pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **WYNDMOOR ASSISTED LIVING COMPANY LLC**
LEGAL ENTITY

To operate **SPRINGFIELD SENIOR LIVING COMMUNITY**
NAME OF FACILITY OR AGENCY

Located at **551 EAST EVERGREEN AVENUE, WYNDMOOR, PA 19038**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Assisted Living-Special Care**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **103**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Special Care Unit - 55 Pa.Code §§ 2800.231-239 - Capacity 34**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2800: Assisted Living Residences
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **July 23,** **2025** until **July 23,** **2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **144840**

ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing date: July 23, 2025

[redacted]
[redacted]
Wyndmoor Assisted Living Company, LLC
551 East Evergreen Avenue
Wyndmoor, Pennsylvania 19038

RE: Springfield Senior Living Community
License #: 144840

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on January 22 and 23, 2025 and March 31, 2025, we have found the above facility to be in compliance with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

Facility Information

Name: *SPRINGFIELD SENIOR LIVING COMMUNITY* **License #**: *14484* **License Expiration**: *02/27/2025*

Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA 19038*

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

Administrator

Name: [redacted]

Legal Entity

Name: *WYNDMOOR ASSISTED LIVING COMPANY LLC*

Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA, 19038*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/31/1990* **Issued By**: *Commonwealth of Pennsylvania, L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *77* **Waking Staff**: *58*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date**: *01/23/2025*

Inspection Dates and Department Representative

01/22/2025 - On-Site: [redacted]

01/23/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *103* **Residents Served**: *54*

Special Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *34* **Residents Served**: *13*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *9* **Are 60 Years of Age or Older**: *52*

Diagnosed with Mental Illness: *4* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *23* **Have Physical Disability**: *4*

Inspections / Reviews

01/22/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/28/2025*

03/10/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/21/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/14/2025*

03/18/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/21/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/21/2025*

06/05/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *03/21/2025*

Reviewer: [redacted] **Follow-Up Type**: *Exception*

3d Post license/VR/Regs

1. Requirements

2800.
3.d. The assisted living residence shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the assisted living residence.

Description of Violation

On 01/23/25, the residence's copy of 55 Pa. Code Chapter 2800 was not posted in a conspicuous and public place in the residence.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The 55 Pa. Code Chapter 2800 is posted in the lobby on 2/10/2025 by the administrator (see attached). Beginning 2/10/2025 The Administrator and/or designee will monitor weekly to ensure that the 55 Pa. Chapter 2800 regulations binder is in place.

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented [redacted] - 06/05/2025)

20b9 Quarterly record account

2. Requirements

2800.
20.b. If the residence provides assistance with financial management or holds resident funds, the following requirements apply:
9. A copy of the itemized account shall be kept in the resident's record.

Description of Violation

There is no copy of the quarterly account of financial transactions in resident #1's record for the period of 10/01/24 to 12/31/24. A copy of the documentation was requested at 9:00 AM on 01/23/25. Staff Person A informed the Department that the documentation is kept off-site and was not provided until after 4:00 PM.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Resident #1's quarterly account of financial transactions were placed in the resident's record on 1/23/2025 by the nursing director (see attached). Resident #1 is currently the only resident who receives assistance with financial management. The Administrator spoke with the new business manager on 2/11/2025, and [redacted] will ensure that a copy of transaction record is placed in records of residents who receive financial management assistance. To maintain compliance, beginning in March 2025 the administrator or designee will review resident record no later than the 10th of each month for 3 months.

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented [redacted] - 06/05/2025)

20b10 Review of account

3. Requirements

2800.
20.b. If the residence provides assistance with financial management or holds resident funds, the following requirements apply:
10. The residence shall provide the resident the opportunity to review his own financial record upon request during normal business hours.

20b10 Review of account *(continued)*

Description of Violation

The home does not keep financial records onsite as stated by staff person A.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Resident #1's quarterly account of financial transactions were placed in the resident's record on 1/23/2025 by the nursing director (see attached). Resident #1 is currently the only resident who receives assistance with financial management. The Administrator spoke with the new business manager on 2/11/2025, and [redacted] will ensure that a copy of transaction record is placed in records of residents who receive financial management assistance. To maintain compliance, beginning in March 2025 the administrator or designee will review resident record no later than the 10th of each month for 3 months beginning 3/2025-6/30/2025.

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented [redacted] - 06/05/2025)

41e Signed statement

4. Requirements

2800.
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.

Resident #3's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Repeat Violation: 12/22/2023 et al.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Resident #2 refused to sign on 3/5/2025 (attached). Resident #3 resident right and complaint procedures signed on 3/5/2025 attached. Marketing Director will be re-educated by the Administrator by 3/14/2025 on the importance of ensuring resident rights and complaint procedure is reviewed and signed upon admission (attached). The Marketing Director will complete an audit of resident files by 3/7/2025 (attached). To ensure compliance the Administrator or designee will check each new admission within 24 hours to maintain compliance with 41e.

Licensee's Proposed Overall Completion Date: *03/14/2025*

Implemented [redacted] - 06/05/2025)

63a First Aid/CPR 1:35

5. Requirements

2800.
63.a. For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

63a First Aid/CPR 1:35 *(continued)*

Description of Violation

On 01/18/25, from 11:00 PM to 7:00 AM on 01/19/25, 54 residents were present in the residence. During this time no staff persons were present in the residence who were trained in first aid and certified in obstructed airway techniques and CPR.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Beginning 2/11/2025-3/04/2025 the medication technicians and 80% of the 11-7 employees were re-certified in CPR (attached). This will ensure that the home meets compliance with 63.a. CPR certified employee's names are bold on the schedule so that everyone is aware who is certified. Beginning 3/3/2025 maintain compliance CPR expiration date spreadsheet will be kept by Nursing Director or designee.

Licensee's Proposed Overall Completion Date: *03/07/2025*

65a Fire Safety-1st day

6. Requirements

2800.

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 C, whose first day of work was [redacted]24, 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.

Repeat Violation: 12/22/2023 et al.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Staff person B who was hired on [redacted]/2024 will be trained no later than 3/10/2025 by Nursing Director (attached). Administrator, Maintenance, Nursing Director attended Fire Safety Expert Train the Trainer on 3/6/2025 (attached). The Administrator will work with team to have each employee trained by fire safety expert by 3/31/2025 (attached). No new employees will begin employment until fire safety training is completed by a fire safety expert. To ensure compliance the administrator or designee will confirm on 1st workday beginning 3/1/2025-6/30/2025

Licensee's Proposed Overall Completion Date: *03/10/2025*

65e Rights/Abuse 40 Hours

7. Requirements

2800.
65.e. 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.
5. Safe management techniques.
6. Core competency training that includes the following:
i. Person-centered care.
ii. Communication, problem solving and relationship skills.
iii. Nutritional support according to resident preference.

Description of Violation

Staff person C completed their 40th scheduled work hour on in November 2024. 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), reporting of reportable incidents and conditions, safe management techniques, core competency training that includes the following: person-centered care , core competency training that includes the following: communication, problem solving and relationship skills , core competency training that includes the following: nutritional support according to resident preference.

Repeat Violation: 12/22/2023 et al.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Staff person B who was hired on [redacted]/2024 received her training per 65e regulation. Unfortunately, the training could not be located. Staff person B completed training beginning the week of 1/27/2025 (attached). Beginning 1/27/2025 the administrator or designee will ensure compliance of 65e on his or her 40th hour. Beginning 3/1/2025, the administrator or designee will also maintain a digital copy to ensure it is available for the Department's review.

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented [redacted] - 06/05/2025)

65h 16 hrs annual training

8. Requirements

2800.
65.h. Direct care staff persons shall have at least 16 hours of annual training relating to their job duties. The training required in § 2800.69 (relating to additional dementia-specific training) shall be in addition to the 16 hour annual training.

Description of Violation

Direct care staff person D received only 6.25 hours of annual training relating to their job duties during training year 2024.

Direct care staff person E received 0 hours of annual training relating to their job duties during training year 2024.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Direct care staff person D received additional trainings by the DON on 2/1/2025 and 2/15/2025 (attached). Direct care staff person E received training by the DON on 2/28/2025-3/2/2025 (attached). To ensure compliance.

65h 16 hrs annual training (continued)

beginning 3/1/2025 the administrator or designee will complete the attached staff training form on each direct care staff person. This will ensure that direct care staff persons meet compliance. Administrator or designee will check quarterly beginning 6/1/2025 to ensure employees are attending the appropriate training. Employees who are not in compliance by 12/31/2025 will be removed from schedule until compliant.

Licensee's Proposed Overall Completion Date: *03/07/2025*

65i Training topics

9. Requirements

2800.
65.i. 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, cognitive and neurological 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. Assisted living 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 residence.

Description of Violation

Direct care staff person D 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, safe management techniques, care for residents with mental illness or an intellectual disability, or both, if the population is served in the residence during the training year 2024.

Direct care staff person E 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, cognitive and neurological 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, assisted living service needs of the resident, safe management techniques, care for residents with mental illness or an intellectual disability, or both, if the population is served in the residence during the training year 2024.

Direct care staff person F 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 mental illness or an intellectual disability, or both, if the population is served in the residence during the training year 2024.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Direct Staff Person E and F received training by DON on 2/28/2025-3/2/2025 (attached). Direct care staff person D received training from DON on 2/1/2025 and 2/15/2025 (attached). To maintain compliance the Administrator or designee will use attached form beginning 3/2025 to ensure each staff member maintains compliance with 65.i. (attached). The Administrator or designee will review direct care staff training sheet quarterly beginning 6/1/2025. Employees who are non-compliant by 12/31/2025 will be removed from schedule.

Licensee's Proposed Overall Completion Date: *03/07/2025*

65j Annual training content

10. Requirements

2800.
65.j. 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—10225.708).
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 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, Falls and accident prevention during training year 2024.

Staff person E 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—10225.708), Falls and accident prevention during training year 2024.

Staff person F 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, Falls and accident prevention during training year 2024.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Staff person D, and F will be trained no later than 3/10/2025 by Nursing Director (attached). Staff Person E who is a [redacted] will be trained by Administrator or nursing director on [redacted] next scheduled day. Administrator, Maintenance, Nursing Director attended Fire Safety Expert Train the Trainer on 3/6/2025 (attached). The Administrator will work with team to have each employee trained by fire safety expert by 3/28/2025 (attached). No new employees will begin employment until fire safety training is completed by a fire safety expert. To ensure compliance the administrator or designee will confirm completion on 1st workday beginning 3/2025-9/2025.

Licensee's Proposed Overall Completion Date: *03/28/2025*

65l Record of training

11. Requirements

2800.
65.l. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

65l Record of training (continued)

The residence's record of direct care staff training for the topics "Early Signs of Dementia" and "10 Tips for Dementia Care" do not include the length of each course.

The residence has not maintained any record of training for staff persons C and E.

Repeat Violation: 12/22/2023 et al.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The Administrator will re-educate managers on the importance of completing the training record in its entirety by 3/14/2025 (attached). Beginning 2/10/2025, the administrator or designee will confirm compliance with 65.l. prior to filing in training manual. Beginning 3/1/2025, the administrator or designee will ensure each team member has a training log (attached).

Licensee's Proposed Overall Completion Date: *03/14/2025*

Implemented [redacted] - 06/05/2025)

81b Resident equip – good repair

12. Requirements

2800.
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

Resident #4 has a bedside mobility device on their bed. The device has an uncovered opening measuring 17 inches wide by 11 inches high. This does not adhere to the FDA guidelines which states "If any openings within the device exceed 120 mm (4 3/4 inches), a cover that allows for safe gripping and use of the device for its intended purpose must be in place."

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Resident #4's mobility device was removed by DON on 1/23/2025, as there was not a MD order. Administrator or designee will complete a monthly enabler audit to ensure adherence to FDA guidelines beginning 3/2025 until 6/30/2025. On 3/10/2025, the administrator will also send a letter to resident family members and responsible parties to notify them of policy (attached).

Licensee's Proposed Overall Completion Date: *03/10/2025*

85a Sanitary conditions

13. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 01/23/25, at approximately 9:35 AM, there was a quarter inch accumulation of dust on the vent in one of the first floor guest bathrooms.

85a Sanitary conditions (continued)

The grill top and sides in the personal care kitchen are dirty and stained with black, brown and white substances, possibly grease.

The steam table in the personal care kitchen had food debris in the heating element compartment, and the chafing pans had dirty water with food debris and grease inside.

The floor of the reach in refrigerator in the personal care kitchen was stained with various spilled substances and food debris.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The dust was immediately cleaned by housekeeping on 1/23/25 (attached). The grill top, steam table and refrigerator were cleaned by dining room manager on 1/24/2025 (attached). The administrator will re-educate the housekeeping supervisor on dusting vents and dining room manager on proper cleaning of the grill top, refrigerator and steam table chafing dishes by 3/14/2025 (attached). The administrator or designee will complete weekly audits of refrigerator, grill top, guest bathroom vents and steam tables from 3/2025-6/30/2025.

Licensee's Proposed Overall Completion Date: *03/14/2025*

Implemented [redacted] - 06/05/2025)

85d Trash cans – kitchen/bath

14. Requirements

2800.
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 01/23/25, at 2:45 PM, there was an uncovered trash can in the personal care kitchen's office space with chicken bones, french fries, and other discarded food items.

On 01/23/25 at 5:59 PM, a partially filled, uncovered trash can was found in the bathroom of a shared apartment room [redacted].

Repeat Violation: 12/22/2023 et al.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The trash can in the kitchen was immediately covered (attached). The Dining Director or designee will re-educate the dining department by 3/14/2025 to ensure trash can is covered at all times (attached). The trash can in [redacted] was replaced with a covered trash can (attached). The Administrator conducted an audit of all shared apartments on 2/19/2025 and purchased and placed covered trash cans in each shared apartment bathroom on 2/21/2025 (attached). The Administrator or designee will include verifying covered trash cans on monthly apartment audits from 2/2025-5/2025 (attached).

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented [redacted] 06/05/2025)

85e Trash outside

15. Requirements

2800.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 01/22/25, during the fire safety walk at approximately 10:20 AM, several trash items were observed outside of the home:

- *pieces of furniture outside of the dumpster,*
- *a large gray sofa in the parking lot outside of the "B" side first floor emergency exit,*
- *a large recliner in the back of the home,*
- *various bags of discarded trash lying in the snow.*

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The items were removed immediately on 1/22/2025 by maintenance during survey. The Administrator will re-educate housekeeping supervisor and maintenance on 85a by 3/14/2025 (attached). To ensure compliance the administrator or designee will check outside area weekly beginning the week of 3/3/2025 through 6/03/2025.

Licensee's Proposed Overall Completion Date: *03/14/2025*

88a Floors, walls, ceilings, windows, doors

16. Requirements

2800.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The latch securing the padlock on an activities closet on the first floor is broken and a screw was sticking out of the latch creating a hazard.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The broken screw was immediately removed by maintenance on 1/22/2025 (attached). The Administrator will re-educate the activity department by 3/14/2025 to notify maintenance immediately if there is a hazard such as a screw protruding from closet (attached).

Licensee's Proposed Overall Completion Date: *03/14/2025*

95 Furniture & Equipment

17. Requirements

2800.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 01/22/25, at 9:35 AM, a broken toilet paper holder was observed in the first floor guest bathroom.

The steam table in the personal care kitchen had been worn down to the point you could see the shape of the heating element burnt into the bottom of the chafing pans.

An outlet in the personal care kitchen office was not attached to a wall, it was hanging freely supported only by the electrical wires providing power to the four plug outlet.

95 Furniture & Equipment (continued)

The toilet seat in the bathroom of shared room [redacted] had duct tape wrapped around the left side of the sitting portion of the toilet seat.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The holder insert was replaced by maintenance assistant on 1/22/2025 (attached). The maintenance director repaired the kitchen office outlet on 2/10/2025 (attached). The toilet seat was replaced on 3/3/2025 by the maintenance assistant (attached). The administrator or designee will complete weekly guest bathroom audits to ensure toilet paper holder insert is present. The administrator or designee will complete monthly bathroom audits from 3/1/2025-6/30/2025 (attached).

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented [redacted] - 06/05/2025)

100b Removal snow/obstructions

18. Requirements

2800.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On 01/22/25, at 10:20 AM, there was an approximate 1-2 inch accumulation of snow on the outside walkways, including outside the emergency exits outside of the "B" stairwell and the dining room.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The snow was immediately removed by maintenance on 1/22/2025. The Administrator re-educated maintenance and housekeeping on the importance of immediately shoveling and salting all exits on 2/27/2025 (attached). Beginning 1/22/2025 the Administrator or designee will confirm compliance with 100.b during snow, rain or windstorms.

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented [redacted] - 06/05/2025)

101j3 Bed linens/pillows/blankets

19. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

The sheets on the bed for resident #5 are soiled with a red, green and yellow substance towards the head of the bed and littered with dirt, sand and debris in the middle of the bed.

Repeat Violation: 12/22/2023 et al.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The sheets were immediately changed on [redacted]/2025 by wellness assistant. Resident #5 refuses often to shower and

101j3 Bed linens/pillows/blankets (continued)

change clothes or allow home to change sheets. Home involves [redacted] who speaks with resident #5, but resident still refuses. Support plan has been updated (attached). The Administrator will include checking for soiled linen to monthly apartment audit beginning 3/1/2025-6/30/2025.

Licensee's Proposed Overall Completion Date: *03/07/2025*

101j7 Lighting/operable lamp

20. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #5 does not have access to a source of light that can be turned on/off at bedside.

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

Repeat Violation: 09/05/24, 05/31/24, 12/22/2023 et al.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Resident #5 stated to surveyor [redacted] unplugged lamp to charge phone. Lamp was plugged in during inspection and was operable. Administrator spoke with resident #5 on 2/19/2025 asked [redacted] not to unplug lamp. Resident #5 stated this was [redacted] apartment and [redacted] can unplug if an additional outlet is needed. Resident #5 given push light on 2/19/2025 (attached). Resident #6 was also given push light on 2/19/2025 (attached). The Administrator or designee will continue to check for compliance with 101j monthly beginning 3/1/2025-6/30/2025.

Licensee's Proposed Overall Completion Date: *03/07/2025*

101q Window coverings

21. Requirements

2800.
101.q. There must be drapes, shades, curtains, blinds or shutters on the living unit windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

The window in living unit C-205 does not have shades, blinds, or shutters.

Plan of Correction ***Accept [redacted] 03/10/2025)***

Drapes were immediately rehung by maintenance on 1/23/2025. Resident stated [redacted] removed, as [redacted] does not like window coverings. Administrator re-educated resident on 2/11/2025 on the importance of adhering to regulation 101.q. To ensure compliance, the administrator or designee will add window coverings to monthly apartment audits which will be completed 3/1/2025-6/30/2025.

Licensee's Proposed Overall Completion Date: *03/07/2025*

103e Leftovers

22. Requirements

2800.
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.

103e Leftovers *(continued)*

Description of Violation

There was an unlabeled, undated plate of breakfast food; scrambled eggs, toast, sausage patty on a counter in the personal care kitchen.

Repeat Violation: 12/22/2023 et al.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The undated plate was immediately discarded by the dietary aide on 1/23/2025. The Dining Director will re-educate the dining staff on 103.e by 3/14/2025(attached). The dining director or designee will complete weekly audits for 3 months beginning 2/24/2025-5/24/2025 (attached) to ensure compliance is maintained.

Licensee's Proposed Overall Completion Date: *03/07/2025*

103g Storing food

23. Requirements

2800.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 01/23/25, at approximately 2:23 PM, leftovers from lunch including a bowl of escarole soup, five bowls of fruit cocktail were opened and unsealed sitting on a counter in the personal care kitchen.

Repeat Violation: 12/22/2023 et al.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The bowl of soup and bowls of fruit cocktail were mediately discarded by the dietary aide on 1/23/2025. The Dining Director will re-educate the dining staff on 103.g by 3/14/2025(attached). The dining director or designee will complete weekly audits for 3 months beginning 2/24/2025-5/24/2025 (attached) to ensure compliance is maintained.

Licensee's Proposed Overall Completion Date: *03/07/2025*

109b Rabies vaccination

24. Requirements

2800.
109.b. Cats and dogs present at the residence shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On 01/22/25, a gray domestic longhair feline was present at the residence. The residence does not have a current certificate of rabies vaccination. The provided documentation from [redacted] and Specialty Hospital show's last vaccination was on 05/26/23 with an expiration date of 05/26/24.

Plan of Correction ***Accept [redacted]J - 03/10/2025)***

The rabies vaccine was administered on 1/23/2025 (see attached). A calendar reminder to make appointment in

109b Rabies vaccination (continued)

December 2025 for January 2026 was sent to Administrator, Nursing Director, Receptionist, Marketing Director and Resident Care Coordinator. The Administrator or Marketing Director will send out a calendar reminder to above positions for any pet who resides in the home.

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented [redacted] - 06/05/2025)

121a Unobstructed egress

25. Requirements

2800.
121.a. Stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed.

Description of Violation

On 01/22/25, at approximately 10:20 AM, snow accumulation blocked easy egress from the residence's emergency egress routes from the building.

Repeat Violation: 02/12/24.

Plan of Correction ***Accept[redacted] - 03/10/2025)***

The snow was immediately removed by maintenance on 1/22/2025. The Administrator re-educated maintenance and housekeeping on the importance of immediately shoveling and salting all exits on 2/27/2025 (attached). Beginning 1/22/2025 the Administrator or designee will confirm compliance with 100.b during snow, rain or windstorms.

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented ([redacted] - 06/05/2025)

123b Emerg. procedures posted

26. Requirements

2800.
123.b. Copies of the emergency procedures as specified in § 2800.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the residence and a copy shall be kept.

Description of Violation

On 01/23/25, the residence's emergency procedures were not posted in a conspicuous and public place in the residence. The manual had to be pulled from the Administrator's office, who was not present on 01/23/25, when requested.

Plan of Correction ***Accept[redacted] - 03/10/2025)***

The Administrator posted the emergency procedures binder in a conspicuous place on 2/10/2025 (attached). Beginning 2/10/2025 The Administrator and/or designee will monitor weekly to ensure that the emergency procedures binder is in place.

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented [redacted] - 06/05/2025)

127a Portable space heaters

27. Requirements

2800.
127.a. Portable space heaters are prohibited.

Description of Violation

On 01/23/25, at 3:50 PM, a black Lasko portable space heater was in use in room B-314, which is in the home's "Memory Care" unit.

Repeat Violation: 02/12/24, 01/22/24, 12/27/23, 12/22/2023 et al

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The heater was immediately removed by the personal care aide. The resident and the family member were made aware portable heaters are not allowed. The Administrator sent a letter to memory care family members on 2/12/2025 (attached). The housekeeping and wellness team will be re-educated by the administrator to notify the Administrator or designee if they observe a heater in a resident apartment by 3/14/2025 (attached). Beginning 2/24/2025, the Administrator or designee will complete weekly audits of the memory care unit for 3 months to ensure compliance is maintained (attached).

Licensee's Proposed Overall Completion Date: *03/14/2025*

132c Fire drill records

28. Requirements

2800.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the residence at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The "Adult Residential Licensing - Personal Care Home Fire Drill Record" form lists the times of the fire drills on 09/16/24 as 4:55 PM and on 08/21/24 as 1 PM. According to the "Record of Fire Drill" from Croker Fire Safety Corporation, these drills started at 4:25 PM and 12:30 PM respectively. The time documented on the fire drill record is the "Time of All Clear".

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

The Administrator will educate the maintenance director and assistant by 3/17/2025 on the correct procedure for completing fire drill record (attached). To ensure compliance is maintained, the administrator or designee will ensure the fire drill record is completed correctly before placing in fire drill book beginning 4/2025 through 12/2025.

Licensee's Proposed Overall Completion Date: *03/17/2025*

Implemented [redacted] - 06/05/2025)

161c Additional portions

29. Requirements

2800.
161.c. Additional portions of meals and beverages at mealtimes shall be available for the resident.

Description of Violation

Resident interviews revealed that the residence frequently runs out of food items. In speaking with staff person G, the Dietary Director, it was confirmed that the residence will run out of the "Chef's Special". The Chef's special is a dish

161c Additional portions (continued)

prepared in addition to the regular posted menu and happens approximately once a week on Sundays or on holidays. Licensing representatives suggested having residents ordering ahead so the kitchen knows how many specials to prepare but staff person G stated that would not be possible due to management concerns. Residents stated the kitchen will run out of other items as well, like coffee and milk, often.

Repeat Violation: 12/22/2023 et al.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The dining director will re-educate dining team by 3/14/2025 on the importance of notifying the director when items are running low and to notify the administrator or designee immediately if we are out of the staples (coffee, tea, milk sugar, cream, bread). The dining team or administration will immediately purchase using petty cash or company credit card. Beginning 3/2/2025 the chef will prepare chef specials for 80% of current occupancy.

Licensee's Proposed Overall Completion Date: *03/14/2025*

Implemented [redacted] - 06/05/2025)

183b Medications and syringes locked

30. Requirements

2800.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's living unit.

Description of Violation

On 01/23/2025, at 3:59 pm, 3 unidentified pills were unlocked, unattended, and accessible in resident #5's room. Resident #5 is not identified as able to self-administer medications.

Repeat Violation: 09/05/2024, 01/22/2024, 12/22/2023 et al

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The medication technicians were re-educated on 2/19/2025 by the DON (attached). The residents will be re-educated during the Resident Council meeting by the DON on 3/20/2025. Beginning 3/2025 until 6/2025, the administrator or designee will complete monthly apartment audits to ensure compliance with 183b.

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented [redacted] 06/05/2025)

183e Storing Medications

31. Requirements

2800.
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 01/23/25, a bottle of Azelastine HCl 0.1% nasal spray belonging to resident #9, was found on the medication cart opened and undated. According to the manufacturer's instructions the medication should be discarded after using

183e Storing Medications (continued)

200 sprays.

On 01/23/25, one of the cells in an Omnicell medication blister pack containing Melatonin Tab 3 MG for resident #10 was punctured with the pill still inside the cell. This is not a sanitary practice for storing medications.

Repeat Violation: 09/05/24, 12/22/2023 et al

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The nasal spray was removed by the DON on 01/23/2025. The puncture cell pill was also removed on 1/23/2025. The DON and Administrator met with the Home's pharmacy on 2/12/2025 to discuss blister pack and protocol moving forward for discarding and reordering one pill. The DON re-educated the medication technicians on 2/19/2025 on examining, removing, discarding and reordering a pill that was in a punctured blister pack. The DON or designee will spot check blister packs for puncture monthly beginning 3/2025-6/30/2025 (attached).

Licensee's Proposed Overall Completion Date: *03/07/2025*

184b - Labeling OTC/CAM

32. Requirements

2800.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 01/23/25, an unlabeled tube of PeriGuard Ointment and a bottle of regular strength Tylenol were found on the 3rd floor medication cart.
On 1/23/25, two unlabeled tubes of Medline Remedy Skin Protectant and a jar of Chest Rub were found on the 1st floor med cart.

Repeat Violation: 12/22/2023 et al.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The PeriGuard, Chest Rub, and Skin Protectant was removed on 1/23/2025 by the DON. The DON educated the medication technicians on 2/19/2025 to ensure all OTC medications are labeled correctly (attached) The DON or designee will continue monthly medication cart audits from 3/2025-6/30/2025 (attached).

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented [redacted] - 06/05/2025)

185b Medication procedures

33. Requirements

2800.
185.b. At a minimum, the procedures must include:
1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.

185b Medication procedures *(continued)*

4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his living unit.

Description of Violation

On 01/23/25, a discrepancy in the remaining number of Alprazolam Tabs 0.5 MG was found in resident #12's controlled substance administration record. The record indicated 30 pills remained when only 29 were present. When questioned, staff person F, the medication technician for that shift, stated the medication had been administered at 12:00 PM that day but was not logged as administered on the controlled substance administration record at the time of administration.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Resident #9's Alprazolam was signed after administration in view of licensing representative (attached). Staff Member E who was medication technician was re-educated by DON on 2/19/2025 (attached). Staff Person F is [redacted] who is not medication certified. The DON or designee will complete monthly MAR/Declining balance sheets beginning 3/2025-6/30/2025 (attached).

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented [redacted] - 06/05/2025)

191 Resident right to refuse

34. Requirements

2800.
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 [redacted]/24, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident #3, admitted [redacted]/24, 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 [redacted] - 03/10/2025)***

Resident #2 refused to sign on 3/05/2025, Resident #3 right to refuse medication if the resident believes that there may be an error was signed on 3/05/2025 (attached). The Marketing Director will complete an audit of resident business files by 3/14/2025 to ensure that resident right to refuse medication was completed. Beginning 3/1/2025-6/30/2025, the administrator or designee will ensure completion prior to or day of move in.

Licensee's Proposed Overall Completion Date: *03/14/2025*

Implemented [redacted] - 06/05/2025)

225b Assessment content

35. Requirements

2800.
225.b. The assessment must, at a minimum include the following:
1. The resident's need for assistance with ADLs and IADLs.
2. The mobility needs of the resident.

225b Assessment content *(continued)*

3. The ability of the resident to self-administer medication.
4. The resident's medical history, medical conditions, and current medical status and how these impact or interact with the individual's service needs.
5. The resident's need for supplemental health care services.
6. The resident's need for special diet or meal requirements.
7. The resident's ability to safely operate key-locking devices.

Description of Violation

Resident #7's assessment, with a signature date of [redacted]/24, does not include the resident's need for assistance with ADLs and IADLs. The first five pages of the Assessment and Support Plan (ASP) are blank.

Plan of Correction ***Accept ([redacted]/10/2025)***

Resident #5 first 5 pages of ASP was blank. DON corrected onsite and gave to licensing representative. The DON or designee will complete an audit of ASP's by 3/17/2025 (attached). The administrator or designee will randomly check 5 updated ADME/ASP per month from 3/2025-6/30/2025 to ensure completion.

Licensee's Proposed Overall Completion Date: *03/17/2025*

Implemented [redacted] - 06/05/2025)

227d Support plan – med/dental

36. Requirements

2800.
227.d. Each residence shall document in the resident's final support plan the dietary, medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

Resident #2's Initial Medical Evaluation (ADME) dated [redacted]/24 indicates the resident's mobility need as minimal as determined by a physician. Resident #2's Assessment and Support Plan (ASP) with a signature date of [redacted]/24 lists the resident as totally immobile requiring total physical and oral assistance to evacuate.

The ASP for resident #8, with a signature date of [redacted]/24, indicates A (Independent) under the Personal Care Needs and Degree column for Turning and positioning in bed/chair; however, resident #8 uses a bedside mobility device. Further, the Resident Support Plan does not indicate the following:

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

227d Support plan – med/dental *(continued)*

Plan of Correction ***Accept [redacted] - 03/10/2025)***

DON notified MD on 1/23/2025 to discuss resident #2 mobility status. MD stated that resident's mobility status should state total (attached). Resident #8 moved in on 8/30/2024 and does not have an enabler (attached). The DON or designee will complete an audit by 3/17/2025 of ASP/ADME to ensure that mobility and turning and positioning match (attached). The administrator or designee will randomly check 5 updated ADME/ASP per month from 3/2025-6/30/2025.

Licensee's Proposed Overall Completion Date: *03/17/2025*

Implemented [redacted] - 06/05/2025)

231d No objection statement

37. Requirements

2800.
231.d. Resident admission to special care unit. Each resident record must have documentation that the resident or potential resident and, when appropriate, the resident's designated person or the resident's family have agreed to the resident's admission or transfer to the special care unit.

Description of Violation

Resident #2 was admitted to the special care unit on [redacted]/24. However, the resident's record does not include documentation that the resident and the resident's designated person or the resident's family have agreed to the resident's admission to the special care unit.

Repeat Violation: 12/22/2023 et al.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Resident #2 refused to sign secure unit placement on 3/05/2025 (attached). [redacted] was contacted to come in and sign, but [redacted] was not available. However, [redacted] sent an email verification which [redacted] approved placement in secured unit on 03/05/2025attached) The Marketing Director will complete an audit of resident business files by 3/14/2025 to ensure that each memory care resident has signed secured unit placement by resident or responsible party was completed. The Marketing Director will be re-educated on 231.d by 3/14/2025 (attached). Beginning 3/1/2025-6/30/2025, the administrator or designee will ensure completion prior to or day of move in.

Licensee's Proposed Overall Completion Date: *03/14/2025*

Implemented [redacted] 06/05/2025)

233a Lock approval

38. Requirements

2800.
233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The residence does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the magnetic locks that prevent immediate egress, used on the exit doors located in the Memory Care unit.

233a Lock approval (continued)

Repeat Violation: 12/22/2023 et al.

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

The magnetic lock was approved by The Township of Springfield on 3/05/2010 (attached). Beginning 3/13/2025, the approval will be placed in the survey ready binder on 3/13/2025 by the administrator for the Department's review.

Licensee's Proposed Overall Completion Date: *03/13/2025*

Implemented [redacted] - 06/05/2025)

233b Lock manufact. statement

39. Requirements

2800.
233.b. A residence shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:

1. Upon a signal from an activated fire alarm system, heat or smoke detector.
2. Power failure to the home.
3. Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

Description of Violation

The residence does not have a statement from the manufacturer of the magnetic locking system verifying that the magnetic locking system locks will release when the fire alarm system is activated, the residence's power fails, and when the lock releasing device is operated.

Repeat Violation: 12/22/2023 et al.

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

The Manufacturer's statement of the Corby 6500 series states that upon signal from a compatible and activated fire system, heat or smoke detector, power failure, overriding the electronic or magnetic locking system(attached) The manufacturer's statement will be placed in the survey ready binder by the Administrator on 3/13/2025 for the Department's review.

Licensee's Proposed Overall Completion Date: *03/13/2025*

236a Staff training

40. Requirements

2800.
236.a. Each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to dementia care and services, in addition to the 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

Description of Violation

Direct care staff person C, date of hire [redacted]/24, works in the special care unit, but did not complete any initial training related to dementia care within the first 30 days of the date of hire.

Direct care staff person H, date of hire [redacted]/24, works in the special care unit, but only completed 4 hours of initial training related to dementia care within the first 30 days of the date of hire.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Staff person C was hired [redacted]/2023 attended dementia training provided by DON 2/28/2025-3/1/2025. Staff

236a Staff training (continued)

person G who was hired [redacted] /2024 will receive an additional 4 hours of training by 3/14/2025, based on [redacted] schedule. To ensure compliance the orientation has been increased to 48 hours which will include the attached 8 hours of dementia training. beginning 3/2025 the administrator or designee will complete the attached staff training form on each direct care staff person. This will ensure that direct care staff persons meet compliance. The Administrator or designee will review direct care staff training sheet quarterly. Employees who are non-compliant by 12/31/2025 will be removed from schedule.

Licensee's Proposed Overall Completion Date: *03/14/2025*

41. Requirements

2800.
236.a. Each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to dementia care and services, in addition to the 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

Description of Violation

Direct care staff person D, who works in the special care unit had only 4 hours of training related to dementia care during the 2024 training year.

Direct care staff person E, who works in the special care unit did not complete any hours of training related to dementia care during the 2024 training year.

Direct care staff person F, who works in the special care unit had only 3 hours and 45 minutes of training related to dementia care during the 2024 training year.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Staff Person D received dementia training from the DON on 2/1/2025 and 2/15/2025 (attached). Staff persons E and F received training from the DON on 2/28/2025-3/2/2025 (attached). The 2025 training plan has been updated to include the 8 hours of dementia training completed by team members 2/2025-3/2025 (attached). To ensure compliance each team member will have the attached training log. The Administrator or designee will review direct care staff training sheet quarterly beginning 6/2025 Employees who are non-compliant by 12/31/2025 will be removed from schedule.

Licensee's Proposed Overall Completion Date: *03/07/2025*

236b Training topics

42. Requirements

2800.
236.b. The training for each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia at a minimum must include the following topics:
1. An overview of Alzheimer's disease and related dementias.
2. Managing challenging behaviors.
3. Effective communications.
4. Assistance with ADLs.
5. Creating a safe environment.

Description of Violation

Direct care staff person E, who works in the special care unit did not complete training in the following topics; an overview of Alzheimer's disease and related dementias, managing challenging behaviors, effective communications, assistance with ADLs, creating a safe environment.

236b Training topics *(continued)*

Plan of Correction ***Accept [redacted] - 03/10/2025)***

Staff person E completed dementia training given by DON on 2/28/2025-3/2/2025 (attached). The Administrator or designee will review direct care staff training sheet quarterly beginning 6/2025 Employees who are non-compliant by 12/31/2025 will be removed from schedule.

Licensee's Proposed Overall Completion Date: *03/07/2025*

Implemented [redacted] - 06/05/2025)

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

Facility Information

Name: *SPRINGFIELD SENIOR LIVING COMMUNITY* **License #**: *14484* **License Expiration**: *02/27/2025*

Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA 19038*

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

Administrator

Name: [redacted]

Legal Entity

Name: *WYNDMOOR ASSISTED LIVING COMPANY LLC*

Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA, 19038*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/31/1990* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *75* **Waking Staff**: *56*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *03/31/2025*

Inspection Dates and Department Representative

03/31/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *103* **Residents Served**: *56*

Special Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *34* **Residents Served**: *16*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *9* **Are 60 Years of Age or Older**: *56*

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

Have Mobility Need: *19* **Have Physical Disability**: *2*

Inspections / Reviews

03/31/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/10/2025*

Inspections / Reviews *(continued)*

06/05/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/11/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/10/2025*

06/24/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/11/2025*

Reviewer: [redacted] **Follow-Up Type:** *Exception*

63a First Aid/CPR 1:35

1. Requirements

2800.
63.a. For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

Description of Violation

From 3/17/25 through 3/31/25, 56 residents were present in the residence. During this time, the residence did not meet the regulatory requirement of two staff members trained in first aid and certified in obstructed airway techniques and CPR on any shift.

Plan of Correction ***Accept [redacted] - 06/05/2025)***

An in-person CPR class was held on 2/27/2025 and 4/3/2025 (attached). An in-person first aid class was held in 4/25/2025 (attached). The Resident Care Coordinator will ensure that one CPR person is scheduled for every 35 residents. To ensure compliance, the administrator or designee will check schedule weekly for 3 months beginning 5/1/25-8/31/25.

Licensee's Proposed Overall Completion Date: *05/10/2025*

63b F/A - CPR trainer quals.

2. Requirements

2800.
63.b. Current training in first aid and certification in obstructed airway techniques and CPR shall be provided by an individual certified as a trainer by a hospital or other recognized health care organization.

Description of Violation

Staff persons were trained in CPR/first aid in February 2025 by an online training source. Training that is conducted online with no hands-on practice does not provide the necessary training to ensure the staff person is able to properly perform CPR or first aid and will not be considered when measuring compliance.

Plan of Correction ***Accept [redacted] - 06/05/2025)***

An in-person CPR class was held on 2/27/2025 and 4/3/2025 (attached). An in-person first aid class was held in 4/25/2025 (attached). The Resident Care Coordinator and Nursing Director was educated by the administrator on 4/1/2025 to only schedule and/or accept in-person CPR/First-Aid Training (attached).

Licensee's Proposed Overall Completion Date: *05/10/2025*

Implemented [redacted] - 06/24/2025)

81b Resident equip – good repair

3. Requirements

2800.
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

The bedside mobility device installed on the bed of resident #1 was covered with a pillowcase. Per FDA guidelines, if any openings within the device exceed 120mm (4 ¾ inches), a cover that allows for safe gripping and use of the device for its intended purpose must be in place. A pillowcase does not allow for safe gripping or use of the device for its intended purpose.

The bedside mobility device installed on the bed of resident #2 was covered with a pillowcase. Per FDA guidelines, if

81b Resident equip – good repair (continued)

any openings within the device exceed 120mm (4 ¾ inches), a cover that allows for safe gripping and use of the device for its intended purpose must be in place. A pillowcase does not allow for safe gripping or use of the device for its intended purpose.

Repeated Violation: 10/22/2024

Plan of Correction ***Accept [redacted] - 06/05/2025)***

The Home purchased a new bedside mobility device with a manufacturer cover for Resident #1 on 4/1/2025 (attached). Resident # 2 no longer has a bedside mobility device. The administrator or designee will continue to ensure compliance with monthly apartment audits from 5/25-11-25 (attached).

Licensee's Proposed Overall Completion Date: *05/10/2025*

85b Infestation

4. Requirements

2800.
85.b. There may be no evidence of infestation of insects or rodents in the residence.

Description of Violation

The mattress in room [redacted] was infested with bed bugs.

Repeated Violation: 8/20/2024, 5/31/2024, 1/22/2024,et al

Plan of Correction ***Accept [redacted] - 06/05/2025)***

The residents were relocated to another apartment on 3/31/2025. The mattress was discarded by the maintenance director on 4/1/2025. The apartment has been treated (attached). The administrator or designee will continue to monitor and assess resident apartments monthly 5-25-11-25 for signs of infestations (attached). Residents will also be reminded at May 15th resident council to report any sightings to the front desk (attach).

Licensee's Proposed Overall Completion Date: *05/15/2025*

Implemented [redacted] - 06/24/2025)

85e Trash outside

5. Requirements

2800.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 9:24 am, the dumpster outside of the residence was uncovered. A storage bin filled with water and a black tarp were observed outside of the dumpster.

Plan of Correction ***Accept [redacted] - 06/05/2025)***

The items were removed by maintenance assistant on 3/31/2025. The dumpster was immediately covered by a dietary aide on 3/31/2025. The administrator will re-educate housekeeping, maintenance and dietary employees on ensuring the dumpster is closed at all times and no trash is placed outside of receptacle by 5/16/2025 (attached). To ensure compliance is maintained the administrator or designee will check dumpster area weekly for 3 months beginning 5/12/2025 (attached).

Licensee's Proposed Overall Completion Date: *05/16/2025*

88a Floors, walls, ceilings, windows, doors

6. Requirements

2800.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

There was a nail sticking out of the doorframe of the second floor employee lounge.

Plan of Correction ***Accept [redacted] - 06/05/2025)***

The nail was removed by maintenance director on 4/1/2025 (attached). Employees were re-educated by the administrator 4/1/2025-4/9/2025 on 2800.88a (attached). The administrator will verify compliance during rounds throughout normal workday beginning 4/1/2025.

Licensee's Proposed Overall Completion Date: *05/10/2025*

95 Furniture & Equipment

7. Requirements

2800.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

At 9:51 am, the first floor kitchen refrigerator was out of order.

Plan of Correction ***Accept [redacted] - 06/05/2025)***

Dietary director reported to maintenance that freezer was not working on 3/25/2025. Vice President of Culinary determined that freezer was no longer needed in the first floor kitchen. Maintenance Director is working on scheduling removal from the community by 5/30/2025.

Licensee's Proposed Overall Completion Date: *05/30/2025*

101j3 Bed linens/pillows/blankets

8. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

The bed belonging to resident #3 did not have pillows or bedsheets.

The bed belonging to resident #4 did not have pillows.

The bed belonging to resident #5 did not have bedsheets.

The bed belonging to resident #6 did not have bedsheets.

Repeated Violation: 12/22/2023, et al

Plan of Correction ***Accept ([redacted] 06/05/2025)***

Resident #4 was relocated on [redacted]/2025 to another apartment. New sheets and a pillow was provided by administrator (attached). Resident #3 pillow was placed in her reclining wheelchair. Resident #3 was given another

101j3 Bed linens/pillows/blankets (continued)

pillow by housekeeping for [redacted] bed on 5/1/2025 (attached). The administrator re-educated wellness and housekeeping 4/1-4/9/25 that beds should be made by 11am unless resident decides to stay in bed(attached). The administrator or designee will complete monthly apartment audits 4/2025-10/25 to ensure residents have bed linens and pillows (attached).

Licensee's Proposed Overall Completion Date: *05/10/2025*

101j5 Bedside table/shelf

9. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf beside resident #1's bed in living unit A205-207.

There is no bedside table or shelf beside resident #3's bed in living unit B111.

Plan of Correction ***Accept[redacted] - 06/05/2025)***

The maintenance assistant placed a shelf in resident #3 apartment on 4/1/25 (attached). Resident #1 no longer resides in the Home. The administrator reviewed 101j5 with residents on 4/17/2025 during resident council meeting (attached). The Administrator re-educated the employees on 101j5 4-1-25-4-9-25 (attached).The administrator or designee will complete monthly apartment audits 4/25-10/25 to ensure compliance is maintained (attached).

Licensee's Proposed Overall Completion Date: *05/10/2025*

Implemented[redacted] - 06/24/2025)

101j7 Lighting/operable lamp

10. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
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.

Repeated Violation: 10/22/2024, 9/05/2024, 5/31/2024, 12/22/2023, et al

Plan of Correction ***Accept[redacted] - 06/05/2025)***

Maintenance Assistant installed a push light in resident #3 apartment on 4/1/2025 (attached). The administrator reviewed 101j7 with residents on 4/17/2025 during resident council meeting (attached). The Administrator re-educated the employees on 101j7 4-1-25-4-9-25 (attached).The administrator or designee will complete monthly apartment audits 4/25-10/25 to ensure compliance is maintained (attached).

Licensee's Proposed Overall Completion Date: *05/10/2025*

103g Storing food

11. Requirements

2800.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At 9:41 am, an unsealed apple sauce was observed in the memory care unit dining room.
At 12:15 pm, an unsealed apple sauce was observed in the memory care unit medication cart.

Repeated Violation: 10/22/2024, 12/22/2023, et al

Plan of Correction ***Accept [redacted] - 06/05/2025)***

The Administrator placed a reminder note on the refrigerator on 4/3/2025 (attached). The Administrator will re-educate memory care employees by 5/16/2025 on making sure items are covered, labeled and dated, before placing in refrigerator(attached). The Administrator or designee will complete weekly audits to monitor compliance (4/25-10/25) attached.

Licensee's Proposed Overall Completion Date: *05/16/2025*

127a Portable space heaters

12. Requirements

2800.
127.a. Portable space heaters are prohibited.

Description of Violation

At 9:28 am, a portable space heater was observed in the activities room. The space heater was not in-use.

Repeated Violation: 12/22/2023, et al, 12/27/2023, 1/22/2024, et al 2/12/2024

Plan of Correction ***Accept [redacted] - 06/05/2025)***

The maintenance assistant removed the heater on 3/31/2025. The Administrator educated employees 4/1-4/9/2025 on regulation 127a (attached). The Administrator also reviewed regulation with residents on 4/17/2025 during resident council meeting (attached). The Administrator or designee will continue to check all areas the community for heaters monthly from 4/25-10/25 (attached).

Licensee's Proposed Overall Completion Date: *05/10/2025*

183e Storing Medications

13. Requirements

2800.
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

The following medication cards were observed to have a punctured blister foil with the medication still present in the spot- exposing it to contamination or improper sanitation:

- *Resident #7's Lorazepam 0.5 mg tab*
- *Resident #8's Lorazepam 0.5 mg tab*

Resident #9 wass prescribed Lorazepam Top Gel 1mg/1ml on 11/7/2024. The discard date on this medication was 1/10/25. The medication was still available in the medication cart as of 3/31/25.

183e Storing Medications (continued)

Resident #10 was prescribed Lorazepam Top Gel .5mg/.5ml on 1/28/2025. The discard date on this medication was 3/30/25. The medication was still available in the medication cart as of 3/31/25.

Resident #11 is prescribed a Trelegy inhaler with a discard date of 6 weeks after opening per manufacturer's instructions. The inhaler was not dated to indicate when it was opened. The inhaler was still available in the medication cart as of 3/31/25.

There was one loose three-sided, red pill observed in the second floor medication cart.

Repeated Violation: 10/22/2024, 9/05/2024, 12/22/2023, et al

Plan of Correction ***Accepti[redacted] - 06/05/2025)***

By 5/23/2025, the Nursing Director will re-educate the nurses and med tech's on checking blister packs for puncture prior to placing in the cart, to ensure expired or discontinued medications are not in cart, to date inhalers, eye drops, creams, when open to ensure we are adhering to the manufacturer's instructions. To check med carts for loose pills and if found remove and give to supervisor (attached). The Nursing Director or designee will complete monthly cart audits 5/25-11/30/25 to ensure compliance is maintained (attached).

Licensee's Proposed Overall Completion Date: *05/23/2025*