



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ERIE OPS LLC**

LEGAL ENTITY

To operate **WESTLAKE WOODS AL**

NAME OF FACILITY OR AGENCY

Located at **3302 WEST LAKE ROAD, ERIE, PA 16505**

(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Assisted Living**

TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **79**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions: _____

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

55 Pa.Code Chapter 2800: Assisted Living Residences

(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **May 1,** **2025** until **October 31,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454071**

Janette Biderup
ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

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



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MAY 2, 2025

[REDACTED], PA Area Director
Erie OPS LLC

[REDACTED]
[REDACTED]

RE: Westlake Woods AL
3302 West Lake Road
Erie, Pennsylvania 16505
License/COC #: 454071

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on November 22, 2024, December 12, 2024, January 6, 2025, January 9, 2025, January 10, 2025, January 15, 2025, and April 9, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2800 (relating to Assisted Living Residence), mistreatment or abuse of residents being cared for in the facility, and failure to comply with plans to correct noncompliance items, the Department hereby REVOKES your certificate of compliance (license number 454070) dated October 31, 2024 - October 31, 2025, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from May 1, 2025 to October 31, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2800 (relating to Assisted Living Residence), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2800	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
<u>Section:</u>					
187(d)	II	49	\$5	\$245	5 calendar days from the date of this letter

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

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

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 30 days of the date of this letter by:

[REDACTED], Workload Manager
 Pennsylvania Department of Human Services
 Bureau of Human Services Licensing
 Forum Place, 6th Floor
 PO Box 2675
 Harrisburg, Pennsylvania 17105-2675
 [REDACTED]

This decision is final 31 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

A handwritten signature in cursive script that reads "Juliet Marsala".

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:



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

Facility Information

Name: WESTLAKE WOODS AL License #: 45407 License Expiration: 10/31/2025
Address: 3302 WEST LAKE ROAD, ERIE, PA 16505
County: ERIE Region: WESTERN

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: ERIE OPS LLC
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 10/31/1997 Issued By: Department of Labor

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 71 Waking Staff: 53

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Complaint Exit Conference Date: 11/22/2024

Inspection Dates and Department Representative

11/22/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 79 Residents Served: 48

Special Care Unit

In Home: No	Area:	Capacity:	Residents Served:
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Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0	Are 60 Years of Age or Older: 48
Diagnosed with Mental Illness: 0	Diagnosed with Intellectual Disability: 0
Have Mobility Need: 23	Have Physical Disability: 2

Inspections / Reviews

11/22/2024 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 12/20/2024

Inspections / Reviews (*continued*)

12/23/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/28/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 01/02/2025

01/06/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/28/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 03/30/2025

04/17/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/28/2025

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

5a1 DHS access

1. Requirements

2800.

5.a. The administrator, administrator designee or staff person designated under § 2800.56(c) (relating to administrator staffing) shall provide, upon request, immediate access to the residence, the residents and records to:

- 1. Agents of the Department.

Description of Violation

At 9:10 a.m., a list of staff members with their respective dates of hire was requested to be provided. However, the home failed to submit the requested staff member list until 9:44 a.m. The home's designee indicated [REDACTED] had no access to the requested document.

Plan of Correction

Accept [REDACTED] - 12/23/2024)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

The Executive Directive or designee will have requested, required, documents such as our census and employee lists updated, printed out, and available to present to DHS starting 12/30/2024. The ED or designee will complete a training with the designee/BOC on how to retrieve documents when DHS arrives at our community on 01/06/25

The Executive Director, or designee, will conduct weekly audits with each department manager assigned to their department until there are four weeks of consistent compliance with this regulation. These audits will begin the week of 01/16/2025 and documentation of the audits will be maintained.

Licensee's Proposed Overall Completion Date: 03/29/2025

Implemented [REDACTED] - 04/17/2025)

16c Incident reporting

2. Requirements

2800.

16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

16c Incident reporting (continued)

Description of Violation

On 10/2/24, Staff member A assaulted staff member B, giving [redacted] a black eye and breaking [redacted] partial. The Millcreek police were summoned, arriving at the home at approximately 7:40 a.m. However, the home failed to notify the department.

Plan of Correction

Accept ([redacted] - 12/23/2024)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

The Executive Director will complete and submit all incidents within the regulated timeframe and the Executive Director or designee will implement tools for the staff to notify verbally and to follow up in written format for reportable incident or condition. Training on regulation 2800.16 and the tools will be completed no later than 12/30/2024.

Starting the week of 01/06/2025, the Executive Director or designee will monitor the use of the tools weekly for four weeks following completion of training and implementation of the tools. Additional weekly audits will be conducted until there are four weeks of consecutive compliance with this regulation.

Licensee's Proposed Overall Completion Date: 03/29/2025

Not Implemented ([redacted] - 04/17/2025)

23a ADL assistance

3. Requirements

2800.

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

Description of Violation

Resident #1's most recent assessment and support plan, completed on [redacted], indicated resident #1 requires moderate assistance with dressing/undressing. However, from 11/1/24, forward, the resident did not receive assistance with dawning [redacted] ordered knee high TED hose.

Resident #2's assessment and support plan, completed [redacted] indicated resident #2 requires minimal assistance with [redacted] rechargeable hearing aids. According to multiple interviews, staff are to assist the resident with removing and charging [redacted] hearing aids in the evening leaving them to charge overnight. However, on the evening on 11/21/24, staff failed to assist with charging resident #2's hearing aides rendering them unusable the following morning.

Plan of Correction

Accept ([redacted] - 12/23/2024)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not

23a ADL assistance (continued)

constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800.23. Activities (a) A residence shall provide each resident with assistance with ADLs and appropriate cueing for ADLs as indicated in the resident's assessment and support plan.

Direct care team members will receive retraining on responding to requests for ADL services identified in the assessment or service plan that differ from the scheduled time in the assessment or service plan. Specifically, direct care staff will be retrained on responsiveness to resident requests for unscheduled care through in-person training by the Executive Director or Care Team Manager with training completion no later than 12/30/24. Training documentation will be maintained.

New direct care team members will receive the above-referenced training from the Executive Director or designee. Training documentation will be maintained.

The Care Team Manager or designee will conduct a sampling of 10% of the residents to audit the delivery of ADLs services per assessment and service plan. The sampling of residents' services will be audited for four weeks beginning the week of 12/30/2024, as a means to audit compliance with the regulation. Additional weekly audits will be conducted until there are four weeks of consistent compliance with this regulation.

Licensee's Proposed Overall Completion Date: 02/28/2025

Not Implemented (█ - 04/17/2025)

42b Abuse/Neglect**4. Requirements**

2800.

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

Description of Violation

Resident #3 is prescribed Hydrocodone APAP 7.5/325mg take 1 tablet by mouth every 4 hours as needed for pain. Resident #3 has requested this medication on multiple dates during the 11:00 p.m., to 7:00 a.m., shift. However, resident #3 was not administered the medication due to there being no staff members present who were trained to administer medications. The non-administration of the requested medication resulted in resident #3 experiencing pain and discomfort during the 11:00 p.m., to 7:00 a.m., shift, and until the arrival of staff members who were qualified to administer the requested medication.

On 7/27/24, at approximately 2:50 p.m., staff member C was transporting resident #4, a wheelchair bound resident to █ resident room. The wheelchair's foot pedals were not attached to the wheelchair due to resident #4 requesting the wheelchair's foot pedals not be used. During the transport resident #4 requested to staff member C that █ slow the rate of the transport several times. However, staff member C failed to slow the rate of the transport █ was providing. Upon reaching the threshold of the resident #4's resident room resident #4's feet became caught under the front of the wheelchair causing █ to fall forward onto the ground. The resident, believed to have suffered █ was subsequently transported and admitted to █ Hospital where █ was diagnosed with a "fall from

42b Abuse/Neglect (continued)

wheelchair" and [REDACTED]

On 4/25/24, resident #5 was prescribed a wedge pillow to be used for bed positioning. Multiple staff interviews indicated the wedge pillow was to be used to prevent resident #5 from falling from bed by positioning the wedge pillow between resident #5's person and the outside edge of [REDACTED] bed. However, on 11/2/24, the resident's wedge pillow was not positioned between [REDACTED] person and the outside of [REDACTED] bed. On 11/2/24, resident #5 had an unwitnessed fall from [REDACTED] bed resulting in [REDACTED]. The resident was transported to the [REDACTED] Hospital where [REDACTED] was treated for "[REDACTED]" and then discharged back to the home's care.

Plan of Correction

Accept ([REDACTED] - 12/23/2024)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

The Executive Director or designee will conduct and complete retraining on 55 Pa. Code § 2800.42(b) with all team members no later than 01/06/25. Additionally, training will continue at hire, annually, and as warranted by the Executive Director or designee weekly for 4 weeks starting 12/30/24. The Executive Director along with the Health and Wellness Director will review schedules to ensure there is consistent med passer coverage starting 12/20/25 outside resources will be brought in for coverage if needed. 4 internal employees are preparing to take the medication administration class starting 12/20/24. Staff training was provided to all team members on safe transport techniques, utilizing footrests, and positioning devices on 11/7/2024 from Interim Therapy company. Weekly audits will be completed to review scheduled med passer coverage, positioning devices, safe wheelchair transports are being utilized starting 12/30/24 and will continue until we remain compliance for 4 weeks.

Licensee's Proposed Overall Completion Date: 03/30/2025

Not Implemented ([REDACTED] - 04/17/2025)

51 Criminal background checks

5. Requirements

2800.

51 Criminal background checks (continued)

- 51.a. 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.b. The hiring policies shall be in accordance with the Department of Aging’s Older Adult Protective Services Act policy as posted on the Department of Aging’s web site.

Description of Violation

Staff member A, date of hire unknown, did not have a criminal history check completed.

Plan of Correction

Accept (█) - 12/23/2024)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community’s policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

All staff members will have a Pennsylvania State Police background check was completed on 01/30/2025 by New Perspective

Human Resource department. Existing team member’s background checks will be verified for completion by the Executive Director or designee no later than 2/28/25. If a team member does not have a background check on file, it will be completed immediately. At hire the Executive Director or designee will submit the background check request within eight days of hire. The Executive Director or designee will complete a weekly audit starting 01/06/25 for 4 weeks to verify new employee background checks are submitted to PA State Police and completed within 30 days of hire Directed: The Executive Director or designee’s background checks will occur on or before the first day of work, not within 8 days of hire. █. 4/28/2025

Licensee’s Proposed Overall Completion Date: 02/28/2025

Implemented (█) - 04/17/2025)

91 Telephone Numbers

7. Requirements

2800.

- 91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and assisted living residence complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire Department on or by the telephone in resident room #229.

Plan of Correction

Accept (█) - 01/06/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community’s policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by

91 Telephone Numbers (continued)

any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Starting 12/30/2024 the Executive Director or designee will ensure compliance is met by completing an audit of all resident rooms starting with 10% of the population weekly and placing the required emergency phone numbers in the designated areas. The Executive Director or designee will complete additional weekly audits for 4 weeks to ensure continued compliance.

All emergency phone numbers will be reviewed, and placed onto resident phone areas and will be completed by 03/30/2025 along with all staff training to be completed 01/30/2025 to identify and communicate when emergency numbers are needing replaced

Licensee's Proposed Overall Completion Date: 01/28/2025

Not Implemented (█ - 04/17/2025)

187d Follow prescriber's orders

8. Requirements

2800.

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

Description of Violation

Resident #1 was prescribed knee-high compression stockings remove stockings every night before bed and put on every morning immediately when getting up. However, the ordered medical devices were not applied on multiple dates to include from 11/1/24, forward.

Resident #3 was prescribed Hydrocodone APAP 7.5/325mg take 1 tablet by mouth every 4 hours as needed for pain. Resident #3 has requested this medication on multiple dates during the 11:00 pm to 7:00 a.m. shift. However, resident #3 was not administered the requested medication.

Repeat Violation: 04/12/2024

Plan of Correction

Accept (█ - 12/23/2024)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

A meeting for med passers and clinicians will be held on 01/14/2025, for documented reeducation by the Health and Wellness Director on medication policy and procedures and the importance of following directions of the prescriber. Any med passers or clinicians not in attendance will be trained by the Health and Wellness Director or designee no later 1/30/2025. Documentation of training will be maintained.

The Health and Wellness Director or designee will conduct a sampling of 10% of the residents during a weekly audit of the electronic medication record for compliance. The weekly audit will be conducted for four weeks beginning the week of 1/6/2025 audits will be conducted until there are four weeks consistent compliance

187d Follow prescriber's orders (continued)

demonstrated with this regulation.

Licensee's Proposed Overall Completion Date: 02/28/2025

Not Implemented ([REDACTED] - 04/17/2025)

227g Support plan - signatures

10. Requirements

2800.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1's assessment and support plan, dated [REDACTED], was not signed by the resident.

Resident #2's assessment and support plan, dated [REDACTED] was not signed by the resident.

Resident #5's assessment and support plan, dated [REDACTED] is not signed by the resident.

Repeat Violation: 06/27/2024 et al.

Plan of Correction

Accept ([REDACTED] - 12/23/2024)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Starting 12/30/24 the Executive Director or designee will ensure compliance is met by obtaining the appropriate signatures for the completed care plans. The Executive Director or designee will provide the resident the opportunity to sign their care plan on or before their next quarterly care plan review. If resident is unable or declines to sign, the Executive Director or designee will make note and maintain documents.

All care plans will be reviewed, and signatures or documentation of decline will be obtained and completed by 02/20/25

Licensee's Proposed Overall Completion Date: 02/20/2025

Not Implemented ([REDACTED] - 04/17/2025)

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

Facility Information

Name: *WESTLAKE WOODS AL* License #: *45407* License Expiration: *10/31/2025*
Address: *3302 WEST LAKE ROAD, ERIE, PA 16505*
County: *ERIE* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *ERIE OPS LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *10/31/1997* Issued By: *Dept of Labor*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *65* Waking Staff: *49*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *01/06/2025*

Inspection Dates and Department Representative

12/12/2024 - On-Site: [REDACTED]
01/06/2025 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* Residents Served: *50*

Special Care Unit

In Home: *No* Area: Capacity: Residents Served:

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *50*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *15* Have Physical Disability: *1*

Inspections / Reviews

12/12/2024 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/17/2025*

01/22/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/28/2025

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 03/30/2025

04/17/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/28/2025

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

42c Dignity/Respect

1. Requirements

2800.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 12/4/24, resident #1 requested staff member A to do laundry. Staff member A responded in a raised voice there is no laundry on Wednesdays while pounding fist in hand. Resident #1 responded to staff member A, stating, there is laundry if there is a need for it. Staff member A stated to resident #1, no you are wrong, before turning back to resident #1 and leaving the area.

Multiple interviews, to include residents and food service staff indicated that residents have been served cold food multiple times during scheduled meals over approximately the past two weeks, and that staff were unavailable to reheat food.

Plan of Correction

Accept (- 01/22/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Executive Director and Care Team Manager will conduct and complete retraining on 55 Pa. Code § 2800.42c with all team members no later than 2/15/2025. The Executive Director or designee will continue to conduct training on this topic at hire, annually and as needed starting on . The Executive Director or designee will conduct a sampling of 6 residents weekly for 4 weeks to monitor compliance with regulation 2800.42(c) to include laundry completion and tray service delivered to be timely and at appropriate temperature. This will begin week of 02/15/2023. The residents sampled will be asked about way care is delivered and about their satisfaction with the caregiving staff. Licensee's Proposed Overall Completion Date: 3/30/2025

Licensee's Proposed Overall Completion Date: 03/30/2025

Not Implemented (- 04/17/2025)

85a Sanitary conditions

2. Requirements

2800.

85.a. Sanitary conditions shall be maintained.

Description of Violation

At 11:10 a.m., there was a piece of feces, approximately the size of a quarter on the floor of shower in the private bathroom located in resident room #223. Repeat Violation: 04/12/2024

Plan of Correction

Accept (- 01/22/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its

85a Sanitary conditions (continued)

receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

The feces had been immediately removed in room 223 and the shower had been sanitized by our housekeeper. Since that time, the Care Team Manager or designee has implemented additional housekeeping checks starting on 2/6/25 for 4 weekly and then monthly for 2 additional months to maintain sanitary conditions in the resident's apartment at a minimum weekly and as needed. Documentation will be maintained The Care Team Manager or designee will provide staff additional retraining on 2/6/25 on how to sanitize and remove feces/urine after each resident's shower . This training will be completed no later than 2/30/2025. Documentation will be maintained.

Licensee's Proposed Overall Completion Date: 02/28/2025

Not Implemented () - 04/17/2025

187d Follow prescriber's orders**5. Requirements**

2800.

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

Description of Violation

Resident #2 was prescribed Vitamin D3 1,000 units IU cap, take one capsule by mouth once daily. However, resident #2 was not administered the medication on multiple dates to include 12/5/24 through 12/7/24. The medication was not in the home.

Resident #2 was prescribed Vitamin B-12 100 mcg, take one capsule by mouth once daily for supplement. However, resident #2 was not administered the medication on 12/3/24. The medication was not in the home.

Resident #2 was prescribed folic acid take one capsule by mouth once daily anemia. However, resident #2 was not administered the medication on multiple dates to include 12/10/24 through 12/10/24. The medication was not in the home.

Resident #2 was prescribed Bacitracin oin 500/gm apply topically [REDACTED] once daily with, hydrocortisone and clotrimazole. However, resident #2 was not administered the medication on 12/3/24. The medication was not in the home.

Resident #3 was prescribed pantoprazole tab 40 mg take one tablet by mouth twice daily. However, resident #3 was not administered the medication on multiple dates to include 12/4/24 and 12/5/24. The medication was not in the home.

Resident #4 was prescribed testosterone gel 1% apply one packet to upper arm / shoulder once daily. However, resident #4 was not administered the medication on 12/1/24. The medication was not in the home.

On 12/10/24, at 12:00 p.m., resident #5 was ordered, starting tomorrow gently rinse with a warm saltwater solution three to four times a day for one week. On 12/11/24, at approximately 5:00 p.m., resident #5 requested assistance

187d Follow prescriber's orders (continued)

with rinsing [redacted] mouth, as per [redacted] physician's order, from staff member B. Staff member B refused to assist the resident stating - we have no salt. Resident #5 did not gently rinse with a warm saltwater solution as per physician's orders. Repeat Violation: 04/12/2024

Plan of Correction

Accept ([redacted] - 01/22/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Team members who administer medications were provided training on 1/21/25, regarding medication administration steps including the 7 rights of medication administration which includes following the directions of the provider. The Health and Wellness Director or designee will complete weekly audits of the resident's medication record to confirm that the home is following the directions of the prescriber starting on 1/18/25. The Health and Wellness Director or designee will continue weekly monitoring of the electronic medication administration records (eMAR) 1/28/25. Additional weekly monitoring of eMAR will be conducted until there are four weeks of consecutive compliance with this regulation. Documentation will be kept

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

Not Implemented ([redacted] - 04/17/2025)

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

Facility Information

Name: WESTLAKE WOODS AL License #: 45407 License Expiration: 10/31/2025
Address: 3302 WEST LAKE ROAD, ERIE, PA 16505
County: ERIE Region: WESTERN

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: ERIE OPS LLC
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 10/31/1997 Issued By: Dept. of Labor

Staffing Hours

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

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Complaint, Incident Exit Conference Date: 01/15/2025

Inspection Dates and Department Representative

01/09/2025 - On-Site: [REDACTED]
01/10/2025 - On-Site: [REDACTED]
01/15/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 79 Residents Served: 49

Special Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 3

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 49
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 11 Have Physical Disability: 1

Inspections / Reviews

01/09/2025 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*

Follow-Up Date: *02/16/2025*

03/10/2025 - POC Submission

Submitted By: [REDACTED] r

Date Submitted: *03/24/2025*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *03/25/2025*

04/17/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *03/24/2025*

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

15a Resident abuse report

1. Requirements

2800.

15.a. The residence shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 12/21/24 at approximately 9:30pm, staff person A, staff person B, and staff person C went into resident #1's bedroom to provide incontinence care. Staff person B and staff person C indicate that while providing incontinence care to resident #1, staff person A was on a video facetime call with a [REDACTED] caller. Staff person A was seen pointing [REDACTED] phone towards resident #1's buttocks, showing the [REDACTED] caller the [REDACTED] resident and [REDACTED] current condition, as well as verbally describing how "disgusting" it was to provide [REDACTED] care because of the amount of feces, calling it a "blowout" and making gagging noises. The [REDACTED] caller commented that it was "disgusting and they need to get the resident something to take care of that." Staff person B had to tell staff person A to get off [REDACTED] phone and stop making gagging noises. Immediately following this incident staff person B and staff person C observed resident #1 crying and embarrassed. Staff person B reported this incident to staff person D on 12/22/24. However, this allegation of abuse was not reported to the local Area Agency on Aging until 12/24/24.

Plan of Correction

Accept [REDACTED] - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800. 15.a. The residence shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Team member A was immediately suspended upon notification of the allegation on [REDACTED] Team member A is no longer employed as of [REDACTED] with the community.

The Executive Director or designer will conduct retraining for all existing team members on regulation 2800.15.a abuse reporting covered by law and abuse reporting requirements. This training will cover the Maltreatment of a Resident and Escalation Reporting policies and procedures, the importance of timely reporting, and the consequences of non-compliance. The mandatory training session will be part of Team Member Re-Orientation and will be completed by 3/25/2025. Documentation of training will be maintained.

The Executive Director or designee will train new team members as part of Team Member Orientation on the Maltreatment of a Resident and Escalation Reporting policies & procedures, focusing on the importance of timely reporting and the consequences of non-compliance prior to assuming duties of their position. The Executive Director or designee will conduct monthly audits of Team Member Orientation including the Maltreatment of a Resident

15a Resident abuse report (continued)

and Escalation reporting policies & procedures for compliance. Audits will begin the week of 2/23/2025.

The Executive Director, or designee will review the plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented () - 04/17/2025)

15d Resident abuse notification

2. Requirements

2800.

15.d. The residence shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

Description of Violation

On 12/21/24 at approximately 9:30pm, staff person A, staff person B, and staff person C went into resident #1's bedroom to provide incontinence care. Staff person B and staff person C indicate that while providing incontinence care to resident #1, staff person A was on a video facetime call with a () caller. Staff person A was seen pointing () phone towards resident #1's buttocks, showing the () caller the () resident and () current condition, as well as verbally describing how "disgusting" it was to provide () care because of the amount of feces, calling it a "blowout" and making gagging noises. The () caller commented that it was "disgusting and they need to get the resident something to take care of that." Staff person B had to tell staff person A to get off () phone and stop making gagging noises. Immediately following this incident staff person B and staff person C observed resident #1 crying and embarrassed. Staff person B reported this incident to staff person D on 12/22/24. However, the residence did not notify the resident or the resident's designated person of the report of suspected abuse until 12/24/24.

Plan of Correction

Accept () - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800. 15.d. The residence shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

The Executive Director or designee will conduct retraining for all existing team members on regulation 2800.15.d and abuse reporting requirements. This training will cover the Maltreatment of a Resident and Escalation Reporting policies and procedures, the importance of timely reporting, and the consequences of non-compliance. The mandatory training session will be part of Team Member Re-Orientation and will be completed by 3/25/2025. Documentation of training will be maintained.

The Executive Director or designee will train new team members on the Maltreatment of a Resident and Escalation

15d Resident abuse notification (continued)

Reporting policies and procedures, focusing on the importance of timely reporting, and the consequences of non-compliance prior to assuming duties of their position. The Executive Director or designee will conduct monthly audits of Team Member Orientation including the Maltreatment of a Resident and Escalation reporting policies & procedures training for compliance. Audits will begin week of 2/23/2025.

The Executive Director, or designee will review plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented () - 04/17/2025)

16c Incident reporting

3. Requirements

2800.

16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On 12/21/24 at approximately 9:30pm, staff person A, staff person B, and staff person C went into resident #1's bedroom to provide incontinence care. Staff person B and staff person C indicate that while providing incontinence care to resident #1, staff person A was on a video facetime call with a () caller. Staff person A was seen pointing () phone towards resident #1's buttocks, showing the () caller the () resident and () current condition, as well as verbally describing how "disgusting" it was to provide () care because of the amount of feces, calling it a "blowout" and making gagging noises. The () caller commented that it was "disgusting and they need to get the resident something to take care of that." Staff person B had to tell staff person A to get off () phone and stop making gagging noises. Immediately following this incident staff person B and staff person C observed resident #1 crying and embarrassed. Staff person B reported this incident to staff person D on 12/22/24. However, the residence did not report this incident to the Department until 12/24/24.

On 1/11/25 resident #2 had an unwitnessed fall with no obvious injuries. On 1/12/25 resident #2 was sent to the hospital complaining of back pain and was admitted for (). However, this incident was not reported to the Department until 1/15/25.

Plan of Correction

Accept () - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800.16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the

16c Incident reporting (continued)

Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

The Executive Director or designee will conduct retraining for leadership team members involved in the reporting process of regulation 2800.16.c. This training will cover regulation 2800.16.c and the Accidents, Incidents, and Unusual Occurrences policy focusing on the importance of timely reporting. A mandatory training session on compliance will be held by 3/25/2025. Documentation of training will be maintained.

The Executive Director or designee will train new leadership team members involved in the reporting process regulation 2800.16.c and the Accidents, Incidents, and Unusual Occurrences policy focusing on the importance of timely reporting and the consequences of non-compliance prior to assuming duties of their position. The Executive Director or designee will conduct monthly audits of new team member trainings for compliance. Audits will begin week of 2/23/2025.

The Executive Director or designee will schedule and conduct monthly internal audits to verify the timeliness of report submissions. The audits will be begin week of 2/23/2025.

The Executive Director, or designee will review plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Not Implemented ([REDACTED] - 04/17/2025)

23a ADL assistance

4. Requirements

2800.

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

Description of Violation

The assessment and support plan dated [REDACTED] for resident #1 indicates the resident requires assistance with toileting, the resident will alert staff using [REDACTED] call bell for assistance with toileting, is a 2 person transfer with Hoyer lift, and is usually changed in bed. Resident #1 indicates [REDACTED] has waited very long periods of time to receive this assistance from staff and indicates there have been many nights [REDACTED] was transferred by only 1 staff person using the Hoyer lift.

The residence's Call Bell Report indicates the following:

- On 12/29/24 at 4:24pm resident #1 pushed [REDACTED] call bell and waited 38 minutes for staff to help [REDACTED]
- On 12/29/24 at 6:26pm resident #1 pushed [REDACTED] call bell and waited 38 minutes for staff to help [REDACTED]
- On 12/30/24 at 11:21am resident #1 pushed [REDACTED] call bell and waited 1 hour 23 minutes for staff to help [REDACTED]
- On 12/30/24 at 1:22pm resident #1 pushed [REDACTED] call bell and waited 42 minutes for staff to help [REDACTED]
- On 12/30/24 at 7:17pm resident #1 pushed [REDACTED] call bell and waited 40 minutes for staff to help [REDACTED]
- On 1/4/25 at 10:25am resident #1 pushed [REDACTED] call bell and waited 1 hour 41 minutes for staff to help [REDACTED]
- On 1/4/25 at 11:11pm resident #1 pushed [REDACTED] call bell and waited 2 hours 20 minutes for staff to help [REDACTED]
- On 1/5/25 at 6:26pm resident #1 pushed [REDACTED] call bell and waited 43 minutes for staff to help [REDACTED]
- On 1/6/25 at 8:43am resident #1 pushed [REDACTED] call bell and waited 56 minutes for staff to help [REDACTED]

23a ADL assistance (continued)

The assessment and support plan dated [REDACTED] for resident #3 indicates the resident requires assistance with toileting, and staff will check on [REDACTED] every 2 hours throughout the day and staff are to respond with additional assistance as required throughout the day or night when the resident alerts staff using [REDACTED] call bell. Resident #3 indicates [REDACTED] has waited very long periods of time to receive this assistance after [REDACTED] alerts staff using [REDACTED] call bell. Additionally, on numerous occasions staff have left resident #3 on the toilet for extended periods of time before they come back to assist [REDACTED] off the toilet. Resident #3 indicated the service [REDACTED] is receiving from the residence makes [REDACTED] feel like [REDACTED] would "rather be dead than to live like this."

The residence's Call Bell Report indicates the following:

On 1/4/25 at 8:40pm resident #3 pushed [REDACTED] call bell and waited 52 minutes for staff to help [REDACTED]

On 1/6/25 at 8:51am resident #3 pushed [REDACTED] call bell and waited 42 minutes for staff to help [REDACTED]

On 1/12/25 at 4:51am resident #3 pushed [REDACTED] call bell and waited 39 minutes for staff to help [REDACTED]

On 1/12/25 at 8:54am resident #3 pushed [REDACTED] call bell and waited 35 minutes for staff to help [REDACTED]

The assessment and support plan dated 10/28/24 for resident #4 indicates the resident requires the assistance of 1 staff for all transfers, requires the assistance of 1 staff to get on and off the toilet and requires assistance with getting pants up and down and the resident will alert staff using [REDACTED] call bell when [REDACTED] requires assistance. Resident #4 indicates [REDACTED] independently transfers [REDACTED] into [REDACTED] wheelchair and then transfers [REDACTED] from [REDACTED] wheelchair to the toilet because [REDACTED] has had to wait so long for staff to come and assist. Resident #4 indicates when [REDACTED] can't wait any longer to use the bathroom, [REDACTED] transfers [REDACTED]

The residence's Call Bell Report indicates the following:

On 12/30/24 at 9:25am resident #4 pushed [REDACTED] call bell and waited 53 minutes for staff to help [REDACTED]

On 1/12/25 at 9:59am resident #4 pushed [REDACTED] call bell and waited 32 minutes for staff to help [REDACTED]

The assessment and support plan dated 10/10/24 for resident #5 indicates the resident requires staff assistance with toileting and staff will check on [REDACTED] every 2 hours throughout the day and assist [REDACTED] to the toilet, and staff are to respond with additional assistance as required throughout the day or night when the resident alerts staff using [REDACTED] call bell. Resident #5 indicates [REDACTED] has to wait long periods of time for staff to help [REDACTED] use the bathroom and gets mad when [REDACTED] has to wait because [REDACTED] does not want to go in [REDACTED] cloths but sometimes, [REDACTED] can't wait that long.

The residence's Call Bell Report indicates the following:

On 12/29/24 at 5:01pm resident #5 pushed [REDACTED] call bell and waited 44 minutes for staff to help [REDACTED]

On 12/30/24 at 8:59am resident #5 pushed [REDACTED] call bell and waited 44 minutes for staff to help [REDACTED]

On 1/4/25 at 7:16am resident #5 pushed [REDACTED] call bell and waited 1 hour and 6 minutes for staff to help [REDACTED]

On 1/4/25 at 11:52pm resident #5 pushed [REDACTED] call bell and waited 1 hour 30 minutes for staff to help [REDACTED]

On 1/5/25 at 9:57am resident #5 pushed [REDACTED] call bell and waited 53 minutes for staff to help [REDACTED]

On 1/6/25 at 4:02am resident #5 pushed [REDACTED] call bell and waited 2 hours 13 minutes for staff to help [REDACTED]

On 1/6/25 at 1:44pm resident #5 pushed [REDACTED] call bell and waited 2 hours 9 minutes for staff to help [REDACTED]

On 1/10/25 at 6:45am resident #5 pushed [REDACTED] call bell and waited 40 minutes for staff to help [REDACTED]

On 1/12/25 at 7:42am resident #5 pushed [REDACTED] call bell and waited 1 hour 57 minutes for staff to help [REDACTED]

The assessment and support plan dated 11/29/24 for resident #6 indicates the resident requires staff assistance with toileting and staff will check on [REDACTED] 3 times during waking hours and 2 times overnight. The resident requires a Hoyer

23a ADL assistance (continued)

lift for transfers, so staff provide incontinence care to [REDACTED] in bed. Numerous staff and family indicate resident #6 is not receiving toileting care as required and is found heavily soiled first thing in the morning and often sits in a soiled brief most of the day.

The residence's Call Bell Report indicates the following:

- On 1/4/25 at 6:59am resident #6 pushed [REDACTED] call bell and waited 41 minutes for staff to help [REDACTED]
- On 1/11/25 at 9:25am resident #6 pushed [REDACTED] call bell and waited 58 minutes for staff to help [REDACTED]
- On 1/12/25 at 7:51am resident #6 pushed [REDACTED] call bell and waited 1 hour 53 minutes for staff to help [REDACTED]

The assessment and support plan dated 8/29/24 for resident #7 indicates the resident requires staff assistance with toileting and staff are to provide regular 2-hour checks and will assist [REDACTED] to the bathroom because [REDACTED] requires assistance pulling up/down [REDACTED] briefs and pants. Resident #7 will use [REDACTED] call bell to alert staff when [REDACTED] needs to use the bathroom. Resident #7 and [REDACTED] family indicate [REDACTED] is not receiving this care as required and is often wearing a soiled brief. Resident #7 indicates [REDACTED] has waited at least 30 minutes for help to the bathroom.

The residence's Call Bell Report indicates the following:

- On 12/30/24 at 9:19am resident #7 pushed [REDACTED] call bell and waited 45 minutes for staff to help [REDACTED]
- On 12/30/24 at 12:51pm resident #7 pushed [REDACTED] call bell and waited 1 hour 36 minutes for staff to help [REDACTED]
- On 1/4/25 at 2:31pm resident #7 pushed [REDACTED] call bell and waited 44 minutes for staff to help [REDACTED]
- On 1/5/25 at 6:55am resident #7 pushed [REDACTED] call bell and waited 1 hour 4 minutes for staff to help [REDACTED]
- On 1/5/25 at 8:58am resident #7 pushed [REDACTED] call bell and waited 42 minutes for staff to help [REDACTED]
- On 1/6/25 at 7:16am resident #7 pushed [REDACTED] call bell and waited 46 minutes for staff to help [REDACTED]
- On 1/6/25 at 8:39am resident #7 pushed [REDACTED] call bell and waited 48 minutes for staff to help [REDACTED]
- On 1/12/25 at 8:09am resident #7 pushed [REDACTED] call bell and waited 1 hour 28 minutes for staff to help [REDACTED]

The assessment and support plan dated [REDACTED] for resident #8 indicates the resident requires assistance with toileting and staff are to provide this care 5 times per day, specifically between 4am-6am, 9am-12pm, 1pm-3pm, at dinner, and 8pm-10pm. Staff interviews indicate the resident is not provided toileting care as required and is often found heavily soiled.

The residence's Call Bell Report indicates the following:

- On 1/4/25 at 8:28pm resident #8 pushed [REDACTED] call bell and waited 42 minutes for staff to help [REDACTED]
- On 1/5/25 at 7:18am resident #8 pushed [REDACTED] call bell and waited 42 minutes for staff to help [REDACTED]
- On 1/5/25 at 11:37am resident #8 pushed [REDACTED] call bell and waited 33 minutes for staff to help [REDACTED]

Additionally, resident #8 had a [REDACTED] procedure on [REDACTED] and returned to the residence the same day. Staff interviews indicate resident #8 had blood in [REDACTED] brief in the afternoon of [REDACTED] and [REDACTED] began vomiting around [REDACTED] and continued to vomit throughout the night. On [REDACTED] at approximately [REDACTED], staff found resident #8 with dried, black vomit that looked like coffee grounds on [REDACTED] face, in [REDACTED] hair, on [REDACTED] clothes, in [REDACTED] sheets and on the floor. An accumulation of liquid vomit was in a bedside commode bucket, on [REDACTED] bed, and in the toilet. Staff could not locate the resident's call bell and it appeared that the resident had not received staff assistance, specifically between [REDACTED]

23a ADL assistance (continued)

Plan of Correction

Accept (█) - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800. 23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

The nurse call pendants were tested on 1/31/2025 by an Executive Director and 2/10/2025 by Environmental Services Manager. The Care Team Manager or designee will test resident nurse call pendants monthly starting February. Documentation of testing will be maintained.

The Care Team Manager or designee will review the call response times from the previous day(s) Monday through Friday. The Care Team Manager or designee will review times over 30 minutes with the team member assigned to the shift. Reviews will begin weekly as of 2/23/2025. Documentation of the review will be maintained.

The Care Team Manager or designee will re-educate team members on the access and monitoring of the call response system to optimize response protocols. Documentation of the education will be maintained and completed by 3/25/2025.

The Care Team Manager or designee will conduct weekly unannounced observations of delivery of care for residents mentioned in the summary of deficiencies for this regulation and an additional 5% of the residents. If unmet services are identified, the service will be promptly provided to affected resident(s). The observations will be documented starting week of 2/23/2025. The observations will continue weekly until 12 weeks of consistent compliance. The audits will then be conducted monthly for 10 % of the residents until 3 months of consistent compliance is achieved.

The Executive Director or designee will follow up weekly with residents and legal representatives mentioned in the summary of deficiencies for this regulation and an additional 5% of the residents to discuss the delivery of care services. If unmet services are identified they will be promptly provided to affected residents. The meetings will be documented starting week of 2/23/2025. The meetings will continue weekly until 12 weeks of consistent compliance. The audits will then be conducted monthly for 10 % of the residents until 3 months of consistent compliance is

23a ADL assistance (continued)

achieved.

The Executive Director or designee will offer the resident and legal representative opportunity to meet and discuss the service plan and services delivered starting week of 2/23/2025. This will be offered quarterly via DocuSign or in person.

The Health and Wellness Director or designee will conduct a review of residents' assessments and service plans for residents mentioned in the summary of deficiencies for this regulation to identify possible gaps in services needed. The review will be completed by 3/1/2025. The Health and Wellness Director or designee will conduct review of remaining resident assessments and service plans by 03/25/2025. As 03/25/2025 the Health and Wellness Director or designee will conduct resident assessments and service plans in accordance with regulations 224 Initial assessment and preliminary support plan and 227 Development of the final support plan. The Executive Director or designee will audit the assessments and service plans monthly.

The Health and Wellness Director or licensed designee will conduct competency evaluations on care skills starting week of 2/23/2025. The competency evaluation will have a focus on delivery of services in service plan, toileting, mechanical lifts, resident transfers, nurse call pendants and response times. Any direct care team member that has not completed Care Skills Competency Evaluation by 3/25/2025 will be removed from the schedule until evaluation is completed. Documentation of evaluation will be maintained.

The Executive Director or designee will implement a reporting system for team members to report any barriers to fulfilling service plan requirements which include Notice of Change Alert form, Resident Service Record, Verification of Services Rendered form, and crossover meeting for shifts. These systems will be in place 3/1/2025.

The Executive Director or designee will establish a weekly interdisciplinary meetings to discuss resident needs and compliance. The meetings will begin 1st week of March 2025.

The Executive Director or designee will review staffing levels to verify adequate coverage to meet service plan needs of residents. The Executive Director or designee will review daily staffing allowance and staffing schedules weekly. The staffing levels are adjusted in accordance to the needs of the residents. These reviews began the week of 1/19/2025.

The Executive Director, or designee will review plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Not Implemented (█ - 04/17/2025)

24 Personal hygiene**5. Requirements**

2800.

24. Personal Hygiene - A residence shall provide the resident with assistance with personal hygiene as indicated in the resident's assessment and support plan. Personal hygiene includes one or more of the following:

1. Bathing.

24 Personal hygiene (continued)

2. Oral hygiene.
3. Hair grooming and shampooing.
4. Dressing, undressing and care of clothes.
5. Shaving.
6. Nail care.
7. Foot care.
8. Skin care.

Description of Violation

The assessment and support plan dated [REDACTED] for resident #3, indicates the resident will receive assistance from staff with fingernail management which includes soak, clean and file nails once per week. On 1/15/25, resident #3 was observed to have long fingernails that appeared to not have been cared for in the past week.

The assessment and support plan dated [REDACTED] for resident #9, indicates the resident will receive assistance from staff with hair washing in the shower 3 times a week on Monday, Wednesday and Friday. On 1/15/25, resident #9 had not had [REDACTED] hair washed in approximately 4 weeks and is only receiving bed baths/wash ups from the staff.

Plan of Correction

Accept [REDACTED] - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800. 2800. 24. Personal Hygiene - A residence shall provide the resident with assistance with personal hygiene as indicated in the resident's assessment and support plan. Personal hygiene includes one or more of the following: 1. Bathing. 2. Oral hygiene. 3. Hair grooming and shampooing. 4. Dressing, undressing and care of clothes. 5. Shaving. 6. Nail care. 7. Foot care. 8. Skin care.

The Care Team Manager or designee will conduct weekly unannounced observations of delivery of hygiene care services for residents mentioned in the summary of deficiencies for this regulation and an additional 5% of the residents. If unmet hygiene services are identified, the service will be promptly provided to affected resident(s). The observations will be documented on the Unlicensed Team Member Supervisory Note starting week of 2/23/2025. The observations will continue weekly until 12 weeks of consistent compliance. The audits will then be conducted monthly for 10 % of the residents until 3 months of consistent compliance is achieved.

The Executive Director or designee will follow up weekly with residents and legal representatives mentioned in the summary of deficiencies for this regulation and an additional 5% of the residents to discuss the delivery of care services. If unmet services are identified they will be promptly provided to affected residents. The meetings will be documented starting the week of 2/23/2025. The meetings will continue weekly until 12 weeks of consistent compliance. The audits will then be conducted monthly for 10 % of the residents until 3 months of consistent compliance is achieved.

24 Personal hygiene (continued)

The Executive Director or designee will offer the resident and legal representative the opportunity to meet and discuss the service plan and services delivered starting week of 2/23/2025. This will be offered quarterly via DocuSign or in person.

The Executive Director or designee will implement a reporting system for team members to report any barriers to fulfilling service plan requirements which include Notice of Change Alert form, Resident Service Record, Verification of Services Rendered form, and crossover meeting for shifts. These systems will be in place on 3/1/2025.

The Executive Director or designee will establish a weekly interdisciplinary meetings to discuss resident needs and compliance. The meetings will begin 1st week of March 2025.

The Executive Director or designee will review staffing levels to verify adequate coverage to meet service plan needs of residents. The Executive Director or designee will review daily staffing allowance and staffing schedules weekly. The staffing levels are adjusted in accordance with the needs of the residents. These reviews began the week of 1/19/2025.

The Executive Director, or designee will review the plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented (█) - 04/17/2025)

42b Abuse/Neglect**6. Requirements**

2800.

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

Description of Violation

On 12/21/24 at approximately 9:30pm, staff person A, staff person B, and staff person C went into resident #1's bedroom to provide incontinence care. Staff person B and staff person C indicate that while providing incontinence care to resident #1, staff person A was on a video facetime call with a █ caller. Staff person A was seen pointing █ phone towards resident #1's buttocks, showing the █ caller the █ resident and █ current condition, as well as verbally describing how "disgusting" it was to provide █ care because of the amount of feces, calling it a "blowout" and making gagging noises. The █ caller commented that it was "disgusting and they need to get the resident something to take care of that." Staff person B had to tell staff person A to get off █ phone and stop making gagging noises. Immediately following this incident staff person B and staff person C observed resident #1 crying and embarrassed.

Plan of Correction

Accept (█) - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its

42b Abuse/Neglect (continued)

receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800. 42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Team member A was immediately suspended upon notification of the allegation on [REDACTED]. Team member A is no longer employed as of [REDACTED] with the community.

The Executive Director or designee will conduct retraining for all existing team members on regulations 2800.42 Resident Rights. The mandatory training session will be part of Team Member Re-Orientation and will be completed by 3/18/2025. Documentation of training will be maintained.

The Executive Director or designee will train new team members on 2800.42 Resident Rights prior to assuming duties of their position. The Executive Director or designee will conduct monthly audits of Team Member Orientation including Resident Rights for compliance. Audits will begin the week of 2/23/2025.

The Business Office Coordinator or designee will maintain the supply of Grievance Forms and business cards for leadership at the front desk. The form and business cards availability at front desk was implemented 2/10/2025.

The Executive Director, or designee will review the plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Not Implemented ([REDACTED] - 04/17/2025)

42c Dignity/Respect

7. Requirements

2800.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

The assessment and support plan dated [REDACTED] for resident #3 indicates the resident requires assistance with toileting, and staff will check on [REDACTED] every 2 hours throughout the day and staff are to respond with additional assistance as required throughout the day or night when the resident alerts staff using [REDACTED] call bell. Resident #3 indicates [REDACTED] has waited very long periods of time to receive this assistance after [REDACTED] alerts staff using [REDACTED] call bell. Additionally, on numerous occasions staff have left resident #3 on the toilet for extended periods of time before they come back to assist [REDACTED] off the toilet. Resident #3 indicated the service [REDACTED] is receiving from the residence makes [REDACTED] feel like [REDACTED] would "rather be dead than to live like this."

The residence's Call Bell Report indicates the following:

On 1/4/25 at 8:40pm resident #3 pushed [REDACTED] call bell and waited 52 minutes for staff to help [REDACTED]

42c Dignity/Respect (continued)

On 1/6/25 at 8:51am resident #3 pushed [REDACTED] call bell and waited 42 minutes for staff to help [REDACTED]

On 1/12/25 at 4:51am resident #3 pushed [REDACTED] call bell and waited 39 minutes for staff to help [REDACTED]

On 1/12/25 at 8:54am resident #3 pushed [REDACTED] call bell and waited 35 minutes for staff to help [REDACTED]

The assessment and support plan dated 10/10/24 for resident #5 indicates the resident requires staff assistance with toileting and staff will check on [REDACTED] every 2 hours throughout the day and assist [REDACTED] to the toilet, and staff are to respond with additional assistance as required throughout the day or night when the resident alerts staff using [REDACTED] call bell. Resident #5 indicates [REDACTED] has to wait long periods of time for staff to help [REDACTED] use the bathroom and gets mad when [REDACTED] has to wait because [REDACTED] does not want to go in [REDACTED] cloths but sometimes, [REDACTED] can't wait that long.

The residence's Call Bell Report indicates the following:

On 12/29/24 at 5:01pm resident #5 pushed [REDACTED] call bell and waited 44 minutes for staff to help [REDACTED]

On 12/30/24 at 8:59am resident #5 pushed [REDACTED] call bell and waited 44 minutes for staff to help [REDACTED]

On 1/4/25 at 7:16am resident #5 pushed [REDACTED] call bell and waited 1 hour and 6 minutes for staff to help [REDACTED]

On 1/4/25 at 11:52pm resident #5 pushed [REDACTED] call bell and waited 1 hour 30 minutes for staff to help [REDACTED]

On 1/5/25 at 9:57am resident #5 pushed [REDACTED] call bell and waited 53 minutes for staff to help [REDACTED]

On 1/6/25 at 4:02am resident #5 pushed [REDACTED] call bell and waited 2 hours 13 minutes for staff to help [REDACTED]

On 1/6/25 at 1:44pm resident #5 pushed [REDACTED] call bell and waited 2 hours 9 minutes for staff to help [REDACTED]

On 1/10/25 at 6:45am resident #5 pushed [REDACTED] call bell and waited 40 minutes for staff to help [REDACTED]

On 1/12/25 at 7:42am resident #5 pushed [REDACTED] call bell and waited 1 hour 57 minutes for staff to help [REDACTED]

Resident #10 is diagnosed with dementia and often enters other resident's rooms. On at least 1 occasion, resident #10 entered resident #7's bedroom at night, causing [REDACTED] to be fearful and constantly ask staff to lock [REDACTED] door. During the overnight shift on 1/14/25 into 1/15/25, resident #10 entered resident #11's bedroom and got into bed with [REDACTED]

Plan of Correction

Accept ([REDACTED]) - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800.42.c. A resident shall be treated with dignity and respect.

The Executive Director or designee will conduct retraining for all existing team members on regulations 2800.42 Resident Rights. The mandatory training session will be part of Team Member Re-Orientation and will be completed by 3/25/2025. Documentation of training will be maintained.

The Executive Director or designee will train new team members on 2800.42 Resident Rights prior to assuming duties of their position. The Executive Director or designee will conduct monthly audits of Team Member Orientation including Resident Rights. for compliance. Audits will begin the week of 2/23/2025.

42c Dignity/Respect (continued)

The Business Office Coordinator or designee will maintain the supply of Grievance Forms and business cards for leadership at the front desk. The form and business cards availability at front desk was implemented 2/10/2025.

The Executive Director or designee will follow up weekly with residents and legal representatives mentioned in the summary of deficiencies for this regulation and an additional 5% of the residents to discuss that services are being delivered in a respectful and dignified manner. The meetings will be documented starting the week of 2/23/2025. The meetings will continue weekly until 12 weeks of consistent compliance. The audits will then be conducted monthly for 10 % of the residents until 3 months of consistent compliance is achieved.

The Care Team Manager or designee will conduct random observations to verify team members interactions are respectful and aligned with dignity policies. This will be a sampling of 10% of the residents and observations will be documented. The observations will begin the week of 2/23/2025. Any team member found violating these principles will receive immediate retraining and corrective action if necessary.

The Executive Director, or designee will review plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Not Implemented (█ - 04/17/2025)

42s Privacy - self/possessions

8. Requirements

2800.

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

Description of Violation

On 12/21/24 at approximately 9:30pm, staff person A, staff person B, and staff person C went into resident #1's bedroom to provide incontinence care. Staff person B and staff person C indicate that while providing incontinence care to resident #1, staff person A was on a video facetime call with a █ caller. Staff person A was seen pointing █ phone towards resident #1's buttocks, showing the █ caller the █ resident and █ current condition, as well as verbally describing how "disgusting" it was to provide █ care because of the amount of feces, calling it a "blowout" and making gagging noises. The █ caller commented that it was "disgusting and they need to get the resident something to take care of that." Staff person B had to tell staff person A to get off █ phone and stop making gagging noises. Immediately following this incident staff person B and staff person C observed resident #1 crying and embarrassed.

Resident #5's family installed a camera in the resident's private room. The residence placed unwanted signage outside the resident's room notifying anyone who entered that video surveillance is occurring.

Plan of Correction

Accept (█ - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in

42s Privacy - self/possessions (continued)

this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800.42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the residents during bathing, dressing, changing and medical procedures.

Team member A was immediately suspended upon notification of the allegation on [REDACTED]. Team member A is no longer employed as of [REDACTED] with the community.

The Executive Director or designee will conduct retraining for all existing team members on regulations 2800.42 Resident Rights, Personal Telephone Use policy, and HIPPA Compliance policy. The mandatory training session will be part of Team Member Re-Orientation and will be completed by 3/25/2025. Documentation of training will be maintained.

The Executive Director, or designee will train new team members on 2800.42 Resident Rights, Personal Telephone policy and HIPPA Compliance policy prior to assuming duties of their position. The Executive Director or designee will conduct monthly audits of Team Member Orientation for compliance. Audits will begin the week of 2/23/2025.

The Executive Director or designee will follow up weekly with resident and legal representative mentioned in the summary of deficiencies for this regulation and an additional 10% of the residents to discuss that services are being delivered consistent with regulation 2800.42.s. The meetings will be documented starting the week of 2/23/2025. The meetings will continue weekly until 12 weeks of consistent compliance. The audits will then be conducted monthly for 10 % of the residents until 3 months of consistent compliance is achieved.

The Business Office Coordinator or designee will maintain the supply of Grievance Forms and business cards for leadership at the front desk. The form and business cards were at the front desk and was implemented 2/10/2025.

The Care Team Manager or designee will conduct random observations to verify team members interactions maintain privacy of the resident and that team members are not using personal cell phones. This will be a sampling of 10% of the residents and observations will be documented. Any team member found violating these principles will receive immediate retraining and corrective action if necessary.

The Operations Specialist removed the signage from apartment home of resident #5 on 2/24/2025. The Operations Specialist confirmed that no other apartment homes have signage as of 2/24/2025. The community will no longer request signage to be posted on apartment homes of residents that have video surveillance as of 2/24/2025.

The Executive Director, or designee will review concerns related to resident rights at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

42s Privacy - self/possessions (*continued*)

Implemented (█) - 04/17/2025)

44d Complaints - investigation

9. Requirements

2800.

44.d. The residence shall ensure investigation and resolution of complaints. The home shall designate the staff person responsible for receiving complaints and determining the outcome of the complaint.

Description of Violation

On 12/21/24, family of resident #2 filed a complaint regarding the treatment of multiple residents in the residence. However, the residence did not ensure investigation and resolution of these complaints. The residence does not identify a specific staff person responsible for receiving complaints and determining outcomes of complaints.

On 1/5/25, family of resident #3 filed a complaint indicating serious concerns about the resident's care. However, the residence did not ensure investigation and resolution of this complaint. The residence does not identify a specific staff person responsible for receiving complaints and determining outcomes of complaints.

On 12/21/24, family of resident #5 filed a verbal complaint to staff that was written up on a New Perspectives Grievance Report regarding the resident not having Oxygen and was not able to come to the dining room for dinner. However, the residence did not ensure investigation and resolution of this complaint. The Grievance Report was filed in a binder; however, the residence does not identify a specific staff person responsible for receiving complaints and determining outcomes of complaints.

On 12/21/24, family of resident #6 filed a verbal complaint to staff that was written up on a New Perspectives Grievance Report regarding resident #6's care. However, the residence did not ensure investigation and resolution of this complaint. The Grievance Report was filed in a binder; however, the residence does not identify a specific staff person responsible for receiving complaints and determining outcomes of complaints.

On 1/6/25, family of resident #7 filed a complaint indicating serious concerns about the resident's care. However, the residence did not ensure investigation and resolution of this complaint. The residence does not identify a specific staff person responsible for receiving complaints and determining outcomes of complaints.

Plan of Correction

Accept (█) - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800. 44.d. The residence shall ensure investigation and resolution of complaints. The home shall designate the staff person responsible for receiving complaints and determining the outcome of the complaint.

44d Complaints - investigation (continued)

During the week of 1/12/2025, the Regional Vice President of Operations meet with the families of residents #2, #3, #5, #6, and #7. Meetings were held, complaints investigated, and resolution was communicated to residents and / or legal representatives. The Operations Specialist will log the complaints and grievances for residents #2, #3, #5, #6, and #7 on the Community Responses to Grievances Log no later than 2/28/2025.

The Regional Vice President, District Leadership, Area Leadership and Community Leadership conducted a town hall for residents and family members to discuss their concerns and provide contact names, information, and method for communicating a grievance. The meeting was held on 01/15/2025.

The Regional Vice President of Operations issued correspondence to residents and designated persons/legal representatives on names and contact information to report complaints and grievances related to the community. The letter was issued in hard copy and email on 01/21/2025.

The resident agreement provides information on the complaint process and contact information which was in place at the time of survey and continued practice. The residency agreement identifies the specific team members responsible for receiving complaints and determining the outcome of the complaints.

The Business Office Coordinator or designee will maintain the supply of Grievance Forms and business cards for leadership at the front desk. The form and business cards availability at front desk was implemented 2/10/2025.

The Business Office Coordinator or designee will continue to maintain contact information postings of leadership at the front entrance of community and postings on community bulletin board with county and state agencies as additional resources.

The Operations Specialist or designee will retrain the leadership team on regulation 44 . Education will be provided by 2/28/2025. Documentation of training will be maintained.

The Executive Director, or designee will review plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented (█) - 04/17/2025)

44e Complaints - status/2 Days

10. Requirements

2800.

44.e. Within 2 business days after the submission of a written complaint, a status report shall be provided by the resident to the complainant. If the resident is not the complainant, the resident and the resident's designated person shall receive the status report unless contraindicated by the support plan. The status report must indicate the steps that the residence is taking to investigate and address the complaint.

Description of Violation

On 12/21/24, family of resident #2 filed a complaint regarding the treatment of multiple residents in the residence. However, the residence did not provide a status report indicating the steps that the residence is taking to investigate and address the complaint to the resident and the resident's designated person.

44e Complaints - status/2 Days (continued)

On 1/5/25, family of resident #3 filed a complaint indicating serious concerns about the resident's care. However, the residence did not provide a status report indicating the steps that the residence is taking to investigate and address the complaint to the resident and the resident's designated person.

On 12/21/24, family of resident #5 filed a verbal complaint to staff that was written up on a New Perspectives Grievance Report regarding the resident not having Oxygen and was not able to come to the dining room for dinner. However, the residence did not provide a status report indicating the steps that the residence is taking to investigate and address the complaint to the resident and the resident's designated person.

On 12/21/24, family of resident #6 filed a verbal complaint to staff that was written up on a New Perspectives Grievance Report regarding resident #6's care. However, the residence did not provide a status report indicating the steps that the residence is taking to investigate and address the complaint to the resident and the resident's designated person.

On 1/6/25, family of resident #7 filed a complaint indicating serious concerns about the resident's care. However, the residence did not provide a status report indicating the steps that the residence is taking to investigate and address the complaint to the resident and the resident's designated person.

Plan of Correction

Accept (█) - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800. 44.e. Within 2 business days after the submission of a written complaint, a status report shall be provided by the resident to the complainant. If the resident is not the complainant, the resident and the resident's designated person shall receive the status report unless contraindicated by the support plan. The status report must indicate the steps that the home is taking to investigate and address the complaint.

During the week of 1/12/2025, the Regional Vice President of Operations meet with the families of residents #2, #3, #5, #6, and #7. Meetings were held, complaints investigated, and resolution was communicated to residents and / or legal representatives. The Operations Specialist will log the complaints and grievances for residents #2, #3, #5, #6, and #7 on the Community Responses to Grievances Log no later than 2/28/2025.

The Executive Director or designee will provide a status report to indicate the steps that the community is taking to investigate and address a complaint to the person whom filed the complaint. This status report will be provided within two business days of receipt of a written complaint by the Executive Director or designee. This practice is effective week of 2/23/2025.

The Executive Director or designee utilizes the Community Responses to Grievances Log effective week of

44e Complaints - status/2 Days (continued)

2/23/2025 consistent with regulation 44 to document responses to written complaints.

The Area Director of Operations or designee will review the Community Responses to Grievance Log monthly starting March 1, 2025, to verify compliance with regulation 44.e.

The Operations Specialist or designee will retrain the leadership team on regulation 44 . Education will be provided by 2/28/2025. Documentation of training will be maintained.

The Executive Director, or designee will review the plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented (█) - 04/17/2025)

44f Written Decision - 7 days**11. Requirements**

2800.

44.f. Within 7 days after the submission of a written complaint, the residence shall give the complainant and, if applicable, the designated person, a written decision explaining the residence's investigation findings and the action the residence plans to take to resolve the complaint. If the resident is not the complainant, the affected resident shall receive a copy of the decision unless contraindicated by the support plan. If the residence's investigation validates the complaint allegations, a resident who could potentially be harmed or █ved, unless designated person shall receive a copy of the decision, with the name of the affected resident removed, unless contraindicated by the support plan.

Description of Violation

On 12/21/24, family of resident #2 filed a complaint regarding the treatment of multiple residents in the residence. However, the residence did not give the affected residents and their designated persons a written decision explaining the residence's investigation findings and the action the residence plans to take to resolve the complaint.

On 1/5/25, family of resident #3 filed a complaint indicating serious concerns about the resident's care. However, the residence did not give the affected resident and the resident's designated person a written decision explaining the resident's investigation findings and the action the residence plans to take to resolve the complaint.

On 12/21/24, family of resident #5 filed a verbal complaint to staff that was written up on a New Perspectives Grievance Report regarding the resident not having Oxygen and was not able to come to the dining room for dinner. However, the residence did not give the affected resident and the resident's designated person a written decision explaining the resident's investigation findings and the action the residence plans to take to resolve the complaint.

On 12/21/24, family of resident #6 filed a verbal complaint to staff that was written up on a New Perspectives Grievance Report regarding resident #6's care. However, the residence did not give the affected resident and the resident's designated person a written decision explaining the resident's investigation findings and the action the residence plans to take to resolve the complaint.

On 1/6/25, family of resident #7 filed a complaint indicating serious concerns about the resident's care. However, the residence did not give the affected resident and the resident's designated person a written decision explaining the

44f Written Decision - 7 days (continued)

resident's investigation findings and the action the residence plans to take to resolve the complaint.

Plan of Correction

Accept (█ - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800. 44.f. Within 7 days after the submission of a written complaint, the home shall give the complainant and, if applicable, the designated person, a written decision explaining the home's investigation findings and the action the residence plans to take to resolve the complaint. If the resident is not the complainant, the affected resident shall receive a copy of the decision unless contraindicated by the support plan. If the residence's investigation validates the complaint allegations, a resident who could potentially be harmed or █ designated person shall receive a copy of the decision, with the name of the affected resident removed, unless contraindicated by the support plan.

During the week of 1/12/2025, the Regional Vice President of Operations meet with the families of residents #2, #3, #5, #6, and #7. Meetings were held, complaints investigated, and resolution was communicated to residents and / or legal representatives.

The Executive Director or designee will provide the complainant and others as indicated by regulations, if applicable, a written decision of the community's investigation findings consistent with 44f. This practice is effective week of 2/23/2025.

The Executive Director or designee will use the Community Responses to Grievances Log effective week of 2/23/2025 consistent with regulation 44 to document completion of written responses to complainant and others as applicable consistent with regulation 44.f.

The Area Director of Operations or designee will review Community Responses to Grievance Log monthly starting March 1, 2025 to verify compliance with regulation 44.f.

The Operations Specialist or designee will retrain the leadership team on regulation 44 . Education will be provided by 2/28/2025. Documentation of training will be maintained.

The Executive Director, or designee will review the plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented (█ - 04/17/2025)

54a Direct care staff quals

12. Requirements

2800.

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.
4. Be able to communicate in a mode or manner understood by the resident. Strategies that promote interactive communication on the part of direct care staff and individual residents shall be developed in accordance with the resident’s final support plan under § 2800.227(e) (relating to development of the final support plan).

Description of Violation

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

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

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

Plan of Correction

Accept ([redacted] - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community’s policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800.54.a. Direct care staff persons shall have the following qualifications: (b). 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Direct care team members A, E, and F no longer worked at the community at the time of the survey. No action needed.

The Care Team Manager or designee will audit all direct care team members personnel files to confirm supporting documentation is on file for caregiver qualifications which include: a high school diploma, GED or active registry status on Pennsylvania nurse aid registry. The audit will be completed by 2/23/2025.

Any caregiver with missing documentation of direct care team members qualifications will be notified, documents obtained, and placed in personnel file. This will be completed by 3/25/2025. Any direct care team members missing documentation of qualifications who have not provided the appropriate documentation will be removed from the schedule as of 3/25/2025 until provided.

54a Direct care staff quals (continued)

The Area Director of Operations or designee will conduct a training session to educate Executive Director and Care Team Manager(s) on regulation 2800.54.a. Education will be provided by 2/28/2025. Documentation on education will be maintained.

The Care Team Manager will verify starting the week of 2/23/2025, all new direct care team members hired are required to submit proof of qualifications based on the guidance and timelines in the DHS, BHSL, Regulatory Compliance Guide 55 Pa. Code Chapter 2800 March 1, 2015 Edition, Revised August 1, 2021.

The Care Team Manager or designee will complete a monthly audit of personnel files for direct care team members to verify continued compliance with PA ALR 2800.54.a. The audits will begin week of 2/23/2025.

The Executive Director, or designee will review plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Not Implemented (█ - 04/17/2025)

60a Staffing/support plan needs

13. Requirements

2800.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

Description of Violation

From 11:57pm on 1/4/24 to 12:45am on 1/5/25 there were 48 residents in the residence, including 11 residents with mobility needs, of which 5 residents require a 2-person assist for transfers and use a Hoyer lift. During this time there was only 1 staff person present in the residence to assist residents to evacuate in the event of an emergency.

From 11:15pm on 1/11/24 to 6:30am on 1/12/25 there were 47 residents in the residence, including 11 residents with mobility needs, of which 5 residents require a 2-person assist for transfers and use a Hoyer lift. During this time there were only 2 staff persons present in the residence to assist residents to evacuate in the event of an emergency.

Plan of Correction

Accept (█ - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

60a Staffing/support plan needs (continued)

55 Pa. Code § 2800 60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

The Executive Director or designee will review the assessment and support plans for care needs to include but not limited to the number of residents, immobile residents, two-person assists, and any changes to resident needs at least weekly. As is the process, adjustments to staffing levels are made based on the needs of the residents as specified in the resident's assessment and support plan. Staffing levels are reviewed to evaluate that sufficient staff are scheduled to provide assisted living services in compliance with applicable regulations and are adjusted accordingly based on the ongoing weekly reviews conducted by the Executive Director or designee. The weekly review will begin the week of 1/19/2025.

The Executive Director or designee will establish a weekly interdisciplinary meetings to discuss residents' needs. The meetings will begin 1st week of March 2025.

The Executive Director, or designee will review the plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented ([redacted] - 04/17/2025)

63a First Aid/CPR 1:35

14. Requirements

2800.

63.a. For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

Description of Violation

On 1/4/25 from 11:57pm to 1/5/25 at 12:45am there were 48 residents present in the residence. During this time only 1 staff person was present in the residence who was trained in first aid and certified in obstructed airway techniques and CPR.

[redacted] violation withdrawn [redacted] 4/28/2025

Plan of Correction

Accept ([redacted] - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

63a First Aid/CPR 1:35 (continued)

55 Pa. Code § 2800 . 63.a. For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

The Executive Director Specialist completed an audit of team member personnel files for active CPR/1st Aid certification. The audit was completed 2/13/2025.

Starting week of 2/23/2025, the Executive Director or designee will confirm that a minimum of the two of the team members scheduled for the shift have current CPR/1st aid certification.

The Executive Director or designee will maintain an updated list of CPR/1st Aid certification team members and expiration dates to prevent future lapses in CPR / 1st Aid certification. The Executive Director will be review list monthly to verify compliance.

As of 2/14/2025, the community has partnered with two training providers to conduct CPR certification and recertification courses. The Care Team Manager or designee will schedule the courses quarterly and as needed to maintain compliance.

The Executive Director, or designee will review the plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented ([REDACTED] - 04/17/2025)

65a Fire Safety-1st day

15. Requirements

2800.

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.
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 A, whose first day of work was [REDACTED] did not receive orientation in any of the training topics as required in 2800.65(a)(1-7).

65a Fire Safety-1st day (continued)

Staff person E, whose first day of work was [REDACTED] did not receive orientation in any of the training topics as required in 2800.65(a)(1-7).

Staff person F, whose first day of work was [REDACTED] did not receive orientation in any of the training topics as required in 2800.65(a)(1-7).

Staff person H, whose first day of work was [REDACTED] did not receive orientation in any of the training topics as required in 2800.65(a)(1-7).

Plan of Correction**Accept ([REDACTED] - 03/10/2025)**

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800. 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. 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.

Team members A, E, F, and H no longer work at the community at the time of the survey. No action needed.

The Executive Director or designee will complete an audit of team member personnel files to identify team members needing training on regulation 65(a)(1-7). The audit will be completed by 2/21/2025.

The Environmental Service Manager or designee will complete training with team members by 3/25/2025. Documentation of training will be maintained. Team members who have not completed the required training will be removed from the schedule as of 3/25/2025 until completion of training.

The Operations Specialist or designee will retrain the leadership team on regulation 65(a)(1-7). Education will be provided by 2/28/2025. Documentation of training will be maintained.

Starting the week of 2/23/2025, the Environmental Services Manager or designee is responsible to conduct new hire team members on regulations 65(a)(1-7) on or prior to 1st day of work. Documentation of training will be maintained.

65a Fire Safety- 1st day (continued)

Starting the week of 2/23/2025, the Executive Director or designee will complete a monthly audit of new hires to verify compliance with PA ALR 2800.65(a)(1-7).

The Executive Director, or designee will review the plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented () - 04/17/2025)

65b Direct care staff initial orientation

16. Requirements

2800.

65.b. Direct care staff persons shall complete an initial orientation approved by the Department before providing direct care to residents.

Description of Violation

Staff person A, whose first day of work was [redacted] did not receive orientation on their job duties.

Staff person E, whose first day of work was [redacted], did not receive orientation on their job duties.

Staff person H, whose first day of work was [redacted] did not receive orientation on their job duties.

Plan of Correction

Accept () - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800. 65.b. Direct care staff persons shall complete an initial orientation approved by the Department before providing direct care to residents.

Staff A, E, and F no longer work at the community at time of the survey. No action needed.

The Executive Director or designee will complete an audit of team member personnel files to identify team members needing training on regulation 65(b). The audit will be completed by 2/21/2025.

The Care Team Manager or designee will schedule each team member a specific time to complete training consistent with 65.b. Training to be completed by 3/25/2025. Documentation of training will be maintained. Team members who have not completed the required training will be removed from the schedule as of 3/25/2025 until completion of training.

65b Direct care staff initial orientation (continued)

The Operations Specialist or designee will train the Care Team Manager and Executive Director on regulation 65(b). Education will be provided by 2/28/2025. Documentation of training will be maintained.

Starting week of 2/23/2025, the Care Team Manager or designee is responsible to conduct new hire team members on regulations 65(b) prior to providing direct care to the residents. Documentation of training will be maintained. Starting week of 2/23/2025, the Executive Director or designee will complete a monthly audit of new hires to verify compliance with PA ALR 2800.65(b).

The Executive Director, or designee will review plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented () - 04/17/2025

65e Rights/Abuse 40 Hours

17. Requirements

2800.

65.e. 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.
5. Safe management techniques.
6. Core competency training that includes the following:
 - i. Person-centered care.
 - ii. Communication, problem solving and relationship skills.
 - iii. Nutritional support according to resident preference.

Description of Violation

Staff person A, with a hire date of (), did not complete training in any training topics as required in 2800.65(e) (1-6).

Staff person E, with a hire date of () did not complete training in any training topics as required in 2800.65(e) (1-6).

Staff person F, with a hire date of (), did not complete training in any training topics as as required in 2800.65(e)(1-6).

Plan of Correction

Accept () - 03/10/2025

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible

65e Rights/Abuse 40 Hours (continued)

by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800.65.e. 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. 5. Safe management techniques. 6. Core competency training that includes the following: i. Person-centered care. ii. Communication, problem solving and relationship skills. iii. Nutritional support according to resident preference

Team members A, E, and F no longer work at the community at time of the survey. No action needed.

The Executive Director or designee will complete an audit of team member personnel files to identify team members needing training on regulation 65(e). The audit will be completed by 2/21/2025.

The Care Team Manager or designee will schedule each team member a specific time to complete training consistent with 65(e). Training to be completed by 3/25/2025. Documentation of training will be maintained. Team members who have not completed the required training will be removed from the schedule as of 3/25/2025 until completion of training.

The Operations Specialist or designee will train the Care Team Manager and Executive Director on regulation 65(e). Education will be provided by 2/28/2025. Documentation of training will be maintained.

Starting week of 2/23/2025, the Care Team Manager or designee is responsible to conduct new hire team members on regulations 65(e) prior to providing direct care to the residents. Documentation of training will be maintained.

Starting week of 2/23/2025, the Executive Director or designee will complete a monthly audit of new hires to verify compliance with PA ALR 2800.65(e).

The Executive Director, or designee will review plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented (█) - 04/17/2025)

65g Initial direct care training**18. Requirements**

2800.

65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
 - i. Safe management techniques.

65g Initial direct care training (*continued*)

- ii. ADLs and IADLs
- iii. Personal hygiene.
- iv. Care of residents with mental illness, neurological impairments, an intellectual disability and other mental disabilities.
- v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
- vi. Implementation of the initial assessment, annual assessment and support plan.
- vii. Nutrition, food handling and sanitation.
- viii. Recreation, socialization, community resources, social services and activities in the community.
- ix. Gerontology.
- x. Staff person supervision, if applicable.
- xi. Care and needs of residents with special emphasis on the residents being served in the residence.
- xii. Safety management and hazard prevention.
- xiii. Universal precautions.
- xiv. The requirements of this chapter.
- xv. The signs and symptoms of infections and infection control.
- xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the residence.
- xvii. Behavioral management techniques.
- xviii. Understanding of the resident's assessment and how to implement the resident's support plan.
- xix. Person-centered care and aging in place.

Description of Violation

Direct care staff person A did not complete 18 hours of training as required by 2800.65g (1-3).

Direct care staff person E did not complete 18 hours of training as required by 2800.65g (1-3).

Direct care staff person F did not complete 18 hours of training as required by 2800.65g (1-3).

Plan of Correction

Accept (█) - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800.65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas: 1. Training that includes a demonstration of job duties, followed by supervised practice. 2. Successful completion and passing the Department-approved direct care training course and passing of the competency test. 3. Initial direct care staff person training to include the following: i. Safe management techniques. ii. ADLs and IADLs iii. Personal hygiene. iv. Care of residents with mental illness, neurological impairments, an intellectual disability and other mental disabilities. v. The normal aging-cognitive, psychological and functional abilities of individuals who are older. vi. Implementation of the initial assessment, annual assessment and support plan. vii. Nutrition, food handling and sanitation. viii. Recreation, socialization, community resources, social services and activities in the community. ix. Gerontology. x. Staff person supervision, if

65g Initial direct care training (continued)

applicable. xi. Care and needs of residents with special emphasis on the residents being served in the residence. xii. Safety management and hazard prevention. xiii. Universal precautions. xiv. The requirements of this chapter. xv. The signs and symptoms of infections and infection control. xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the residence. xvii. Behavioral management techniques. xviii. Understanding of the resident’s assessment and how to implement the resident’s support plan. xix. Person-centered care and aging in place.

Team members A, E, and F no longer work at the community at time of the survey. No action needed.

The Executive Director or designee will complete an audit of team member personnel files to identify team members needing training on regulation 65(g). The audit will be completed by 2/21/2025.

The Care Team Manager or designee will schedule each team member a specific time to complete training consistent with 65(g). Training to be completed by 3/25/2025. Documentation of training will be maintained. Team members who have not completed the required training will be removed from the schedule as of 3/25/2025 until completion of training.

The Operations Specialist or designee will train the Care Team Manager and Executive Director on regulation 65(g). Education will be provided by 2/28/2025. Documentation of training will be maintained.

Starting week of 2/23/2025, the Care Team Manager or designee is responsible to conduct new hire team members on regulations 65(g) prior to providing direct care to the residents. Documentation of training will be maintained.

Starting week of 2/23/2025, the Executive Director or designee will complete a monthly audit of new hires to verify compliance with PA ALR 2800.65(g).

The Executive Director, or designee will review plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented ([redacted]) - 04/17/2025)

69 Dementia training

19. Requirements

2800.

69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Staff person A, date of hire [redacted], did not receive dementia-specific training within 30 days of hire.

Staff person E, date of hire [redacted], did not receive dementia-specific training within 30 days of hire.

69 Dementia training (continued)

Staff person H, date of hire [REDACTED], did not receive dementia-specific training within 30 days of hire.

Plan of Correction

Accept ([REDACTED]) - 03/10/2025)

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800. 69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Team members A, E, and H no longer work at the community at time of the survey. No action needed.

The Executive Director or designee will complete an audit of team member personnel files to identify team members needing training on regulation 69. The audit will be completed by 2/21/2025.

The Executive Director or designee will schedule each team member a specific time to complete training consistent with 69. Training to be completed by 3/25/2025. Documentation of training will be maintained. Team members who have not completed the required training will be removed from the schedule as of 3/25/2025 until completion of training.

The Operations Specialist or designee will train the leadership team on regulation 69. Education will be provided by 2/28/2025. Documentation of training will be maintained.

Starting week of 2/23/2025, the Executive Director or designee is responsible to conduct new hire team members on regulations 69 within the first 30 days of employment. Documentation of training will be maintained.

Starting week of 2/23/2025, the Executive Director or designee will complete a monthly audit of new hires to verify compliance with PA ALR 2800.65(b).

The Executive Director, or designee will review plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented ([REDACTED]) - 04/17/2025)

82c Locked poisons

20. Requirements

2800.

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

Description of Violation

On 1/9/25 at 10:41am, multiple poisonous cleaners on the housekeeping cleaning cart in the 2nd floor hallway were unlocked, unattended, and accessible to residents, to include:

- * Comet Disinfecting Sanitizing Bathroom Cleaner, with a manufacture's label indicating "If swallowed drink 1-2 glasses of water and call a DR or Poison Control Center for treatment advice."*
- * Clorox Toilet Bowl Cleaner with Bleach, with a manufacture's label indicating "If swallowed call a Poison Control Center or DR immediately for treatment advice."*
- * GermX Hand Sanitizer, with a manufacture's label indicating "If swallowed get medical help or contact a Poison Control Center right away."*

Not all the residents of the home, including resident #11, have been assessed capable of recognizing and using poisons safely.

Plan of Correction

Accept () - 03/10/2025

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800. 82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

The Business Office Coordinator secured the housekeeping carts containing the chemicals at the end of the business day on 1/9/2025.

Resident care plans will be updated to reflect any restrictions regarding hazardous material access. This will be completed by the Health and Wellness Director or designee by 2/24/2025.

The Environmental Services Manager or designee will conduct training sessions with the housekeeping and maintenance team members on proper storage of poisonous materials. This training will include instruction on regulation 2800.82. Education will be provided by 2/28/2025. Documentation of the education will be maintained.

Starting week of 2/23/2025, the Environmental Services Manager or designee will train new housekeeping or maintenance personnel on regulation 2800.82 prior to assuming position duties. Documentation of the education will be maintained.

Starting week of 2/23/2025, weekly walks will be completed and documented by the Environmental Services Manager or designee to measure compliance with regulation 82.c.

82c Locked poisons (continued)

The Executive Director, or designee will review the plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented (█ - 04/17/2025)

101j3 Bed linens/pillows/blankets**21. Requirements**

2800.

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

3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 1/9/25 at 10:31am, resident #13's bed linens were soiled with urine and feces, with 2 layers of bed pads on top of the soiled bed sheets and a comforter pulled up over top of the pads.

Plan of Correction

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55 Pa. Code § 2800. 101.j. Each resident shall have the following in the living unit: 3. Pillows, bed linens and blankets that are clean and in good repair.

Soiled linens for resident #13 were removed, laundered and replaced with clean linens on 1/9/2025 during the time of the survey by a team member.

The Care Team Manager or designee will provide retraining to all direct care team members and housekeeping team members on linen changing processes as of 03/25/2025. Training will emphasize that linens must be change immediately if soiled. Team members reminded to document and report any soiled bedding issues promptly. Documentation of the training will be maintained.

Direct Care Team members will document soiled linen changes on the 24-hour report log starting week of 2/23/2025. The Care Team Manager or designee will monitor the log for trends.

Starting the week of 2/23/2025, the Care Team Manager or designee will conduct room inspections for 10 % of the residents weekly for three months. The Care Team Manager will immediately address non-compliance with team members retraining or corrective action as warranted.

The Executive Director, or designee will review the plan of correction at the Quality Management Plan meetings

101j3 Bed linens/pillows/blankets (continued)

quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented (█) - 04/17/2025)

132a Monthly fire drill**22. Requirements**

2800.

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of December 2024.

Plan of Correction

Accept (█) - 03/10/2025)

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55 Pa. Code § 2800. 132.a. An unannounced fire drill shall be held at least once a month.

The Environmental Services Manager conducted unannounced fire drills on 2/5/2025 on 1st shift and 2/13/2025 on 3rd shift to make up fire drill missed in December 2024 and January 2025.

The Environmental Services Manager or designee will conduct an unannounced fire drill on 2nd shift by end of February.

The Operations Specialist or designee will train the Environmental Services Manager, Executive Director, Business Office Coordinator on regulation 2800.132 Fire Drills by 2/28/2025. Documentation of training will be maintained.

An unannounced monthly fire drill schedule has been established for 2025 by the Operations Specialist which includes 3rd shift fire drill once every 6 months. The fire drill schedule will be shared with the Executive Director and Environmental Services Manager to conduct the fire drills in accordance with regulations.

Starting February 2025, the fire drill log will be reviewed monthly by the Area Director of Operations to measure accuracy and compliance.

The Executive Director, or designee will review the plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

132a Monthly fire drill (continued)

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented (█) - 04/17/2025)

132e Fire drill - sleeping hours

23. Requirements

2800.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 5/28/24 at 6:08am with 7 staff.

Plan of Correction

Accept (█) - 03/10/2025)

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55 Pa. Code § 2800. 132.e. A fire drill shall be held during sleeping hours once every 6 months.

The Environmental Services Manager conducted an unannounced 3rd shift fire drill on 2/13/2025 to make up for the 3rd shift fire drill missed at end of 2024.

The Operations Specialist or designee will train the Environmental Services Manager and Executive Director on regulation 2800.132 Fire Drills by 2/28/2025. Documentation of training will be maintained.

A monthly fire drill schedule has been established for 2025 by the Operations Specialist which includes 3rd shift fire drill once every 6 months. The fire drill schedule will be shared with the Executive Director and Environmental Services Manager to conduct the fire drills in accordance with regulations.

Starting February of 2025, the fire drill log will be reviewed monthly by the Area Director of Operations to measure accuracy and compliance.

The Executive Director, or designee will review the plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented (█) - 04/17/2025)

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] violation withdrawn 4/28/2025

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] violation withdrawn 4/28/2025

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] Violation withdrawn 4/22/2025

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Violation withdrawn [REDACTED] 4/22/2025

[REDACTED]

187a Medication record

27. Requirements

2800.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #5's is prescribed Pantoprazole 40mg tablet, take by mouth twice daily. On 1/2/25, 1/3/25, 1/4/24, 1/5/25, 1/8/25 and 1/9/25 multiple staff indicated on the resident's January 2025 medication administration record that the medication was administered; however the medication was not administered because it was not available in the residence.

Plan of Correction

Accept [REDACTED] - 03/10/2025)

This Plan of Correction is submitted as required under state law. The submission of this Plan of Correction does not constitute an admission of civil or criminal liability on the part of the named Community regarding the contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800. 187.a. A medication record shall be kept to include the following for each resident for whom medications are administered: 1. Resident's name. 2. Drug allergies. 3. Name of medication. 4. Strength. 5. Dosage form. 6. Dose. 7. Route of administration. 8. Frequency of administration. 9. Administration times. 10. Duration of therapy, if applicable. 11. Special precautions, if applicable. 12. Diagnosis or purpose for the medication, including

187a Medication record (continued)

pro re nata (PRN). 13. Date and time of medication administration. 14. Name and initials of the staff person administering the medication.

On December 22, 2024, the Area Director of Clinical Services conducted a Medication Administration Training for all Med Passers. Documentation of training is maintained.

The Health and Wellness Director will conduct a Med Passer Training to retrain Med Passers on the Medication Administration Documentation policy. Documentation of training will be maintained. This will be completed by 3/25/2025.

Beginning week of February 23, 2025, the Health and Wellness Director or designee will conduct audits weekly of 10% of the residents to verify that the medication administrations are properly documented in the electronic MAR. The weekly audits will continue until 12 weeks of consistent compliance. The audits will then be conducted monthly for 10 % of the residents until 3 months of consistent compliance is achieved.

If the Health and Wellness Director or designee identifies any discrepancies during audits, immediate corrective actions will be implemented, and additional training will be provided as necessary.

The Executive Director, or designee will review the plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Implemented (█ - 04/17/2025)

187d Follow prescriber's orders**28. Requirements**

2800.

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

Description of Violation

Resident #5's is prescribed Pantoprazole 40mg tablet, take by mouth twice daily. On 1/2/25, 1/3/25, 1/4/24, 1/5/25, 1/8/25 and 1/9/25 multiple staff indicated on the resident's January 2025 medication administration record that the medication was administered; however the medication was not administered because it was not available in the residence.

On the morning of 1/8/25, resident #18 was not administered the prescribed medications listed below because the medications were not available in the residence:

Acetaminophen 650mg, take 2 tablets by mouth daily for pain.

Cholestram Powder 4gm lite, give 1 scoopful with 2.6 oz of liquid and drink by mouth daily for cholesterol.

Duloxetine 60mg, take 1 capsule by mouth once daily for depression.

Furosemide 20mg, take 1 tablet by mouth every morning.

Losartan POT 50mg, take 1 tablet by mouth daily for hypertension. Repeat Violation: 04/12/2024

Plan of Correction

Accept (█ - 03/10/2025)

This Plan of Correction is submitted as required under state law. The submission of this Plan of Correction does not

187d Follow prescriber's orders (continued)

constitute an admission of civil or criminal liability on the part of the named Community regarding the contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

55 Pa. Code § 2800. 187.d. The home shall follow the directions of the prescriber.

The Health and Wellness Director had medications delivered for resident #18 from the pharmacy prior to the next dose for administration 1/9/2025. The Health and Wellness Director had medication delivered from pharmacy prior to the next dose for administration 1/10/2025.

On December 22, 2024, the Area Director of Clinical Services conducted a mandatory training session on Medication Administration procedures for all Med Passers. Documentation of training is maintained.

Beginning February 23, 2025, the Health and Wellness Director or designee will conduct audits weekly of 10% of the residents to verify that medications listed on the Medication Administration Record (MAR) are available on the carts for administration. The weekly audits will continue until 12 weeks of consistent compliance. The audits will then be conducted monthly for 10 % of the residents until 3 months of consistent compliance is achieved.

If the Health and Wellness Director or designee identifies any discrepancies during audits, immediate corrective actions will be implemented, and additional training will be provided as necessary.

The Executive Director, or designee will review plan of correction at the Quality Management Plan meetings quarterly to verify ongoing compliance. The quarterly Quality Management Plan meetings will start March 2025.

Licensee's Proposed Overall Completion Date: 03/25/2025

Not Implemented (█ - 04/17/2025)