pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **WG CENTER CITY SH LLC**
LEGAL ENTITY

To operate **ATRIA CENTER CITY**
NAME OF FACILITY OR AGENCY

Located at **150 NORTH 20TH STREET, PHILADELPHIA, PA 19103**
(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 **165**
(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 25**

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 **October 28,** **2025** until **October 28,** **2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **136570**

ISSUING OFFICER

Juliet Marsala
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: October 28, 2025

[redacted]
WG Center City SH, LLC
Attn: Atria Mgmt Co. – Legal Department
[redacted]

RE: Atria Center City
150 North 20th Street
Philadelphia, Pennsylvania 19103
License #: 136570

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on January 30 and 31, 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 - PUBLIC

March 31, 2025

[redacted]
WG CENTER CITY SH LLC
[redacted]

RE: ATRIA CENTER CITY
150 NORTH 20TH STREET
PHILADELPHIA, PA, 19103
LICENSE/COC#: 13657

Dear [redacted] ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/30/2025, 01/31/2025 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: *ATRIA CENTER CITY* **License #**: *13657* **License Expiration**: *05/15/2025*

Address: *150 NORTH 20TH STREET, PHILADELPHIA, PA 19103*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *WG CENTER CITY SH LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/12/2024* **Issued By**: *City of Philadelphia, L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *170* **Waking Staff**: *128*

Inspection Information

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

Reason: *Renewal, Provisional, Incident, Monitoring* **Exit Conference Date**: *01/31/2025*

Inspection Dates and Department Representative

01/30/2025 - On-Site: [redacted]

01/31/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *165* **Residents Served**: *126*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Life Guidance Neighborhood* **Capacity**: *25* **Residents Served**: *19*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *122*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *44* **Have Physical Disability**: *0*

Inspections / Reviews

01/30/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/13/2025*

Inspections / Reviews *(continued)*

03/18/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/25/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/28/2025*

03/31/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/25/2025*

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

On 01/31/25, there was no Carbon Monoxide detector for the kitchen which uses gas in their equipment.
Per the Care Facility Carbon Monoxide Alarms Standards Act of Jun. 23, 2016; Carbon Monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance.

Plan of Correction ***Accept [redacted] - 03/13/2025)***

On 1/31/2025, the Maintenance Director (MD) immediately installed a carbon monoxide detector in the kitchen where gas is used when operating equipment.

On 1/31/2025, the MD conducted a walkthrough of the community to ensure all carbon monoxide detectors were installed and in working order. No additional concerns identified.

On 2/7/25 and ongoing, the MD or designee will conduct a monthly preventive maintenance inspection on each carbon monoxide detector for the kitchen and all in the community.

On 3/6/2025, the Executive Director (ED) in-serviced all department directors, maintenance, and culinary employees on the importance of carbon monoxide alarms being installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance.

On 3/20/25 the ED will hold an Employee Townhall meeting to review the Applicable Health and Safety Laws – Care Facility Carbon Monoxide Alarms Standards Act.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

25a - Written Contract and Review

2. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

- Resident #1, moved into the home on [redacted]/25 and signed the Residency Agreement on 01/13/25.

- Resident #2, moved into the home on [redacted]/24 and signed the Residency Agreement on 12/09/24.

25a - Written Contract and Review (continued)

Plan of Correction ***Accept [redacted] - 03/13/2025)***

Starting on 3/6/25 and completed on 3/12/25, the ED and Community Business Director (CBD) conducted an audit of all resident administrative files to verify the resident-home contract was signed prior to admission or within 24 hours after admission by the resident.

When there is a new resident admitted into the community, the CBD or ED will review the written resident-home contract and explain its contents to the resident and the resident's designated person if any, prior to signature. The CBD or ED will ensure signature is received prior to admission or within 24 hours after admission. CBD will secure all resident files in the CBD office. No new residents scheduled at this time.

The CBD and ED will complete a monthly audit for 90 days from the first new resident to verify that all signatures on the resident-home contract have been obtained prior to admission or within 24 hours after admission. No new residents scheduled at this time.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

25b - Contract Signatures

3. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The Residency Agreement, dated [redacted]/2023, for resident #5 was not signed by the resident.

Plan of Correction ***Accept [redacted] - 03/13/2025)***

1/31/25, Resident #5 is on a leave of absence in rehab and to date, still out of the community. Upon resident (tentative) return, we will immediately have Resident #5 sign the contract.

Starting on 3/6/25 and completed on 3/12/25, the ED and CBD conducted an audit of all resident administrative files to verify the resident contract was signed by administrator or designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

The CBD and ED will review and sign the resident-home contract with the resident and the payer (if different from the resident) and cosigned by the residents designated responsible person if any, if the resident agrees. No new move ins scheduled at this time. CBD will secure all resident files in the CBD office.

The CBD or ED will complete a monthly audit for 90 days from the first new resident and verify that all signatures on the resident-home contract have been obtained prior to admission or within 24 hours after admission.

25b - Contract Signatures (continued)

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

42b - Abuse

4. Requirements

2600.
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 [redacted]/09/2024, at 6:30am, resident #2 was missing and was observed on the home's video recording system exiting the home through the Race Street Exit with [redacted]r rollator at 6:41am. Resident #2. requires 24-hour supervision and resides in the home's secured dementia care unit, located on the 2nd floor of the home. The resident was able to navigate two steep stairwells with a rollator, walk through the personal care neighborhood and exit through the 1st floor exit door at 6:41am, without detention or alarms alerting staff. The homes secure dementia unit alarm system was not functioning from 11/30/2024 at 11:39pm through 1/2/2025 at 7:38am, allowing the resident to elope without the needed supervision.

Plan of Correction ***Accept [redacted] - 03/13/2025)***

On 12/9/24 at 6:28am, the receptionist was notified by our Lifeline notification system stationed at the front desk that the Life Guidance front entrance door alarmed. Resident #2 was seen exiting the community through the Race Street Exit door at 6:41am. Our Wellness Nurse immediately followed behind resident #2 after exiting the Race Street exit door. The Wellness Nurse immediately assessed Resident #2 who was safe with no physical acute complaints, had no changes in skin condition, and presented at [redacted]r baseline with no additional concerns. Respectfully, the Executive Director (ED) is asking the department to change the narrative to reflect that our Lifeline alarm system was in working order as that is how the community was notified of this elopement.

On 12/9/24, the ED and Regional Director of Life Guidance (RDLG) conducted an in-service with all memory care employees on elopement protocols and recognizing elopement behaviors.

On 12/13/24, the ED sent an email to all responsible parties notifying them the importance of signing in and out of the community and visiting protocols in our memory care neighborhood.

On 12/19/24 and ongoing, the RSD and ED will hold an elopement drill for all employees on a monthly basis.

On 12/19/24, the ED held an employee town hall on elopement protocols, recognizing elopement behaviors and violation 2600.42b.

On 12/20/24, the Life Guidance Director (LGD) conducted an in-service with the leadership team on elopement protocols and recognizing elopement behaviors.

42b - Abuse (continued)

On 3/20/25, the ED will hold a team member townhall to discuss elopement protocols and recognizing elopement behaviors.
On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

42s - Privacy

5. Requirements

2600.
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 01/30/25 at approximately 9:00 AM, video recording devices were identified in the home's elevator vestibule of the parking garage. The home does not have a sign posted in this area indicating images are being recorded.

Plan of Correction ***Accept [redacted] - 03/13/2025)***

On 1/30/25, the MD immediately ordered signage to put in the community elevator vestibule of the parking garage that this area is being recorded.

On 1/31/25, the ED conducted a building walk through to ensure all areas with video recording devices had signage stating that the area was being recorded. No additional concerns identified.

On 2/3/25, signage was put in the community elevator vestibule of the parking garage that this area is being recorded.

On 3/20/25 the ED will hold an Employee Townhall meeting to review the importance of signage where recording devices are identified along with the resident right to privacy.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

44g - Telephone Number

6. Requirements

2600.

44g - Telephone Number *(continued)*

44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

On 01/31/25, the telephone number for the local ombudsman posted in the first floor lobby was incorrect. The posted number was for the Montgomery County Ombudsman instead of the telephone number for The Center for Advocacy for the Rights and Interests of the Elders (CARIE) which represents as the ombudsman's office for this area of Philadelphia.

Plan of Correction ***Accept [redacted] - 03/13/2025)***

On 1/31/25, the ED immediately removed the incorrect signage with the incorrect telephone number for the local Ombudsman and replaced the signage with the correct telephone number for The Center for Advocacy for the Rights and Interests of the Elders (CARIE) which represents as the ombudsman's office for this area of Philadelphia. No additional concerns identified.

On 1/31/25, the ED conducted a building walk through to ensure that all signage mentioning Ombudsman services with phone numbers are current and up to date with The Center for Advocacy for the Rights and Interests of the Elders (CARIE) which represents as the ombudsman's office for this area of Philadelphia. No additional concerns identified.

On 3/20/25 the ED will hold an Employee Townhall meeting to review the locations of the Ombudsman's telephone numbers, the contact information for The Center for Advocacy for the Rights and Interests of the Elders (CARIE) which represents as the Ombudsman's office for this area of Philadelphia and the importance of this information being up to date and current.

On 3/27/25, the ED or designee will advise residents during monthly resident council the contact information for The Center for Advocacy for the Rights and Interests of the Elders (CARIE) which represents as the ombudsman's office for this area of Philadelphia.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

51 - Criminal Background Check

7. 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

The home currently has four residents on hospice. The home does not have criminal background checks for any of the hospice workers providing services to the residents in the home.

51 - Criminal Background Check *(continued)*

Plan of Correction ***Accept [redacted] - 03/13/2025)***

Between 1/30/25 and 1/31/25, ED and Resident Services Director (RSD) immediately created and completed an outside provider binder with our hospice providers which included hospice workers criminal background checks. This binder was presented during survey exit to surveyors.

When there is a new hospice provider or an outside agency providing services to the residents in the community, the ED and RSD will obtain criminal background checks prior to the outside agency providing services. No new outside providers scheduled to service our residents at this time.

2/28/25, the ED will complete a monthly audit of the outside agency binder and will verify all criminal history checks are complete and update to date for all of 2025.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

65g - Annual Training Content

8. Requirements

2600.

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

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

Description of Violation

Staff persons A, B and C did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.

Plan of Correction ***Accept [redacted] - 03/13/2025)***

On 1/31/25, the MD contacted our fire safety expert: Fire & Life Safety Solutions to schedule fire safety training for all employees including Staff Persons A, B & C.

On 2/5/25, Fire & Life Safety Solutions completed our fire safety training for the community.

The ED will ensure fire safety training is conducted by a fire safety expert and completed annually for all employees. ED reached out to Fire Safety expert to schedule another training to capture new employees and employees who were unable to attend 2/5, date pending.

65g - Annual Training Content (continued)

On 3/20/25 the ED will hold an Employee Townhall meeting to review the importance of fire safety training by a fire safety expert.
On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

101j5 - Bedside Table/Shelf

10. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

Description of Violation

- There is no bedside table or shelf beside resident #4's bed in bedroom #506.

- There is no bedside table or shelf beside resident #6's bed in bedroom #406.

Plan of Correction ***Directed [redacted] - 03/18/2025)***

On 3/10/25, the ED offered to put a bedside table/shelf in resident #4 and resident #6 bedroom beside the resident beds – both residents refused, and consent was signed advising residents of this requirement.

On 3/7/25, the ED, MD and LGD completed an audit of all resident apartments to ensure there is a bedside table/shelf in the bedroom near resident's bed.

On 3/14/25, the ED or designee will conduct random weekly checks of resident rooms including new move ins to verify there is a bedside table/shelf in the bedroom near resident's bed for 90 days.

When a new resident moves in the ED or designee will confirm that there is a bedside table/shelf in the bedroom near resident's bed. No new move ins scheduled at this time.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Directed Plan of Correction [redacted] 3/18/25):
**The ED will meet with the residents to discuss the requirement of the regulations and offer a shelf next to the resident's bed and the maintenance staff will install a shelf by 3/31/25.*
**The maintenance staff will check all resident rooms monthly to ensure either a bedside table or shelf are available next to each resident bed, starting 4/1/25.*

101j5 - Bedside Table/Shelf (continued)

Proposed Overall Completion Date: 03/31/2025

Directed Completion Date: *03/31/2025*

Implemented (- 03/31/2025)

101j7 - Lighting/Operable Lamp

11. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

- Resident #4 does not have access to a source of light that can be turned on/off at bedside.

- Resident #6 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept - 03/13/2025)***

On 2/3/25, the MD installed push lights that can be turned off/on at bedside for Resident #4 and Resident #6.

On 3/7/25, the ED and MD completed an audit of all resident apartments to ensure there is an operable lamp or other source of lighting that can be turned off/on at bedside.

On 3/14/25, the ED or designee will conduct random weekly checks of resident rooms including new move ins to verify there is an operable lamp or other source of lighting that can be turned off/on at bedside for 90 days. When a new resident moves in the ED or designee will confirm that there is an operable lamp or other source of lighting that can be turned off/on at bedside. No new move ins scheduled at this time.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented - 03/31/2025)

103f - Refrigerator/Freezer Temps

12. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 01/31/25 at 3:40 PM the temperature in the kitchen refrigerator was 42 degrees Fahrenheit and at 3:45 PM it was 45 degrees Fahrenheit.

103f - Refrigerator/Freezer Temps *(continued)*

Plan of Correction ***Accept [redacted] - 03/13/2025)***

On 1/31/25, the Assistant Director Culinary Services (ADCS) immediately contacted our third-party vendor to service the kitchen thermometer/thermostat in the refrigerator which read over 40 degrees Fahrenheit.

On 1/31/25, the ADCS relocated all perishable foods from the refrigerator to walk in refrigerator.

On 2/1/25 and ongoing, the ADCS or designee will conduct daily temperature checks to ensure the kitchen refrigerators are below 40 degrees Fahrenheit.

On 2/3/25, the third-party refrigeration vendor came on site to service the thermometer/thermostat and concluded both needed to be replaced.

On 2/7/25, the thermometer and thermostat were replaced with no additional concerns and the temperature remains under 40 degrees.

On 3/20/25 the ED will hold an Employee Townhall meeting to review the importance of food that requires refrigeration should be stored at or below 40 degrees Fahrenheit.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

162c - Menus Posted

13. Requirements

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

Description of Violation

On 01/30/25, only the menu for the current day was posted in the first floor dining room.

Plan of Correction ***Accept [redacted] - 03/13/2025)***

On 1/30/25, the ED ordered appropriate frames to hang the weekly menus in a conspicuous and public place near the entrance of the dining room.

On 2/3/25, the ED posted the weekly menu near the entrance of the dining room.

On 3/7/25, the ED in-serviced the Director of Culinary Services and ADCS on the importance of the weekly menus being in a public space and menus to be posted 1 week in advance.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it

162c - Menus Posted (continued)

will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

183e - Storing Medications

14. Requirements

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

Description of Violation

Resident #7 is prescribed Oxycodone Cap 5 MG - Take 1 tablet by mouth every 3 hours as needed for pain/dyspnea. On 01/31/25, during a medication cart audit, a tear in slots #7 and #28 on the blister pack for this medication was noted. The medication was present but due to the tears, the medication is no longer sanitary and should be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations.

Repeat Violation: 08/05/24.

Plan of Correction ***Accept [redacted] - 03/13/2025)***

On 1/31/25, the Resident Services Director (RSD) immediately destroyed slots #7 and #28 on the blister pack for Resident #7 according to Atria policy, the Department of environmental protection and federal and state regulations.

On 1/31/25, the RSD and Resident Service Supervisor (RSS) completed an audit on all resident blister packs to ensure there were no tears or separations in the cards. No additional concerns identified.

On 2/1/25, the RSD completed an in-service to all Resident Medication Assistants and Wellness Nurses on MED-0003-07 Medication Controls- Access, Storage, and Labeling and the importance of inspecting the packaging for any tears or separations in the blister pack cards.

On 2/3/25 and will continue weekly for 90 days, the RSD and RSS will audit all medication carts to ensure there are no tears or separations in blister packs. Any issues found will be addressed immediately with the pharmacy to obtain new medication in correct packaging. Damaged packages will be destroyed immediately per regulations and Atria guidelines.

On 3/12/25, the RSD reached out to our Pharmacy Provider, Medication Management Partners (MMP), to conduct an in-service for all Resident Medication Assistants and Wellness Nurses. Pending response from MMP on in-service date.

The Regional Care Director will provide training to the Executive Director and Resident Services Director on work instruction MED-0003-07 Medication Controls- Access, Storage, and Labeling by 3/17/2025. Regional Care Director will train to the importance of inspecting the packaging for any tears or separations in the blister pack cards.

On 3/19/25, the RSD and RSS scheduled an in-service for all Resident Medication Assistants and Wellness Nurses on MED-0003-07 Medication Controls- Access, Storage, and Labeling the importance of inspecting the packaging for

183e - Storing Medications (continued)

any tears or separations in the blister pack cards.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

185a - Implement Storage Procedures

15. 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 #7 is prescribed Motrin 800 MG Tablet as needed. On 01/31/25 this medication was not available in the home.

Repeat Violation: 08/05/24.

Plan of Correction ***Accept [redacted] - 03/13/2025)***

On 1/31/25, Resident #7 was prescribed Motrin 800 MG Tablet as needed and this medication was not available as Resident #7 had a duplicate order of generic Ibuprofen. Duplicate order of Motrin was discontinued on 2/17/25.

On 2/1/25, RSD and RSS completed an audit of all prescribed orders to ensure medication is available in medication carts. No additional concerns identified.

On 2/1/25, the RSD and RSS completed an in-service to all Resident Medication Assistants and Wellness Nurses on the med cart audit process, triple check process aka order verification, and ordering and receiving medication policy MED-0003-03.

On 2/3/25 and will continue weekly for 90 days, the RSD and RSS will review triple checks aka order verification and conduct medication cart audits to ensure all prescribed medications are available as ordered.

On 3/12/25, the RSD reached out to our Pharmacy Provider, Medication Management Partners (MMP), to conduct an in-service for all Resident Medication Assistants and Wellness Nurses. Pending response from MMP on in-service date.

The Regional Care Director will provide training to the Executive Director and Resident Services Director/designee on the med cart audit process, triple check process aka order verification, and ordering and receiving medication policy MED-0003-03 by 3/17/2025 to ensure understanding of policies and processes related to ordering and receiving medications.

On 3/19/25, the RSD and RSS scheduled an in-service to all Resident Medication Assistants and Wellness Nurses on the med cart audit process, triple check process aka order verification, and ordering and receiving medication

185a - Implement Storage Procedures (continued)

policy MED-0003-03 to ensure understanding of policies and processes related to ordering and receiving medications.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

187d - Follow Prescriber's Orders

16. Requirements

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

Description of Violation

Resident #6 is prescribed Nuplazid Tab 10 MG - Take 1 tablet by mouth once daily for neurocognitive disorder with [redacted] bodies. This prescription has a start date of 01/28/25; however, this prescription has not been filled because a prior authorization is required. This has resulted in missed administrations on 01/28/25, 01/29/25 and 01/30/25.

Repeat Violation: 06/17/24.

Plan of Correction ***Accept [redacted] - 03/13/2025)***

On 1/31/25, Resident #6 received a hold order for Nuplazid Tab 10 MG due to resident needing prior authorization.

On 2/1/25, RSD and RSS completed an audit of to ensure that all medications are available on the medication carts and ensure that all prescriber's orders are being followed properly.

On 2/1/25, the RSD and RSS completed an in-service to all Resident Medication Assistants and Wellness Nurses on the importance of all medication administration is completed accurately per the directions of the prescriber.

On 2/3/25 and weekly for 90 days, the RSD and RSS will monitor the Electronic Medication Administration Record to ensure all medication administration is completed accurately per the directions of the prescriber.

The Regional Care Director will provide training to the Executive Director and Resident Service Director/Designee on work instruction MED-0002-01 regarding medication administration by 3/17/2025.

On 3/12/25, the RSD reached out to our Pharmacy Provider, Medication Management Partners (MMP), to conduct an in-service for all Resident Medication Assistants and Wellness Nurses. Pending response from MMP on in-service date.

On 3/19/25, the RSD and RSS scheduled an in-service to all Resident Medication Assistants and Wellness Nurses to ensure all medication administration is completed accurately per the directions of the prescriber.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the

187d - Follow Prescriber's Orders (continued)

ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

225a - Assessment 15 Days

18. 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

Resident #5, with a listed "Move-In" date of [redacted]/23 on the Daily Census sheet, a physical move in date of [redacted]/23; did not have an initial assessment completed until [redacted]/25/23, marked as 30-day assessment.

Plan of Correction ***Accept [redacted] - 03/13/2025)***

Resident #5 is on a [redacted] and will not be returning to the community.

Resident Service Director will complete audit of all move-in assessment/service plan for current residents by 3/31/2025. All assessments not completed within the regulatory guideline's timeframe will be documented by utilizing a POC tie back tool to document what was found but could not be corrected and attach it in the resident record.

Regional Care Director will provide education to the Executive Director and Resident Service Director/ designee by 3/17/2025 on the importance of ensuring resident assessments are completed and signed within 15 days of the admission accordance with regulation 2600 225a.

Executive Director will meet with Resident Services Director/ designee weekly starting 3/17/2025 for the next 90 days to review all new resident assessments to ensure they are completed and signed per regulation 2600 225a.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

227d - Support Plan Medical/Dental

19. Requirements

2600.

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

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

Description of Violation

- The assessment for resident #1, dated [redacted]1/25, and signed on [redacted]/13/25 does not address behaviors or aggression. Resident #1 had an episode of aggression towards a staff member on 01/12/25 as noted on a "Notification of Incident or Change of Condition" form sent to resident #1's primary physician on 01/12/25.

- The assessment for resident #4, dated [redacted]/24, indicates resident #4 "does not require" Assistive/Adaptive Devices or assistance with transfers. However, resident #4 has a bedside mobility device attached to their bed. This requires that the resident's support plan include the following:

- *The specific need for the device,*
- *The intended use,*
- *Any risks associated with the device,*
- *The resident's ability to use the device safely for the intended purpose,*
- *Identification of the specific device to be used,*
- *If a cover is required to meet FDA guidelines.*

- The assessment for resident #8, dated [redacted]/24, has not been updated to include the resident's need for hospice care as identified on a "Physician Order Form" dated [redacted]24.

Plan of Correction ***Accept ([redacted] - 03/13/2025)***

On [redacted]/25, the assessment for Resident #4 was completed and signed on [redacted]/25 to ensure the correct needs are captured on resident support plan including bed rails, hospice care, and behavior management interventions.

On [redacted]25, the assessment for Resident #8 was completed and signed on 2/3/25 to ensure the correct needs are captured on resident support plan including bed rails, hospice care, and behavior management interventions.

On [redacted]/25, the assessment for Resident #1 was completed and signed on 2/15/25 to ensure the correct needs are captured on resident support plan including bed rails, hospice care, and behavior management interventions.

Regional Care Director will provide additional training to the Executive Director and Resident Services Director/designee by 3/17/2025 to ensure all service plans/support plans are capturing the correct needs for residents.

Resident Service Director/designee will complete an audit of the current residents' service plans/support plans by 3/31/2025, to ensure the correct needs including bed rails, hospice care, and behavior management interventions are captured on resident support plan. Any issues found during the audit will be addressed immediately.

Executive Director will meet with Resident Services Director/designee weekly for the next 90 days to review all new support plans to ensure the correct needs are captured on resident support plan including bed rails, hospice care, and behavior management interventions.

On [redacted]/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it

227d - Support Plan Medical/Dental (continued)

will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

227g -Support Plan Signatures

20. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

- Resident #1 participated in the development of [redacted] support plan on [redacted]/25. However, the resident did not sign the support plan.

- Resident #8 participated in the development of [redacted] support plan on [redacted]/24. However, the resident did not sign the support plan.

Repeat Violation: 06/17/24.

Plan of Correction ***Accept [redacted] - 03/13/2025)***

On [redacted]25, the assessment for Resident #8 was completed and signed on 2/3/25.

On [redacted]/25, the assessment for Resident #1 was completed and signed on 2/15/25.

Regional Care Director will provide additional training to the Executive Director/Resident Services Director to ensure all service plans are sign appropriately in accordance with regulation 2600 227g. Regional Care Director will provide additional training to Executive Director and Resident Service Director on Assessment process to ensure understanding of requirements for obtaining signatures for assessments/service plans by 3/17/2025.

The Resident Service Director and/or designee will complete an audit of current resident service plans/support plan by 3/31/2025, to ensure compliance with regulation 2600 227g. Any issues found during the audit will be addressed immediately using POC tie back tool.

Executive Director will meet with Resident Services Director weekly starting 3/17/2025 for the next 90 days to review all new support plans to ensure compliance with regulation 2600 227g.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

231c - Preadmission Screening

21. Requirements

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

Description of Violation

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/24. However, the resident's cognitive screening was incomplete by omitting whether or not the resident requires secured care due to Alzheimer's disease or other dementia.

Repeat Violation: 08/05/24.

Plan of Correction ***Accept [redacted] - 03/13/2025)***

Regional Care Director will provide education to the Executive Director/designee and Resident Services Director/designee to ensure compliance with regulation 2600 231.c to make sure Preadmission Screening is completed within the required timeframe according to regulation and Atria expectations. Regional Care Director will provide additional training to Executive Director/designee and Resident Service Director/designee on move in process to ensure understanding of requirements for obtaining Preadmission Screening 72 hours prior to move in for all residents requiring secured dementia care unit by 3/17/25.

Executive Director/designee will be meeting with the Resident Services Director weekly starting 03/17/2025 to review preadmission screening for all new admissions for next 90 days to ensure compliance with regulation 2600 231.c.

The Resident Service Director and/or designee will complete an audit of current resident Preadmission Screening forms by 3/31/25 to ensure forms are filled out 72 hours prior to move in for all residents requiring secured dementia care unit. Any issues found during the audit will be addressed immediately using POC tie back tool.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)

231e - No Objection Statement

22. Requirements

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

Description of Violation

Resident #9 has a listed "Move-In" date to the Life Guidance Neighborhood/Secure Dementia Care Unit on [redacted]/24 but physically moved in on [redacted]/12/24. The "Life Guidance Neighborhood Consent Form" was not signed by the resident's designated person until [redacted]3/24 and the resident did not sign the form until 01/02/25.

Plan of Correction ***Accept [redacted] - 03/13/2025)***

Starting on 3/6/25 and completed on 3/12/25, the ED and CBD conducted an audit of all memory care residents have signed documentation ('Life Guidance Neighborhood Consent Form') stating residents who have been

231e - No Objection Statement (continued)

transferred or admitted into memory have had no objections prior to admission or on admission. No additional concerns identified.

For 90 days from when there is a new or internal transfer to our Life Guidance Neighborhood, the CBD and Life Guidance Director (LGD) will ensure there is documentation verifying no objections. No move ins or transfers scheduled at this time.

On 3/31/25 and ongoing, This Plan of Correction will be discussed and evaluated quarterly for two quarters by the ED and Leadership Team at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented [redacted] - 03/31/2025)