pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail [redacted]
March 18, 2025

[redacted]
Administrator
Arden Courts of Yardley PA, LLC
493 Stony Hill Road
Yardley, Pennsylvania 19067

RE: Arden Courts (Yardley)
License #: 12997

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on January 13, 2025 and March 12, 2025 of the above facility, we have determined that your submitted plan of correction for the December 10, 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]
[redacted]

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *ARDEN COURTS (YARDLEY)* **License #**: *12997* **License Expiration**: *04/30/2025*

Address: *493 STONY HILL ROAD, YARDLEY, PA 19067*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *ARDEN COURTS OF YARDLEY PA LLC*

Address: *493 STONY HILL ROAD, YARDLEY, PA, 19067*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/24/1995* **Issued By**:

Staffing Hours

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

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *12/10/2024*

Inspection Dates and Department Representative

12/10/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served**: *38*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire Home* **Capacity**: *66* **Residents Served**: *38*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *38*

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

Have Mobility Need: *38* **Have Physical Disability**: *0*

Inspections / Reviews

12/10/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/02/2025*

Inspections / Reviews *(continued)*

01/13/2025 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/18/2025*

01/13/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/13/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/13/2025*

03/17/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *02/14/2025*

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

19 - Review Waiver

1. Requirements

2600.
19.e. The home shall notify the affected resident and designated person of the approval or denial of the waiver. A copy of the waiver request and the Department's written decision shall be posted in a conspicuous and public place within the home.

Description of Violation

On 9/08/2014, the home received a waiver of qualifications of direct care staff persons for staff person A. The home failed to post a copy of the waiver request and the Department's written decision in a conspicuous and public place within the home.

On 5/22/2017, the home received a waiver of qualifications of direct care staff persons for staff person B. The home failed to post a copy of the waiver request and the Department's written decision in a conspicuous and public place within the home.

Plan of Correction ***Do Not Accept ([redacted] - 01/13/2025)***

Waivers were posted in viewable location within lobby entrance of community.
Current staff files were reviewed to ensure all current waivers are posted in a conspicuous place.
Executive Director / designee completed education with Administration Services Coordinator on waiver regulations 2600.19(e)- waivers shall be posted in viewable location within the community on 1/7/2025.
Administration Services Coordinator / designee will audit new hires one time per week for 2 months to ensure educational qualifications are on file and required waivers are posted. Findings will be submitted to the QAPI committee for review and recommendations on 3/14/2025.

Proposed Overall Completion Date: 03/14/2025

Licensee's Proposed Overall Completion Date: *03/14/2025*

Update: *01/13/2025*

Overall completion date is too far in the future.

Plan of Correction ***Accept ([redacted] - 01/13/2025)***

Waivers were posted in viewable location within lobby entrance of community.
Current staff files were reviewed to ensure all current waivers are posted in a conspicuous place.
Executive Director / designee completed education with Administration Services Coordinator on waiver regulations 2600.19(e)- waivers shall be posted in viewable location within the community on 1/7/2025.
Administration Services Coordinator / designee will audit new hires one time per week for 4 weeks to ensure educational qualifications are on file and required waivers are posted. Findings will be submitted to the QAPI committee for review and recommendations on 2/11/2025.

Proposed Overall Completion Date: 02/13/2025

Licensee's Proposed Overall Completion Date: *02/13/2025*

Evidence of Completion ***Implemented ([redacted] - 03/12/2025)***

See attached.

54a - Direct Care Staff

2. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person C, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Repeat violation: 9/10/24

Plan of Correction ***Do Not Accept ([redacted] - 01/13/2025)***

Staff Member C was removed from providing assistance with activities of daily living until waiver has been approved by DHS.
Current staff members will be audited to ensure educational qualifications are on file by 1/10/25.
Executive Director / Designee completed education with Administration Services Coordinator director on Chapter 2600.54a, direct care staff qualifications needed to provide personal care services.
The Executive Director/designee will audit all new hires 1 time per week for 2 months to ensure required educational qualifications are on file for direct care staff. Findings will be submitted to the QAPI committee for review and recommendations on 3/14/2025.

Proposed Overall Completion Date: 03/14/2025

Licensee's Proposed Overall Completion Date: *03/14/2025*

Update: *01/13/2025*

Overall completion date is too far in the future.

Plan of Correction ***Accept ([redacted] - 01/13/2025)***

Staff Member C was removed from providing assistance with activities of daily living until waiver has been approved by DHS.
Current staff members will be audited to ensure educational qualifications are on file by 1/10/25.
Executive Director / Designee completed education with Administration Services Coordinator director on Chapter 2600.54a, direct care staff qualifications needed to provide personal care services.
The Executive Director/designee will audit all new hires 1 time per week for 4 weeks to ensure required educational qualifications are on file for direct care staff. Findings will be submitted to the QAPI committee for review and recommendations on 2/11/2025.

Proposed Overall Completion Date: 02/13/2025

Licensee's Proposed Overall Completion Date: *02/13/2025*

Evidence of Completion ***Implemented ([redacted] - 03/12/2025)***

See attached.

65e - 12 Hours Annual Training

3. Requirements

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

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

1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff persons C and D received 0 hours of annual training in training year 2023.

Plan of Correction ***Do Not Accept ([redacted] - 01/13/2025)***

2023 staff training plan for direct care staff persons C and D was reviewed and not able to be corrected due to being out of time frame. Staff persons C & D were reviewed and found to have completed 12 hours of the 2024 staff training plan.
2025 training schedule was created on 12/2/2024 and reviewed to ensure all required direct care staff training is scheduled and adhered to.
The Executive Director/designee completed education with the Resident Services Coordinator on Chapter 2600.65(e) for direct care staff 12-hour annual training related to care staff job duties.
Executive Director/ designee will audit direct care staff files 1 time a week for 2 months to ensure completion of staff training plan. Findings will be submitted to the QAPI committee for review and recommendations on 3/14/2025.

Licensee's Proposed Overall Completion Date: *03/14/2025*

Update: *01/13/2025*

Overall completion date is too far in the future.

Plan of Correction ***Accept ([redacted] - 01/13/2025)***

2023 staff training plan for direct care staff persons C and D was reviewed and not able to be corrected due to being out of time frame. Staff persons C & D were reviewed and found to have completed 12 hours of the 2024 staff training plan.
2025 training schedule was created on 12/2/2024 and reviewed to ensure all required direct care staff training is scheduled and adhered to.
The Executive Director/designee completed education with the Resident Services Coordinator on Chapter 2600.65(e) for direct care staff 12-hour annual training related to care staff job duties.
Executive Director/ designee will audit direct care staff files 1 time a week for 4 weeks to ensure completion of staff training plan. Findings will be submitted to the QAPI committee for review and recommendations on 2/11/2025.

Licensee's Proposed Overall Completion Date: *02/13/2025*

Evidence of Completion ***Implemented ([redacted] - 03/12/2025)***

See attached.

65f - Training Topics

4. 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.

65f - Training Topics *(continued)*

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 C and D 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.

Plan of Correction ***Do Not Accept ([redacted] - 01/13/2025)***

Direct care staff persons C and D had 2023 training topics reviewed and was not able to be corrected due to being out of time frame. Staff persons C & D were reviewed and found to have completed the required training topics of the 2024 staff training plan for direct care staff.
2025 training schedule was created on 12/2/2024 and reviewed to ensure all required direct care staff training is scheduled and adhered to.
Executive Director / designee completed education with Resident Services Coordinator on chapter 2600.65(f) of training topics for the annual training for direct care staff persons on 1/7/2025.
Executive Director / designee will audit completed staff trainings 1 time per week for 2 months. Findings will be submitted to the QAPI committee for review and recommendations on 3/14/2025.

Proposed Overall Completion Date: 03/14/2025

Licensee's Proposed Overall Completion Date: *03/14/2025*

Update: *01/13/2025*

Overall completion date is too far in the future.

Plan of Correction ***Accept ([redacted] - 01/13/2025)***

Direct care staff persons C and D had 2023 training topics reviewed and was not able to be corrected due to being out of time frame. Staff persons C & D were reviewed and found to have completed the required training topics of the 2024 staff training plan for direct care staff.
2025 training schedule was created on 12/2/2024 and reviewed to ensure all required direct care staff training is scheduled and adhered to.
Executive Director / designee completed education with Resident Services Coordinator on chapter 2600.65(f) of training topics for the annual training for direct care staff persons on 1/7/2025.
Executive Director / designee will audit completed staff trainings 1 time per week for 4 weeks. Findings will be submitted to the QAPI committee for review and recommendations on 2/11/2025.

Proposed Overall Completion Date: 02/13/2025

Licensee's Proposed Overall Completion Date: *02/13/2025*

Evidence of Completion ***Implemented ([redacted] - 03/12/2025)***

See attached.

65g - Annual Training Content

5. Requirements

65g - Annual Training Content *(continued)*

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 C, D, 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. § § 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 ***Do Not Accept ([redacted] - 01/13/2025)***

2023 annual staff training plan for staff persons C, D and E were reviewed and not able to be corrected due to being out of time frame. Staff persons C, D & E were reviewed and found to have completed the required annual training of the 2024 staff training plan.
2025 Annual training content for direct care staff persons, ancillary staff persons training was created on 12/2/2024 and projected to be completed in compliance.
The Executive Director/designee completed education with the Building Services Coordinator/ fire safety expert on chapter 2600.65(g) for completion of fire safety training for direct care staff and ancillary staff persons on 1/7/2025.
Executive Director/ designee will audit staff files 1 time a week for 2 months to ensure completion of staff training for direct care staff and ancillary staff. Findings will be submitted to the QAPI committee for review and recommendations on 3/14/2025.

Proposed Overall Completion Date: 03/14/2025

Licensee's Proposed Overall Completion Date: *03/14/2025*

Update: *01/13/2025*

Overall completion date is too far in the future.

Plan of Correction ***Accept ([redacted] - 01/13/2025)***

2023 annual staff training plan for staff persons C, D and E were reviewed and not able to be corrected due to being out of time frame. Staff persons C, D & E were reviewed and found to have completed the required annual training of the 2024 staff training plan.
2025 Annual training content for direct care staff persons, ancillary staff persons training was created on 12/2/2024 and projected to be completed in compliance.
The Executive Director/designee completed education with the Building Services Coordinator/ fire safety expert on chapter 2600.65(g) for completion of fire safety training for direct care staff and ancillary staff persons on 1/7/2025.
Executive Director/ designee will audit staff files 1 time a week for 4 weeks to ensure completion of staff training for direct care staff and ancillary staff. Findings will be submitted to the QAPI committee for review and recommendations on 2/11/2025.

65g - Annual Training Content (continued)

Proposed Overall Completion Date: 02/13/2025

Licensee's Proposed Overall Completion Date: *02/13/2025*

Evidence of Completion ***Implemented ([redacted] - 03/12/2025)***

See attached.

82a - Poisonous Materials

6. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 12/10/2024 at 1:54 pm there was an unlabeled spray bottle with yellow liquid, which appeared to be cleaning solution, under the sink in The Studio Activity Room.

Plan of Correction ***Do Not Accept ([redacted] - 01/13/2025)***

Non-labeled spray bottle was immediately removed and discarded from the studio activity room.
Environmental rounds completed by Program Services Coordinator to locate and discard any additional non-labeled cleaners was completed on 12/10/2024.
Executive Director / designee completed education with Program Services staff on chapter 2600.82(a) Poisonous materials shall be stored in their original, labeled containers on 1/7/2025.
Program Services Coordinator /designee will conduct environmental rounds once a week for 2 months to ensure all poisonous products within activities area are labeled in original container and stored in a locked place. Findings will be submitted to the QAPI committee for review and recommendations on 3/14/2025.

Licensee's Proposed Overall Completion Date: *03/14/2025*

Update: *01/13/2025*

Overall completion date is too far in the future.

Plan of Correction ***Accept ([redacted] - 01/13/2025)***

Non-labeled spray bottle was immediately removed and discarded from the studio activity room.
Environmental rounds completed by Program Services Coordinator to locate and discard any additional non-labeled cleaners was completed on 12/10/2024.
Executive Director / designee completed education with Program Services staff on chapter 2600.82(a) Poisonous materials shall be stored in their original, labeled containers on 1/7/2025.
Program Services Coordinator /designee will conduct environmental rounds one time per week for 4 weeks to ensure all poisonous products within activities area are labeled in original container and stored in a locked place. Findings will be submitted to the QAPI committee for review and recommendations on 2/11/2025.

Licensee's Proposed Overall Completion Date: *02/13/2025*

Evidence of Completion ***Implemented ([redacted] - 03/12/2025)***

See attached.

82c - Locking Poisonous Materials

7. Requirements

2600.

82c - Locking Poisonous Materials *(continued)*

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

TB disinfectant cleaner, with a manufacture's label indicating "if swallowed, call a poison control center or doctor immediately for treatment advice", and Peroxide Multi Surface Cleaner, with a manufacture's label indicating "If in eyes call a poison control center or doctor for treatment advice", was unlocked, unattended, and accessible to residents in The Studio Activity Room. All of the residents of the home have been assessed not capable of recognizing and using poisons safely.

Sparklefresh Toothpaste, with a manufacture's label indicating "If more than used for brushing is swallowed seek medical help or contact a poison control center immediately", was unlocked, unattended, and accessible to residents in room 45. Not all the residents of the home, including residents 1 and 2, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Do Not Accept ([redacted] - 01/13/2025)***

TB disinfectant cleaner and Sparklefresh Toothpaste were immediately removed from accessible area and placed in a secured location.
Identified secure location for poisonous materials to be locked and secured when not in use in activities. Locks replaced in activities studio on 12/12/2024. Identified secure location to place poisonous material within community that is not accessible by residents.
Executive Director / designee completed education with Program Services Staff and Resident Services Coordinator on chapter 2600.82c locking of poisonous materials on 12/19/2024.
Program Services Coordinator / designee and Resident Services Coordinator / designee to complete environmental rounds one time a week for 2 months to ensure environmental safety and that no poisonous material is accessible within the community. Findings will be submitted to the QAPI committee for review and recommendations on 3/14/2025.

Licensee's Proposed Overall Completion Date: *03/14/2025*

Update: *01/13/2025*

Overall completion date is too far in the future.

Plan of Correction ***Accept ([redacted] - 01/13/2025)***

TB disinfectant cleaner and Sparklefresh Toothpaste were immediately removed from accessible area and placed in a secured location.
Identified secure location for poisonous materials to be locked and secured when not in use in activities. Locks replaced in activities studio on 12/12/2024. Identified secure location to place poisonous material within community that is not accessible by residents.
Executive Director / designee completed education with Program Services Staff and Resident Services Coordinator on chapter 2600.82c locking of poisonous materials on 12/19/2024.
Program Services Coordinator / designee and Resident Services Coordinator / designee to complete environmental rounds one time a week for 4 weeks to ensure environmental safety and that no poisonous material is accessible within the community. Findings will be submitted to the QAPI committee for review and recommendations on 2/11/2025.

Licensee's Proposed Overall Completion Date: *02/13/2025*

82c - Locking Poisonous Materials *(continued)*

Evidence of Completion ***Not Implemented ([redacted] - 03/12/2025)***

See attached.

96a - First Aid Kit

8. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kits in the Harvest Glen and Berry Ridge neighborhoods do not include eye protection, a mouth shield and a thermometer.

Plan of Correction ***Do Not Accept ([redacted] - 01/13/2025)***

Missing items from first aid kits within the home have been identified and purchased to be compliant with DHS regulations of kit containing all required items on 12/13/2024.
Audits of first aid kits required contents completed for each neighborhood and found to be in compliance on 12/16/2024.
Executive Director / designee completed education with department heads of chapter 2600.96(a) of equipment needed to provide first aid in the case of an emergency and identify designated location on each neighborhood within the community on 1/7/2025.
Executive Director / designee will conduct audits monthly to ensure required contents for first aid kits are in place and in compliance. Findings will be submitted to the QAPI committee for review and recommendations on 3/14/2025.

Licensee's Proposed Overall Completion Date: *03/14/2025*

Update: *01/13/2025*

Overall completion date is too far in the future.

Plan of Correction ***Accept ([redacted] - 01/13/2025)***

Missing items from first aid kits within the home have been identified and purchased to be compliant with DHS regulations of kit containing all required items on 12/13/2024.
Audits of first aid kits required contents completed for each neighborhood and found to be in compliance on 12/16/2024.
Executive Director / designee completed education with department heads of chapter 2600.96(a) of equipment needed to provide first aid in the case of an emergency and identify designated location on each neighborhood within the community on 1/7/2025.
Executive Director / designee will conduct audits monthly to ensure required contents for first aid kits are in place and in compliance. Findings will be submitted to the QAPI committee for review and recommendations on 2/11/2025.

Licensee's Proposed Overall Completion Date: *02/13/2025*

Evidence of Completion ***Implemented ([redacted] - 03/13/2025)***

See attached.

107d - Procedure Emergency Management Agency Submission

9. Requirements

107d - Procedure Emergency Management Agency Submission *(continued)*

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 were submitted to the local Emergency Management Agency on 2/9/2024, however documentation of the emergency procedure submission for the year 2023 was not available for DHS review.

Plan of Correction ***Accept ([redacted] - 01/13/2025)***

Proof of submission for 2023 was not able to be located.
Executive director / designee will maintain 2 years' worth of submissions on file. 2024 proof of submission is available dated 2/9/2024.
Executive director / designee completed education with Building Services Coordinator of chapter 2600.107(d) of procedure emergency management agency submission to ensure all required documentation is up-to-date and properly filed.
Executive Director / designee will submit emergency procedure by 2/9/2025.

Proposed Overall Completion Date: 02/09/2025

Licensee's Proposed Overall Completion Date: *02/09/2025*

Evidence of Completion ***Implemented ([redacted] - 03/13/2025)***

See attached.

132g - Fire Drills Days/Times

10. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills during the last 2 weeks of each month, and does not hold fire drills on weekends as evidenced by the following drills: 6/20/2024, 7/30/2024, 8/28/2024, 9/30/2024, 10/30/2024, 11/19/2024.

Plan of Correction ***Do Not Accept ([redacted] - 01/13/2025)***

Prior fire drills that have not been conducted on weekends are not able to be corrected because they have exceeded the appropriate time period.
Fire drills since the last inspection were reviewed. Fire drills have since been completed in compliance.
Executive Director / designee completed education with Building Services Coordinator on "Fire Drills and Evacuation Requirements" on 12/19/2024.
Executive Director / designee will audit fire drills monthly to ensure they are in compliance. Findings will be submitted to the QAPI committee for review and recommendations on 3/14/2025.

Proposed Overall Completion Date: 03/14/2025

Licensee's Proposed Overall Completion Date: *03/14/2025*

Update: *01/13/2025*

Overall completion date is too far in the future.

132g - Fire Drills Days/Times *(continued)*

Plan of Correction ***Accept (- 01/13/2025)***

Prior fire drills that have not been conducted on weekends are not able to be corrected because they have exceeded the appropriate time period.
Fire drills since the last inspection were reviewed. Fire drills have since been completed in compliance.
Executive Director / designee completed education with Building Services Coordinator on "Fire Drills and Evacuation Requirements" on 12/19/2024.
Executive Director / designee will audit fire drills monthly to ensure they are in compliance. Findings will be submitted to the QAPI committee for review and recommendations on 2/11/2025.

Proposed Overall Completion Date: 02/13/2025

Licensee's Proposed Overall Completion Date: *02/13/2025*

Evidence of Completion ***Not Implemented (- 03/13/2025)***

See attached.

183e - Storing Medications

11. 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 12/10/2024 at 2:31 pm, the back of the bubble pack for resident 3's prescription of Lorazepam Tab .5 mg , take one tablet by mouth daily at bedtime, had tape on spot 19 and the pill was still in place.

On 12/10/2024 at 2:39 pm, the back of the bubble pack for resident 4's prescription of Alprazolam Tab .25mg, take 1/2 tablet (0.125mg) by mouth once daily as needed, had tears/punctures at spots 24 and 28 and the pills were still in place.

On 12/10/2024 at 2:57 pm, the back of the bubble pack for resident 5's prescription of Lorazepam Tab .5 mg , take one tablet by mouth every 4 hours as needed, had tears/punctures at spots 18, 20 and 26 and the pills were still in place.

Plan of Correction ***Do Not Accept (- 01/13/2025)***

Medications with tape or punctures were discarded appropriately. Undated eye drops were discarded and reordered. Comprehensive review of medications and storage completed by Resident Services Coordinator to ensure seals are secured and opened eye drops are dated.
Resident Services Coordinator / designee to complete education with nurses and medication technicians on Medication Administration by 1/29/2025.
Resident Services Coordinator/ designee will audit medication pill packs and eye drops 1 time per week for 2 months to ensure medications are stored correctly and eye drops dated when opened. Findings will be submitted to the QAPI committee for review and recommendations on 3/14/2025.

Proposed Overall Completion Date: 03/14/2025

183e - Storing Medications *(continued)*

Licensee's Proposed Overall Completion Date: *03/14/2025*

Update: *01/13/2025*

Overall completion date is too far in the future.

Plan of Correction ***Accept (- 01/13/2025)***

Medications with tape or punctures were discarded appropriately. Undated eye drops were discarded and reordered. Comprehensive review of medications and storage completed by Resident Services Coordinator to ensure seals are secured and opened eye drops are dated.
Resident Services Coordinator / designee to complete education with nurses and medication technicians on Medication Administration by 1/29/2025.
Resident Services Coordinator/ designee will audit medication pill packs and eye drops 1 time per week for 4 weeks to ensure medications are stored correctly and eye drops dated when opened. Findings will be submitted to the QAPI committee for review and recommendations on 2/11/2025.

Proposed Overall Completion Date: 02/13/2025

Licensee's Proposed Overall Completion Date: *02/13/2025*

Evidence of Completion ***Not Implemented (- 03/13/2025)***

See attached.

187b - Date/Time of Medication Admin.

12. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident 1 is prescribed Lorazepam Tab .5 mg, one tab by mouth every 24 hours as needed. On 12/3/2024 at 8 am, and on 12/9/2024 at 10 am, Lorazepam Tab .5 mg, one tab, was signed out on resident 1's controlled substance log, however, administration of this medication was not documented on resident 1's medication administration record (MAR) for these dates and times.

Plan of Correction ***Do Not Accept (- 01/13/2025)***

Training for current nurses and medtechs on medication administration at the time of administration was completed on 1/7/2025. Staff person who administered medication to resident "1" on 12/3/2024 and 12/9/2024 was educated by Resident Services Coordinator on medication administration guidelines.
Comprehensive review of MARS completed to ensure accurate documentation of date/ time of medication administration and to ensure no other discrepancies existed.
The Resident Services Coordinator / designee will complete education with current nurses and medtechs on medication administration guidelines by 2/14/2025.
Resident Services Coordinator / designee to complete MARS audits one time a week for 2 months to ensure date/time of medication administration is in compliance. Findings will be submitted to the QAPI committee for review and recommendations on 3/14/2025.

Proposed Overall Completion Date: 03/14/2025

Licensee's Proposed Overall Completion Date: *03/14/2025*

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

Update: *01/13/2025*

Overall completion date is too far in the future.

Plan of Correction ***Accept ([redacted] - 01/13/2025)***

Training for current nurses and medtechs on medication administration at the time of administration was completed on 1/7/2025. Staff person who administered medication to resident "1" on 12/3/2024 and 12/9/2024 was educated by Resident Services Coordinator on medication administration guidelines.
Comprehensive review of MARS completed to ensure accurate documentation of date/ time of medication administration and to ensure no other discrepancies existed.
The Resident Services Coordinator / designee will complete education with current nurses and medtechs on medication administration guidelines by 2/11/2025.
Resident Services Coordinator / designee to complete MARS audits one time a week for 4 weeks to ensure date/time of medication administration is in compliance. Findings will be submitted to the QAPI committee for review and recommendations on 2/11/2025.

Proposed Overall Completion Date: 02/13/2025

Licensee's Proposed Overall Completion Date: *02/13/2025*

Evidence of Completion ***Not Implemented ([redacted] - 03/13/2025)***

See attached.

231c - Preadmission Screening

13. Requirements

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

Description of Violation

Resident 6 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident 6's written cognitive preadmission screening was completed on [redacted]

Repeat violation: 9/10/24

Plan of Correction ***Do Not Accept ([redacted] - 01/13/2025)***

Resident "6" preadmission screen was reviewed and not able to be corrected due to being out of time frame.
Current residents who moved into the community in the last 3 months were reviewed to ensure preadmission evaluation accuracy and timeliness.
The Executive Director/designee educated the department heads on completing the resident preadmission screening evaluation within 72 hours prior to admission on 12/19/24.
Executive Director/ designee will audit new resident preadmission screening evaluations 1 time per week for 2 months to ensure any new residents have had their evaluations completed 72 hours prior to admission. Findings will be submitted to the QAPI committee for review and recommendations on 3/14/2025.

Proposed Overall Completion Date: 03/14/2025

Licensee's Proposed Overall Completion Date: *03/14/2025*

231c - Preadmission Screening *(continued)*

Update: *01/13/2025*

Overall completion date is too far in the future.

Plan of Correction ***Accept (- 01/13/2025)***

Resident "6" preadmission screen was reviewed and not able to be corrected due to being out of time frame.
Current residents who moved into the community in the last 3 months were reviewed to ensure preadmission evaluation accuracy and timeliness.
The Executive Director/designee educated the department heads on completing the resident preadmission screening evaluation within 72 hours prior to admission on 12/19/24.
Executive Director/ designee will audit new resident preadmission screening evaluations 1 time per week for 4 weeks to ensure any new residents have had their evaluations completed 72 hours prior to admission. Findings will be submitted to the QAPI committee for review and recommendations on 2/11/2025.

Proposed Overall Completion Date: 02/13/2025

Licensee's Proposed Overall Completion Date: *02/13/2025*

Evidence of Completion ***Implemented (- 03/13/2025)***

See attached.

231e - No Objection Statement

14. 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 7 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.

Plan of Correction ***Do Not Accept (- 01/13/2025)***

Resident "7" objective statement form was located and completed in a timely manner upon admission on .
Current residents' files were reviewed to ensure objective statement forms were reviewed, signed and filed.
The Executive Director/designee educated department heads on chapter 2600.231(e) reviewing objective statement form 72hrs prior to admission.
Executive Director / designee will audit new resident admission documentation 1 time per week for 2 months to ensure any new residents have had the objective statement form reviewed and signed. Findings will be submitted to the QAPI committee for review and recommendations on 3/14/2025.

Proposed Overall Completion Date: 03/14/2025

Licensee's Proposed Overall Completion Date: *03/14/2025*

Update: *01/13/2025*

Overall completion date is too far in the future.

Plan of Correction ***Accept (- 01/13/2025)***

Resident "7" objective statement form was located and completed in a timely manner upon admission on

231e - No Objection Statement (continued)

Current residents' files were reviewed to ensure objective statement forms were reviewed, signed and filed.
The Executive Director/designee educated department heads on chapter 2600.231(e) reviewing objective statement form 72hrs prior to admission.
Executive Director / designee will audit new resident admission documentation 1 time per week for 4 weeks to ensure any new residents have had the objective statement form reviewed and signed. Findings will be submitted to the QAPI committee for review and recommendations on 2/11/2025.

Proposed Overall Completion Date: 02/13/2025

Licensee's Proposed Overall Completion Date: *02/13/2025*

Evidence of Completion ***Implemented ([redacted] - 03/13/2025)***

See attached.

231f - Assessed Annually

15. 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 6 was assessed for the need for Secure Dementia Care Unit (SDCU) on [redacted] and was not assessed again in 2024.

Plan of Correction ***Do Not Accept ([redacted] - 01/13/2025)***

Resident "6" annual assessment was located. Annual assessment was reviewed and found to be completed in a timely manner, signed on [redacted]
Current residents were audited to ensure annual assessments were completed timely, reviewed and signed by physician and resident/ POA.
The Executive Director/designee completed education with Resident Services Coordinator on chapter 2600.231(f) on annual assessment completion on 1/7/2025.
The Resident Services Coordinator / designee will audit resident files 1 time per week for 2 months to ensure annual assessments are in compliance of being completed, reviewed and signed on time. Findings will be submitted to the QAPI committee for review and recommendations on 3/14/2025.

Proposed Overall Completion Date: 03/14/2025

Licensee's Proposed Overall Completion Date: *03/14/2025*

Update: *01/13/2025*

Overall completion date is too far in the future.

Plan of Correction ***Accept ([redacted] - 01/13/2025)***

Resident "6" annual assessment was located. Annual assessment was reviewed and found to be completed in a timely manner, signed on [redacted].
Current residents were audited to ensure annual assessments were completed timely, reviewed and signed by physician and resident/ POA.
The Executive Director/designee completed education with Resident Services Coordinator on chapter 2600.231(f) on annual assessment completion on 1/7/2025.
The Resident Services Coordinator / designee will audit resident files 1 time per week for 4 weeks to ensure annual

231f - Assessed Annually (continued)

assessments are in compliance of being completed, reviewed and signed on time. Findings will be submitted to the QAPI committee for review and recommendations on 2/11/2025.

Proposed Overall Completion Date: 02/13/2025

Licensee's Proposed Overall Completion Date: *02/13/2025*

Evidence of Completion ***Implemented (- 03/13/2025)***

See attached.

236 - Staff Training

16. 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 persons C and D, who work in the Secure Dementia Care Unit (SDCU) had 0 hours of training in dementia care during the 2023 training year.

Plan of Correction ***Do Not Accept (- 01/13/2025)***

2023's 6hr dementia care training plan for staff persons C and D were reviewed and not able to be corrected due to being out of time frame. Staff persons C & D were reviewed and found to have completed the required annual 6hr dementia care training for 2024.
2025 annual 6hr dementia care training plan was created on 12/2/2024 and projected to be completed in compliance.
The Executive Director/designee completed education with the department heads on chapter 2600.236 for completion of mandatory annual 6hr dementia care training 1/7/2025.
Executive Director / designee will audit completed staff trainings 1 time per week for 2 months. Findings will be submitted to the QAPI committee for review and recommendations on 3/14/2025.

Proposed Overall Completion Date: 03/14/2025

Licensee's Proposed Overall Completion Date: *03/14/2025*

Update: *01/13/2025*

Overall completion date is too far in the future.

Plan of Correction ***Accept (- 01/13/2025)***

2023's 6hr dementia care training plan for staff persons C and D were reviewed and not able to be corrected due to being out of time frame. Staff persons C & D were reviewed and found to have completed the required annual 6hr dementia care training for 2024.
2025 annual 6hr dementia care training plan was created on 12/2/2024 and projected to be completed in compliance.
The Executive Director/designee completed education with the department heads on chapter 2600.236 for completion of mandatory annual 6hr dementia care training 1/7/2025.
Executive Director / designee will audit completed staff trainings 1 time per week for 4 weeks. Findings will be submitted to the QAPI committee for review and recommendations on 2/11/2025.

Proposed Overall Completion Date: 02/13/2025

236 - Staff Training *(continued)*

Licensee's Proposed Overall Completion Date: *02/13/2025*

Evidence of Completion ***Implemented ([redacted] - 03/13/2025)***

See attached.