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

July 3, 2025

[redacted], COO
CARE HSL NEWTOWN OPCO LLC
[redacted]

RE: THE BIRCHES AT NEWTOWN
70 DURHAM ROAD
NEWTOWN, PA, 18940
LICENSE/COC#: 14230

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/12/2025, 02/13/2025 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: *THE BIRCHES AT NEWTOWN* **License #**: *14230* **License Expiration**: *09/15/2025*

Address: *70 DURHAM ROAD, NEWTOWN, PA 18940*

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

Administrator

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

Legal Entity

Name: *CARE HSL NEWTOWN OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *06/17/2016* **Issued By**: *Newtown Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *179* **Waking Staff**: *134*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *02/26/2025*

Inspection Dates and Department Representative

02/12/2025 - On-Site: [redacted]

02/13/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served**: *110*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Daybreak* **Capacity**: *57* **Residents Served**: *52*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *109*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *69* **Have Physical Disability**: *2*

Inspections / Reviews

02/12/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/27/2025*

Inspections / Reviews *(continued)*

04/07/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/25/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/12/2025*

04/17/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/25/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/30/2025*

07/03/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/25/2025*

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

15b - Supervisor Plan

1. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On [redacted], resident #1 alleged that a staff member hurt [redacted] arm previous night and the home suspended staff A who was assigned to the resident. On [redacted], the resident pointed to staff B as the perpetrator to a medication technician, who reported this to the management: however, the home did not immediately develop and implement a plan of supervision or suspend staff B.

Plan of Correction ***Accept ([redacted] - 04/17/2025)***

Immediate Correction: Executive Director was educated by Director of QA on the need to clarify statements to ensure it is understood when allegations are made, and ensuring it is reported timely on 3/20/25.
Additional Corrective Action: Staff will be in-serviced and educated on investigatory statements and given to the Executive Director to ensure the information is accurate and thorough when allegations are made regarding abuse and ensuring that they are reported timely. This will be completed by 4/4/25. Staff will be suspended immediately when there is a suspicion of abuse.
Ongoing Quality Assurance Actions: The Executive Director will review allegations made immediately and ongoing. They will be discussed at Quarterly QA meeting beginning 4/15/25 and ongoing.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 05/30/2025)

25b - Contract Signatures

2. 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 #2 was not signed by the resident. The resident-home contract, dated [redacted] for resident #3 was not signed by the resident. The resident-home contract, dated [redacted] for resident #4 was not signed by the resident.

Plan of Correction ***Accept ([redacted] - 03/25/2025)***

Immediate Corrective Action: These documents were updated by the Business Office Director to include that residents were unable to sign on 3/18/25.
Additional Corrective Actions: The Executive Director will complete an audit of all current Resident Agreements by 4/4/25, to ensure all contracts include resident signatures. The Executive Director trained the Business Office Manager on 3/19/25, to ensure all agreements are signed by residents on day of admission before uploading the document to the resident record.
Ongoing Quality Assurance Actions: The Executive Director or Resident Care Director will review a sample of resident records each quarter, as part of Quality Assurance Reviews, including verification of all required signatures on contract. Ongoing compliance will be reviewed at Quarterly QA meetings, beginning on 4/15/25.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 05/30/2025)

25b - Contract Signatures *(continued)*

41e - Signed Statement

3. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #2's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept ([redacted] - 04/07/2025)***

Immediate Corrective Action: The resident was unable to sign, and that was documented on 3/18/25 by the Business Office Manager.
Additional Corrective Actions: The Executive Director will complete an audit of all residents' records by 4/4/25 to ensure all residents have a signed copy of Resident Rights. The Executive Director trained the Business Office Manager on 3/19/25, to ensure that all files have a signed copy of resident rights at the time of admission.
Ongoing Quality Assurance Actions: The Executive Director or Resident Care Director will review a sample of resident records each quarter, as part of Quality Assurance Reviews, including verification of signatures on Resident Rights. Ongoing compliance will be reviewed at Quarterly QA meetings, beginning on 4/15/25.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 05/30/2025)

51 - Criminal Background Check

4. 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

[redacted] *the home's administrator, resides in a different state. The home conducted a PA PATCH (state) background check but did not utilize the Federal Bureau of Investigation (FBI) check.*

Repeat Violation: 04/30/2024

Plan of Correction ***Accept ([redacted] - 04/07/2025)***

Immediate Corrective Action: The Executive Director completed an FBI check on 2/14/25.
Additional Corrective Actions: The Business Office Manager and all department managers were educated by the Executive Director on 3/31/25 regarding regulatory requirements for criminal background checks and FBI checks on employees.
Ongoing Quality Assurance Actions: The Business Office Manager will audit a sample of staff records each month as part of the Quality Assurance process to ensure clearances are completed accurately and on file. Findings will be reviewed at the Quarterly QA Meetings, beginning on 4/15/25.

51 - Criminal Background Check *(continued)*

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 05/30/2025)

54a - Direct Care Staff

5. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

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

Repeat Violation: 05/16/2024

Plan of Correction ***Accept ([redacted] - 04/17/2025)***

Immediate Corrective Action: Staff D has provided [redacted] high school diploma and it is in [redacted] employee file.
Additional Corrective Actions: The Business Office Manager was trained by the Executive Director on 3/31/25 to ensure all direct care staff shall have a high school diploma prior to working with residents. All charts were audited for compliance for high school diploma on 4/4/25.
Ongoing Quality Assurance Actions: The Business Office Manager will audit a sample of staff records each month as part of the Quality Assurance process to ensure all educational requirements are met and on file. Findings will be reviewed at the Quarterly QA Meetings, beginning on 4/15/25.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 05/30/2025)

65a - FS Orientation 1st Day

6. Requirements

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

Description of Violation

The home does not have a documentation showing that staff person D hired [redacted], E hired [redacted] and F hired [redacted] had an orientation in general fire safety and emergency preparedness prior to or during the first work day.

65a - FS Orientation 1st Day (continued)

Repeat Violation: 04/30/2024

Plan of Correction ***Accept (- 04/17/2025)***

Immediate Corrective Action: Staff D, E, and F will complete the general fire safety trainings with Maintenance Director by 3/31/25 and sign a training attendance sheet.
Additional Corrective Actions: The Executive Director trained the Business Office Manager on 3/19/25 to ensure all new employees have fire training before day one of work. BOM will have staff member sign off when the training is completed. All employee files were audited for compliance for Day 1 orientation.
Ongoing Quality Assurance Actions: The Business Office Manager will audit a sample of staff records each month as part of the Quality Assurance process to ensure all required trainings are completed and recorded. Findings will be reviewed at the Quarterly QA Meetings, beginning on 4/15/25.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented (- 05/30/2025)

65b - Rights/Abuse 40 Hours

7. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

The home does not have a documentation showing that staff person D hired E hired and F hired had an orientation within their 40 scheduled working hours that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Repeat Violation: 04/30/2024

Plan of Correction ***Accept (- 04/17/2025)***

Immediate Corrective Action: Staff D, E, and F will complete the required orientation trainings with the Business Office Manager by 3/31/25 and sign a training attendance sheet.
Additional Corrective Actions: The Executive Director trained the Business Office Manager on 3/19/25 to ensure all new employees have all required trainings within 40 hours. BOM will have staff member sign off when the training is completed. All employee files were audited for compliance.
Ongoing Quality Assurance Actions: The Business Office Manager will audit a sample of staff records each month as part of the Quality Assurance process to ensure all required trainings are completed and recorded. Findings will be reviewed at the Quarterly QA Meetings, beginning on 4/15/25.

Licensee's Proposed Overall Completion Date: *04/15/2025*

65b - Rights/Abuse 40 Hours *(continued)*

Implemented (- 05/30/2025)

65e - 12 Hours Annual Training

8. Requirements

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

Description of Violation

Direct care staff person A, hired on received only 10.25 hours of annual training in training year 2024.

Plan of Correction ***Accept (- 04/07/2025)***

Immediate Corrective Action: Staff person A is no longer employed here, as of
Additional Corrective Actions: The Business Office Manager will complete a review of all employee training records to ensure that everyone is up to date with training by 4/4/25.
Ongoing Quality Assurance Actions: The Executive Director and BOM will review training monthly and quarterly as part of our Quality Assurance process. Findings will be reviewed at the Quarterly QA Meetings, beginning on 4/15/25.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented (- 05/30/2025)

65f - Training Topics

9. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Description of Violation

Direct care staff person A, hired on did not receive training in (1) Medication self-administration training and (2) Instruction on meeting the needs of the residents as described in the DME, RASP, Prescreening during training year 2024.

Repeat Violation: 05/16/2024, 04/30/2024

Plan of Correction ***Accept (- 04/17/2025)***

Immediate Corrective Action: Staff person A is no longer employed here, as of
Additional Corrective Actions: Staff were trained by the Executive Director of the importance of completing assigned Relias training on 3/18/25. The Executive Director has begun reviewing Relias completion reports weekly as of 3/17/25, and the leadership team will be made aware of the staff in their departments that need to complete monthly training courses to remain in compliance with training regulations. Any non-compliant staff member will be removed from the schedule until training is completed. HSL developed a course specific to medication self-administration, meeting the needs of the residents, preadmission screen form, assessment tool, medical evaluation and support plan; and uploaded them to Relias. All direct care staff received this training.
Ongoing Quality Assurance Actions: The Business Office Manager will complete a review of a sample of staff

65f - Training Topics (continued)

records each month as part of the Quality Assurance Review, to ensure all required training has been completed. This will begin by 3/17/25. Findings will be reviewed at the Quarterly QA Meetings, beginning on 4/15/25.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 05/30/2025)

81b - Resident Personal Equipment

10. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 2/13/25, a covered bedside mobility device was present on resident #5's bed. However, the enabler slid under the bed and was not securely attached to the structure of the bed. Bedside mobility devices that slide under the mattress and are not securely attached to the structure of the bed can move and create entrapment zones not always present upon inspection. These types of devices are not permitted under any circumstance.

Repeat Violation: 04/30/2024

Plan of Correction ***Accept ([redacted] - 04/17/2025)***

Immediate Corrective Action: The enabler device was removed on 3/20/25 and the Resident Care Director will work with the resident's physician and rehab department to get appropriate bedside mobility device by 4/4/25.
Additional Corrective Action: An audit of all bedside mobility devices will be completed by the Resident Care Director by 4/4/25 for compliance with regulatory requirements and HSL policy. The Safety Committee will inspect and review monthly and any findings will be reviewed at quarterly QA meeting
Ongoing Quality Assurance Actions: RCD will review as part of the quarterly Quality Assurance process. Findings will be reviewed at the Quarterly QA Meetings, beginning on 4/15/25.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 05/30/2025)

82c - Locking Poisonous Materials

11. 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 02/12/2025 around 09:30 AM, the door to the salon located in the home's SDCU was unlocked and hair products including dyes, hair sprays, shampoo, and cleaning products including Diversey Virex TB disinfectant cleaner were found kept in cabinets which were not locked either. Colgate Total Toothpaste was unlocked, unattended, and accessible in resident #4's bathroom. Not all the residents of the home, including resident #4, have been assessed capable of recognizing and using poisons safely.

Repeat Violation: 04/30/2024

82c - Locking Poisonous Materials *(continued)*

Plan of Correction ***Accept ([redacted] - 04/07/2025)***

Immediate Corrective Action: The salon was locked on 2/12/25 by Memory Care Director.
Additional Corrective Actions: P salon was educated by the Memory Care Director on 3/31/25 to ensure the Salon is locked when not in use. The Memory Care Director will visually inspect the salon doors on daily rounds, beginning 3/19/25
Ongoing Quality Assurance Actions: Findings from walk throughs will be reviewed at the Quarterly QA Meetings, beginning on 4/15/25.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 07/03/2025)

85a - Sanitary Conditions

12. Requirements

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

Description of Violation

On 2/13/25 at 10:00 AM, feces were observed hardened around the toilet handle, seat, and bowl in resident #1's bathroom.

Plan of Correction ***Accept ([redacted] - 04/07/2025)***

Immediate Corrective Action: Bathroom was cleaned by housekeeping staff on 2/13/25.
Additional Corrective Actions: All bathrooms were inspected on 2/13/25 to ensure they were clean. The Executive Director, Maintenance Director and Memory Care Director will educate caregiver and housekeeping staff on cleaning & disinfecting bathrooms and high-touch surfaces by 4/4/25.
Ongoing Quality Assurance Actions: The Memory Care Director will visually inspect bathrooms in resident apartments on a weekly basis starting 3/18/25 as part of the quarterly QA process. Findings will be reviewed at the Quarterly QA Meetings, beginning on 4/15/25.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 07/03/2025)

85d - Trash Receptacles

13. Requirements

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

Description of Violation

On 02/12/2025 around 09:25 AM, three trash cans in the main kitchen were not covered and they were not actively in use.

Repeat Violation: 04/30/2024

Plan of Correction ***Accept ([redacted] - 04/07/2025)***

Immediate Corrective Action: Trash can lid(s) were secured on trash cans by Dining Service Director on 2/12/25.

85d - Trash Receptacles (continued)

Additional Corrective Actions: Dining Services Staff will be in-serviced on the regulatory sanitation requirements regarding trash can lids, by the Executive Director by 3/31/25.
Ongoing Quality Assurance Actions: The Dining Services Director will complete a daily kitchen inspection, including trash can lids, beginning 3/18/25. Findings will be reviewed at the Quarterly QA Meetings, beginning on 4/15/25.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented (- 07/03/2025)

103e - Left Overs

14. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 02/12/2025 around 09:20 AM, the following left-over food items were not labeled or dated:
-A container of mayonnaise and a juice pitcher in the main kitchen fridge
-A chunk of grilled chicken and a tray of frozen spinach in the walk-in freezer

Plan of Correction ***Accept (- 04/07/2025)***

Immediate Corrective Action: Food was immediately discarded by Dining Service Director on 2/12/25.
Additional Corrective Actions: The Executive Director and Dining Services Director will train all dietary staff on the regulatory requirements for dating, labeling and storage of leftovers by 3/31/25.
Ongoing Quality Assurance Actions: The Dining Services Director will complete a daily kitchen inspection, including food labels, beginning 3/18/25. Findings will be reviewed at the Quarterly QA Meetings, beginning on 4/15/25.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented (- 07/03/2025)

103g - Storing Food

15. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 02/12/2025 around 09:20 AM, the following food items were not covered or sealed:
-Eleven ice cream cups in the ice cream freezer
-A bag of granulated sugar in dry food storage
-A bag of beef patties and a bag of crab meat patties in the walk-in freezer

Repeat Violation: 04/30/2024

Plan of Correction ***Accept (- 04/07/2025)***

Immediate Corrective Action: Food was immediately discarded by Dining Service Director on 2/12/25.
Additional Corrective Actions: The Executive Director and Dining Services Director will train all dietary staff on regulatory requirements for food storage by 3/31/25.

103g - Storing Food (continued)

Ongoing Quality Assurance Actions: The Dining Services Director will complete a daily kitchen inspection, including the inspection of food storage areas, beginning 3/18/25. Findings will be reviewed at the Quarterly QA Meetings, beginning on 4/15/25.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 07/03/2025)

162c - Menus Posted

16. 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 02/12/2025, the home posted only current week's menu.

Repeat Violation: 04/30/2024

Plan of Correction ***Accept ([redacted] - 04/07/2025)***

Immediate Corrective Action: The Dining Service Director posted 2 weeks of menus on 2/13/25.
Additional Corrective Actions: The Dining Service Director was educated by the Executive Director on 3/31/25 regarding the regulatory requirements for posting menus.
Ongoing Quality Assurance Actions: The Dining Service Director will post a two-week menu every Friday, beginning the week of 3/31/25. Ongoing compliance will be reviewed during daily walk throughs of kitchen and dining area, as part of Quality Assurance process. Findings will be reviewed at the Quarterly QA Meetings, beginning on 4/15/25.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 07/03/2025)

181c - Self-administration Assessment

17. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #1 self-administers eye drops (Dorzol/Timol Sol and Latanoprost Sol); however, the resident has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction ***Accept ([redacted] - 04/07/2025)***

Immediate Corrective Action: The medications were removed from the resident's room by Memory Care Director on 3/19/25.
Additional Corrective Actions: Physician contacted on 3/19/25 by Resident Care Director, and med techs will

181c - Self-administration Assessment (continued)

administer all medication per physician's orders. The DME and RASP will be updated by 3/21/25 by the Resident Care Director. The Resident Care Director will review all residents' DMEs and RASPs to ensure they are accurate in documenting ability to self-administer medications by 4/8/25.
Ongoing Quality Assurance Actions: The RCD will complete self-administration assessments every 90 days, beginning 3/31/25, and ensure the DME and RASP are updated and accurate. Findings will be reviewed at the Quarterly QA Meetings, beginning on 4/15/25.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 07/03/2025)

182c - Medication Administration

18. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

On 02/13/2025 at 09:45 AM, staff G was observed removing medications from the blister packs, initialing the medications as administered, and then taking the pills to a resident. Staff G did not follow the proper procedures of medication administration by documenting before observing the resident ingest the pills.

Plan of Correction ***Accept ([redacted] - 04/07/2025)***

Immediate Corrective Action: Resident Care Director will Inservice all Med Techs on "The Five Rights" by 3/31/25.
Additional Corrective Action: Resident Care Director and/or the Train the Trainer will complete a Med Pass observation on all med techs by 4/8/25.
Ongoing Quality Assurance: RCD will complete quarterly Med/MAR observations thereafter. RCD will review as part of the QA Process. Will review at the Quarterly QA Meeting on 4/15/25 and ongoing.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 07/03/2025)

183e - Storing Medications

19. 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 02/13/2025 around 11:10 AM, there were two loose pills (one pink and round and the other white and elongated oval) in the home's SDCU medication cart #1.

Repeat Violation: 04/30/2024

183e - Storing Medications *(continued)*

Plan of Correction ***Accept ([redacted] - 04/07/2025)***

Immediate Corrective Actions: Loose pills were removed and corrected immediately by Med tech on the day of survey 2/14/25.
Additional Corrective Action: Med Tech will do weekly audits of carts starting 3/24/25. MAR to CART audit will be done monthly by Wellness nurse starting 3/23/25.
Ongoing Quality Assurance Actions: This documentation will be reviewed at the Quarterly QA Meeting on April 15, 2025, and ongoing.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 07/03/2025)

185a - Implement Storage Procedures

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 #6's glucometer was not calibrated to correct time. On 02/13/2025 at 10:07 AM, the glucometer displayed 10:35 AM. The numbers on the glucometer and the resident's medication administration record (MAR) did not match:
-02/11 04:00 PM 218 (glucometer) vs 216 (MAR)
-02/10 04:00 PM 187 (glucometer) vs184 (MAR)
-02/10 08:00 AM 168 (glucometer) vs 143/78 (MAR)
-02/09 08:00 AM 142 (glucometer) vs 184 (MAR)

Repeat Violation: 04/30/2024

Plan of Correction ***Accept ([redacted] - 04/07/2025)***

Immediate Corrective Action: Wellness nurse immediately calibrated glucometer on 2/13/25.
Additional Corrective Action: Frontline staff will utilize the shift change responsibilities checklist daily at crossover meeting to ensure that glucometers are calibrated correctly starting 3/24/25 and ongoing.
Ongoing Quality Assurance Actions: Wellness nurse will audit glucometers on monthly basis as part of the cart audit process with Resident Service Director oversight. Will be reviewed at the Quarterly QA Meeting on 4/15/25 and ongoing.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 07/03/2025)

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

Resident #7 is prescribed Lorazepam 0.5 mg twice a day. The sign out sheet for this medication indicates that one pill was signed out on 02/08/2025 at 10:00 AM in addition to the morning and evening dose. The home cannot explain

185a - Implement Storage Procedures (continued)

what happened to this medication.

Plan of Correction ***Accept ([redacted] - 04/07/2025)***

Immediate Corrective Action: Signature was on the incorrect narc sheet. The date was actually 2/2/25 not 2/8/25, the MAR was correct. Resident Care Director in-serviced all med-techs on making sure their signatures are clear on narcotic sheets on 3/24/25.
Additional Corrective Action: Frontline staff will utilize the shift change responsibilities checklist daily at crossover meeting to ensure that narcotic sheets are documented on correctly starting 3/24/25 and ongoing. Wellness Nurse will inspect narc sheets as part of the monthly MAR to cart audits starting 3/18/25 and ongoing with oversight by the Resident Care Director
Ongoing Quality Assurance: These audits will be reviewed at the Quarterly QA Meeting on 4/15/25 and ongoing.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 07/03/2025)

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:
6. Dose.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #1 is prescribed Dorzol/Timol Sol, Latanoprost Sol, and Digoxin 0.125. However, the resident's Feb MAR does not indicate the diagnoses for these medications.

Resident #8 is prescribed Novolog 100 U/ML before meals and at bedtime based on a sliding scale (<65 notify MD, 0-150 = 0 units; 151-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; greater than 400 give 10 units and notify MD) . The resident's Feb MAR does not indicate the blood sugar reading and units given on 02/06/2025 before breakfast and 02/04/2025 before lunch.

Plan of Correction ***Accept ([redacted] - 04/17/2025)***

Immediate Corrective Action: RCD consulted physician and had pharmacy add diagnoses to the MAR for Resident #1's medications by 3/31/25. Glucometer only holds a 30-days of readings, so the MAR could not be corrected.
Additional Corrective Action: RCD will review SMART reports monthly to look for any missing diagnosis and correct beginning 3/31/25 and ongoing. Glucometer results in the EMar will be reviewed weekly by the RCD/Wellness Nurse for all insulin dependent diabetics in a weekly MAR to cart audit.
Ongoing Quality Assurance: MAR /CART review will be conducted on a weekly basis as well as number of units administered. These reports will be reviewed during the April 15, 2025, QA Meeting and ongoing.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 07/03/2025)

187b - Date/Time of Medication Admin.

23. Requirements

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

Description of Violation

Resident #9 is prescribed Clonazepam 0.5 mg (1/2 tab) twice a day at 08:00 AM and 08:00 PM. The resident's Feb MAR does not include the initials of the staff person who administered it on 02/01/2025 at 08:00 AM. The same medication was not signed out/administered on 02/02/2025 at 08:00 AM; however, there is staff initials as administered.

Plan of Correction ***Accept ([redacted] - 04/07/2025)***

Immediate Corrective Action: Resident Care Director will educate med techs on the 5 rights of Med Management/Documentation by 3/31/25.
Additional Corrective Action: Wellness Nurse will provide ongoing oversight in monthly MAR to cart audits starting 3/24/25.
Ongoing Quality Assurance Audit: These audits will be reviewed in the Quarterly QA Meeting being held on 4/15/25 and ongoing.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 07/03/2025)

187d - Follow Prescriber's Orders

24. Requirements

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

Description of Violation

Resident #8 is prescribed Novolog 100 U/ML before meals and at bedtime based on a sliding scale: 0-150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units.

- *On 02/03/2025 before lunch, the reading was 163, requiring 2 units of this medication. However, no medication was administered.*
- *On 02/06/2025 before lunch, the resident's blood sugar reading was 198, requiring 2 units of this medication . However, no medication was administered.*

Resident #9 is prescribed Clonazepam 0.5 mg 1/2 tab twice a day at 08:00 AM and 08:00 PM. The resident was not administered this medication on 02/02/2025 at 08:00 AM.

Repeat Violation: 04/30/2024

Plan of Correction ***Accept ([redacted] - 04/17/2025)***

Immediate Corrective Action: Resident Care Director will schedule immediate diabetic training for all med-techs 3/26/25.
Additional Corrective Action: Diabetic education will be completed for all Med Tech's by 3/31/25 by Diabetic Nurse. Wellness Nurse will provide weekly oversight of insulin delivery during MAR to Cart audits starting 3/18/25.
Ongoing Quality Assurance Overview: Audits will be reviewed during April 15, 2025, QA Meeting and ongoing.

Licensee's Proposed Overall Completion Date: *04/15/2025*

187d - Follow Prescriber's Orders *(continued)*

Implemented (- 07/03/2025)

191 - Resident Right to Refuse

25. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #2, admitted has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept (- 04/07/2025)***

Immediate Corrective Action: Executive Director educated BOM on ensuring that all files have a signed copy of resident rights on 3/19/25.
Additional Corrective Action: Executive Director will complete an audit of all residents' records to ensure all residents have a signed copy of Resident Rights by 4/4/25.
Ongoing Quality Assurance Actions: Executive Director and/or designee will review any newly completed Resident Agreements for the next three months and ongoing to verify all residents have signed a copy of resident rights in the residents' record. Audits will be reviewed at QA meeting April 15, 2025, and ongoing.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented (- 07/03/2025)

225c - Additional Assessment

26. Requirements

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

Description of Violation

Resident #10's current assessment was completed on . However, the resident's previous assessment was completed on

Plan of Correction ***Accept (- 04/07/2025)***

Immediate Corrective Action: Resident Care Director and Memory Care Director audited the due dates for all RASPS Tabula Pro on 3/21/24.
Additional Corrective Action: Resident Care Director will utilize Tabula Pro dashboard dates to review RASPs/DME in the morning clinical huddle starting on 3/18/25 and ongoing. Once completed, RCD/ED will audit a sampling of files on a monthly basis to ensure that RASPs/DMEs are up to date starting 3/31/25 and ongoing.
Ongoing Quality Assurance Actions: These audits will be reviewed and discussed during QA review starting on 4/15/25 and ongoing.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented (- 07/03/2025)

227c - Support Plan Revision

27. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #5's initial assessment and support plan, dated [redacted], does not include the use of a bedside mobility device. However, this device was observed attached to the resident's bed on 02/13/2025.

Plan of Correction ***Accept ([redacted] - 04/07/2025)***

Immediate Corrective Action: Community has updated the RASP to include the use of the mobility device on 3/24/25.
Additional Corrective Action: Audit of bedside mobility devices will be completed by the Resident Care Director by 4/4/25 for compliance. RCD will review as part of the quarterly QA process on 4/15/25 and ongoing.
Ongoing Quality Assurance Actions: RCD will review as part of the quarterly QA process on 4/15/25 and ongoing.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 07/03/2025)

233c - Key-Locking Devices

28. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the Exit door 30 from the Secured Dementia Care Unit (SDCU).

Plan of Correction ***Accept ([redacted] - 04/07/2025)***

Immediate Corrective Action: This was immediately corrected with the number to the door on the day of the survey 2/13/25.
Additional Corrective Action: Memory Care Director and Maintenance Director will audit doors on a weekly basis starting 3/24/25 and ongoing.
Ongoing Quality Assurance Actions: These audits will be reviewed at the Quarterly QA Meeting on April 15, 2025, and ongoing.

Licensee's Proposed Overall Completion Date: *04/15/2025*

Implemented ([redacted] - 07/03/2025)