monthly round to ensure it is in working order and any irregularities will be discussed at quarterly QAPI

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 01/15/2025)

28a - Refunds

2. Requirements

2600.
28.a. If, after the home gives notice of discharge or transfer in accordance with § 2600.228(b) (relating to notification of termination), and the resident moves out of the home before the 30 days are over, the home shall give the resident a refund equal to the previously paid charges for rent and personal care services for the remainder of the 30-day time period. The refund shall be issued within 30-days of discharge or transfer. The resident’s personal needs allowance shall be refunded within 2 business days of discharge or transfer.

Description of Violation

On the home issued a discharge notice to resident #1. On the resident moved out of the home, removing all personal belongings. The resident was due a refund of $3057.67. The home did not issue a refund to the resident until

Plan of Correction ***Accept (- 11/25/2024)***

The incident was reviewed with Accounts payable and the Business Office Coordinator(BOD) 0n 11/11/24. An audit of discharged residents was conducted 11/11/24. Residents that were due refunds were issued within 30 days. Effective 11/11/24 BOD will audit the aging report monthly to ensure all refunds are issued within 30 days. These monthly audits are indefinite, to maintain compliance.

28a - Refunds *(continued)*

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 01/15/2025)

41c - Rights Poster

3. Requirements

2600.
41.c. The Department’s poster of the list of resident’s rights shall be posted in a conspicuous and public place in the home.

Description of Violation

On 10/28/24, The Department's resident's rights poster was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (- 11/21/2024)***

The residents right poster was posted immediately in the SDU.

Executive Director (ED) and Director of Virtue (DOV) will monitor during daily walkthroughs of the home, Any irregularities will be addressed immediately.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 01/15/2025)

62 - Contact List

4. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person the administrator, could not provide a current list of substitute personnel for the home.

Plan of Correction ***Accept (- 11/25/2024)***

On 11/8/24 an audit was conducted for all agency and regular staff. A binder was created.

If any Agency or staff are not listed or their information is not in the binder, it will be added and updated.

ED, Director of Health and Wellness (DHW) or DOV will review binders monthly to monitor for accuracy.

Effective 11/8/24 an audit and all additions will be completed monthly on the agency binder. A current list of regular employees will be added to the personnel binder. These audits are ongoing and indefinite to maintain compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 04/14/2025)

64c - Annual Training

5. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

64c - Annual Training *(continued)*

Description of Violation

Staff person █ the home's administrator, completed only 9 hours of Department-approved training in the 2023 training year.

Plan of Correction ***Accept (█ - 11/21/2024)***

The administrator is compliant with this year's training. A monthly calendar reminder is set up as reminder to complete training.
Moving forward, the administrator will monitor █ training hours to ensure compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (█ - 01/15/2025)

65g - Annual Training Content

6. Requirements

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

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

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

Repeat Violation Date: 7/6/23 et al

Plan of Correction ***Accept (█ - 11/25/2024)***

Staff B is current on this year's training. On 11/8/24 an audit was conducted on scheduled annual training for staff. Staff are completing their annual training.
The annual training requirement checklist was updated.
Effective 11/8/24 ,all directors will make sure their staff complete all the required annual training. Ongoing audits of training will be completed quarterly and reviewed at QAPI . These audits are ongoing and indefinite to maintain compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (█ - 01/15/2025)

66b - Training Plan Content

7. Requirements

2600.

66b - Training Plan Content *(continued)*

66.b. The plan must include training aimed at improving the knowledge and skills of the home’s direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

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

Description of Violation

The home's staff training plan does not include the following:

1. The name, position and duties of each direct care staff person.

2. The required training courses for each staff person.

3. The dates, times and locations of the scheduled training for each staff person for the upcoming year

Repeat Violation Date: 7/6/23 et al

Plan of Correction ***Accept (- 11/25/2024)***

On 11/4/24 an audit was conducted of scheduled annual training.
An annual training requirement checklist was created to include: name position and duty of each staff as well as their required training.
All directors will make sure all of the required annual training is completed for their staff.
Ongoing audits of training checklists will be completed and reviewed quarterly.

These audits are ongoing and indefinite to maintain compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 01/15/2025)

81b - Resident Personal Equipment

8. Requirements

2600.
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

On 10/29/24, an uncovered bedside mobility device was installed on the bed of resident #3. Per FDA guidelines, the openings within the device should be less than 120 mm (4 ¾ inches). If any openings within the device exceed 120mm (4 ¾ inches), a cover that allows for safe gripping and use of the device for its intended purpose must be in place. The opening of resident #3's bedside mobility device measured 10in wide by 5in high, and the device was not covered.

Plan of Correction ***Accept (- 11/25/2024)***

The bedside mobility device was removed immediately on 10/29/24.
Family was made aware of the size of device and will be ordering the correct bedside mobility device.
On 11/4/24 an audit of bedside mobility devices was completed, all are within compliance.
Effective 11/4/24 daily checks for mobility devices will be completed by the DOV and irregularities will be reviewed at QAPI.
These audits are ongoing and indefinite to maintain compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 04/14/2025)

82c - Locking Poisonous Materials

9. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 10/29/24 in the home's Virtue SDCU, the following unsecured poisons were found accessible to residents of the unit:

- *Room 411- Advanced Healing Ointment with a manufacturer's label indicating "If swallowed, contact poison control center or seek medical help right away"*
- *Room 431- Desitin Ointment with a manufacturer's label indicating "If swallowed, contact poison control center or seek medical help right away"*
- *Virtue Unit Kitchen- EcoLab Greaselift with a manufacturer's label indicating "FOR INDUSTRIAL USE ONLY- DO NOT DRINK-If irritation occurs, seek medical attention", Odor Eliminator with a manufacturer's label indicating "If swallowed, seek medical attention and contact poison control."*

Not all the residents of the home's Virtue Unit have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 11/25/2024)***

0n 11/29/24, a safety check was completed while DHS was on site, for removal of all poisonous materials from rooms. No other poisonous materials were found. On 11/13/24 the violation was reviewed and training provided at the all staff meeting by the Executive Director .
Effective 10/30/24, daily rounds are provided by staff and Director of Virtue to make sure poisonous materials are locked. Director of Virtue to make daily rounds. A sign-off sheet will be completed by staff noting that cabinets are locked and any poisonous materials are removed.
Ongoing compliance will be maintained by Daily checks of Virtue area and sign-off sheets are monitored daily by DOV. These audits are ongoing and indefinite to maintain compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 04/14/2025)

85a - Sanitary Conditions

10. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 10/29/24 at approximately 1pm, remnants of chocolate chip cookies were found on the floor of the bathroom and smeared inside of the toilet of Virtue room 411.

Plan of Correction ***Accept (- 11/25/2024)***

The room was cleaned and sanitized immediately, 0n 10/29/24.
On 11/13/24 the violation was reviewed and training was provided at all staff meeting by the Executive Director .
Rooms are checked daily to maintain sanitary conditions.
Housekeeping has a schedule of rooms to be cleaned. Care staff to alert housekeeping when room is in need of

85a - Sanitary Conditions (continued)

cleaning if not scheduled. Compliance will be maintained by Daily checks provided by care staff to maintain sanitary conditions.
Effective 10/29/24 ED , DOV and Director of Plant operation (DPO) will monitor during daily rounds to maintain compliance. These daily rounds are ongoing and indefinite to maintain compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 04/14/2025)

103e - Left Overs

11. Requirements

2600.
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

On 10/29/24, there was an unlabeled, undated container of chopped cucumbers in the Virtue kitchen refrigerator.

On 10/29/24, there was an unlabeled, undated piece of cake in the Virtue kitchen freezer.

Plan of Correction ***Accept (- 11/25/2024)***

The container was removed immediately on 10/29/24.
On 11/13/24 the violation was reviewed and training was provided at all staff meeting by the Executive Director .
Effective 10/30/24 daily audit of the SDU refrigerator is conducted by care and kitchen staff.
Effective 10/30/24, ED, DOV and Director of Culinary (DOC) to monitor weekly during rounds and correct any deficiency immediately.
All rounds are ongoing and indefinite to maintain compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 04/14/2025)

106 - Swimming Areas

12. Requirements

2600.
106. Swimming Areas - If a home operates a swimming area, the following requirements apply:
1. Swimming areas shall be operated in accordance with applicable laws and regulations.

Description of Violation

The home does not have a current registration to operate a public bathing place from the Montgomery County Office of Public Health. The registration document provided by the home for pool license #P1542 expired 4/30/2024.

Plan of Correction ***Accept (- 11/25/2024)***

The pool license was renewed on 11/11/24 and is current.
Audit and review of all public health licenses was conducted on 11/30/24 by the Executive Director . All public health licenses are current.
Effective 11/30/24, DOC and DPO to monitor licenses expiration monthly to ensure compliance.
ED will monitor quarterly and review any deficiency at QAPI.
These audits are ongoing and will continue indefinitely to maintain compliance.

106 - Swimming Areas *(continued)*

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 01/15/2025)

107d - Procedure Emergency Management Agency Submission

13. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency management agency since 3/17/21.

Repeat Violation Date: 7/6/23 et al

Plan of Correction ***Accept (- 11/25/2024)***

The emergency management plan was submitted to Upper Merion Township office of emergency management on 11/7/24.
On 11/30/24 The survey ready binder was audited by the Executive Director to ensure all required notifications have been submitted, the home is in compliance. The home emergency procedure will be reviewed in conjunction with the Maintenance Director and delivered annually to the local emergency response team. In addition, the survey readiness binder will be reviewed at quarterly QAPI meetings, any deficiencies will be corrected immediately.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 01/15/2025)

141a 1-10 Medical Evaluation Information

14. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #4's medical evaluation completed did not include:
1. A general physical examination by a physician, physician's assistant or nurse practitioner

141a 1-10 Medical Evaluation Information (continued)

7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

Repeat Violation Date: 7/6/23 et al

Plan of Correction ***Accept (█ - 11/25/2024)***

On 11/4/24, an audit was conducted on said file and new DME was sent to the PCP for completion. An audit will be conducted on all new move ins within 15 days to make sure of compliance.
DHW, DOV, ED to audit files within 30 days to ensure paperwork is completed in full.
Ongoing compliance will be maintained through quarterly audits that will be reviewed at QAPI. The quarterly audits will continue indefinitely to ensure compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (█ - 01/15/2025)

141b1 - Annual Medical Evaluation

15. 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 █

Plan of Correction ***Accept (█ - 11/25/2024)***

On 11/4/2024 an audit was conducted on said file and new DME was sent to the PCP for completion
Effective 11/4/24 an audit will be conducted on all residents DME to make sure they are completed annually. DHW, DOV, ED to audit files within 30 days to ensure paperwork is completed in full.
Ongoing monitoring for compliance of proper paperwork will be reviewed at QAPI. The quarterly audits will continue indefinitely to ensure compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (█ - 01/15/2025)

162c - Menus Posted

16. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 10/29/24, the home's current menus were not posted. Menus posted for the home were from the weeks of 8/11/24 and 8/18/24.

162c - Menus Posted *(continued)*

Plan of Correction ***Accept (█ - 11/25/2024)***

The current menu was printed and posted immediately on 11/29/2024 and training was provided to the Director of Culinary by the Executive Director.
On 11/13/24 the violation was reviewed and training was provided to all staff by the Executive Director .
Effective 11/30/24, The DOC, ED and DOV will monitor during daily walkthroughs of the home, any irregularities will be addressed immediately and reviewed at quarterly QAPI. daily monitoring is ongoing and will continue indefinitely to maintain compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (█ - 04/14/2025)

183c - Refrigerated Meds Locked

17. Requirements

2600.
183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked.

Description of Violation

On 10/29/24, Afrin nasal spray, Bayer 81mg chewable aspirin and Ipratropium Bronide nasal solution .06% were found unsecured in resident #4's unlocked medicine cabinet. Resident #4 is not capable of self-administering medications.

Plan of Correction ***Accept (█ - 11/25/2024)***

Immediate removal of medications and audit of rooms' medicine cabinets for OTCs was conducted on 11/29/24. On 11/13/24 the violation was reviewed and training provided at the all staff meeting by the Executive Director .
Effective 11/30/24, an audit will be completed by daily checklist for care staff and medication technicians with room checks.
Director Of Virtue to audit daily task sheets and conduct room audits as needed.
Ongoing monitoring of room checks will continue daily and indefinitely to maintain compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (█ - 04/14/2025)

183e - Storing Medications

18. Requirements

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

Description of Violation

On 10/29/24, The following medication cards were observed to have a punctured blister foil with the medication still present in the spot.

- *Resident #6’s Gabapentin 100mg blister pack*
- *Resident #6’s Trazodone 50mg tab blister pack*

183e - Storing Medications (continued)

- *Resident #6’s Clonazepam 0.5mg tab blister pack*
- *Resident #7’s Lorazepam 1 mg tab blister pack*
- *Resident #8’s’s Vitamin D-3 capsule blister pack*

Repeat Violation Date: 7/6/23 et al

Plan of Correction ***Accept (- 11/25/2024)***

An inspection of medication blister packs was conducted on 10/29/24 . Medications that had punctured blister foils were destroyed immediately. On 11/13/24 the violation was reviewed and training was provided to all staff by the Executive Director .
Effective 11/13 /24 Medtechs will be conducted daily audits to ensure medications are sealed properly, any unsealed blister will be wasted immediately.
Nurse, DHW, DOV to conduct weekly medication cart audits to ensure medications are sealed properly. Monitoring is ongoing with proper sign offs of staff acknowledging the medications are properly packaged.
Ongoing monitoring will continue indefinitely daily to maintain compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 04/14/2025)

184b - Labeling OTC/CAM

19. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident’s name.

Description of Violation

On 10/29/24, a bottle of over the counter Thera-Cran One Cranberry supplement was found unlabeled in the Virtue unit med cart.

Plan of Correction ***Accept (- 11/25/2024)***

On 10/29/24 an audit of all medication in cart was conducted. Bottle was labeled during the time of audit. An audit will be conducted daily to ensure medications are labeled properly before placing in the cart and during checks from medication technician, LPN, DOV, DHW. On 11/13/24 the violation was reviewed and training was provided to all staff by the Executive Director .
Nurse, DHW, DOV to conduct weekly medication cart audits to ensure medications are labeled properly. Monitoring is ongoing with daily sign-off sheets from staff on the cart to ensure any medications have the proper labeling. These audits will continue indefinitely to maintain compliance .

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (- 04/14/2025)

227a - Support Plan 30 Days

20. Requirements

2600.

227a - Support Plan 30 Days *(continued)*

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #3 was admitted on [redacted] however, the resident's initial support plan had not been completed.

Plan of Correction ***Accept ([redacted] - 11/25/2024)***

On 10/29/24 Support plan was updated immediately on all residents after being made known. Support plan was printed and placed in file. Support plan was already discussed with resident and family.
Effective 11/4/24 Nurse, DHW, DOV to conduct audit of all support plans in residents paper file and add as needed. Monthly audits of each resident file to ensure proper documents are in compliance is ongoing and indefinite to maintain compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented ([redacted] - 01/15/2025)

227d - Support Plan Medical/Dental

21. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident #2, dated [redacted], indicates the resident has a need for managing health care, laundry, shopping, securing and using transportation, and managing finances. The resident's support plan, dated [redacted] does not document how these needs will be met.

The assessment for resident #4, dated [redacted], indicates the resident has a need for managing health care, transferring in/out of bed/chair and ambulating. The resident's support plan, dated [redacted] does not document how these needs will be met.

The assessment for resident #5, dated [redacted], was completed when the resident returned from the hospital [redacted]. The resident's need for bladder management is marked as not applicable. The resident's support plan, dated [redacted] does not document how resident #5's bladder management/catheter needs will be met.

Plan of Correction ***Accept ([redacted] - 11/25/2024)***

Support plan was not printed from system and placed in file.
On 10/29/24 Support plan was printed and placed in file. Support plan was already discussed with resident and family.
On 11/4/24 Nurse, DHW, DOV conducted an audit of all support plans in residents paper file and add as needed. Monthly audits of each resident file is ongoing to ensure proper documents are in compliance. These audits are indefinite to maintain compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

227d - Support Plan Medical/Dental *(continued)*

Implemented (█ - 01/15/2025)

231e - No Objection Statement

22. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on █ The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on █ The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Resident #6 was admitted to the Secure Dementia Care Unit (SDCU) on █ The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Repeat Violation Date: 7/6/23 et al

Plan of Correction ***Accept (█ - 11/25/2024)***

On 10/30/24, the violation was reviewed with the Sales and Marketing team by the Executive Director and an addendum to the SDU contract was created with the no objection added. Effective 10/30/24, all new SDU contracts will include the no objection statement. Executive Director and Director of Sales and Marketing will review all residency agreement for the no objection to SDU . These reviews are ongoing and indefinite to maintain compliance.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented (█ - 01/15/2025)