pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail [redacted]
March 7, 2025

[redacted]
Regional Director of Operation
VS Wallingford, LLC
2700 Chestnut Parkway
Chester, Pennsylvania 19013

RE: Chestnut Ridge Retirement Living
2700 Chestnut Parkway
Wallingford, Pennsylvania 19086
License #: 14141

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on January 7, 2025 and February 10, 2025 of the above facility, we have determined that your submitted plan of correction for the November 25 and 27, 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]

[redacted]

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *CHESTNUT RIDGE RETIREMENT LIVING* **License #:** *14141* **License Expiration:** *04/04/2025*

Address: *2700 CHESTNUT PARKWAY, CHESTER, PA 19086*

County: *DELAWARE* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *VS WALLINGFORD LLC*

Address: *2700 CHESTNUT PARKWAY, CHESTER, PA, 19013*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *05/19/1997* **Issued By:** *COPA L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *115* **Waking Staff:** *86*

Inspection Information

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

Reason: *Provisional* **Exit Conference Date:** *11/27/2024*

Inspection Dates and Department Representative

11/25/2024 - On-Site: [redacted]
11/27/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *130* **Residents Served:** *85*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *4th & 5th floor* **Capacity:** *50* **Residents Served:** *30*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *85*

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

Have Mobility Need: *30* **Have Physical Disability:** *0*

Inspections / Reviews

11/25/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/14/2025*

03/07/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *01/14/2025*

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

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

On 11/25/2024, there was no Carbon Monoxide detector for the kitchen which uses gas appliances. Per the Care Facility Carbon Monoxide Alarms Standards Act of June 23, 2016, Carbon Monoxide alarms must be installed in proximity of but not less than 15 feet from any fossil-fuel burning device or appliance

Plan of Correction ***Directed ([redacted] - 01/07/2025)***

Immediately: *The administrator or designee shall follow the Care Facility Carbon Monoxide Alarms Standards Act. as follows:*

** Carbon monoxide detectors and alarm systems installed at a care facility shall be tested and cleaned as indicated in the manufacturer's guidelines.*
** If the unit operates by a battery, the battery may not be removed for any length of time beyond that necessary to change the battery.*
** The battery shall be labeled with the date of installation and replaced at least once annually or at such time as the unit signals a drained or failing battery, whichever is sooner.*
** In the event that an alarm installed in accordance with this section sounds, the care facility staff shall:*
1. Take immediate action to introduce fresh outside air into the care facility by opening available windows and doors, unless opening a specific door presents additional risk to resident safety.
2. Contact emergency services in accordance with the care facility's written policies and procedures relating to carbon monoxide alarms and evacuations.
3. Move residents to the nearest source of fresh outside air, account for all residents and remain with the residents until first responders arrive and assess the need for evacuation.
4. Evacuate residents when first responders consider an evacuation necessary.

Directed Completion Date: *01/09/2025*

Evidence of Completion ***Implemented ([redacted] - 02/10/2025)***

It is important that the community complies with all Federal, State and local laws and regulations and always remains in compliance. We have had carbon monoxide detectors in our kitchen as required since the regulation came into effect. Unfortunately, the executive director at the time of the inspection was new and did not provide the inspectors with correct information. Attached is a picture of our dual detectors located throughout our kitchen. Each detector has two heads. The white head is the smoke detector, and the tan head is the carbon monoxide detector. Going forward, the Executive Director will ensure the Director of Plant Operations is available for all DHS inspection site tours to answer regulatory questions directed towards his department.

51 - Criminal Background Check

2. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

51 - Criminal Background Check *(continued)*

Description of Violation

A criminal background check was not requested for staff person A.

Repeat violation: 4/8/24, 7/10/24 et al, 8/20/24 et al

Plan of Correction ***Directed ([redacted] - 01/07/2025)***

Immediately: *The administrator or designee shall review the records of all current staff members to ensure that a PA State Police criminal background check has been completed and that an FBI background check has been completed for employees who were not residents of Pennsylvania for the past two consecutive years prior to the date of hire. Documentation shall be kept in the staff records.*

Within 3 days of receipt of the plan of correction: *A new staff person document tracking system shall be developed and implemented to ensure and track all new staff person required documentation.*

Directed Completion Date: *01/10/2025*

Evidence of Completion ***Not Implemented ([redacted] - 03/07/2025)***

It is important to protect the safety and well-being of our residents and staff by ensuring a criminal background check is run on every new employee prior to their first day of employment. The previous executive director did not know where to look for the criminal background checks. Staff person A had [redacted] background run prior to hire. The Executive Director and Regional Director of Operations will complete an audit of all employees to ensure each employee has a valid criminal background check on file. This audit was completed on 1/10/25. All missing background checks were rerun on 1/13/25. The community will be hiring an Employee Relations and Administration Coordinator. This position will be responsible for the oversight of new hires and ensuring the required paperwork is completed prior to the new employee's first day of work. Until this position is filled, the Executive Director will oversee the hiring of new employees and will ensure all criminal background checks are completed prior to orientation.

57c - 2 Hours/Day

3. Requirements

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 11/10/2024, there were 85 residents in the home, including 30 residents with mobility needs, requiring a total minimum of 115 hours of direct care service. On this date, only 97.5 hours of direct care staffing was provided.

On 11/23/2024, there were 85 residents in the home, including 30 residents with mobility needs, requiring a total minimum of 115 hours of direct care service. On this date, only 97.5 hours of direct care staffing was provided.

Plan of Correction ***Directed ([redacted] - 01/07/2025)***

Immediately: *The administrator or designated staff person shall develop and implement a schedule that includes the availability of providing at least one hour per day of personal care services for each mobile resident and two hours per day of personal care services for each resident who has mobility needs. At least 75% of the required personal care service hours shall be available during waking hours and additional personal care service staffing hours shall be scheduled to meet the needs of the residents as specified in the resident's assessments, support plans and as needed to safely evacuate the residents in the event of an emergency.*

57c - 2 Hours/Day (continued)

Directed Completion Date: *01/09/2025*

Evidence of Completion ***Implemented (- 02/10/2025)***

It is important for the safety and overall well-being of our residents that we always provide appropriate staffing levels to ensure proper care for our residents. On 1/9/25, the Regional Director of Operations re-educated the Director of Health & Wellness, the Director of Memory Care and the Wellness Coordinator on required staffing levels. The current staffing schedule was reviewed and updated. The Executive Director will review staffing levels with the team every day at Morning Stand Up to ensure appropriate staffing levels are in place.

63a - First Aid/CPR Training

4. 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 11/10/2024, there were 85 residents present in the home. On this date no staff persons were present in the home who were certified in first aid, obstructed airway techniques and CPR.

On 11/23/2024, there were 85 residents present in the home. On this date no staff persons were present in the home who were certified in first aid, obstructed airway techniques and CPR.

Plan of Correction ***Directed (- 01/07/2025)***

Immediately: *The administrator or designee shall review the schedule and staff working hours weekly to ensure at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation is present in the home at all times.*

Directed Completion Date: *01/09/2025*

Evidence of Completion ***Implemented (- 02/10/2025)***

It is important for the safety and overall health of our residents that we ensure we have CPR certified staff working on each shift. On 1/9/25, the Regional Director of Operations re-educated the Director of Health & Wellness, the Director of Memory Care and the Wellness Coordinator on required staffing levels and CPR requirements. The current staffing schedule was reviewed and updated to include staff with CPR certification. The Executive Director will review staffing levels/CPR certified staff with the team every day at Morning Stand Up to ensure appropriate staffing levels are in place. An additional CPR training class has bene set up for 1/15/25 for all nursing and activity staff with Educational Services.

65a - FS Orientation 1st Day

5. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

65a - FS Orientation 1st Day *(continued)*

3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, whose first day of work was [redacted], did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Staff person C, whose first day of work was [redacted], did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Staff person D, whose first day of work was [redacted], did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Repeat violation: 4/8/24, 7/10/24 et al, 9/9/24 et al

Plan of Correction ***Directed ([redacted] - 01/07/2025)***

Immediately: *Staff persons B, C and D shall receive orientation in evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services. Documentation of training shall be kept in accordance with 2600.65i.*

Within 3 days of receipt of this plan of correction: *The administrator or designee shall review all training records for newly hired staff or staff hired within the past year to ensure all direct care staff persons including ancillary staff persons, substitute personnel and volunteers have completed an orientation in general fire safety and emergency preparedness in accordance with regulation 2600.65(a). Documentation of the review shall be kept.*

Within 3 days of receipt of the plan of correction:

65a - FS Orientation 1st Day (continued)

A new staff person document tracking system shall be developed and implemented to ensure and track all new staff person required documentation.

Within 5 days of receipt of this plan of correction: *All staff persons involved in the hiring and retention of staff shall be educated on the home's policy and procedures for new staff person training including the requirements of regulation 2600.65(a). Documentation of training shall be kept in accordance with 2600.65i.*

Directed Completion Date: *01/12/2025*

Evidence of Completion ***Not Implemented (- 03/07/2025)***

It is important that all staff be provided with the proper training required to safely care for our residents prior to working on the floor. The staff persons identified as requiring training are no longer employed by the community. On 1/10/25, the Regional Director of Operations, , PCHA, CALA, provided education on Orientation Requirements to the directors responsible for providing the required trainings. This includes: the Director of Plant Operations Director of Heath & Wellness, Director of Memory Care, Wellness Coordinator and Executive Director. A training binder was created and implemented on 1/10/25 for the Wellness Coordinator to review with any agency staff, prior to beginning their shift on the floor. All agency staff will review this binder and sign off on trainings beginning 1/10/25, to ensure all agency staff have the required day 1 orientation trainings completed. The community will be hiring an Employee Relations and Administration Coordinator. This position will be responsible for the oversight of new hires and ensuring that all new employees receive the training required per DHS at New Employee Orientation. Until this position is filled, the Executive Director will oversee all new hire orientation classes to ensure all required trainings are completed and documented. A New Hire Orientation Checklist will be completed and kept on file for all new employees going forward. The Executive Director will conduct random audits of employee files to monitor ongoing compliance.

65b - Rights/Abuse 40 Hours

6. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person B completed 40th scheduled work hour in However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Staff person D completed 40th scheduled work hour on . However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

65b - Rights/Abuse 40 Hours (continued)

Repeat violation: 4/8/24, 7/10/24 et al, 9/9/24 et al

Plan of Correction ***Directed (- 01/07/2025)***

Immediately: *Staff persons B and D shall receive training in resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions. Documentation of training shall be kept in accordance with 2600.65i.*

Within 3 days of receipt of this plan of correction: *The administrator or designee shall review all training records for newly hired staff or staff hired within the past year to ensure all direct care staff persons including ancillary staff persons, substitute personnel and volunteers have completed an orientation in resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions in accordance with regulation 2600.65(b). Documentation of the review shall be kept.*

Within 3 days of receipt of the plan of correction: *A new staff person document tracking system shall be developed and implemented to ensure and track all new staff person required documentation.*

Within 5 days of receipt of this plan of correction: *All staff persons involved in the hiring and retention of staff shall be educated on the home's policy and procedures for new staff person training including the requirements of regulation 2600.65(b). Documentation of training shall be kept in accordance with 2600.65i.*

Directed Completion Date: *01/12/2025*

Evidence of Completion ***Not Implemented (- 03/07/2025)***

It is important that all staff be provided with the proper training required to safely care for our residents prior to working on the floor. Staff person D was an agency worker and is no longer utilized in the community. On 1/10/25, the Regional Director of Operations, , PCHA, CALA, provided education on Orientation Requirements to the directors responsible for providing the required trainings. This includes: the Director of Plant Operations Director of Heath & Wellness, Director of Memory Care, Wellness Coordinator and Executive Director. A training binder was created and implemented on 1/10/25 for the Wellness Coordinator to review with any agency staff, prior to beginning their shift on the floor. All agency staff will review this binder and sign off on trainings beginning 1/10/25, to ensure all agency staff have the required day 1 orientation trainings completed. The community will be hiring an Employee Relations and Administration Coordinator. This position will be responsible for the oversight of new hires and ensuring that all new employees receive the training required per DHS at New Employee Orientation. Until this position is filled, the Executive Director will oversee all new hire orientation classes to ensure all required trainings are completed and documented. A New Hire Orientation Checklist will be completed and kept on file for all new employees going forward. The Executive Director will conduct random audits of employee files to monitor ongoing compliance.

65d - Initial Direct Care Training

7. Requirements

2600.

65d - Initial Direct Care Training *(continued)*

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, hired on [redacted], provides unsupervised ADL services to residents. However, there is no documentation available to verify that the staff person completed the Department-approved direct care training course and passed the competency test.

Direct care staff person C, hired on [redacted] provides unsupervised ADL services to residents. However, there is no documentation available to verify that the staff person completed the Department-approved direct care training course and passed the competency test.

Plan of Correction ***Directed ([redacted] - 01/07/2025)***

Immediately: *Staff person A shall not be permitted to provide unsupervised direct care services until the training requirements of 2600.65d have been met. Documentation of training shall be kept in accordance with 2600.65i.*

Within 3 days of receipt of this plan of correction: *The administrator or designee shall review all current direct care staff training records to ensure all current direct care staff persons providing unsupervised direct care services have completed the required training in accordance with regulation 2600.65d. Documentation of the review shall be kept.*

Within 3 days of receipt of the plan of correction: *A new staff person document tracking system shall be developed and implemented to ensure and track all new staff person required documentation.*

Within 5 days of receipt of this plan of correction: *All staff persons involved in the hiring and retention of staff shall be educated on the home's policy and procedures for new staff person training including the requirements of regulation 2600.65(b). Documentation of training shall be kept in accordance with 2600.65i.*

Directed Completion Date: *01/12/2025*

Evidence of Completion ***Not Implemented ([redacted] - 03/07/2025)***

It is important that all staff be provided with the proper training required to safely care for our residents prior to working on the floor. Staff person A was observed for direct care competency. Staff person C is no longer employed with the company. An audit was completed on 1/13/25 by the Regional Director of Health and Wellness and The Executive Director to ensure compliance with required trainings. The community will be hiring an Employee Relations and Administration Coordinator. This position will be responsible for the oversight of new hires and ensuring that all new employees receive the training required per DHS at New Employee Orientation. Until this position is filled, the Executive Director will oversee all new hire orientation classes to ensure all required training is completed and documented. A New Hire Orientation Checklist will be completed and kept on file for all new employees going forward. A tracking form has been created and implemented to ensure all training is completed in the required timeframe. The Executive Director will conduct random audits of employee files to monitor ongoing compliance.

65e - 12 Hours Annual Training

8. Requirements

65e - 12 Hours Annual Training *(continued)*

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff persons A and E received 0 hours of annual training in training year 2023.

Plan of Correction ***Directed (- 01/07/2025)***

Immediately: *The administrator or designated staff person shall monitor all direct care staff training through the quality management review process to ensure all staff persons receive the required 12 hours of annual training during each established training year. Documentation shall be kept.*

Directed Completion Date: *01/09/2025*

Evidence of Completion ***Not Implemented (- 02/10/2025)***

It is important for all staff to remain in compliance with the required annual training requirements. The community is now utilizing RELIAS online training program to ensure all staff are compliant with annual trainings. The Regional Director of Operations, has created, enrolled and implemented this training program effective 1/1/2025 for all staff employed at the community. The community will be hiring an Employee Relations and Administration Coordinator. This position will be responsible for the oversight of ensuring staff complete the monthly Relias Trainings as assigned by running monthly audit reports from the RELIAS system to ensure all staff are in compliance. Until this position is filled, the Executive Director will oversee and monitor the training site monthly to ensure ongoing compliance. These monthly reports will be reviewed with the team every month during QAPI to ensure ongoing compliance.

65f - Training Topics

9. 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.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff persons A and E did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques , care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2023.

Repeat violation: 9/9/24

65f - Training Topics (continued)

Plan of Correction ***Directed ([redacted] - 01/07/2025)***

Immediately: *Staff persons A and E shall receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, and safe management techniques. Documentation of education shall be kept in accordance with 2600.65i.*

Immediately: *The administrator or designee shall monitor all direct care staff training through the quality management review process to ensure all staff persons receive the required trainings in accordance with regulation 2600.65(f) during each established training year. Documentation shall be kept.*

Directed Completion Date: *01/09/2025*

Evidence of Completion ***Not Implemented ([redacted] - 02/10/2025)***

It is important for all staff to remain in compliance with the required annual training requirements. Staff persons A & E will attend training on 1/15/25 to ensure they are in compliance with training requirements. The community is now utilizing RELIAS online training program to ensure all staff are compliant with annual trainings. The Regional Director of Operations, [redacted] has created, enrolled and implemented this training program effective 1/1/2025 for all staff employed at the community. The community will be hiring an Employee Relations and Administration Coordinator. This position will be responsible for the oversight of ensuring staff complete the monthly Relias Trainings as assigned by running monthly audit reports from the RELIAS system to ensure all staff are in compliance. Until this position is filled, the Executive Director will oversee and monitor the training site monthly to ensure ongoing compliance. These monthly reports will be reviewed with the team every month during QAPI to ensure ongoing compliance.

65g - Annual Training Content

10. 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 persons A and E did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § §

65g - Annual Training Content (continued)

10225.101—10225.5102), falls and accident prevention, new population groups that are being served at the home that were not previously served, if applicable during training year 2023.

Plan of Correction ***Directed (- 01/07/2025)***

Immediately: *Staff persons A and E shall receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention. Documentation of education shall be kept in accordance with 2600.65i.*

Immediately: *The administrator or designee shall monitor all direct care staff persons, ancillary staff persons, substitute personnel and regularly-scheduled volunteers training through the quality management review process to ensure all staff persons receive the required trainings in accordance with regulation 2600.65(g) during each established training year. Documentation shall be kept.*

Directed Completion Date: *01/09/2025*

Evidence of Completion ***Not Implemented (- 02/10/2025)***

It is important that all staff be provided with the proper fire safety training required to ensure the safety and well-being of our residents and visitors. Staff person A & E were trained on 1/9/25 by the Regional Director of Operations, [redacted], who is trained as a Fire Safety Expert. All new hires will complete fire safety training during New Hire Orientation and all staff will have an annual in-service with a Fire Safety Expert. The Director of Plant Operations will be responsible for scheduling the annual Fire Safety Training with our contracted company, Fire Safety Solutions. The Employee Relations and Administration Coordinator will be responsible for tracking that all employees attend each annual training. The Executive Director will review Fire Safety Trainings monthly during QAPI, beginning on February 2/5/25, to monitor for ongoing compliance.

82c - Locking Poisonous Materials

11. 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

Alcohol Prep Pads, with a manufacture's label indicating "if accidentally swallowed, seek medical assistance or contact a Poison Control Center right away", were unlocked, unattended, and accessible to residents on the 5th floor Memory Care Unit, in the Activity Room. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Repeat violation: 2/21/24, 4/8/24 et al, 7/10/24 et al, 9/9/24 et al, 10/10/24 et al

Plan of Correction ***Directed (- 01/07/2025)***

Immediately: *The administrator or designated staff person shall check the home daily on each shift to ensure poisonous materials are locked and inaccessible to residents. Documentation of daily checks shall be kept.*

82c - Locking Poisonous Materials (continued)

Within 3 days of receipt of the plan of correction: *All staff persons shall be educated concerning the safe storage of poisonous materials and the risks to residents. Documentation of education shall be kept in accordance with 2600.65i.*

Directed Completion Date: *01/10/2025*

Evidence of Completion ***Implemented (- 02/10/2025)***

The Regional Director of Operations, , PCHA, CALA, will be conducting a training on poisonous materials for the Executive Director, Director of Health & Wellness and the Director of Memory Care on 1/10/25. The Directors will then provide trainings to all staff on each shift on 1/13/25, 1/14/25and 1/15/25. A new audit tool was created to ensure that staff receive on the spot immediate re-education of any poisonous items that are left out after use. After an initial on the spot retraining is provided with an employee, should any items be found again, the employee will receive immediate corrective action, up to and including termination. The Director of Memory Care will complete random daily checks for poisonous materials. These checks will be documented and reviewed monthly by the Executive Director during QAPI. The next QAPI meeting will be held on 2/5/25.

85c - Trash

12. Requirements

2600.
85.c. Trash shall be removed from the premises at least once a week.

Description of Violation

According to staff interviews, trash is removed from the premises every other Tuesday.

Plan of Correction ***Directed (- 01/07/2025)***

Immediately: *The administrator shall arrange for trash to be removed from the premises at least once per week. Documentation of the schedule shall be kept.*

Directed Completion Date: *01/09/2025*

Evidence of Completion ***Implemented (- 02/10/2025)***

It is important to ensure trash is removed from the premises on a regular basis. Unfortunately, the executive director at the time of the inspection was new and did not provide the inspectors with correct information. The dumpster on the community's premises is emptied weekly by Republic Waste.

89a - Water Pressure

13. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 11/25/2024, the home did not have sufficient hot and cold water to the kitchen sink in room 608; the water was coming out of the faucet at a trickle.

Plan of Correction ***Directed (- 01/07/2025)***

Immediately: *The faucet at the kitchen sink in room 608 shall be repaired or replaced.*

89a - Water Pressure (continued)

Within 3 days of receipt of the plan of correction: *the administrator or designee shall conduct a walkthrough of the home and ensure that all sinks have sufficient water pressure. Any areas on noncompliance shall be corrected immediately. Documentation of walkthrough shall be kept.*

Directed Completion Date: *01/10/2025*

Evidence of Completion ***Implemented (- 02/10/2025)***

It is important to ensure all residents have the appropriate water pressure from all water faucets. The faucet in room 608 was repaired on 11/25/24. The screen on the faucet was clogged. Once replaced, the water pressure returned to normal flow. The Director of Plant Operations and/or designee will complete an environmental checklist for resident rooms weekly for 3 weeks, bi-weekly for 6 weeks and monthly thereafter for 6 months. These audits will begin 1/13/25. All audits will be brought to the monthly QAPI meetings for the Executive Director to review for ongoing compliance. The next QAPI meeting will be held on 2/5/25.

103e - Left Overs

14. 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

There were unlabeled, undated fish and chicken patties in the main kitchen freezer at 1:58 pm.

Plan of Correction ***Directed (- 01/07/2025)***

Immediately: *A designated staff person shall check all food storage areas daily including refrigerators and freezers to ensure all food items are labeled, dated, stored in closed or sealed containers and that food is not stored on the floor. Documentation shall be kept.*

Directed Completion Date: *01/09/2025*

Evidence of Completion ***Implemented (- 02/10/2025)***

It is important for the safety of our residents that all food is labeled and dated. On 1/9/25, the Regional Director of Operations, , PCHA, CALA in-serviced the Director of Dining Services on proper protocol and regulations for labeling and dating food. An audit was created and implemented 1/10/25. The Director of Dining Services will be responsible for completing this audit weekly for 6 weeks, bi-weekly for 6 weeks and monthly for 6 weeks. These audits will be reviewed monthly at QAPI by the Executive Director to monitor for ongoing compliance. The next QAPI meeting will be held on 2/5/25.

132h - Designated Meeting Place

15. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

On 11/25/2024 at 2:46 pm the fire alarm sounded in the home. An agent of the Department was onsite at the time. Residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. Staff and residents did not immediately acknowledge the alarm. After approximately 1 minute, residents on the Main Entrance floor were evacuated to the lobby area. Residents were instructed by staff that they were free to move about the building prior to receiving the "all clear" by the fire department.

132h - Designated Meeting Place *(continued)*

Plan of Correction ***Directed (- 01/07/2025)***

Immediately: *All direct care staff persons, ancillary staff persons, substitute personnel and regularly-scheduled volunteers shall be educated on the requirement that all residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during a fire drill and any time the fire alarm sounds. The education shall include instructions that identify the designated meeting place and/or fire-safe area(s). Documentation of education shall be kept in accordance with 2600.65i.*

Directed Completion Date: *01/09/2025*

Evidence of Completion ***Implemented (- 02/10/2025)***

It is important that all staff follow the fire safety procedures for evacuation. On 1/10/25, the Director of Plant Operations conducted an unannounced fire drill and had staff follow the protocol to evacuate to our designated meeting area. All staff will be re-educated on emergency evacuation procedures at our next scheduled all staff meeting on 1/16/25.

141b1 - Annual Medical Evaluation

16. 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 [redacted] The resident's previous medical evaluation was completed on [redacted]

Repeat violation: 4/8/24, 9/9/24 et al

Plan of Correction ***Directed (- 01/07/2025)***

Immediately: *A resident document tracking system shall be developed and implemented to ensure all residents have a medical evaluation completed within the required timeframe. Documentation shall be kept.*

Within 3 days of receipt of the plan of correction: *The administrator or designated staff person shall check all resident records to ensure a current medical evaluation is completed and present in each resident's record. Documentation shall be kept.*

Within 5 days of receipt of the plan of correction: *All staff persons involved with the medical evaluation process shall be educated that a medical evaluation shall be completed at least annually. Documentation of education shall be kept in accordance with 2600.65i.*

Directed Completion Date: *01/12/2025*

Evidence of Completion ***Not Implemented (- 03/07/2025)***

It is important that all DME are in compliance with regulations to ensure the overall health and well-being of our residents. The Regional Director of Health and Wellness, [redacted], LPN set up a DME tracking system in our electronic medical records system (ECP). On 12/23/24, the Regional Director of Health and Wellness conducted a training on DMEs, completion of DME and due dates, and the tracking system in ECP for the Director of Health and Wellness and the Director of Memory Care. On 1/13/25, the Regional Director of Health & Wellness and the Executive Director conducted an audit of all residents' charts and DME to ensure compliance. The Executive director

141b1 - Annual Medical Evaluation (continued)

and/or designee will conduct random DME audits to ensure ongoing compliance.

171b4 - Staff Training

17. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
4. At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation).

Description of Violation

Staff person B, [redacted] Staff person B has not completed the initial new hire direct care staff person training, and transports residents unaccompanied by trained direct care staff.

Staff person F, [redacted]. Staff person F has not completed the initial new hire direct care staff person training, and transports residents unaccompanied by trained direct care staff.

Plan of Correction ***Directed ([redacted] - 01/07/2025)***

Immediately: *Staff persons B and F shall not transport residents alone until each staff person has completed the initial new hire direct care staff person training. Documentation of training shall be kept.*

Immediately: *The administrator or designee shall conduct an audit of all transportation staff records. Any transportation staff person who has not completed the initial new hire direct care staff person training shall have someone who has received the training accompany them when transporting residents until training for that staff person is complete. Documentation of audit and training shall be kept.*

Within 3 days of receipt of the plan of correction: *A staff person document tracking system shall be developed and implemented to ensure and track all transportation staff person required documentation.*

Directed Completion Date: *01/10/2025*

Evidence of Completion ***Implemented ([redacted] - 02/10/2025)***

It is important that any employee transporting residents has completed the DHS Direct Care Competency Course and Test. Both employees have completed the required coursework. These are the only two employees currently providing transportation for the community. A checklist has been implemented for all new employees to ensure the proper training, including the DHS Direct Care Competency Course/Test is completed prior to working on with the residents. The Executive Director and/or designee will conduct random employee fil audits to ensure ongoing compliance.

181f - Record of Medication

18. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

181f - Record of Medication *(continued)*

Description of Violation

On 11/27/2024, resident 2's record did not include a current list of medications. The list in the resident's record included discontinued medications: Amiodarone HCL 200 mg tablet, Aspirin 81 mg tab chew, Doxycycline Hyclate 100 mg cap, and Senna Plus tablet.

Plan of Correction ***Directed ([redacted] - 01/07/2025)***

Immediately: *The administrator or designee shall audit all resident medications for residents who are self-administering medications on a monthly basis to ensure the resident's record has a current list of prescription, OTC and CAM medications for each resident.*

Directed Completion Date: *01/09/2025*

Evidence of Completion ***Implemented ([redacted] - 02/10/2025)***

It is important that for all residents that can self-administer medications, the community keeps a current list of all medications. On 1/9/25, the Regional Director of Health and Wellness, [redacted], LPN conducted a medication audit for all self-administering medications. The Director of Health and Wellness and/or designee will be responsible for completing monthly audits of all self-administering residents to ensure all medications lists remain current. These audits will be reviewed at the monthly QAPI meetings by the Executive Director to ensure ongoing compliance. The next QAPI meeting will be held on 2/5/25.

183d - Prescription Current

19. 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 11/27/2024 at 10:07 am, Milk of Magnesia Susp prescribed for resident 3, was in the home's medication cart; however, the medication was discontinued on 4/27/2024.

Plan of Correction ***Directed ([redacted] - 01/07/2025)***

Immediately: *A designated staff person qualified to administer medications shall check the medication cart at least daily to ensure all medications are current. Documentation of checks shall be kept.*

Directed Completion Date: *01/09/2025*

Evidence of Completion ***Implemented ([redacted] - 02/10/2025)***

It is important for the safety and health of our residents that medications carts are organized and only contain current mediations. On 1/9/25, the Regional Director of Health & Wellness, Melissa Thomas, conducted audits of all medication carts. Going forward, the Director of Health & Wellness and Director of Memory Care and/or designees will conduct daily medication cart audits. These audits will be conducted daily for 30 days, weekly for 6 weeks and monthly thereafter. These audits will be reviewed at the monthly QAPI meeting by the Executive Director to ensure ongoing compliance. The next QAPI meeting will be held on 2/5/25.

183e - Storing Medications

20. Requirements

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

183e - Storing Medications *(continued)*

Description of Violation

On 11/27/2024:

- *Resident 4's Lorazepam .5 mg tablet prescription bubble pack had a tear/puncture on the back at spot 12 and the pill was still in place.*
- *Resident 5's Tramadol HCL 50 mg tablet prescription bubble pack had a tear/puncture on the back at spot 1 and the pill was still in place.*
- *Resident 6's Lorazepam .5 mg tablet prescription bubble pack had a tear/puncture on the back at spot 16 and the pill was still in place.*

Plan of Correction ***Directed (- 01/07/2025)***

Immediately: *A designated staff person qualified to administer medications shall check the medication cart at least daily to ensure all medications are properly packaged and stored including that there are no unpackaged or loose medications in the medication cart. Documentation of checks will be kept.*

Directed Completion Date: *01/09/2025*

Evidence of Completion ***Implemented (- 02/10/2025)***

It is important for the safety and health of our residents that medications are properly stored in the medication carts. On 1/9/25, the Regional Director of Health & Wellness, [redacted], conducted audits of all medications in the carts. Going forward, the Director of Health & Wellness and Director of Memory Care and/or designees will conduct daily medication cart audits. These audits will be conducted daily for 30 days, weekly for 6 weeks and monthly thereafter. These audits will be reviewed at the monthly QAPI meeting by the Executive Director to ensure ongoing compliance. The next QAPI meeting will be held on 2/5/25.

184a - Resident's Meds Labeled

21. Requirements

2600.

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

1. The resident's name.
2. The name of the medication.
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

The pharmacy label for resident 7's Wonder sleep mini's THC does not include the resident's name.

Plan of Correction ***Directed (- 01/07/2025)***

Immediately: *A designated staff person qualified to administer medications shall complete an initial and weekly audit of the medication carts and any other medication storage areas to ensure all prescription medications are labeled to include: the resident's name, medication name, date prescription issued, prescribed dosage and instructions for administration and name and title of the prescriber.*

Directed Completion Date: *01/09/2025*

184a - Resident's Meds Labeled *(continued)*

Evidence of Completion ***Implemented (- 02/10/2025)***

it is important for the safety and health of our residents that medications are properly stored in the medication carts. On 1/9/25, the Regional Director of Health & Wellness, , conducted audits of all medications in the carts. Going forward, the Director of Health & Wellness and Director of Memory Care and/or designees will conduct daily medication cart audits. These audits will be conducted daily for 30 days, weekly for 6 weeks and monthly thereafter. These audits will be reviewed at the monthly QAPI meeting by the Executive Director to ensure ongoing compliance.
o The next QAPI meeting will be held on 2/5/25.

185a - Implement Storage Procedures

22. 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

The following glucometers were not calibrated:

- *On 11/27/2024 at 12:22 pm, resident 1's glucometer indicated the date and time as 11/27 at 6:41 am.*
- *On 11/27/2024 at 11:19 am, resident 8's glucometer indicated the date and time as 11/27 at 12:18 am.*

Resident 3 is prescribed Acetaminophen 325 mg, 2 tablets every 4 hours as needed. On 11/27/2024 at 10:07 am this medication was not available in the home.

Resident 4 is prescribed Loperimide 2 mg, every 6 hours as needed. On 11/27/2024 at 9:44 am this medication was not available in the home.

Repeat violation: 8/20/2024

Plan of Correction ***Directed (- 01/07/2025)***

Immediately: *The glucometers for residents 1 and 8 shall be calibrated for the correct and time.*

Immediately: *The administrator or designated staff person qualified to administer insulin medications shall conduct an initial and weekly audit of all glucometers in the home to ensure they are calibrate to the correct date and time. Documentation of audits shall be kept.*

Within 3 days of receipt of the plan of correction: *The administrator or designated staff person qualified to administer medications shall complete an initial and weekly audit of the medication cart, medication administration records and prescription orders to ensure all prescription medications are available for administration. Documentation of audits shall be kept.*

Directed Completion Date: *01/10/2025*

185a - Implement Storage Procedures *(continued)*

Evidence of Completion ***Not Implemented ([redacted] - 02/10/2025)***

It is important for the safety and health of our residents that all glucometers are calibrated with the correct date and time. On 1/9/25 the Director of Health and Wellness and the Director of Memory Care (both LPNs) completed an initial audit of all glucometers. The Director of Health and Wellness and Director of memory Care and/or designee will complete weekly audits of the medication carts, the MAR and prescription orders. These audits will be completed weekly for 6 weeks, biweekly for 6 weeks and monthly for 6 weeks. These audits will be reviewed at the monthly QAPI meetings by the Executive Director to ensure ongoing compliance. The next QAPI meeting will be held on 2/5/25.

187d - Follow Prescriber's Orders

23. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 8 is prescribed Polyethylene glycol 3350 powder, dissolve in 8oz fluid and drink by mouth twice a day. However, on 11/27/2024 at 11:20 am this medication was not available in the home.

Repeat violation: 12/14/23, 7/10/24 et al, 10/10/24 et al

Plan of Correction ***Directed ([redacted] - 01/07/2025)***

Within 3 days of receipt of the plan of correction: *The administrator or designated staff person qualified to administer medications shall complete an initial and weekly audit of the medication cart, medication administration records and prescription orders to ensure all prescription medications are available for administration. Documentation of audits shall be kept.*

Directed Completion Date: *01/10/2025*

Evidence of Completion ***Implemented ([redacted] - 02/10/2025)***

It is important for the health of our residents that prescription orders are always followed. The Director of Health and Wellness and Director of memory Care and/or designee will complete weekly audits of the medication carts, the MAR and prescription orders. These audits will be completed weekly for 6 weeks, biweekly for 6 weeks and monthly for 6 weeks. These audits will be reviewed at the monthly QAPI meetings by the Executive Director to ensure ongoing compliance. The next QAPI meeting will be held on 2/5/25.

190b - Insulin Injections

24. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 11/18/2024 at 11:30 am, staff person G, who has not successfully completed a Department-approved diabetes patient education program with in the last 12 months, administered insulin to resident 1.

190b - Insulin Injections *(continued)*

Plan of Correction ***Directed (- 01/07/2025)***

Immediately: *Staff person G shall not be permitted to administer insulin until the staff person has completed a Department-approved diabetes patient education program.*

Immediately: *The administrator or designated staff person shall review all staff records to ensure all staff persons administering insulin have completed a Department-approved diabetes patient education program. Documentation of the audit shall be kept.*

Directed Completion Date: *01/09/2025*

Evidence of Completion ***Not Implemented (- 03/07/2025)***

It is important that all certified medication technicians complete the required diabetic trainings. On 1/9/25, the Regional Director of Health & Wellness, The Director of Health and Wellness and the Director of Memory Care audits all certified med tech trainings to ensure compliance. A Diabetic training has been scheduled for 1/21/25 to ensure all CMT remain in compliance. A training log will be implemented and maintained by the Director of Health & Wellness to ensure ongoing compliance.

227a - Support Plan 30 Days

25. Requirements

2600.
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 9 was admitted on ; however, the resident's initial support plan was not completed.

Plan of Correction ***Directed (- 01/07/2025)***

Immediately: *A support plan shall be completed for resident 9.*

Within 3 days of the receipt of the plan of correction: *The administrator or designated staff person shall review all resident records to ensure all residents have a current support plan completed. Documentation of the audit shall be kept.*

Within 5 days of the receipt of the plan of correction: *The administrator shall develop and implement a policy and procedure to ensure all residents have a support plan completed within 30 days of admission. All staff persons completing support plans shall be educated on the updated policy and procedures. Documentation shall be kept.*

Directed Completion Date: *01/12/2025*

Evidence of Completion ***Not Implemented (- 03/07/2025)***

On 1/10/25, the RASP was completed for resident 9. On 1/13/25, the Regional Director of Health and Wellness and the Executive Director completed audits of all residents to ensure a current RASP was completed and in the residents' charts. The Regional Director of Health and Wellness conducted a RASP training with the Director of Health and

227a - Support Plan 30 Days (continued)

Wellness and the Director of Memory Care on 1/13/25. The Executive Director will conduct random audits to ensure ongoing compliance.

231f - Assessed Annually

26. Requirements

2600.
231.f. In addition to the requirements in § 2600.225 (relating to initial and annual assessment), the resident shall also be assessed annually for the continuing need for the secured dementia care unit.

Description of Violation

Resident 10 was assessed for the need for Secure Dementia Care Unit (SDCU) on [redacted] and was not assessed again in 2023 and 2024.

Resident 11 was assessed for the need for Secure Dementia Care Unit (SDCU) on [redacted] and was not assessed again in 2023 and 2024.

Plan of Correction ***Directed ([redacted] - 01/07/2025)***

Immediately: *Residents 10 and 11 shall be assessed for the need for Secure Dementia Care Unit (SDCU).*

Within 3 days of receipt of the plan of correction: *records for all residents in the SDCU shall be reviewed to ensure that an annual assessment that addresses the continuing need for the secured dementia care unit is present. Documentation shall be kept.*

Directed Completion Date: *01/10/2025*

Evidence of Completion ***Implemented ([redacted] - 02/10/2025)***

All residents residing in the secured memory care units will be assessed annually for the need to remain in the secured unit. On 1/10/25, residents 10 and 11 were assessed and their care plan updated. On 1/13/25, the Regional Director of Health and Wellness and Executive Director reviewed all residents residing in the secured dementia units to ensure their assessments were completed and up to date. The Executive Director will conduct random audits to ensure these assessments are in compliance going forward.

234a - Admission Support Plan

27. 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 12 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was completed on [redacted]

Repeat violation: 9/9/24

Plan of Correction ***Directed ([redacted] - 01/07/2025)***

Within 5 days of receipt of the plan of correction:

234a - Admission Support Plan (continued)

All staff persons involved with the completion of support plans shall be educated on the proper completion and accuracy of the support plans including the documentation of the care and services the home will provide to each resident. This education shall also include the requirement that each resident shall have a support plan completed within 72 hours of admission to the SDCU. Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: *01/12/2025*

Evidence of Completion ***Implemented ([redacted] - 02/10/2025)***

It is important that all residents residing in the secured memory care units have their care plans completed in the regulatory timeframes. On 1/13/25, the Regional Director of Health and Wellness conducted a re-education on the regulatory requirements with the Director of Health and Wellness and the Director of Memory Care. The Executive Director will conduct random RASP audits to ensure ongoing compliance.

236 - Staff Training

28. 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 E, who works in the Secure Dementia Care Unit (SDCU) had 0 hours of training in dementia care during the 2023 training year.

Repeat violation: 2/21/24, 9/9/24 et al

Plan of Correction ***Directed ([redacted] - 01/07/2025)***

Immediately: *The administrator or designated staff person shall monitor all direct care staff training through the quality management review process to ensure all staff persons 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) during each established training year. Documentation shall be kept.*

Directed Completion Date: *01/09/2025*

Evidence of Completion ***Not Implemented ([redacted] - 02/10/2025)***

It is important for all staff to remain in compliance with the required annual training requirements for working in a secured memory care unit. The community is now utilizing RELIAS online training program to ensure all staff are compliant with annual trainings. The Regional Director of Operations, [redacted] has created, enrolled and implemented this training program effective 1/1/2025 for all staff employed at the community. The community will be hiring an Employee Relations and Administration Coordinator. This position will be responsible for the oversight of ensuring staff complete the monthly Relias Trainings as assigned by running monthly audit reports from the RELIAS system to ensure all staff are in compliance. Until this position is filled, the Executive Director will oversee and monitor the training site monthly to ensure ongoing compliance. These monthly reports will be reviewed by the team every month during QAPI to ensure ongoing compliance.