

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

June 9, 2025

[REDACTED]
VS WALLINGFORD LLC
[REDACTED]

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

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/20/2025, 02/21/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: CHESTNUT RIDGE RETIREMENT LIVING License #: 14141 License Expiration: 04/04/2025
 Address: 2700 CHESTNUT PARKWAY, CHESTER, PA 19086
 County: DELAWARE Region: SOUTHEAST

Administrator

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

Legal Entity

Name: VS WALLINGFORD LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 96 Waking Staff: 72

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Complaint, Incident Exit Conference Date: 02/21/2025

Inspection Dates and Department Representative

02/20/2025 - On-Site: [REDACTED]
 02/21/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 130 Residents Served: 71

Secured Dementia Care Unit
 In Home: Yes Area: 4th & 5th floor Capacity: 30 Residents Served: 21

Hospice
 Current Residents: 6

Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 71
 Diagnosed with Mental Illness: 5 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 25 Have Physical Disability: 1

Inspections / Reviews

02/20/2025 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/22/2025

03/26/2025 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 03/22/2025
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/31/2025

Inspections / Reviews *(continued)*

04/02/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/31/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 04/14/2025

06/09/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/14/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

51 Criminal Background Check

1. Requirements

2600.

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

Description of Violation

Staff person A, whose date of hire is [REDACTED] has lived in the state of Pennsylvania for less than 2 years. However, as of [REDACTED] the home has not completed an FBI criminal background check for staff person A.

Repeat violation: [REDACTED] et al, [REDACTED] et al, [REDACTED] et al

Plan of Correction

Accept ([REDACTED] - 03/26/2025)

It is important to protect the safety and well-being of our residents and staff by ensuring a criminal background check is run on every new employee prior to their first day of employment. An onboarding process has been created and implemented to ensure all DHS regulatory requirements are met prior to a new hire attending orientation. The community hired an Employee Relations and Administration Coordinator (ERAC). This position will be responsible for the oversight of new hires and ensuring that the required paperwork is completed prior to the new employee's first day of work. The new ERAC was trained on 2/26/25 on all DHS requirements. The new ERAC's first day in [REDACTED] new position is 4/1/25. The ERAC will be responsible for conducting an audit on all new employee files within 1 week after their scheduled orientation. The Executive Director was trained on all DHS hiring requirements on 3/12/25 by the Regional Director of Operations, [REDACTED], PCHA, CALA. The Executive Director has conducted audits on all current employees to ensure every employee has a criminal background check/FBI clearances. The Executive Director will conduct random audits monthly on employee files to ensure all required documentation is on file. These audits will be reviewed at the monthly QAPI meetings, beginning 4/28/25 to ensure ongoing compliance.

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

Implemented ([REDACTED] - 05/21/2025)

64c Annual Training

2. Requirements

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person A, the home's administrator, completed only 21 hours of Department-approved training in training year 2024.

Plan of Correction

Directed ([REDACTED] - 04/02/2025)

It is important that all administrators meet the DHS training requirement of 24 hours of annual training, while working as an administrator. The community hired a new Executive Director on 2/3/25. The Executive Director was not employed as an administrator from 2/5/24 through 2/3/25. [REDACTED] did complete 21 annual hours of training on [REDACTED] own, while unemployed. [REDACTED] resumed working as a PCHA in February 2025 and has begun [REDACTED] annual trainings for 2025. The Executive Director will complete 24 hours of annual training relating to the job duties by December 31, 2025. The Regional Director of Operations, [REDACTED], PCHA, CALA reviews annual training hours with the Executive Director quarterly to ensure ongoing compliance with required training hours.

64c Annual Training (continued)

Proposed Overall Completion Date: 03/31/2025'

Directed steps of POC:

Immediately: An annual staff training plan shall be developed for the administrator which includes 24 hours of Department approved training.

Directed Completion Date: 04/04/2025

Implemented [REDACTED] 05/21/2025)

65a - FS Orientation 1st Day

3. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, whose first day of work was [REDACTED], did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, or, telephone use and notification of emergency services.

Repeat violation: [REDACTED] et al, [REDACTED] et al, [REDACTED] et al

Plan of Correction

Directed [REDACTED] - 04/02/2025)

It is important that all staff be provided with the proper training required to safely care for our residents prior to working on the floor. Staff person B was trained on all required 1st Day Orientation topics. The community hired Employee Relations and Administration Coordinator (ERAC). This position will be responsible for the oversight of new hires and ensuring that all required training topics are reviewed during a new employee's orientation class. The new ERAC was trained on 2/26/25 on all DHS requirements. The new ERAC's first day in [REDACTED] new position is [REDACTED]. A new Orientation Program was created and implemented to ensure all training requirements are included. We have new directors for this community. The new Executive Director, Director of Health & Wellness and Director of Memory Care were all training on Orientation training requirements on 3/12/25 by the Regional Director of Operations, [REDACTED] and the Regional Director of Health & Wellness [REDACTED]). The new Director of Plant Operations is scheduled to take the Fire Safety Expert class on 4/5/25. In the interim, the Regional Director of

65a - FS Orientation 1st Day (continued)

Operations () and the Senior Director of Plant Operations () will conduct the Fire Safety portion of orientation as scheduled for new hires. All staff will be receiving Fire Safety Training on 4/1/25, facilitated by a PA UCC Fire Inspector/NFPA Certified Fire Inspector. The ERAC will ensure all new hires receive all required training during Orientation. The Executive Director will conduct monthly employee file audits to ensure all training was completed and documented. All audits will be reviewed monthly at the QAPI meetings, beginning 4/28/25 to monitor for ongoing compliance.

Proposed Overall Completion Date: 03/31/2025

Directed steps of POC:

Within 3 days of the receipt of the plan of correction: All staff persons involved in the hiring and retention of staff shall be educated on the requirements of regulation 2600.65(a). Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 04/05/2025

Implemented () 06/09/2025)

65b - Rights/Abuse 40 Hours

4. 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

Staff person B completed () 40th scheduled work hour on (). However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), or, reporting of reportable incidents and conditions.

Repeat violation: () et al, () et al, () et al

Plan of Correction

Directed () 04/02/2025)

It is important that all staff be provided with the proper training required to safely care for our residents prior to working on the floor. Staff person B was trained on all required 1st Day Orientation topics. The community hired Employee Relations and Administration Coordinator (ERAC). This position will be responsible for the oversight of new hires and ensuring that all required training topics are reviewed during a new employee's orientation class. The new ERAC was trained on 2/26/25 on all DHS requirements. The new ERAC's first day in () new position is (). A new Orientation Program was created and implemented to ensure all training requirements are included. We have new directors for this community. The new Executive Director, Director of Health & Wellness and Director of Memory Care were all training on Orientation training requirements on 3/12/25 by the Regional Director of Operations, () and the Regional Director of Health & Wellness (). The ERAC will ensure all new

65b Rights/Abuse 40 Hours (continued)

hires receive all required training during Orientation. The Executive Director will conduct Rights/Abuse 40 Hours training on 4/3/25 to current staff who have not previously received the training. The Executive Director will conduct monthly employee file audits to ensure all training was completed and documented. All audits will be reviewed monthly at the QAPI meetings, beginning 4/28/25 to monitor for ongoing compliance.

Proposed Overall Completion Date: 03/31/2025

Directed steps of POC:

Within 3 days of the receipt of the plan of correction: All staff persons involved in the hiring and retention of staff shall be educated on the requirements of regulation 2600.65(b). Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: 03/31/2025

Implemented [redacted] - 06/09/2025)

82c - Locking Poisonous Materials

6. 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] at 11:07 am, the following were unlocked, unattended, and accessible in room [redacted]. Not all the residents of the home, including resident [redacted] have been assessed capable of recognizing and using poisons safely:

- Air freshener/disinfectant, with a manufacturer's label indicating "If swallowed Immediately call a poison control center or doctor for treatment advice".
- Roll on anti perspirant, with a manufacturer's label indicating "If swallowed get help or contact a Poison Control Center.
- Tartar Control mouthwash, with a manufacturer's label indicating "If more than used for rinsing is accidentally swallowed, get medical help or contact a Poison Control Center right away".

On [redacted], at 10:59 am, the following were unlocked, unattended, and accessible in room [redacted]. Not all the residents of the home, including resident [redacted] have been assessed capable of recognizing and using poisons safely:

- Toothpaste, with a manufacturer's label indicating "If more than used for brushing is accidentally swallowed get medical help or contact a Poison Control Center right away".
- [redacted], with a manufacturer's label indicating "If swallowed get medical help or contact a Poison Control Center right away".
- [redacted], with a manufacturer's label indicating "If swallowed get medical help or contact a Poison Control Center right away"

On [redacted] at 11:10 am, the following was unlocked, unattended, and accessible in room [redacted]. Not all the residents of the home, including resident [redacted], have been assessed capable of recognizing and using poisons safely:

- Toothpaste, with a manufacturer's label indicating "If more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away".

On 2/20/2025, at 10:44 am, Hand Sanitizer, with a manufacturer's label indicating "if swallowed, get medical help or

82c Locking Poisonous Materials (continued)

contact a Poison Control Center right away", was unlocked, unattended, and accessible to residents in the 5th floor common/activity room. Not all the residents of the home, including residents [REDACTED] and [REDACTED], have been assessed capable of recognizing and using poisons safely.

Repeat violation: [REDACTED] et al, [REDACTED] et al, [REDACTED] et al

Plan of Correction

Accept [REDACTED] - 03/26/2025)

It is important for the safety and well being of our residents that all poisonous materials be securely locked at all times. Staff (Director of Memory Care, Memory Care direct care staff and housekeeping staff) were re educated on poisonous materials on 3/18/25, by the Regional Director of Operations, [REDACTED] PCHA, CALA. The maintenance staff installed new locking cabinetry in each memory care room. All cabinets were installed by 3/18/25. The Director of Memory Care/designee is conducting daily poisonous material audits of each room and common area in our secured memory care units. These audits began 3/15/25. All audits are reviewed weekly by the Executive Director and Regional Director of Health and Wellness. On 3/18/25 posters were produced and placed in the secured memory care units as well as employee breakroom to remind staff of what poisonous materials consist of. All staff have been educated that if any poisonous materials are left unsecured, they will be disciplined/terminated as needed. All audits will be reviewed monthly at the QAPI meetings, beginning 4/28/25 to monitor for ongoing compliance.

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

Implemented [REDACTED] - 05/21/2025)

103e - Left Overs

7. 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 [REDACTED] at 10:45 am:

- there was an unlabeled, undated and uncovered bowl of partially melted ice cream in the 5th floor freezer.
- there were undated and unlabeled containers of applesauce in the 5th floor refrigerator.

Repeat violation: [REDACTED] et al

Plan of Correction

Accept [REDACTED] - 03/26/2025)

It is important to ensure all leftovers are dated and properly disposed of. The Director of Dining will be re educating all dining staff on leftovers, dating food and disposing of food on 3/24/25. On 3/18/25, the Executive Director re educated nursing staff on the proper usage of facility refrigerators/freezers. Staff are only permitted to place personal food in the provided refrigerator in the staff breakroom. The Director of Dining will be conducting weekly audits of all kitchen refrigerators to ensure all food is dated and disposed of. The Executive Director/designee will conduct random weekly refrigerator checks to ensure staff remain in compliance with only using the provided refrigerator for personal food items. These audits will be reviewed monthly by the Executive Director at the QAPI meetings, beginning 4/25/25 to monitor for ongoing compliance.

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

103e - Left Overs (continued)

Implemented [REDACTED] - 05/21/2025)

141b1 - Annual Medical Evaluation

8. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident [REDACTED] most recent medical evaluation was completed on [REDACTED]

Repeat violation: [REDACTED] et al, [REDACTED] et al

Plan of Correction

Accept [REDACTED] - 04/02/2025)

It is important that all residents receive an annual medical evaluation. On 2/21/25, the Director of Memory Care was re-educated on the importance of having medical evaluations completed timely. The community has hired a new Director of Health & Wellness and a new Director of Memory Care. These directors were educated on medical evaluations by the Regional Director of Operations [REDACTED] and the Regional Director of Health & Wellness ([REDACTED]) on 3/12/25. The Regional Director of Health & Wellness created a tickler system in the electronic medical chart for residents (ECP). This tickler will provide the DHW and DMC with alerts to ensure all residents' medical evaluations are completed annually and within the required timeframe. The Regional Director of Health and Wellness or designee will complete monthly audits to ensure ongoing compliance. On 2/21/25, DMC located most recent DME, dated 10/17/24 and filed document in resident's chart. The community will also employ two Wellness nurses by 4/30/25; the Wellness nursing team will also receive educating/training on medical evaluations in accordance with PA 2600 regulations.

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

Implemented [REDACTED] - 05/21/2025)

190a - Completion Medication Course

9. Requirements

2600.

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

Description of Violation

Staff person B, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:

- On [REDACTED] at 10:54 am, [REDACTED] Ec Tablet, [REDACTED] Tablet, [REDACTED] [REDACTED] Tab and [REDACTED] tablet to resident [REDACTED].

Plan of Correction

Accept [REDACTED] - 03/26/2025)

It is important that any staff person administering medications has completed the required DHS approved medication administration course. The Regional Director of Health and Wellness, [REDACTED] is now our DHS approved medication administration trainer. [REDACTED] reviewed all medication technician certifications to ensure that all

190a Completion Medication Course (continued)

were accurate and up to date. Staff person B is no longer administering medications. A binder has been created for easy access to all required medication technician certifications and observations. The Director of Health and Wellness is responsible for reviewing this binder monthly and ensuring all required documentation is up to date. The Regional Director of Health and Wellness will review this binder monthly to ensure ongoing compliance.

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

Implemented [redacted] - 05/21/2025)

190b - Insulin Injections

10. Requirements

2600.

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

Description of Violation

On [redacted] at 11:16 am, staff person B, who has not successfully completed the Department approved medications administration course, administered insulin to resident [redacted]

Repeat violation: [redacted] et al

Plan of Correction

Accept [redacted] - 03/26/2025)

It is important that any staff person administering medications has completed the required DHS approved medication administration course as well as diabetic training. A new process has been implemented to schedule diabetic training every 6 months or as needed to ensure all medication technicians remain in compliance with trainings, certifications and observations. The Regional Director of Health and Wellness, [redacted] is now our DHS approved medication administration trainer. [redacted] reviewed all medication technician certifications to ensure that all were accurate and up to date and all med tech have diabetic training. It is a community requirement that all medication technicians receive diabetic training, effective 3/1/25. Staff person B is no longer administering medications. A binder has been created for easy access to all required medication technician certifications and observations. The Director of Health and Wellness is responsible for reviewing this binder monthly and ensuring all required documentation is up to date. The Regional Director of Health and Wellness will review this binder monthly to ensure ongoing compliance.

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

Implemented [redacted] 05/21/2025)

190c - Record of Training

11. Requirements

2600.

190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

Staff person B began the initial medication administration training course on [redacted] The home's medication administration training record for staff person B does not include the electronic User Report documenting successful completion of the online examinations and observations.

190c - Record of Training (continued)

Plan of Correction

Accept [REDACTED] 03/26/2025)

It is important that any staff person administering medications has completed the required DHS approved medication administration course as well as diabetic training. A new process has been implemented to schedule diabetic training every 6 months or as needed to ensure all medication technicians remain in compliance with trainings, certifications and observations. The Regional Director of Health and Wellness, [REDACTED] is now our DHS approved medication administration trainer. [REDACTED] reviewed all medication technicians certifications to ensure that all were accurate and up to date and all med tech have diabetic training. It is a community requirement that all medication technicians receive diabetic training, effective 3/1/25. Staff person B is no longer administering medications. A binder has been created for easy access to all required medication technician certifications and observations. The Director of Health and Wellness is responsible for reviewing this binder monthly and ensuring all required documentation is up to date. The Regional Director of Health and Wellness will review this binder monthly to ensure ongoing compliance.

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

Implemented [REDACTED] - 05/21/2025)

225a - Assessment 15 Days

12. Requirements

2600.

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

Description of Violation

An assessment was not completed for resident [REDACTED] who was admitted to the home on [REDACTED].

Plan of Correction

Directed ([REDACTED] - 04/02/2025)

It is important that all resident assessments be completed within 15 days of admission to remain in compliance with DHS regulations. The community has hired a new Director of Health & Wellness and a new Director of Memory Care. These directors were educated on RASPs by the Regional Director of Operations ([REDACTED]) and the Regional Director of Health & Wellness ([REDACTED]) on 3/12/25. The DMC conducted a complete audit of Memory Care charts on 3/10/25; charts found out of compliance were updated to reflect accurate and timely documentation. The Regional Team, [REDACTED] and [REDACTED] or designee will conduct random monthly RASP audits of 5 residents to ensure all care plans/assessments are in the timeframes per DHS regulations. These audits will be reviewed monthly by the Executive Director at the QAPI meetings, beginning 4/28/25 to monitor for ongoing compliance. The community will also employ two Wellness nurses by 4/30/25; the Wellness nursing team will also receive educating/training on Initial Assessments in accordance with PA 2600 regulations.

Proposed Overall Completion Date: 03/31/2025

Directed steps of POC:

Within 10 days of the receipt of the plan of correction: The administrator or designated staff person shall review all resident records to ensure all residents have a current assessment completed. Documentation of the audit shall be kept.

225a Assessment 15 Days (continued)

Directed Completion Date: 04/12/2025

Implemented [redacted] - 06/09/2025)

225c - Additional Assessment

13. 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 an assessment for using the telephone, judgement and aggression.

Plan of Correction

Directed [redacted] - 04/02/2025)

It is important that all areas of the resident's assessment are completed. Resident [redacted], assessment was reviewed and updated. The new Director of Health and Wellness and the new Director of Memory Care received training on care plans on 3/12/25 by the Regional Director of Operations, [redacted] and the Regional Director of Health & Wellness, [redacted]. The DMC conducted a complete audit of Memory Care charts on 3/10/25; charts found out of compliance were updated to reflect accurate and timely documentation. The Regional Team, [redacted] and [redacted] or designee will conduct random monthly RASP audits of 5 residents to ensure all care plans/assessments are completed appropriately and in it entirety. These audits will be reviewed monthly by the Executive Director at the QAPI meetings, beginning 4/25/25 to monitor for ongoing compliance. The community will also employ two Wellness nurses by 4/30/25; the Wellness nursing team will also receive educating/training on RASPs in accordance with PA 2600 regulations.

Proposed Overall Completion Date: 03/31/2025

Directed steps of POC:

Within 10 days of the receipt of the plan of correction: The administrator or designated staff person shall review all resident records to ensure all residents have a current assessment completed. Documentation of the audit shall be kept.

Directed Completion Date: 04/12/2025

Implemented [redacted] - 06/09/2025)

227g -Support Plan Signatures

14. Requirements

2600.

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

Description of Violation

Resident [redacted] participated in the development of [redacted] support plan on [redacted]. However, the resident did not sign the support plan.

227g Support Plan Signatures (continued)

Repeat violation: [REDACTED] et al

Plan of Correction

Directed [REDACTED] - 04/02/2025)

It is important that all residents participate in their care plans and sign off on the care plan. Resident [REDACTED] care plan was reviewed with the resident and signed off on. The new Director of Health and Wellness and the new Director of Memory Care received training on care plans on 3/12/25 by the Regional Director of Operations, [REDACTED] and the Regional Director of Health & Wellness, [REDACTED]. The DMC conducted a complete audit of Memory Care charts on 3/10/25; charts found out of compliance were updated to reflect accurate and timely documentation. The Regional Team, [REDACTED] and [REDACTED] or designee will conduct random monthly RASP audits of 5 residents to ensure all care plans/assessments are signed off on by each resident. These audits will be reviewed monthly by the Executive Director at the QAPI meetings, beginning 4/28/25 to monitor for ongoing compliance. The community will also employ two Wellness nurses by 4/30/25; the Wellness nursing team will also receive educating/training on RASPs in accordance with PA 2600 regulations.

Proposed Overall Completion Date: 03/31/2025

Directed steps of POC:

Within 10 days of the receipt of the plan of correction: The administrator or designated staff person shall review all resident records to ensure all resident support plans have signatures. Documentation of the audit shall be kept.

Directed Completion Date: 04/12/2025

Implemented [REDACTED] - 06/09/2025)

231b - Medical Evaluation

15. Requirements

2600.

231.b. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident’s diagnosis of Alzheimer’s disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident [REDACTED] was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED] however, the resident’s medical evaluation was completed on [REDACTED]

Plan of Correction

Accept ([REDACTED] 04/02/2025)

It is important that all resident's medical evaluation is completed in the time frame as required by DHS, this includes annual evaluations and new admission evaluations. On 2/21/25, the Director of Memory Care was re educated on the importance of having medical evaluations completed timely; re education included when medical evaluations are due for both PC and SDCU residents as well as what portions need to be completed by the physician and also where/how to appropriately document addendums or supplemental information. The community has hired a new Director of Health & Wellness and a new Director of Memory Care. These directors were educated on medical evaluations by the Regional Director of Operations ([REDACTED]) and the Regional Director of Health & Wellness ([REDACTED]) on 3/12/25. The Regional Team ([REDACTED] and [REDACTED]) or designee will complete monthly audits to ensure ongoing compliance. These audits will be reviewed monthly by the Executive Director at the QAPI meetings, beginning 4/28/25 to monitor for ongoing compliance.

231b - Medical Evaluation (continued)

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

Implemented [REDACTED] - 06/09/2025)

231c - Preadmission Screening

16. Requirements

2600.

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

Description of Violation

Resident [REDACTED] was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]. However, resident [REDACTED] written cognitive preadmission screening was completed on [REDACTED].

Repeat violation. [REDACTED] et al

Plan of Correction

Accept [REDACTED] - 04/02/2025)

It is important that all resident's Preadmission Screening completed in the time frame as required by DHS, this includes annual evaluations and new admission evaluations. On 2/21/25, the Director of Memory Care was re-educated on the importance of having medical evaluations completed timely; re-education included when medical evaluations are due for both PC and SDCU residents as well as what portions need to be completed by the physician and also where/how to appropriately document addendums or supplemental information. The community has hired a new Director of Health & Wellness and a new Director of Memory Care. These directors were educated on medical evaluations by the Regional Director of Operations [REDACTED] and the Regional Director of Health & Wellness [REDACTED] on 3/12/25. The Regional Team [REDACTED] and [REDACTED] or designee will complete monthly audits to ensure ongoing compliance. These audits will be reviewed monthly by the Executive Director at the QAPI meetings, beginning 4/28/25 to monitor for ongoing compliance. The community will also employ two Wellness nurses; the Wellness nursing team will also receive educating/training on Preadmission Screenings in accordance with PA 2600 regulations.

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

Implemented [REDACTED] - 06/09/2025)

231e - No Objection Statement

17. Requirements

2600.

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

Description of Violation

Resident [REDACTED] was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction

Accept [REDACTED] 03/26/2025)

It is important that all new residents and the designated person are made aware that the memory care unit is a locked, secured unit and they sign off that they were educated on this prior to admission to the unit. Resident [REDACTED] was re-educated on this secured unit and signed off on the No Objection Acknowledgment. It is the responsibility of the Director of Sales and Marketing to ensure this form is reviewed and signed at the time of admission. The Director

231e - No Objection Statement (continued)

of Memory Care will be responsible for auditing all new admissions to the memory care unit resident file within 24 hours of admission to ensure this form was completed. The ERAC will be responsible for conducting monthly audits on all new admissions to ensure the required documentation is in the resident financial file. These audits will be reviewed monthly by the Executive Director at the QAPI meetings, beginning 04/28/25 to monitor for ongoing compliance.

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

Implemented [redacted] - 06/09/2025)

234a - Admission Support Plan

18. Requirements

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident [redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, on [redacted], there was no verification provided of a support plan having been completed.

Repeat violation: [redacted] et al, [redacted]

Plan of Correction

Directed [redacted] - 04/02/2025)

It is important that all memory care residents have a completed care plan within 72 hours of admission. On 2/21/25, the Director of Memory Care was re-educated on the importance of having medical evaluations completed timely; re-education included when medical evaluations are due for both PC and SDCU residents as well as what portions need to be completed by the physician and also where/how to appropriately document addendums or supplemental information. The community has hired a new Director of Health & Wellness and a new Director of Memory Care. These directors were educated on RASPs by the Regional Director of Operations [redacted] and the Regional Director of Health & Wellness [redacted] on 3/12/25. The Regional Team [redacted] and [redacted] or designee will complete monthly audits to ensure ongoing compliance. These audits will be reviewed monthly by the Executive Director at the QAPI meetings, beginning 04/28/25 to monitor for ongoing compliance.

Proposed Overall Completion Date: 03/31/2025

Directed steps of POC:

Immediately: A support plan shall be developed, implemented and documented in resident [redacted] record.

Directed Completion Date: 04/04/2025

Implemented [redacted] - 06/09/2025)