pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **VS WALLINGFORD LLC**
LEGAL ENTITY

To operate **CHESTNUT RIDGE RETIREMENT LIVING**
NAME OF FACILITY OR AGENCY

Located at **2700 CHESTNUT PARKWAY, CHESTER, PA 19086**
(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 **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **130**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 50**

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

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **June 11, 2025** until **June 11, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **141410**

ISSUING OFFICER

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.

HS 628 – 04/23

Pennsylvania
Department of Human Services

Emailing date: June 11, 2025

[redacted]
VS Wallingford, LLC
[redacted]

RE: Chestnut Ridge Retirement Living
2700 Chestnut Parkway
Wallingford, Pennsylvania 19086
License #: 141410

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on January 22 and 23, 2025, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

June 9, 2025

[redacted]
VS WALLINGFORD LLC
[redacted]

RE: CHESTNUT RIDGE RETIREMENT LIVING
2700 CHESTNUT PARKWAY
CHESTER, PA, 19086
LICENSE/COC#: 14141

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/22/2025, 01/23/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

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

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

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

Administrator

Name: [redacted]

Legal Entity

Name: *VS WALLINGFORD LLC*

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

Phone: [redacted]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *81* **Waking Staff**: *61*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *01/23/2025*

Inspection Dates and Department Representative

01/22/2025 - On-Site: [redacted]

01/23/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *130* **Residents Served**: *55*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *4th and 5th floors* **Capacity**: *30* **Residents Served**: *23*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *55*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *26* **Have Physical Disability**: *2*

Inspections / Reviews

01/22/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *Bypass Document Submission*

Inspections / Reviews *(continued)*

06/09/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted**: *04/07/2025*

Reviewer: [redacted] **Follow-Up Type**: *Not Required*

18 - Compliance With Laws

1. Requirements

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

Description of Violation

Per the Influenza Awareness Act (NH 1785) of 2016, personal care residences must post required influenza information in a public place year-round. On 1/22/2025, the home did not display an influenza poster.

Plan of Correction ***Directed [redacted] - 03/03/2025)***

Immediately: *The home shall post required influenza information in a public place in the home. The administrator or designated staff person shall conducted weekly checks for the next 3 months to ensure the posting remains displayed. Documentation of checks shall be kept.*

Directed Completion Date: *03/05/2025*

Bypass Document Submission ***Implemented [redacted] - 05/21/2025)***

On January 23, 2025, the community promptly printed and displayed the necessary influenza signage. The Executive Director or their designee will conduct weekly inspections to ensure the posters remain in place throughout the community. These inspections will continue for three months and will be reviewed during Quality Assessment and Performance Improvement (QAPI) meetings to ensure compliance. Additionally, the Executive Director will perform random checks on the signage during walking rounds to maintain ongoing compliance.

51 - Criminal Background Check

2. Requirements

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

Description of Violation

Staff person A was hired [redacted]/2023. Staff person A's criminal background check was requested and disseminated 5/1/18.

Staff person B was hired [redacted]/24. Staff person B's criminal background check was not requested until 1/13/25.

Plan of Correction ***Directed [redacted] - 03/03/2025)***

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

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

Directed Completion Date: *03/06/2025*

Bypass Document Submission ***Implemented [redacted] - 05/21/2025)***

The Regional Business Office Manager and Executive Director conducted an audit of all employee files on January 28 and January 29, 2025. For any current employee with a missing criminal background check, a new report was generated.

51 - Criminal Background Check (continued)

On February 26, 2025, the newly appointed Employee Relations and Administration Coordinator (ERAC) received training from the Regional Director of Operations regarding Department of Human Services (DHS) requirements for hiring. On the same day, a process for conducting criminal background checks was implemented. Additionally, a checklist was introduced to ensure that all required documentation is included in employee files.

To maintain compliance, the Executive Director or their designee will audit new employee files within five days following each orientation. These audits will be reviewed monthly during Quality Assurance Performance Improvement (QAPI) meetings by the Executive Director, starting on March 17, 2025, to monitor ongoing compliance.

54a - Direct Care Staff

3. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:

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

Description of Violation

Direct care staff persons B and C do not have a high school diploma from the United States, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Directed [redacted] 03/03/2025)***

Immediately: *Staff persons B and C shall not be permitted to provide direct care services in the home until they have met the educational qualifications.*

Immediately: *The administrator or designee shall review all current direct care staff records to ensure all direct care staff persons meet the qualifications in accordance with regulation 2600.54(a) to include a Diploma issued by the Pennsylvania Department of Education or Department of Education in another state. Documentation shall be kept in the staff records. Only those staff persons who meet the direct care staff qualifications shall provide direct care services. Documentation of the review shall be kept.*

Directed Completion Date: *03/05/2025*

Bypass Document Submission ***Implemented [redacted] - 05/21/2025)***

On January 22, 2025, Staff Members B and C were removed from the nursing schedule, and they no longer work for our organization. The Regional Business Office Manager and the Executive Director conducted an audit of all employee files on January 28 and 29, 2025. Any current employee who was missing a high school diploma was removed from the nursing schedule until a copy of their diploma was received by the community.

On February 26, 2025, the newly appointed Employee Relations and Administration Coordinator (ERAC) received training from the Regional Director of Operations regarding the Department of Human Services (DHS) hiring requirements. Additionally, a checklist was introduced to ensure that all required documentation is included in employee files.

54a - Direct Care Staff (continued)

To maintain compliance, the Executive Director or their designee will audit new employee files within five days following each orientation. These audits will be reviewed monthly during Quality Assurance Performance Improvement (QAPI) meetings by the Executive Director, beginning on March 17, 2025, to monitor ongoing compliance.

62 - Contact List

4. Requirements

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

Description of Violation

Staff person B, hired [redacted]/2024, was not on the staff list.

Plan of Correction ***Directed [redacted] - 03/03/2025)***

Immediately: The administrator shall review the staff list and ensure that a list is being maintained that includes the names, addresses and telephone numbers of all staff persons including substitute personnel and volunteers.

Directed Completion Date: *03/05/2025*

Bypass Document Submission ***Implemented [redacted] - 05/21/2025)***

On January 23, 2025, the Executive Director conducted a thorough audit of ADP, our payroll system, to ensure the employee list was current. On February 26, 2025, the newly appointed Employee Relations and Administration Coordinator (ERAC) received training from the Regional Director of Operations regarding the documentation requested by the Department of Human Services (DHS) during inspections. The ERAC was instructed on how to print an up-to-date and accurate employee roster. The ERAC will generate this roster on the first of each month to verify its accuracy. The Executive Director will review this report monthly to ensure ongoing compliance.

65a - FS Orientation 1st Day

5. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, whose first day of work was [redacted]/2024, did not receive orientation on any of the required topics.

Plan of Correction ***Directed [redacted]/03/2025)***

Immediately:

65a - FS Orientation 1st Day (continued)

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

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

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

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

Directed Completion Date: *03/08/2025*

Bypass Document Submission ***Implemented [redacted] - 06/09/2025)***

On January 22, 2025, Staff Member B was removed from the nursing schedule and is no longer [redacted] by our organization. The Regional Business Office Manager and the Executive Director conducted an audit of all employee files on January 28 and 29, 2025. Any current employees missing required training were re-educated.

On February 26, 2025, the newly appointed Employee Relations and Administration Coordinator (ERAC) received training from the Regional Director of Operations regarding the Department of Human Services (DHS) orientation requirements. A new orientation program was implemented, and a checklist was created to ensure that all required DHS topics are reviewed with new employees before their first day working with residents.

On March 5, 2025, the Regional Director of Operations conducted training for the new Director of Health and Wellness and the new Director of Memory Care on the community's Orientation Program and required documentation.

To maintain compliance, the Executive Director or their designee will audit new employee files within five days following each orientation. These audits will be reviewed monthly during Quality Assurance Performance Improvement (QAPI) meetings by the Executive Director, starting on March 17, 2025, to monitor ongoing compliance.

65d - Initial Direct Care Training

6. Requirements

2600.

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

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

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 dementia, mental illness, cognitive 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 home.
   - xii. Safety management and hazard prevention.
   - xiii. Universal precautions.
   - xiv. The requirements of this chapter.
   - xv. 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 home.

Description of Violation

Direct care staff person A began providing unsupervised ADL services on 5/9/2023. The staff person did not complete and pass the Department-approved direct care training course and pass the competency.

Direct care staff person B began providing unsupervised ADL services on 11/25/2024. The staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Directed [redacted] - 03/03/2025)***

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

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

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

Directed Completion Date: *03/06/2025*

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

Bypass Document Submission ***Implemented [redacted] - 05/21/2025)***

On January 22, 2025, Staff Members B and C were removed from the nursing schedule and are no longer [redacted] by our organization. An audit of all employee files was conducted by the Regional Business Office Manager and the Executive Director on January 28 and 29, 2025. Employees lacking documentation of direct care competencies were retrained.

On February 26, 2025, the newly appointed Employee Relations and Administration Coordinator (ERAC) received training from the Regional Director of Operations regarding the Department of Human Services (DHS) orientation requirements. A new orientation program was implemented, along with a direct care competency checklist to ensure that all new employees shadow a mentor and complete the supervised tasks listed before providing unsupervised care to our residents. On March 5, 2025, the Regional Director of Operations trained the new Directors of Health and Wellness and Memory Care on the implementation of this process and checklist.

To ensure ongoing compliance, the Executive Director or their designee will audit new employee files within five days following each orientation. These audits will be reviewed monthly during Quality Assurance Performance Improvement (QAPI) meetings by the Executive Director, starting on March 17, 2025, to monitor continued compliance.

65e - 12 Hours Annual Training

7. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff persons A, D, and E received no annual training in training year 2024.

Plan of Correction ***Directed [redacted] - 03/03/2025)***

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

Directed Completion Date: *03/05/2025*

Bypass Document Submission ***Implemented [redacted] - 05/21/2025)***

The Regional Director of Operations implemented RELIAS training for all employees, effective March 1, 2025. All staff members received a letter detailing how to access and complete these online trainings.

On February 26, 2025, the newly appointed Employee Relations and Administration Coordinator (ERAC) received training from the Regional Director of Operations regarding the Department of Human Services (DHS) annual training requirements. A process was established to ensure the ERAC regularly reviews the RELIAS system to monitor employee compliance with the completion of assigned trainings.

On March 5, 2025, the newly appointed Directors of Health and Wellness and Memory Care also received education on the DHS annual training requirements.

65e - 12 Hours Annual Training (continued)

These trainings will be reviewed monthly at each Quality Assurance and Performance Improvement (QAPI) meeting by the Executive Director to ensure ongoing compliance.

65f - Training Topics

8. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff persons A, D and E did not receive training in any of the required topics during training year 2024.

Plan of Correction ***Directed [redacted] - 03/03/2025)***

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

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

Directed Completion Date: *03/05/2025*

Bypass Document Submission ***Implemented [redacted] - 05/21/2025)***

On 3/5/25, staff persons A, D and E were re-educated on the required training topics by the Director of Health and Wellness, the Director of Memory Care and the Director of Plant Operations.

The Regional Director of Operations implemented RELIAS training for all employees, effective March 1, 2025. All staff members received a letter detailing how to access and complete these online trainings.

On February 26, 2025, the newly appointed Employee Relations and Administration Coordinator (ERAC) received training from the Regional Director of Operations regarding the Department of Human Services (DHS) annual training requirements. A process was established to ensure the ERAC regularly reviews the RELIAS system to monitor employee compliance with the completion of assigned trainings.

On March 5, 2025, the newly appointed Directors of Health and Wellness and Memory Care also received

65f - Training Topics (continued)

education on the DHS annual training requirements.

These trainings will be reviewed monthly at each Quality Assurance and Performance Improvement (QAPI) meeting by the Executive Director to ensure ongoing compliance.

65g - Annual Training Content

9. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person A, D, and E did not receive training in any of the required content areas during training year 2024.

Plan of Correction ***Directed [redacted] - 03/03/2025)***

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

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

Directed Completion Date: *03/05/2025*

Bypass Document Submission ***Implemented [redacted] - 05/21/2025)***

On March 5, 2025, staff members A, D, and E received re-education on fire safety, preventing falls and accidents, and emergency preparedness from the Regional Director of Operations, who is a certified Fire Safety Expert. On the same day, the Director of Health and Wellness conducted a training session on Resident Rights and the Older Adult Protective Services Act (OAPSA).

The Regional Director of Operations implemented RELIAS training for all employees, effective March 1, 2025. All staff members received a letter detailing how to access and complete these online trainings.

On February 26, 2025, the newly appointed Employee Relations and Administration Coordinator (ERAC) received training from the Regional Director of Operations regarding the Department of Human Services (DHS) annual

65g - Annual Training Content (continued)

training requirements. A process was established to ensure the ERAC regularly reviews the RELIAS system to monitor employee compliance with the completion of assigned trainings.

On March 5, 2025, the newly appointed Directors of Health and Wellness and Memory Care also received education on the DHS annual training requirements.

These trainings will be reviewed monthly at each Quality Assurance and Performance Improvement (QAPI) meeting by the Executive Director to ensure ongoing compliance.

88a - Surfaces

10. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 1/23/2025 at 10:24 am, the wall of the dining room, under and next to the window facing the courtyard, was warped and protruding. The wall appeared to be water damaged.

Plan of Correction ***Directed [redacted] - 03/03/2025)***

Immediately: *The administrator or designee shall check all areas of the home at least weekly to ensure floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Hazardous conditions shall be corrected immediately. Documentation of checks shall be kept.*

Directed Completion Date: *03/05/2025*

Bypass Document Submission ***Implemented [redacted] - 05/21/2025)***

The Director of Plant Operations repaired the wall.

The Director of Plant Operations, or their designee, will conduct weekly environmental rounds to ensure that the building is clean and well-maintained. These audits will be reviewed by the Executive Director on a monthly basis during QAPI meetings, beginning on March 17, 2025, to monitor ongoing compliance.

141a - Medical Evaluation

11. Requirements

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

Description of Violation

Resident #1 received their medical evaluation on [redacted]/2023. The resident was not admitted until [redacted]/23, more than 60 days later.

141a - Medical Evaluation *(continued)*

Plan of Correction ***Directed [redacted] - 03/03/2025)***

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

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

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

Directed Completion Date: *03/08/2025*

Bypass Document Submission ***Implemented [redacted] 06/09/2025)***

On March 5, 2025, the Regional Director of Health and Wellness conducted an audit of resident charts to verify that all DMEs, Prescreens, and RASPs were completed within the timeframes required by DHE regulations.

On the same day, March 5, 2025, the Regional Director of Operations provided training for the newly hired Director of Health and Wellness and the Director of Memory Care. This training focused on the completion dates and documentation requirements for Prescreens, DMEs, and RASPs in accordance with DHS regulations.

Additionally, the Regional Director of Health and Wellness established a tickler system within our electronic medical records (ECP). This system ensures that daily alerts pop up for the completion of DMEs and RASPs.

The Executive Director or designated representative will perform random chart audits each month to ensure all documentation is compliant.

These audits will be reviewed monthly at each QAPI meeting starting on March 17, 2025, to monitor ongoing compliance.

181d -Storing Medication

12. Requirements

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident #2 self-administers medications and stores medications in their room. On 1/23/2025 at 9:34 am, the door to resident #2's room was unlocked while the resident was absent. The resident's medications were in an unlocked, clear container on the kitchen counter. There were nine loose pills in a pile on the resident's microwave: 7 white ovals, a round white pill, and ovular red and green pill. There was a round, white pill and two white ovals nearby on the floor.

Plan of Correction ***Directed [redacted] - 03/03/2025)***

Immediately: *The administrator or designee shall ensure that medications stored in resident #2's room are locked in a safe and secure location to protect against contamination, spillage and theft.*

181d -Storing Medication (continued)

Within 3 days of receipt of this plan of correction*: The administrator or designee shall conduct an initial and weekly review of all residents that self-administer medication and store medication in their rooms, to ensure that each resident's medications are locked in a safe and secure location to protect against contamination, spillage and theft. Documentation of the reviews shall be kept.*

Directed Completion Date: *03/06/2025*

Bypass Document Submission ***Implemented [redacted] - 06/09/2025)***

The Director of Health and Wellness promptly met with the resident to re-educate them on the importance of locking their door and securely storing all medications. The resident was provided with a lock box for their medications.

The Director of Health and Wellness, or their designee, will conduct weekly checks with all residents who self-administer their medications. These checks will ensure that all medications are properly locked away and that all medications are up-to-date.

These audits will be reviewed monthly by the Executive Director during each QAPI meeting, starting on March 17, 2025, to monitor ongoing compliance..

185a - Implement Storage Procedures

13. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #3's glucometer was not calibrated for the correct date and time. On 1/23/2025 at 11:18 am, the glucometer displayed a time of 11:18 pm.

Plan of Correction ***Directed [redacted] - 03/03/2025)***

Immediately: *The glucometer for resident #3 shall be calibrated for the correct and time.*

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

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

Directed Completion Date: *03/06/2025*

Bypass Document Submission ***Implemented [redacted] - 05/21/2025)***

The Regional Director of Health and Wellness recalibrated all glucometers. It was later discovered by the Executive Director that the glucometers in use had actually been recalled by the manufacturer. The Director of Health and Wellness reached out to the primary care providers (PCPs) and received orders to acquire new glucometers. As a

185a - Implement Storage Procedures (continued)

result, all residents who use glucometers now have a new device.

The Director of Health and Wellness, or a designated team member, will conduct ongoing weekly audits of all glucometers to ensure they are in proper working order and that all staff members are documenting usage correctly.

These audit results will be reviewed each month by the Executive Director during the Quality Assurance and Performance Improvement (QAPI) meetings, starting on March 17, 2025, to monitor ongoing compliance. are in working order and all staff are documenting correctly.

These audits will be reviewed each month by the Executive director at QAPI beginning 3/17/25 to monitor for ongoing compliance.

190a - Completion Medication Course

14. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person B, who has not successfully completed the Department-approved medications administration course, administered three medications to resident #3 at 8:00 am on 1/1/2025 and on 1/2/25: Aspirin 81mg, Finasteride 5 mg, Levothyroxine 75 mcg.

Staff person B administered medications to resident #4 on 1/1 and 1/2 at 8:00pm: Metropolol Tartrate 25 mg tab, Hydralazine 50 mg tab, Atorvastatin 40 mg tab.

Staff person B administered two medications to resident #5 on 1/4/2025: a 15-mg Mirtazapine tablet at 8:00 pm and a 3-mg Melatonin tablet at 9:00pm.

Plan of Correction ***Directed [redacted] - 03/03/2025)***

Immediately: *Staff person B shall not administer medications until the completion of a medication administration course conducted by a Department-approved medication Train – the – Trainer. Documentation of training shall be kept in the staff record.*

Immediately: *The administrator or designated staff person shall review all staff records to ensure all staff persons administering medications have completed a Department-approved medication administration training course. Documentation of the audit shall be kept.*

Directed Completion Date: *03/05/2025*

Bypass Document Submission ***Implemented [redacted] - 05/21/2025)***

Staff Person B has been promptly removed from the nursing schedule and is no longer employed with our organization. Our Regional Director of Health and Wellness, who is a certified Med Tech Trainer with the Department of Health Services (DHS), conducted a thorough audit of all medication technician paperwork. This audit ensured that all training and observation requirements were completed and up to date.

190a - Completion Medication Course (continued)

The Director of Health and Wellness will maintain a binder in her office containing all the required medication technician documentation. Additionally, the Regional Director of Health and Wellness will review this binder on a monthly basis to ensure ongoing compliance. technician documentation. The Regional Director of Health and Wellness will review this binder monthly to ensure ongoing compliance.

190b - Insulin Injections

15. Requirements

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

Description of Violation

On 1/4/2025 at 4:30pm, staff person B, who has not completed a Department-approved medications administration course, administered insulin to resident #6 through a Novolog Flexpen.

Plan of Correction ***Directed [redacted] - 03/03/2025)***

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

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

Directed Completion Date: *03/05/2025*

Bypass Document Submission ***Implemented [redacted] - 05/21/2025)***

Staff Person B has been promptly removed from the nursing schedule and is no longer employed with our organization. Our Regional Director of Health and Wellness, who is a certified Med Tech Trainer with the Department of Health Services (DHS), conducted a thorough audit of all medication technician paperwork. This audit ensured that all training and observation requirements were completed and up to date.
The Director of Health and Wellness will maintain a binder in [redacted] office containing all the required medication technician documentation. Additionally, the Regional Director of Health and Wellness will review this binder on a monthly basis to ensure ongoing compliance. technician documentation. The Regional Director of Health and Wellness will review this binder monthly to ensure ongoing compliance.

225a - Assessment 15 Days

16. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for resident #7, who was admitted to the home on [redacted]/2024.

Plan of Correction ***Directed [redacted] - 03/03/2025)***

Immediately: *An assessment shall be completed for resident #7.*

225a - Assessment 15 Days (continued)

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

Within 5 days of the receipt of the plan of correction: *The administrator shall develop and implement a policy and procedure to ensure all residents have an assessment completed within 15 days of admission. All staff persons completing assessments shall be educated on the updated policy and procedures. Documentation shall be kept.*

Directed Completion Date: *03/08/2025*

Bypass Document Submission ***Implemented [redacted] - 06/09/2025)***

The Regional Director of Health and Wellness examined the medical charts of all current residents to ensure that each resident had completed all necessary assessments.

On the same day, March 5, 2025, the Regional Director of Operations provided training for the newly hired Director of Health and Wellness and the Director of Memory Care. This training focused on the completion dates and documentation requirements for Prescreens, DMEs, and RASPs in accordance with DHS regulations.

Additionally, the Regional Director of Health and Wellness established a tickler system within our electronic medical records (ECP). This system ensures that daily alerts pop up for the completion of DMEs and RASPs.

The Executive Director or designated representative will perform random chart audits each month to ensure all documentation is compliant.

These audits will be reviewed monthly at each QAPI meeting starting on March 17, 2025, to monitor ongoing compliance.

236 - Staff Training

17. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person A, who works in the Secure Dementia Care Unit (SDCU), had no training in dementia care during the training year 2024.

Plan of Correction ***Directed [redacted] - 03/03/2025)***

Immediately: *The administrator or designated staff person shall monitor all direct care staff training through the quality management review process to ensure all staff persons working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation) during each established training year. Documentation shall be kept.*

Directed Completion Date: *03/05/2025*

236 - Staff Training *(continued)*

Bypass Document Submission ***Implemented [redacted] - 05/21/2025)***

The Regional Director of Operations implemented RELIAS training for all employees, effective March 1, 2025. All staff members received a letter detailing how to access and complete these online trainings.

On February 26, 2025, the newly appointed Employee Relations and Administration Coordinator (ERAC) received training from the Regional Director of Operations regarding the Department of Human Services (DHS) annual training requirements. A process was established to ensure the ERAC regularly reviews the RELIAS system to monitor employee compliance with the completion of assigned trainings.

On March 5, 2025, the newly appointed Directors of Health and Wellness and Memory Care also received education on the DHS annual training requirements.

These trainings will be reviewed monthly at each Quality Assurance and Performance Improvement (QAPI) meeting by the Executive Director to ensure ongoing compliance.