Pennsylvania
Department of Human Services

Sent via e-mail [redacted]
June 10, 2025

[redacted]
Interim Executive Director
600 Paoli Pointe Drive Operations LLC
600 Paoli Pointe Drive
Paoli, Pennsylvania 19301

RE: Highgate at Paoli Pointe
License #: 13610

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on May 8, 2025 and June 9, 2025 of the above facility, we have determined that the submitted plan of correction for the March 20, 2025 inspection is not implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

[redacted]

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *HIGHGATE AT PAOLI POINTE* **License #:** *13610* **License Expiration:** *10/02/2025*

Address: *600 PAOLI POINTE DRIVE, PAOLI, PA 19301*

County: *CHESTER* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *600 PAOLI POINTE DRIVE OPERATIONS LLC*

Address: *600 PAOLI POINTE DRIVE, PAOLI, PA, 19301*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *05/15/1996* **Issued By:** *COPA L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *68* **Waking Staff:** *51*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *03/20/2025*

Inspection Dates and Department Representative

03/20/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *124* **Residents Served:** *49*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *3rd floor* **Capacity:** *30* **Residents Served:** *18*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *49*

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

Have Mobility Need: *19* **Have Physical Disability:** *0*

Inspections / Reviews

03/20/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/11/2025*

06/09/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *04/11/2025*
Reviewer: [redacted]
Follow-Up Type: *Bypass Document Submission*

06/09/2025 - Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *06/09/2025*
Reviewer: [redacted]
Follow-Up Type: *Exception*

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, hired [redacted] did not have a background check requested until [redacted]

Plan of Correction ***Directed ([redacted] - 05/08/2025)***

An audit is in process, by The Administrator and business manager, to ensure all background checks are completed properly. it began on 3/21/25 and will be completed by 4/30/25. The business manger will be responsible for maintaining compliance.

Proposed Overall Completion Date: 04/30/2025

Directed Step of POC:

In addition to the above-mention plan:

Within 10 days of receipt of the plan of correction: *The administrator and any staff person involved in the hiring and retention of staff shall review the Older Adult Protective Services Act. Documentation of the review shall be kept.*

Directed Completion Date: *05/18/2025*

Update: *05/08/2025*

More information is needed.

Please indicate the immediate action that was taken to correct the violation.

Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Bypass Document Submission ***Not Implemented ([redacted] - 06/09/2025)***

65a - FS Orientation 1st Day

2. 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.

65a - FS Orientation 1st Day *(continued)*

Description of Violation

Staff person A, 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, telephone use and notification of emergency services until 2/19/2025.

Repeat violation: 9/17/2024, 7/2/2024

Plan of Correction ***Directed ([redacted] - 05/08/2025)***

Administrator and business manager will be doing an audit to ensure the 1st day of orientation has all required topics covered to all new hires. it began on 3/21/2025 and will be completed by 4/30/25. Business manager will be responsible for maintaining compliance.

Proposed Overall Completion Date: 04/30/2025

Directed Step of POC:

In addition to the above-mention plan:

Within 10 days of receipt of the accepted plan of correction: *All staff persons involved in the hiring and retention of staff shall be educated on the home's policy and procedures for new staff person training including the requirements of regulation 2600.65(a). Documentation of education shall be kept in accordance with 2600.65i.*

Directed Completion Date: *05/18/2025*

Update: *05/08/2025*

More information is needed.

Please indicate the immediate action that was taken to correct the violation.

Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Bypass Document Submission ***Not Implemented ([redacted] - 06/09/2025)***

65e - 12 Hours Annual Training

3. 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 B received 0 hours of annual training in training year 2024.

Direct care staff person C received 0 hours of annual training in training year 2024.

65e - 12 Hours Annual Training *(continued)*

Plan of Correction ***Directed (- 05/08/2025)***

Administrator and business manager has a new training program for new hires and the current workers. An audit is being done starting on 3/24/25 to ensure 12 hours of annual training is being done correctly. Then the audit will be done on 4/30/25. Moving forward all training requirements will be done by the business manager.

Proposed Overall Completion Date: 04/30/2025

Directed Step of POC:

In addition to the above-mention plan:

Within 10 days of receipt of the accepted plan of correction: *The administrator or designated staff person shall monitor all direct care staff training through the quality management review process to ensure all staff persons receive the required 12 hours of annual training.*

Directed Completion Date: *05/18/2025*

Update: *05/08/2025*

More information is needed.

Please indicate the immediate action that was taken to correct the violation.

Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Bypass Document Submission ***Not Implemented (- 06/09/2025)***

65f - Training Topics

4. Requirements

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

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

Description of Violation

Direct care staff person B did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques , or, care for

65f - Training Topics (continued)

residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2024.

Direct care staff person C did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, personal care service needs of the resident, safe management techniques , or, care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2024.

Repeat violation: 11/26/2024, 9/17/2024, 7/2/2024

Plan of Correction ***Directed ([redacted] - 05/08/2025)***

An audit is in process, by administrator and business manager, to ensure all staff training topics are completed properly. It began on 3/24/25 and will be completed by 4/30/25. The business manager will be responsible for maintaining compliance.

Proposed Overall Completion Date: 04/30/2025

Directed Steps of POC:

In addition to the above-mention plan:

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

Within 10 days of receipt of the accepted plan of correction: *The administrator or designee shall review all required staff training as part of the quality management review process to ensure all staff persons receive the required annual training in accordance with regulation 2600.65(f) and a record of all training is maintained in the staff records.*

Directed Completion Date: *05/18/2025*

Update: *05/08/2025*

More information is needed.

Please indicate the immediate action that was taken to correct the violation.

Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Bypass Document Submission ***Not Implemented ([redacted] - 06/09/2025)***

65g - Annual Training Content

5. Requirements

2600.

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

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

Description of Violation

Staff person B did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, or, new population groups that are being served at the home that were not previously served, if applicable during training year 2024.

Staff person C did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, or, new population groups that are being served at the home that were not previously served, if applicable during training year 2024.

Staff person D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, or, new population groups that are being served at the home that were not previously served, if applicable during training year 2024.

Repeat violation: 11/26/2024, 9/17/2024, 7/2/2024

Plan of Correction ***Directed ([redacted] - 05/08/2025)***

The Maintenance director is now a fire safety expert. Also audits will be done by the administrator and business manager starting on 3/24/25 and will be completed by 4/30/25. The business office will be responsible for maintaining compliance.

Proposed Overall Completion Date: 04/30/2025

Directed Steps of POC:

65g - Annual Training Content (continued)

In addition to the above-mention plan:

Immediately: *Staff persons B, C and D shall receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, or, new population groups that are being served at the home that were not previously served, if applicable. Documentation of education shall be kept in accordance with 2600.65i.*

Within 10 days of receipt of the accepted plan of correction: *The administrator or designee shall review all required staff training as part of the quality management review process to ensure all staff persons receive the required annual training in accordance with regulation 2600.65(g) and a record of all training is maintained in the staff records.*

Directed Completion Date: *05/18/2025*

Update: *05/08/2025*

More information is needed.

Please indicate the immediate action that was taken to correct the violation.

Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Bypass Document Submission ***Not 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

Head and Shoulders Dry Scalp Care Shampoo, with a manufacture's label indicating "If swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to residents in room 308. Not all the residents of the home, including resident [redacted] have been assessed capable of recognizing and using poisons safely.

Zinc Oxide Paste, with a manufacture's label indicating "If swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to residents in room 318. Not all the residents of the home, including resident [redacted] have been assessed capable of recognizing and using poisons safely.

Crest Pro Health Toothpaste, with a manufacture's label indicating "If more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away", and, Gillette Clear Shield anti perspirant/deodorant, with a manufacture's label indicating "If swallowed, get medical help or contact a Poison Control Center right away" was unlocked, unattended, and accessible to residents in room 322. Not all the residents of the home, including resident [redacted] have been assessed capable of recognizing and using poisons safely.

Repeat violation: 11/26/2024

82c - Locking Poisonous Materials (continued)

Plan of Correction ***Directed ([redacted] - 05/08/2025)***

An audit is in process, by administrator and memory care director, to ensure that poisonous materials are locked. It began on 3/21/25 and will be completed by 4/30/25. The memory care director will be responsible for maintaining compliance.

Proposed Overall Completion Date: 04/30/2025

Directed POC:

Immediately: *A designated staff person will check the home daily on each shift to ensure poisonous materials are locked and inaccessible to residents.*

Within 3 days of receipt of the plan of correction: *All staff persons shall be educated concerning the safe storage of poisonous materials and the risks to residents. Documentation of education shall be kept in accordance with 2600.65i.*

Within 7 days of receipt of the plan of correction: *The administrator shall monitor the home weekly to ensure poisonous materials are locked and inaccessible to residents. Documentation of monitoring shall be kept for review by the Department.*

Directed Completion Date: *05/15/2025*

Update: *05/08/2025*

More information is needed.

Please indicate the immediate action that was taken to correct the violation.

Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Bypass Document Submission ***Not Implemented ([redacted] - 06/09/2025)***

86b - Bathroom

7. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathrooms in rooms 305, 308 and 314, do not have an operable window or ventilation fan. The ventilation fans are inoperable and there are no windows in the bathroom.

Repeat violation: 11/24/2024, 11/14/2024

Plan of Correction ***Directed ([redacted] - 05/08/2025)***

The maintenance director is to do audits every week for three months until compliance is met. Audit began on 3/25/25 and will be finished 6/25/25. Rooms that need to be fixed will be done by the maintenance director. The

86b - Bathroom (continued)

maintenance director will be maintaining compliance.

Proposed Overall Completion Date: 06/25/2025

Directed POC:

Immediately: *A designated staff person shall check all bathrooms at least weekly to ensure there is an operable outside window or an operable exhaust fan. If the exhaust fan is inoperable and there is no outside window repairs to the exhaust fan will be made immediately.*

Directed Completion Date: *05/10/2025*

Update: *05/08/2025*

The overall completion date is too far in the future.

More information is needed.

Please indicate the immediate action that was taken to correct the violation.

Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Bypass Document Submission ***Not Implemented ([redacted] - 06/09/2025)***

91 - Telephone Numbers

8. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephones in rooms 314 and 325.

Plan of Correction ***Accept ([redacted] - 04/11/2025)***

All rooms have emergency telephone numbers in place with all information. Audit is in process and begins on 3/25/25, with a completion date of 4/25/25. The Maintenance Director will maintain compliance.

Licensee's Proposed Overall Completion Date: *04/25/2025*

Bypass Document Submission ***Not Implemented ([redacted] - 06/09/2025)***

95 - Furniture and Equipment

9. Requirements

95 - Furniture and Equipment *(continued)*

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The ceiling light in the shower of the bathroom in room 314 continuously flickers.

Plan of Correction ***Directed (- 05/08/2025)***

Rooms Audits for ceiling light in showers began on 3/25/25, with completion date of 4/25/25. Rooms will be fixed by the maintenance director and keep in compliance too.

Proposed Overall Completion Date: 04/25/2025

Directed POC:

Immediately: *A designee shall check the home daily to ensure furniture and equipment is in good repair, clean and free of hazards. Any hazards shall be immediately corrected. If furniture or equipment is in disrepair and cannot be repaired immediately it shall be immediately removed from service.*

Directed Completion Date: *05/10/2025*

Update: *05/08/2025*

More information is needed.

Please indicate the immediate action that was taken to correct the violation.

Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Bypass Document Submission ***Not Implemented (- 06/09/2025)***

101j7 - Lighting/Operable Lamp

10. Requirements

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

Description of Violation

Resident 3 does not have access to a source of light that can be turned on/off at bedside.

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

Repeat violation: 11/26/2024, 9/17/2024, 2/26/2024

Plan of Correction ***Directed (- 05/08/2025)***

All rooms will be audited for lights at the bedside, began on 3/25/25 and completion date of 4/25/25. The maintenance director will be responsible for maintaining compliance.

Proposed Overall Completion Date: 04/25/2025

Directed POC:

101j7 - Lighting/Operable Lamp (continued)

Immediately: *A designated staff person shall check the home at least daily to ensure all resident beds have an operable bedside lamp or source of lighting that can be turned on/off from bedside.*

Directed Completion Date: *05/10/2025*

Update: *05/08/2025*

More information is needed.

Please indicate the immediate action that was taken to correct the violation.

Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Bypass Document Submission ***Not Implemented ([redacted] - 06/09/2025)***

102i - Soap Dispenser

11. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

There was not an available dispenser with soap within reach of the bathroom sinks in rooms 305, 306, 308 or 318.

Plan of Correction ***Directed ([redacted] - 05/08/2025)***

The memory care director is in the process of doing audits to ensure that access to soap is in the bathroom for residents. Audit began on 3/25/25 and will be done by 4/25/25. The memory care director will be responsible for maintaining compliance.

Proposed Overall Completion Date: 04/25/2025

Directed POC:

Within 10 days of receipt of the approved plan of correction: *All staff persons shall be educated on the need to maintain soap at each bathroom sink, including the health risk involved in not providing soap for proper hand washing and the use of shared soap. Documentation of education shall be kept in accordance with 2600.65i.*

Within 10 days of receipt of the approved plan of correction: *The administrator will monitor the home weekly to ensure a dispenser of soap is available and bar soap is clearly labeled at each bathroom sink. Documentation of the checks shall be kept.*

Directed Completion Date: *05/18/2025*

Update: *05/08/2025*

More information is needed.

Please indicate the immediate action that was taken to correct the violation.

102i - Soap Dispenser (continued)

Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Bypass Document Submission ***Not Implemented ([redacted] - 06/09/2025)***

183e - Storing Medications

12. 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 3/20/2025 at 1:30 pm, there were 5 loose pills observed in the medication cart.

Plan of Correction ***Directed ([redacted] - 05/08/2025)***

The nursing director will do audits to ensure that pills are stored correctly and not to be loose on carts. The audit began on 3/21/25 and will be done on 4/21/25. The nursing director will be responsible for maintaining compliance.

Proposed Overall Completion Date: 04/25/2025

Directed steps of POC:

Immediately: *A designated staff person qualified to administer medications shall check the medication cart at least daily to ensure all medications are properly packaged and stored including that there are no unpackaged or loose medications in the medication cart. Documentation of checks shall be kept.*

Within 10 days of receipt of the plan of correction: *All staff persons administering medication shall be reeducated on medication administration and storage practices. Documentation of the training shall be kept in accordance with 2600.65i.*

Directed Completion Date: *05/18/2025*

Update: *05/08/2025*

More information is needed.

Please indicate the immediate action that was taken to correct the violation.

Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Bypass Document Submission ***Not Implemented ([redacted] - 06/09/2025)***

185a - Implement Storage Procedures

13. Requirements

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

185a - Implement Storage Procedures *(continued)*

Description of Violation

On 3/20/2025 at 1:40 pm, the following pro re nata (PRN) medications prescribed to resident 5 were not available in the home: Prochlorperazine 10 mg tab and Hyoscyamine Sulf 0.125 mg tab.

Plan of Correction ***Directed ([redacted] - 05/08/2025)***

The nursing director will be doing audit to ensure there are no issues with medications not being here at the community for residents. The audit began on 3/25/25 and will be finished on 4/25/25. The nursing director will be responsible for maintaining compliance.

Proposed Overall Completion Date: 04/25/2025

Directed Steps of POC:

Immediately: *The administrator or designated person qualified to administer medication shall complete an initial and monthly audit of the medication cart and prescription orders to ensure all medications are available in the home and available for administration***.**

Within 10 days of receipt of the accepted plan of correction: *All staff persons qualified to administer medications shall be educated on the home's policy and procedures for ordering and distribution of medications and the home's policy and procedures for ordering medications to ensure all prescribed medications, including as needed "PRN" medications, are available in the home for administration. Documentation of education shall be kept in accordance with 2600.65i.*

Directed Completion Date: *05/18/2025*

Update: *05/08/2025*

More information is needed.

Please indicate the immediate action that was taken to correct the violation.

Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Bypass Document Submission ***Not Implemented ([redacted] - 06/09/2025)***

236 - Staff Training

14. Requirements

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

Description of Violation

Direct care staff person B, who works in the Secure Dementia Care Unit (SDCU) had 0 hours of training in dementia care during the 2024 training year.

236 - Staff Training (continued)

Direct care staff person C, who works in the Secure Dementia Care Unit (SDCU) had 0 hours of training in dementia care during the 2024 training year.

Plan of Correction ***Directed ([redacted] - 05/08/2025)***

Business managers are in the process of auditing to ensure all staff has dementia training. Staff that don't have training will be required to attend dementia training led by the nursing director and memory care director. The audit begun on 3/25/25 and will be finished by 4/25/25. Business manager will be responsible for making sure training is being done and keeping up with the compliance to this topic.

Proposed Overall Completion Date: 04/25/2025

Directed Step of POC:

In addition to the above-mention plan:

Within 10 days of receipt of the accepted plan of correction: *The administrator or designated staff person shall monitor all direct care staff training through the quality management review process to ensure all staff persons receive the required additional 6 hours of dementia-related training.*

Directed Completion Date: *05/18/2025*

Update: *05/08/2025*

More information is needed.

Please indicate the immediate action that was taken to correct the violation.

Please include detailed information regarding start dates, frequencies and titles of person responsible for each step.

Bypass Document Submission ***Not Implemented ([redacted] - 06/09/2025)***