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

April 14, 2025

[redacted]
CA SENIOR VALLEY FORGE OPERATOR LLC
[redacted]

RE: ANTHOLOGY OF KING OF PRUSSIA
350 GUTHRIE ROAD
KING OF PRUSSIA, PA, 19406
LICENSE/COC#: 14788

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/30/2025 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: *ANTHOLOGY OF KING OF PRUSSIA* **License #**: *14788* **License Expiration**: *01/16/2025*

Address: *350 GUTHRIE ROAD, KING OF PRUSSIA, PA 19406*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *CA SENIOR VALLEY FORGE OPERATOR LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1*	**Date**: *12/08/2020*	**Issued By**: *Upper Merion Township*
Type: *I-2*	**Date**: *12/08/2020*	**Issued By**: *Upper Merion Township*
Type: *Other*	**Date**: *12/08/2020*	**Issued By**: *Upper Merion Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *123* **Waking Staff**: *92*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *01/30/2025*

Inspection Dates and Department Representative

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

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *128* **Residents Served**: *99*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Virtue* **Capacity**: *28* **Residents Served**: *24*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *99*

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

Have Mobility Need: *24* **Have Physical Disability**: *0*

Inspections / Reviews

01/30/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/23/2025*

Inspections / Reviews *(continued)*

03/04/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/24/2025*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *03/09/2025*

03/12/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/24/2025*

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

04/14/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/24/2025*

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

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On [redacted], at 11:41 AM, an agent of the Department, requested access to staff training information and discharged resident refund information. Staff person A, the administrator, could not provide access to this information.

Plan of Correction ***Accept ([redacted] 03/12/2025)***

The primary benefit of 5a: Allows the Department to measure compliance with all regulations.

Resident refund information *was not available under the previous ownership and therefore the Residence Director was unable to produce refund information. As of 02.06.2025 the new management in place does have systems to secure refund records on demand through our computer programs and/or Home Office and no further instances of this nature will occur.*

To prevent future occurrence the Residence Director and/or Business Office Manager will secure a copy of the refund record as issued by Home Office and retain this information as part of the resident record.

Beginning 02.20.2025 the Residence Director and/or Business Office Manager will review monthly discharged resident records to ensure they include refund information on file. In addition, effective 02.20.2025 the refund review will be included as part of the monthly Quality Management Plan meeting.

Staff Training Information*: The violation was incurred due to the Residence Directors failure to maintain printed updated training records to be readily available.*

The training records are presently on-site for the Administrator and/ or designee for immediate access.

On 3/5/25 the Director of Compliance educated the Administrator and the Business Office Manager on regulation 2600.5a1.

Beginning 3/15/25, the Business Office Manager will monitor Relias completion on a monthly basis. Training binder will be updated by the Business Office Manager as needed to include non-Relias trainings.

To prevent future occurrence, a training binder was put into place on 2/10/2025 by the Operations Specialist & Residence Director. The training binder contains each associates individual training records readily accessible upon request 24/7.

Licensee's Proposed Overall Completion Date: *03/15/2025*

Implemented [redacted] - 04/14/2025)

16c - Written Incident Report

2. Requirements

16c - Written Incident Report *(continued)*

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

The following medication errors were not reported to the Department.

Resident [redacted] is prescribed [redacted] - one tablet orally at bedtime. On [redacted] Resident [redacted] did not receive this medication as prescribed.

Resident [redacted] is prescribed [redacted] - one tablet orally in the evening- scheduled for 7pm. Resident [redacted] did not receive this medication on [redacted] at 7 PM.

Resident [redacted] is prescribed [redacted] - one tablet orally daily, scheduled for 8am. On [redacted] at 8 AM Resident [redacted] did not receive this medication.

On [redacted] Resident [redacted] did not received any of their prescribed medications throughout the day and there was no indication on why medications were not received.

Plan of Correction ***Accept [redacted] - 03/04/2025)***

Primary Benefit: Reporting incidents allows the Department to respond promptly to serious situations, and offers homes the opportunity to provide information that may reduce the need for the Department to pursue additional information

Resident [redacted]; The violation occurred because the Medication administration record did not reflect that the medications were administered due to an ongoing WIFI issue at the home causing intermittent disruption for connectivity. The e-mar system remained active however the signature of record for administration would not register on the e-mar.

Resolution: The home is under new acquisition management and the New IT department identified on 02.06.2025 two inoperable network switches on floors 4 and 5 and replaced both switches on 02.07.2025 and have resolved the connectivity issue.

Beginning 01.31.2025, the Residence Director/designee shall file reportable incidents timely to the Bureau of Human Services Licensing as applicable. In addition the Healthcare Director/Assistant Healthcare Director/Memory Care Director will complete a daily review of the ECP Medication Administration records to identify any recording exceptions as well as to note any clerical changes accordingly. In the event there are any true medication administration errors the Residence Director and/or Healthcare Director will file any necessary medication errors

16c - Written Incident Report (continued)

timely to BHSL. The MAR review will be reported by the Healthcare Director to the Residence Directo and included on the monthly Quality Management Plan report x two quarters.

The Residence Director/Designee shall re-educate current associates on incident reporting by 02.28.2025. Documentation shall be kept.

Beginning 02.28.2025 adherence to 2600.16c, Written Incident Report, will be monitored during our regularly scheduled monthly Quality Assurance meetings for two quarters. Documentation of these meetings will be maintained for reference.

Resident [redacted] was out of facility as of 01.20.2025 per Memory Care Director and all medications were discontinued and therefore not administered.

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

Implemented ([redacted] - 04/14/2025)

18 - Compliance With Laws

3. 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 [redacted] an inspection for food establishments was conducted by Montgomery County Office of Public Health and the following violations were cited:
2-102.12(A): No Certified Food Protection Manager on-site
6-301.12: No Hand Drying Provision for Hand sink
3-305.11: Containers of food stored on floor in walk in freezer
4-502.12: Single service containers stored with food contact surface exposed
4-502.12: Single service containers stored on floor
4-302.13: Temperature gauge on dish machine on 4th floor not working properly.

On [redacted] the home received a hand delivered Notice of Violation from the Upper Merion Township Fire and Emergency Medical Services Department for an inoperable "Jockey Pump" for the Fire Suppression Sprinkler System. Violation of the 2018 International Fire Code Section 901.6 which states "Fire detection, alarm, and extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective"

An invoice dated [redacted] indicated that a faulty jockey pump controller was found during a service call. An annual fire protection system report dated [redacted] indicated the homes jockey pump was still out of service.

Plan of Correction ***Accept ([redacted] - 03/04/2025)***

The Primary Benefit: Ensures compliance with other applicable health, safety, and wellness requirements not incorporated by Chapter 2600.

18 - Compliance With Laws (continued)

With Respect to the specific deficiencies cited: Relative to the citations of the Montgomery County Office of Public Health The former owners, Residence Director and Chef failed to responsibly follow applicable regulations.

202.12A *In response to "no certified Food Protection Manager on-site": To immediately address the need for Servsafe credentials, the Chef is scheduled 02.27.2025 for Serv Safe Certification- the cook staff are scheduled 02.26.2025 for Serv Safe course certification. A copy of the certification will be displayed in the primary kitchen and in the staff credentials record of training.*

The new management company currently maintains a credentials tracker system to identify the date of Serv Safe Certification. The purpose of the credential's tracker allows monitoring so that on-going training is maintained up to date.

Beginning 02/20/2025 the Residence Director/Chef will ensure certifications are maintained timely which will prevent further violations and will be noted on the Quality Managment Plan through the second quarter of 2025.

301.12 *in response to "no hand drying provision for hand sink". There is a paper towel dispenser located at the sink for hand drying provisions however the Chef failed to supply the dispenser with consistency. To prevent further occurrence on 1.31.2025 the Chef assumed full responsibility to maintain c-fold paper towels in his kitchen stock/supply and has assumed responsibility to himself and/or his kitchen staff to verify the dispenser remains fully stocked daily.*

305.11 *in response to "containers of food stored on the floor in the walk-in freezer": The reason for the violation is the Chef/Cooks failed to follow regulatory requirements and did not maintain proper storage procedures. On 01.31.2025 the Chef & Cook staff did re-arrange the food storage and all items are stored appropriately and in full compliance.*

To prevent future violations, on 02.26.2025 the Operations Specialist did conduct an educational review of the LIS and regulatory requirements and also the Chef was provided with a copy of chapter 2600 regulations and the requirements for this chapter as well as all other applicable health and safety regulations.

Beginning 02/21/2025 the Chef will inspect weekly that the kitchen/storage areas/paper goods/ kitchen equipment and chemical supply are maintained in accordance with all applicable regulations and will be noted on the Quality Managment Plan through the second quarter of 2025.

502.12 *in response to "Single service containers stored with food contact surface exposed": The reason for the violation is the Chef/Cooks failed to follow regulatory requirements and did not maintain proper storage procedures. On 01.31.2025 the Chef & Cook staff did re-arrange the food storage and all items are stored appropriately and in full compliance.*

To prevent future violations on 02.26.2025 the Operations Specialist did conduct an educational review of the LIS and regulatory requirements and also the Chef was provided with a copy of chapter 2600 regulations and the requirements for this chapter as well as all other applicable health and safety regulations.

Beginning 02/21/2025 the Chef will inspect weekly that the kitchen/storage areas/paper goods/ kitchen equipment

18 - Compliance With Laws (continued)

and chemical supply are maintained in accordance with all applicable regulations and will be noted on the Quality Managment Plan through the second quarter of 2025.

***502.12** in response to "single service containers stored on floor": The reason for the violation is the Chef/Cooks failed to follow regulatory requirements and did not maintain proper storage procedures.*

On 01.31.2025 the Chef & Cook staff did re-arrange the food storage and all items are stored appropriately and in full compliance.

To prevent future violations on 02.26.2025 the Operations Specialist did conduct an educational review of the LIS and regulatory requirements and also the Chef was provided with a copy of chapter 2600 regulations and the requirements for this chapter as well as all other applicable health and safety regulations.

Beginning 02/21/2025 the Chef will inspect weekly that the kitchen/storage areas/paper goods/ kitchen equipment and chemical supply are maintained in accordance with all applicable regulations and will be noted on the Quality Managment Plan through the second quarter of 2025.

***502.13** in response to 'temperature gauge on dish machine on 4th floor not working properly": The reason for the violation is the Chef/Cooks failed to follow regulatory requirements and did not maintain proper equipment maintenance procedures.*

On 01.31.2025 the Chef and Maintenance Director did complete an assessment of the gauge and ensured it is fully functioning and in full compliance.

To prevent future violations on 02.26.2025 the Operations Specialist did conduct an educational review of the LIS and regulatory requirements and also the Chef and Maintenance Director were provided with a copy of chapter 2600 regulations and the requirements for this chapter as well as all other applicable health and safety regulations and the importance of equipment monitoring/maintenance.

Beginning 02/21/2025 the Chef will inspect weekly that the kitchen/storage areas/paper goods/ kitchen equipment and chemical supply are maintained in accordance with all applicable regulations and will be noted on the Quality Managment Plan through the second quarter of 2025.

***Violation Fire code 901.6:** An invoice dated 4.17.2024 indicated that a faulty Jocky pump controller was found during a service call and again on 5.20.24 and it remained out of service. The cause of the violation was that although the Maintenance Director submitted several requests, the former owners failed to authorize the repair the home failed to implement the recommendations of the annual fire protection report in a timely manner.*

On 01.21.2025 The Fire Department was notified, and an incident was filed regarding a second-floor sprinkler head break. The EMS/Fire Dept service call prompted a visit from the Upper Merion Township Fire and EMS Department, it was discovered the homes jockey pump was still out of service. On 1/23/2025 the home received a hand delivered "notice of violation" accordingly.

With Respect to Systemic Measures that have been put into place to address the stated concern: On 1/21/2025 The Maintenance Director and Residence Director were verbally educated by the Deputy Fire Marshall on the

18 - Compliance With Laws (continued)

importance of maintaining a functional "Jockey pump".

The new acquisition management company authorized full repair and on 01.25.2025 the Upper Marion Township Fire Marshall issued a letter of full compliance regarding the Jockey Pump which is evidenced by the uploaded attachment.

The Residence Director and Maintenance Director are enrolled in an educational course "The Basics of the Life Safety Code" to be completed 02.28.2025, the certificates of completion will be retained on each of the associate's education file.

With Respect to How the Plan of Corrective Measures will be Monitored:
Effective 1/25/2025 The Maintenance Director will monitor inspection reports received by governing agencies to be sure the home is compliant with all applicable Federal, State, and local laws, ordinances and regulations to ensure recommendations are implemented timely.

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

Implemented [redacted] - 04/14/2025)

25b - Contract Signatures

4. 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 resident-home contract, dated [redacted], for Resident [redacted] was not signed by the resident.

Plan of Correction ***Accept [redacted] - 03/04/2025)***

Primary Benefit: Signing the contract constitutes a pledge by both parties to abide by the specified terms.

With Respect to the specific deficiency cited: The violation occurred because the Residence Director and/or designee did not ensure the presence of the resident at the time of the contract signing nor was there a review within 24 hours of admission to be sure the residency agreement contained all required signatures.

With Respect to Systemic Measures that have been put into place to address the stated concern: The resident agreement signatures were completed on 01.25.2025 per the uploaded document in Sanswrite as verification.

With Respect to How the Plan of Corrective Measures will be Monitored:
Commencing on 02.07.2025, on day of move in, The Residence Director, Business Office Manager and/or designee will review that all of the move in paperwork contains the resident's signature. The former owners did not maintain compliance and the new management does have the Business File Checklist in place as an ongoing tool for each move in. In addition to the date of move in, the Residence Director/Business Office Manager and/or designee will monitor compliance through a monthly audit.

As of 02.07.2025 the monthly audits will be conducted through the second quarter and captured as part of Quality

25b Contract Signatures (continued)

Assurance Management Plan.

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

Implemented [redacted] - 04/14/2025)

51 - Criminal Background Check

5. 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 Member B was hired [redacted], however a background check was completed on [redacted], over a year prior to date of hire. A additional or updated criminal history background check was not requested on or prior to Staff Member B's first date of work.

Plan of Correction ***Accept [redacted] - 03/04/2025)***

Primary Benefit: Ensures that employees with prohibitive offenses do not work in personal care homes.

With Respect to the specific deficiency cited: The prior legal entity/Home failed to identify that the staffing ***agency associate's*** *criminal background check was out of regulatory compliance.*

With Respect to Systemic Measures that have been put into place to address the stated concern: Prior to scheduling any future agency staffing associates, the Residence Director will request updated criminal background checks.

The Residence Director/Business Office Manager have conducted a review of the Agency staff binder on 02.07.2025 and all current agency staff are in compliance.

With Respect to How the Plan of Corrective Measures will be Monitored: To prevent a recurrence effective 02.07.2025 the Business Office Manager/Residence Director/designee will review the background check for timely receipt and compliance with OAPSA prior to or on the associate start date.

Hiring, retention and utilization of staff persons shall be in accordance with the Older Adult Protective Services Act.

Licensee's Proposed Overall Completion Date: 02.28.2025

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

Implemented [redacted] - 04/14/2025)

62 - Contact List

6. Requirements

62 - Contact List *(continued)*

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 A, the administrator, maintains a list of staff persons that does not include all substitute or agency staff.

Plan of Correction ***Accept ([redacted] - 03/04/2025)***

Primary Benefit: Ensures that the administrator can quickly reach staff if additional or substitute help is required

With Respect to the specific deficiency cited: The home had a separate binder containing the name of all agency staff personnel at the time inspection yet failed to produce that roster.

With Respect to Systemic Measures that have been put into place to address the stated concern: Effective 1/31/2025 the Residence Director will continue to maintain such binder and update regularly as needed when agency staff are secured for shifts and furthermore produce the staff roster to include agency personnel upon request of the department. On 02/18/2025 the Residence Director was provided re-education/training by the Operations Specialist on the expectations of licensing to have the full list of all staff to include any agency personnel readily available and documentation of this training is maintained in the Residence Director's training file.

With Respect to How the Plan of Corrective Measures will be Monitored
Beginning 02/28/2025 The Residence Director and/or designee will complete verification of the staff roster to include agency personnel monthly. Compliance monitoring will be conducted through the second quarter as part of Quality Managment meetings, and the Residence Director will retain the meeting minutes on file.

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

Implemented [redacted] - 04/14/2025)

82a - Poisonous Materials

7. Requirements

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

Description of Violation

An unlabeled spray bottle with a pink liquid in it was stored in the dishwashing area in the Secure Dementia Care Unit (SDCU). Staff person A could not identify the contents of this bottle.

Plan of Correction ***Accept [redacted] - 03/04/2025)***

Primary Benefit: Minimizes the possibility that a resident or staff person will mistake a poisonous substance for a harmless substance.

With Respect to the specific deficiency cited: The violation occurred due to the housekeeper's failure to abide by the policies and procedures taught during orientation.

The Memory Care Director and housekeepers were re-trained on 02.07.202 by the Residence Director and the training sign in sheet is uploaded as verification of attendance.

82a - Poisonous Materials (continued)

Commencing on 02.07.2025 the Memory care Director will oversee during work day walkthrough and documentation will be maintained.

Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Residence Director will retain the meeting minutes on file.

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

Implemented [redacted] - 04/14/2025)

82b - Poisonous Material Storage

8. Requirements

2600.
82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation

On [redacted], bottles or cans of Eco Label Lime-a-Way, ZEP Carpet and Upholstery spot remover, and Satin Shine with manufacturer's label indicating "if swallowed call poison center", was stored on a shelf in the SDCU dishwashing area alongside an ice cream scoop, utensils, a box of maxwell coffee and containers of Rice Crispies cereal.

On [redacted] a bottle of Febreze with manufacturer's label indicating "Keep out of reach from children and pets, do not use around birds" was stored on its side, resting on top of an unsealed bag of Raisin Bran cereal.

Plan of Correction ***Accept [redacted] - 03/04/2025)***

Primary Benefit: Minimizes the risk of food contamination, illness, or death from improperly stored poisons.

With Respect to the specific deficiency cited: The violation occurred due to the Chef, Maintenance Director, and Housekeeper's failure to abide by the policies and procedures taught during orientation.

The Eco Label Lime-a-Way, ZEP Carpet and Upholstery spot remover, and Satin Shine removed were removed immediately at the time of inspection.

The Memory Care Director and housekeepers were re-trained on 02.07.202 by the Residence Director.

Commencing on 02.07.2025 the Memory care Director will oversee during work day walkthrough and documentation will be maintained.

Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Residence Director will retain the meeting minutes on file.

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

Implemented [redacted] - 04/14/2025)

82c - Locking Poisonous Materials

9. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On [redacted], a bottle of Febreze, with a manufacture's label indicating "Keep out of reach from children and pets, do not use around birds ", was unlocked, unattended, and accessible to residents in the Secure Dementia Care Unit (SDCU) kitchen area in the bottom cabinet near the half door.

On [redacted], a bottle of Diversey R5.1 Plus Air and Fabric Refresher with "Floor" handwritten on it , with a manufacture's label indicating "If swallowed call poison control ", was unlocked, unattended, and accessible to residents in the SDCU kitchen area under the sink.

Not all the residents of the home, including residents of the SDCU, have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] 03/12/2025)***

Primary Benefit: Protects residents who are unable to safely use or avoid poisonous materials from illness, injury, or death related to misuse of accessible poisons.

With Respect to the specific deficiency cited: The violation occurred due to the housekeeper's failure to abide by the policies and procedures taught during orientation as well as ongoing training coursework.

The cited chemicals were removed immediately at time of survey.

The Memory Care Director and housekeepers were re-trained on 02.07.202 by the Residence Director.

By 3/14/25, the Administrator shall educate current staff on regulation 2600.82c (locking of poisonous materials)

Commencing on 02.07.2025 the Memory care Director will oversee during workday walkthrough and documentation will be maintained.

Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Residence Director will retain the meeting minutes on file.

Licensee's Proposed Overall Completion Date: *03/15/2025*

Implemented [redacted] 04/14/2025)

85a - Sanitary Conditions

10. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

85a - Sanitary Conditions *(continued)*

Description of Violation

On [redacted] at 3:12pm, the upper and lower cabinets in the SDCU kitchen were sticky to the touch, and an unlabeled syrup container was sticky with syrup dripping down the side.

At 3:30pm, in the SDCU medication cart a two bottles of Ketoconazole Shampoo prescribed for Resident [redacted] were covered in a sticky red substance and leaking from the cap of the bottle in a plastic bag containing other topical medications belonging to Resident [redacted].

Plan of Correction ***Accept ([redacted] 03/12/2025)***

Discussion: "Sanitary conditions" can include many different situations in a personal care home. Extremely unclean surfaces have been indicated as a "possible condition"

In this particular case the Primary Benefit: Greatly minimizes the risk of resident illness.

With Respect to the specific deficiency cited: The violation occurred due to kitchen staff and care staff's failure to monitor the syrup condiment container was in proper condition without leaking prior to storage and the Medication Technicians not following proper medications supply monitoring or cleaning procedures.
On 1/31/2025 the syrup was removed and discarded by the Administrator and the cabinetry was cleaned and disinfected by housekeeping staff.

On 1/31/2025 the leaky container of shampoo was discarded by the Administrator and the med cart cleaned immediately by the Medication Technician.

The Memory Care Director and housekeepers were re-trained on 02.21.2025 by the Administrator.

By 3/14/25, current staff including staff who access and administer medications shall be educated by the Administrator on regulation 2600.85.a (sanitary conditions).

Beginning 3/14/25, during shift change, Medication Technicians to complete shift change checklist which includes cart cleaning.

Commencing on 02.07.2025 the Memory care Director will oversee during work day walkthrough and documentation will be maintained.

Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Residence Director will retain the meeting minutes on file.

Licensee's Proposed Overall Completion Date: *03/15/2025*

Implemented ([redacted] - 04/14/2025)

85d - Trash Receptacles

11. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

85d - Trash Receptacles *(continued)*

Description of Violation

On [redacted] at 3:18 PM there was a half full, uncovered, unattended trash can in the hallway behind the SDCU kitchen and a trash can with an broken lid in the SDCU dish washing area.

Plan of Correction ***Accept ([redacted] 03/04/2025)***

Primary Benefit: Covered trash receptacles prevent the spread of disease through exposure to body fluids. The risk of insect and rodent infestation due to open food containers is also minimized.

With Respect to the specific deficiency cited: The violation occurred due to the Chef's failure to abide by the regulatory requirements.

With Respect to Systemic Measures that have been put into place to address the stated concern: The Maintenance Director, Chef, Memory Care Director and housekeepers were re-trained on 02.07.202 by the Residence Director and the training sign in sheet is uploaded as verification of attendance.

The Maintenance Director secured new waste receptacles/trash cans with working lids and full compliance is in place.

Commencing on 02.07.2025 the Memory care Director will oversee during work day walkthrough and documentation will be maintained.

Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Residence Director will retain the meeting minutes on file.

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

Implemented [redacted] - 04/14/2025)

88a - Surfaces

12. 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 [redacted] at 9:00am, at the entrance and in the mail room, large pieces of the ceiling had been removed as well as baseboards on the walls. Large holes had been drilled into the walls near the floor through the first and second floor of the building. Damages had been caused by a burst pipe several days prior. There were no caution signs warning of hazards in the area.

At 2:59 PM a large broken pane of glass was leaning up against the wall in the hallway in front of the elevators on the second floor. There were multiple shards of glass present.

Plan of Correction ***Accept [redacted] - 03/12/2025)***

Primary Benefit: Safe surfaces help to maintain sanitary conditions in the home, minimize the risk that residents will suffer an injury while ambulating, and provide dignified living conditions.

With Respect to the specific deficiency cited: The cause of the violation is the ceiling tiles were missing as a result of burst sprinkler pipe, causing a flood. The tiles were removed to allow water to flow. The former owner has not

88a Surfaces (continued)

approved the repair, but the acquisition management has authorized the repair work to be completed on or before 02.28.25 by the Maintenance Director.

At 2:59 PM a large broken pane of glass was leaning up against the wall in the hallway in front of the elevators on the second floor. There were multiple shards of glass present.

With Respect to the specific deficiency cited: In the midst of a resident passing by the Maintenance Director involved in a repair, the resident mentioned [redacted] had broken a personal glass item and had asked maintenance how to discard of it; to avoid risk of injury to the resident the Maintenance Director advised resident to simply place it at his nearby office door and [redacted] would take care of it for [redacted] and simply had not addressed the matter prior to the observation of the inspector; However, this item was discarded appropriately to the dumpster at time of inspection.

By 3/14/25 Administrator shall educate current staff on regulation 2600.88a(surfaces).

Beginning 3/14/25, Administrator shall perform a weekly building walkthrough, documentation of such walkthrough shall be kept.

Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Residence Director will retain the meeting minutes on file.

Licensee's Proposed Overall Completion Date: *03/15/2025*

Implemented [redacted] - 04/14/2025)

97 - Elevators/Lifting Devices

13. Requirements

2600.
97. Elevators and Stair Glides - Each elevator and stair glide must have a certificate of operation from the Department of Labor and Industry or the appropriate local building authority in accordance with 34 Pa. Code Chapter 405 (relating to elevators and other lifting devices).

Description of Violation

The elevators in the home do not have a valid certificate of operation from the Department of Labor and Industry or appropriate local building authority. The current posted certificates expired on [redacted].

Plan of Correction ***Accept [redacted] - 03/04/2025)***

Primary Benefit: Reduces risk of injury to residents, staff, and visitors by ensuring that elevators and stair glides are safe and free of hazards.

With Respect to the specific deficiency cited: The reason for the violation is the former owners would not authorize the timely inspection.

At the acquisition managements approval, the elevators were inspected on 2/13/2025 and are approved for use/operable and safe.

A letter was received by Apex Inspectors & Testing verifying the process was completed.

All necessary reports have been submitted by Apex Inspectors to the Elevator Division of PA.

97 - Elevators/Lifting Devices (continued)

New updated tags issued to the new acquisition management will be posted upon receipt from Harrisburg.

To avoid further violations Apex Elevator is scheduled with the Maintenance Director for ongoing services as required for elevator inspections/compliance.

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

Implemented [redacted] 04/14/2025)

103i - Outdated Food

14. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was an opened, unlabeled, undated, unsealed, squirt bottle of sauce or dressing in the door of the refrigerator in the SDCU.

On [redacted] there was an unlabeled, undated plastic container of ice cream in SDCU freezer.

There was an open, unlabeled, and undated, dispenser of syrup in on an open shelf near the floor in the SDCU.

Plan of Correction ***Accept [redacted] - 03/04/2025)***

Primary Benefit: Ensures that food is safe for use.

With respect to the opened, unlabeled, undated, unsealed, squirt bottle of sauce in the refrigerator as well as the unlabeled, undated plastic container of ice cream in the freezer and the open, unlabeled, undated dispenser of syrup on a shelf; The reason for the violation is the Chef/Cooks failed to follow regulatory requirements and did not maintain proper storage procedures.

On 01.31.2025 the Chef & Cook and server staff did remove and discard the sauce, ice cream and syrup. The team also conducted a quality check and noted all remaining items were stored, labeled, and dated and in full compliance.

On 2/07/25 & 2/21/2025 the Chef provided re-education to dining service staff on regulation 103i. Documentation shall be kept.

To prevent future violations on 02.26.2025 the Operations Specialist conducted an educational review of the LIS and regulatory requirements, and the Chef was provided with a copy of chapter 2600 regulations and the requirements for this chapter as well as all other applicable health and safety regulations.

Beginning 02/21/2025 the Chef and/or cook will inspect the food storage areas & kitchens weekly for compliance in accordance with applicable regulations and findings will be noted on the Quality Managment Plan through the second quarter of 2025.

103i Outdated Food *(continued)*

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

Implemented [redacted] - 04/14/2025)

107b - Emergency Procedures

15. Requirements

2600.
107.b. The home shall have written emergency procedures that include the following:

1. Contact information for each resident's designated person.
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.
5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.
6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

The home's written emergency procedures do not include contact information for each resident's designated person, and the home's plan to provide the emergency medical information for each resident that ensures confidentiality.

Plan of Correction ***Accept [redacted] - 03/04/2025)***

Primary Benefit: Ensures that the home is prepared to respond to localized and general emergencies.

The violation occurred due to the Residence Director not auditing the emergency binder for the current resident list. On [redacted] a current resident list was added to the binder immediately at the time of inspection.

With Respect to How the Plan of Corrective Measures will be Monitored:
Commencing on 02.07.2025, the Residence Director and/or Designee will monitor for ongoing compliance through monthly audits.

Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Residence Director will retain the meeting minutes on file.

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

Implemented [redacted] - 04/14/2025)

127a - Portable Space Heaters

16. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

On [redacted] at 2:49 PM, a large metal box portable space heater was in use in room [redacted].

Plan of Correction ***Accept ([redacted] - 03/04/2025)***

Primary Benefit: Portable space heaters are a frequent cause of fire and cause burns to residents who come into contact with them. Residents are protected from fire and injury by this prohibition.

127a Portable Space Heaters (continued)

With Respect to the specific deficiency cited: This was an unoccupied room. The portable space heaters were in use as a result of burst sprinkler pipe, causing a flood.

The violation was incurred because the blowers were put in use by the service repair company and were in use to dry out the area and prevent mold. The blowers were removed on 1/31/2025 at time of survey.

Effective 02.28.2025, to prevent recurrence, the Maintenance Director will coordinate with any outside services to be clear on the regulatory guidelines regarding space heaters.

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

Implemented [redacted] - 04/14/2025)

130h - Inoperable Smoke Detector

17. Requirements

2600.
130.h. The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

On [redacted], a sprinkler pipe in room [redacted] burst due to lack of heat in the room. Water was completely shut off in one fire stair tower. On [redacted] the fire panel showed 28 troubles including "1 60 SD 1st FL Hall by Mail Rm Not responding"

The home's emergency procedures indicate 30 minute fire watch procedures as defined by the National Fire Protection Agency will be implemented when a smoke detector or fire alarm is inoperable. Additionally, the home's policy requires a fire watch if their sprinkler system is out of service for more than 10 hours in a 24 hour period.

A fire watch was only completed on the second floor of the building hourly on [redacted] from 2:30 AM to 6:30 AM, then on [redacted] every 30 minutes from 3:30 PM to 7:30 PM. A fire watch was not completed throughout the entire building during this time, or at any other time the system was inoperable.

Plan of Correction ***Accept [redacted] - 03/04/2025)***

With Respect to the specific deficiency cited:
The inoperable smoke detectors were as a result of burst sprinkler pipe, causing a flood. The water got into the detectors causing them to malfunction.

The cause of the violation was due to the lack of guidance provided by the Residence Director and Maintenance Director.

On 02.17.2025 Education was provided by the Operations Specialist with a full review of the policy and best practices with the Residence Director and Maintenance Director.

Necessary repairs were made, and the Fire Marshall has provided a letter dated 01.25.2025 that the systems are in full working order. Per the uploaded document.

To prevent further occurrence and in addition to the in person training provided on 02.17.2025, both the Residence

130h Inoperable Smoke Detector (continued)

Director and the Maintenance Director will complete additional training and coursework "The basics of LIfe Safety Code" on or before 02.28.2025 as assigned.

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

Implemented [redacted] - 04/14/2025)

183e - Storing Medications

18. Requirements

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

Description of Violation

On [redacted], Resident [redacted] tablet blister pack [redacted] had a punctured foil at pill spot 8, with the pill still present in the blister. Additionally, pill spot 6 was also punctured and then taped over to keep the pill in the blister.

On [redacted], Resident [redacted] tablet blister pack #2 was punctured and taped over at pill spot 52 with the pill still present in the blister.

On [redacted] Resident [redacted] tablet blister pack was punctured at pill spot 1 and the pill was still in the package.

On [redacted], a bottle of [redacted] wound cleaner spray that was observed to be leaking was in the home's SDCU medication cart.

Plan of Correction ***Accept [redacted] 03/04/2025)***

Primary Benefit: Ensures that medications will be stored in a manner that prevents damage or loss.

With Respect to the specific deficiency cited: The violation was incurred due to the fragility of the foil lined blister package and snugly fitting blister cards causing friction in storage likely causing the tear.

The findings were corrected onsite at time of inspection, the bottle of DermaKlenz and the altered blister packs containing punctures or tape were removed and wasted according to the handling policy by the Memory Care Director.

With Respect to Systemic Measures that have been put into place to address the stated concern:
The Memory Care Director educated med techs on 2/18/2025 regarding the proper protocol of this regulation. Med techs/nurses were in serviced that while administration of medication is conducted, they are to ensure that blister cards are intact without punctures. In the event a blister pack is found to have a puncture, they are to dispose of the medication.

With Respect to How the Plan of Corrective Measures will be Monitored:
Med cart audit completed 2/7/25 by the Regional Healthcare Director and Regional Healthcare Specialist. The Healthcare Director/Assistant Healthcare Director/Designee will conduct monthly med cart audits commencing

183e - Storing Medications (continued)

02.07.25. The Healthcare Director/Assistant Healthcare Director/Designee will monitor for ongoing compliance. Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings.

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

Implemented ([redacted] - 04/14/2025)

185a - Implement Storage Procedures

19. 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

On [redacted] at 3:33 PM, resident [redacted] was not calibrated to the correct time. The [redacted] was set to [redacted] - 4:34 PM.

Plan of Correction ***Accept ([redacted] 03/04/2025)***

Primary Benefit: Reduces the risk that medications and medical equipment will be misplaced, lost, or misused.

With Respect to the specific deficiency cited:
The violation occurred due to the lack of quality assurance by the Healthcare Director/Assistant Healthcare Director/Designee. The glucometer was immediately calibrated at time of inspection.

Staff education and training regarding 185a was provided on 2/21/2025 and the training documentation is uploaded into Sanswrite for verification and content.

Commencing on 02.17.2025, the Healthcare Director/Assistant Healthcare Director /Designee will monitor for ongoing compliance through weekly glucometer audits. In addition, the monthly med cart audits were completed on 2/7/2025 by the Regional Healthcare Director and Healthcare Operations Specialist and will commence monthly X two quarters. The audit information will be included in the monthly Quality Management Plan and retained on file.

Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Residence Director will retain the meeting minutes on file.

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

Implemented ([redacted] - 04/14/2025)

20. 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 [redacted] is prescribed [redacted] as needed. On [redacted] this

185a - Implement Storage Procedures (continued)

medication was not available in the home.

Plan of Correction ***Accept [redacted] - 03/04/2025)***

Primary Benefit: Reduces the risk that medications and medical equipment will be misplaced, lost, or misused.

With Respect to the specific deficiency cited: The violation occurred due to the lack of quality assurance by the Healthcare Director/Assistant Healthcare Director/Designee.

Resident [redacted] was ordered and received at time of inspection and is presently available for administration as ordered.

Staff education and training regarding 185a was provided on 2/21/2025 and the training documentation is uploaded into Sanswrite for verification and content.

Commencing on 02.17.2025 the Healthcare Director/Assistant Healthcare Director /Designee shall monitor for ongoing compliance by performing monthly med cart audits. Audits were completed on 2/7/2025 by the Regional Healthcare Director and Healthcare Operations Specialist and will commence monthly X two quarters. The audit information will be included in the monthly Quality Management Plan and retained on file.

Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Residence Director will retain the meeting minutes on file.

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

Implemented ([redacted] - 04/14/2025)

21. 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

On [redacted] at 2:49pm, [redacted] were unlocked, unattended, and accessible to residents in room [redacted] At that time, the room had multiple fans, air movers, and an active space heater running to dry out the room after a sprinkler pipe had burst on [redacted]

Plan of Correction ***Accept [redacted] 03/12/2025)***

Primary Benefit: Reduces the risk that medical equipment will be misplaced, lost, or misused.

With Respect to the specific deficiency cited: The violation occurred due to the lack of quality assurance by the Administrator and management team.

The 13 tanks of oxygen were removed from the unoccupied resident apartment by the Maintenance Director at time of survey; the Oxygen tanks were returned to the DME supplier.

At time of survey, fans, air movers and space heater were removed from the unoccupied room by the Maintenance Director and returned to the contractor.

By 3/14/25, Administrator shall educate current staff on regulation 2600.185a (Implement storage procedures).

185a - Implement Storage Procedures (continued)

Beginning 3/14/25, Administrator shall perform a weekly building walkthrough, documentation of such walkthrough shall be kept.

Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings and the Administrator shall retain the meeting minutes on file.

Licensee's Proposed Overall Completion Date: *03/15/2025*

Implemented [redacted] - 04/14/2025)

187a - Medication Record

22. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

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

Description of Violation

Resident[redacted] is prescribed insulin injections on a sliding scale, inject units subcutaneously three times daily if [redacted] is [redacted] According to resident [redacted] medication administration record, this medication was administered from [redacted]; however, the number of units administered it is not included on resident [redacted]s [redacted] medication administration record.

Plan of Correction ***Accept ([redacted] 03/04/2025)***

Primary Benefit: The home's staff persons will be able to track all medications a resident receives and to ensure all medications are administered as prescribed

With Respect to the specific deficiency cited: The violation occurred due to the lack of quality assurance by the Healthcare Director/Assistant Healthcare Director/Designee. The field was added at time of inspection 01.30.2025 for recording units administered.

The med techs were provided education on 02.21.2025 on regulation 187a, attached to Sanswrite.

On 02.21.2025 The new entity has implemented a new documentation system "ECP" which does include the proper

187a - Medication Record (continued)

field to include units administered.

Commencing on 02.17.2025 the Healthcare Director/Assistant Healthcare Director /Designee will monitor for ongoing compliance through a weekly glucometer audits. In addition, the monthly med cart audits were completed on 2/7/2025 by the Regional Healthcare Director and Healthcare Operations Specialist and will commence monthly X two quarters.

The audit information will be included in the monthly Quality Management Plan and retained on file.

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

Implemented [redacted] - 04/14/2025)

187d - Follow Prescriber's Orders

23. Requirements

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

Description of Violation

Resident [redacted] is prescribed [redacted] - one tablet orally at bedtime. On [redacted] Resident [redacted] did not receive this medication as prescribed.

Resident [redacted] is prescribed [redacted] - one tablet orally in the evening- scheduled for 7pm. Resident [redacted] did not receive this medication on [redacted] at 7 PM.

Resident [redacted] is prescribed [redacted] - one tablet orally daily, scheduled for 8am. On [redacted] at 8 AM Resident [redacted] did not receive this medication.

On [redacted] Resident [redacted] did not received any of their prescribed medications throughout the day and there was no indication on why medications were not received.

Plan of Correction ***Accept ([redacted] - 03/04/2025)***

Primary Benefit: Ensures that residents receive medications and treatments as ordered by a physician.

Resident [redacted] The violation occurred because the Medication administration record did not reflect that the

187d - Follow Prescriber's Orders (continued)

medications were administered due to an ongoing WIFI issue at the home causing intermittent disruption for connectivity. The e-mar system remained active however the signature of record for administration would not register on the e-mar.

Resolution: The home is under new acquisition management and the New IT department identified on 02.06.2025 two inoperable network switches on floors 4 and 5 and replaced both switches on 02.07.2025 and have resolved the connectivity issue.

Resident [redacted] was out of facility as of 01.20.2025 and all medications were discontinued and therefore not administered.

The staff received education regarding this regulation on 01.21.2025 as uploaded to Sanswrite for verification.

In addition, the monthly med cart to MAR audits were completed on 2/7/2025 by the Regional Healthcare Director and Healthcare Operations Specialist and will commence monthly X two quarters.

The audit information will be included in the monthly Quality Management Plan and retained on file.

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

Implemented ([redacted] - 04/14/2025)

188b - Medication Error Reporting

24. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident [redacted] is prescribed [redacted] - one tablet orally at bedtime. On [redacted] Resident [redacted] did not receive this medication as prescribed.

Resident [redacted] is prescribed [redacted] - one tablet orally in the evening- scheduled for 7pm. Resident [redacted] did not receive this medication on [redacted] at 7 PM.

Resident [redacted] is prescribed [redacted] - one tablet orally daily, scheduled for 8am. On [redacted] at 8 AM Resident [redacted] did not receive this medication.

On [redacted] Resident [redacted] did not received any of their prescribed medications throughout the day and there was no indication on why medications were not received.

These medication errors were not reported to the residents' prescribers.

Plan of Correction ***Accept [redacted] 03/04/2025)***

Primary Benefit: Ensures that medication errors are handled appropriately to avoid resident injury as a result of

188b Medication Error Reporting (continued)

the error.

Resident [redacted]; The violation occurred because the Medication administration record did not reflect that the medications were administered due to an ongoing WIFI issue at the home causing intermittent disruption for connectivity. The e mar system remained active however the signature of record for administration would not register on the e mar.

Resolution: The home is under new acquisition management and the New IT department identified on 02.06.2025 two inoperable network switches on floors 4 and 5 and replaced both switches on 02.07.2025 and have resolved the connectivity issue.

Resident [redacted] was out of facility as of 01.20.2025 and all medications were discontinued and therefore not administered.

Beginning 01.31.2025, the Residence Director/designee shall file reportable incidents timely to the Bureau of Human Services Licensing as applicable as well as to the prescriber.

The Residence Director/Designee shall re educate current associates on incident reporting by 02.28.2025. Documentation shall be kept.

Beginning 02.28.2025 adherence to 2600.188, Written Incident Report, will be monitored utilizing our internal Vitals software system to identify any medication error occurrences, these will be reviewed during our regularly scheduled monthly Quality Assurance meetings for two quarters. Documentation of these meetings will be maintained.

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

Implemented ([redacted] - 04/14/2025)

225c - Additional Assessment

25. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident [redacted] assessment, dated [redacted] does not include the name, title, signature or date signed of the Assessor. .

Plan of Correction ***Accept [redacted] - 03/04/2025)***

Primary Benefit: Allows homes to create a comprehensive profile of a resident's needs and serves as the basis for the plan to meet those needs.

With Respect to the specific deficiency cited:
The violation occurred due to a clerical oversight from Health Care Director, who forgot to sign the assessment as indicated.

225c - Additional Assessment (continued)

With Respect to Systemic Measures that have been put into place to address the stated concern:
The Healthcare Director at the time of inspection is no longer employed at this location and therefore unavailable to sign the assessment. Any future Healthcare Directors will be provided with training regarding this regulatory requirement.

With Respect to How the Plan of Corrective Measures will be Monitored: Chart audits were completed on 2/7/2025 by the Regional Healthcare Director and Healthcare Operations Specialist and will commence monthly X two quarters.

The audit information will be included in the monthly Quality Management Plan and retained on file.

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

Implemented [redacted] - 04/14/2025)