Pennsylvania
Department of Human Services

Sent via e-mail [redacted]
June 20, 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 June 10 and 20, 2025 of the above facility, we have determined that the submitted plan of correction for the April 30, 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]

[redacted]
[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**: *10/11/2025*

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**: *65* **Waking Staff**: *49*

Inspection Information

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

Reason: *Fine* **Exit Conference Date**: *04/30/2025*

Inspection Dates and Department Representative

04/30/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *124* **Residents Served**: *48*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Homestead* **Capacity**: *30* **Residents Served**: *15*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *48*

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

Have Mobility Need: *17* **Have Physical Disability**: *2*

Inspections / Reviews

04/30/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/15/2025*

Inspections / Reviews *(continued)*

06/20/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *06/15/2025*

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, whose date of hire was [redacted] does not have a criminal background available in the employee file.

Staff person B, whose date of hire was [redacted] attested that they have not been a resident of Pennsylvania for the last two years, however, as of [redacted], an FBI clearance and a PA Patch criminal background check was not completed for this staff person.

Staff person C, whose date of hire was [redacted] moved to Pennsylvania on [redacted] however, as of [redacted] an FBI clearance was not completed for this staff person.

Plan of Correction ***Directed ([redacted] - 06/10/2025)***

Immediately: The administrator or designee shall review the records of all current staff members to ensure that a PA State Police criminal background check has been completed and that an FBI background check has been completed for employees who were not residents of Pennsylvania for the past two consecutive years prior to the date of hire. Documentation shall be kept in the staff records.

Directed Completion Date: *06/12/2025*

Evidence of Completion ***Not Implemented ([redacted] - 06/20/2025)***

HR Director to be re-educated by Interim Executive Director. New Audit Forms have been developed for tracking of new hires. HR Manger to complete Audit for recent hires from 4/2025 to present date and continue to utilize audit form for all new hires. Interim Executive Director or Designee to review new hires prior to date of hire.

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.

Description of Violation

Staff person C, 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

65a - FS Orientation 1st Day (continued)

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, and, telephone use and notification of emergency services.

Staff person D, 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, and, telephone use and notification of emergency services.

Staff person E, 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, and, telephone use and notification of emergency services.

Repeat violation: 9/17/2024

Plan of Correction ***Directed ([redacted] - 06/10/2025)***

Within 3 days of receipt of the plan of correction: The administrator or designee shall review all training records for staff hired within the past year to ensure all direct care staff persons including ancillary staff persons, substitute personnel and volunteers have completed an orientation in general fire safety and emergency preparedness in accordance with regulation 2600.65(a) including, evacuation procedure; staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable. Documentation of the training shall be kept in the employee's record.

Directed Completion Date: *06/13/2025*

Evidence of Completion ***Not Implemented ([redacted] - 06/20/2025)***

HR Manager will be re-educated by Interim Executive Director by 6/20/25. New Audit Forms have been developed for tracking of new hires. HR Manger to complete Audit for recent hires from 4/2025 to present date and continue to utilize audit form for all new hires.

65b - Rights/Abuse 40 Hours

3. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

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

Description of Violation

Staff person B completed [redacted] 40th scheduled work hour as of [redacted]. However, as of 4/30/2025, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) or reporting of reportable incidents and conditions.

Staff person C completed [redacted] 40th scheduled work hour as of [redacted] However, as of 4/30/2025, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) or reporting of reportable incidents and conditions.

Staff person D completed [redacted] 40th scheduled work hour as of [redacted] However, as of 4/30/2025, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) or reporting of reportable incidents and conditions.

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

Plan of Correction ***Directed ([redacted] - 06/10/2025)***

Within 3 days of receipt of the plan of correction: The administrator or designee shall review all training records for newly hired staff or staff hired within the past year to ensure all direct care staff persons including ancillary staff persons, substitute personnel and volunteers have completed an orientation in resident rights, emergency medical plan, mandatory reporting of abuse and neglect and reporting of reportable incidents and conditions in accordance with regulation 2600.65(b). Documentation of the training will be placed in the employee's record.

Within 3 days of receipt of the plan of correction: The administrator shall create a tracking system for new hires to ensure that newly-hired staff persons receive the training required by this regulation within 40 scheduled working hours and the documentation of training is kept in the staff person's record.

Directed Completion Date: *06/13/2025*

Evidence of Completion ***Not Implemented ([redacted] - 06/20/2025)***

HR Manager and Director of Health and Wellness will be re-educated by Interim Executive Director by 6/20/2025. HR Manger to complete Audit for recent hires from 4/2025 to present date and continue to utilize audit form for all new hires.

65d - Initial Direct Care Training

4. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

65d - Initial Direct Care Training *(continued)*

Description of Violation

Direct care staff person C, hired on [redacted], began providing unsupervised ADL services on [redacted]. However, verification of the staff person completing and passing the Department-approved direct care training course and competency test is not in the staff person's record.

Plan of Correction ***Directed ([redacted] - 06/10/2025)***

Immediately: The administrator or designee shall review all current direct care staff records to ensure all direct care staff persons meet the qualifications in accordance with regulation 2600.65(d) and the documentation is in the staff records. If direct care staff qualifications are not met, staff will be assigned a position which does not include providing direct care services. Only those staff persons whom meet the direct care staff qualifications will provide direct care services. Documentation of the audit shall be kept.

Directed Completion Date: *06/12/2025*

Evidence of Completion ***Not Implemented ([redacted] - 06/20/2025)***

HR Manager and Director of Health and Wellness will be re-educated by Interim Executive Director by 6/20/2025. HR Manger or designee to complete audit form for all current employees by 6/20/2025. HR Manager will continue to complete audit form for all new hires prior to start date.

65e - 12 Hours Annual Training

5. 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 F received only 4.65 hours of annual training in training year 2024.

Direct care staff person G received only 2.9 hours of annual training in training year 2024.

Plan of Correction ***Directed ([redacted] - 06/10/2025)***

Immediately: 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 during each established training year.

Directed Completion Date: *06/12/2025*

Evidence of Completion ***Not Implemented ([redacted] - 06/20/2025)***

HR Manager and Director of Health and Wellness will be re-educated by Interim Executive Director by 6/20/2025. Annual Training Topic/ Content forms to be completed going forward and kept in employee files.

65f - Training Topics

6. 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.

65f - Training Topics *(continued)*

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 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, 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.

Direct care staff person G 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 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

Plan of Correction ***Directed (- 06/10/2025)***

Within 3 days of receipt of the 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: *06/13/2025*

Evidence of Completion ***Not Implemented (- 06/20/2025)***

HR Manager and Director of Health and Wellness will be re-educated by Interim Executive Director by 6/20/2025. Annual Training Topic/ Content forms to be completed going forward and kept in employee files.

65g - Annual Training Content

7. 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 F did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a

65g - Annual Training Content (continued)

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, or new population groups that are being served at the home that were not previously served, if applicable during training year 2024.

Staff person G 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 H 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, or new population groups that are being served at the home that were not previously served, if applicable during training year 2024.

Staff person I 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

Plan of Correction ***Directed ([redacted] - 06/10/2025)***

Within 3 days of receipt of the plan of correction: The administrator or designee shallreview 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: *06/13/2025*

Evidence of Completion ***Not Implemented ([redacted] - 06/20/2025)***

HR Manager and Director of Health and Wellness will be re-educated by Interim Executive Director by 6/20/2025. Annual Training Topic/ Content forms to be completed going forward and kept in employee files.

83b - Air Conditioner/Fans

8. Requirements

2600.
83.b. If a home does not provide air conditioning, fans shall be made available to residents when the indoor temperature exceeds 80°F.

Description of Violation

On 4/30/2025 at 10:32 am, the indoor air temperature in the Memory Care dining room in the home was 82 degrees Fahrenheit. The home, whose air conditioning was not working properly, did not make fans available to the residents.

83b - Air Conditioner/Fans (continued)

On 4/30/2025 at 2:51 pm, the indoor air temperature in resident room 318 in the home was 80.2 degrees Fahrenheit. The home, whose air conditioning was not working properly, did not make fans available to the residents.

Plan of Correction ***Directed ([redacted] - 06/10/2025)***

Immediately: The administrator or designated staff person shall monitor the home at least daily to ensure fans are provided to residents when the temperature of the home exceeds 80 degrees Fahrenheit. Documentation of monitoring shall be kept.

Directed Completion Date: *06/12/2025*

Evidence of Completion ***Not Implemented ([redacted] - 06/20/2025)***

Maintenance Director will be re-educated by Interim Executive Director by 6/20/2025. Maintenance Director or designee will monitor the homes temperature daily, New audit form has been developed for tracking of compliance. Fans will be provided to residents when/ if the temperature of the home exceeds 80 degrees Fahrenheit.

88a - Surfaces

9. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 4/30/2025:

- *there was an open ceiling tile in the Terrace Level activity room, and water leaking into a trash can that was placed under it*
- *there was an open ceiling tile in the hall just outside of the Terrace Level activity room*
- *there was an open ceiling tile in the hall just outside of the Main Dining room on the Terrace Level*
- *there was a large hole in the ceiling of the Terrace Level Main Dining room with plastic sheeting hanging from the ceiling, surrounding the area*
- *there was a hole in the ceiling in the 1st floor laundry room, just above the dryer, with a trash can half full of water on top of the dryer, catching the water leaking from the ceiling*

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

Plan of Correction ***Directed ([redacted] - 06/10/2025)***

Immediately: The administrator or designee shall check all areas of the home at least daily to ensure floors, walls, ceilings, windows, doors and other surfaces are clean, in good repair and free of hazards. Hazardous conditions shall be corrected immediately. Documentation shall be kept.

Directed Completion Date: *06/12/2025*

Evidence of Completion ***Not Implemented ([redacted] - 06/20/2025)***

Areas remain open, awaiting contract to be signed for repair. Maintenance or Designee monitor areas daily for hazardous conditions.

89a - Water Pressure

10. Requirements

2600.

89a - Water Pressure *(continued)*

89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 4/30/2025 at 2:50 pm, the home did not have sufficient hot and cold water to the bathroom shower and the kitchen sink in room 318.

Plan of Correction ***Directed (- 06/10/2025)***

Immediately: The administrator or designee shall monitor the water pressure throughout the home at least daily. Any areas of noncompliance shall be corrected immediately. Documentation shall be kept.

Directed Completion Date: *06/12/2025*

Evidence of Completion ***Not Implemented (- 06/20/2025)***

Maintenance Director to be re-educated by Interim Executive Director by 6/20/25. Temperature log will be maintained. Maintenance Director or designee will monitor water temperatures daily x 5 days then weekly x 4 weeks. If water temperatures remain in compliance water temperatures will be checked monthly. New audit form has been created for monitoring of compliance.

92 - Windows

11. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 4/30/2025, the screen in the Terrace Level Dining Room was torn.

Plan of Correction ***Directed (- 06/10/2025)***

Immediately: The administrator or designated staff person shall check the home daily to ensure all windows, including windows in doors, are in good repair.

Directed Completion Date: *06/12/2025*

Evidence of Completion ***Not Implemented (- 06/20/2025)***

Maintenance Director to be re-educated by Interim Executive Director that all windows, including windows in doors, must be in good repair and securely screened when doors or windows are open. Maintenance Director to complete initial audit by 6/20/2025.

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 4/30/2025 Resident 1's Latanoprost Opthalmic .005% eye drops were observed in the medication cart with an open date of 2/26/2025. According to the manufacturer's instructions this medication is to be discarded 6 weeks after opening.

Plan of Correction ***Directed (- 06/10/2025)***

Immediately: A designated staff person qualified to administer medications shall check the medication cart at least

183e - Storing Medications (continued)

daily to ensure all medications are properly packaged and stored including that there are no expired, unpackaged or loose medications in the medication cart. Documentation of checks shall be kept.

Directed Completion Date: *06/12/2025*

Evidence of Completion ***Not Implemented ([redacted] - 06/20/2025)***

New Director of Health and Wellness will be educated by Interim Executive Director by 6/20/25. Daily med cart audits tracking form has been developed for monitoring of compliance. Audit form to be completed by medication Technician/ nurse daily. DHW will audit daily forms for completion and monitor compliance.

187b - Date/Time of Medication Admin.

13. Requirements

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

Description of Violation

Resident 3's April 2025 medication administration record does not include the initials of the staff person who administered the following medications:

- *4/8 and 4/9 at 8 am: Sertraline HCL 25 mg tab, Oxycodone HCL 5 mg tab, Acetaminophen 325 mg tab, Hydralazine, 25mg tab, Labetalol HCL 100 mg tab and Lorazepam*

Resident 4's April 2025 medication administration record does not include the initials of the staff person who administered the following medications:

- *4/7 at 8 pm: Nasonex 24 hr allergy 50 mcg*
- *4/23 at 9 pm: Donepezil HCL 10 mg tab and Metoprolol Succ ER 50 mg*

Resident 5's April 2025 medication administration record does not include the initials of the staff person who administered the following medications:

- *4/1, 4/2, 4/3, 4/4, 4/10, 4/11 and 4/15 at 2 pm: Gabapentin 100 mg capsule*
- *4/15 and 16 at 8 am: Acetaminophen 500 mg cap, Aspirin EC 81 mg, and Docusate Sodium 100 mg*
- *4/17, 4/21, 4/22, and 4/29 at 8 pm: Gabapentin 100 mg capsule*
- *4/23 and 4/24 at 8 pm: Lantus Solostar 100 unit/ml*

Resident 6's April 2025 medication administration record does not include the initials of the staff person who administered the following medications:

- *4/12 at 8am: Vit D3 25 mcg*
- *4/29 at 8 pm: Atorvastatin 10 mg tab, Donepezil HCL 10 mg tab and Sertraline HCL 100 mg tab*

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

Plan of Correction ***Directed ([redacted] - 06/10/2025)***

Immediately: The administrator or designee qualified to administer medications shall review all resident MARs at least weekly and observe at least two medication passes of each staff person qualified to administer medications

187b - Date/Time of Medication Admin. (continued)

for two months to ensure the proper documentation of medication administration at the time of administration. Documentation of reviews shall be kept.

Within 3 days of receipt of the plan of correction: All staff persons qualified to administer medications will be re-educated on the proper procedures for medication administration including documentation of medication administration at the time of administration in accordance with regulation 2600.187(b). Documentation of education shall be kept in accordance with 2600.65i.

Directed Completion Date: *06/13/2025*

Evidence of Completion ***Not Implemented (- 06/20/2025)***

New Director of Health and Wellness to be educated by Interim Executive Director by 6/20/2025. DHW to educate all medication technicians and nurses on proper medication administration by 6/23/25. Medication Administration Records will be audited weekly x 4 weeks and then monthly by DHW or designee. New audit form has been created to monitor compliance.

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 persons F and G, who work in the Secure Dementia Care Unit (SDCU) had 0 hours of training in dementia care during the 2024 training year.

Plan of Correction ***Directed (- 06/10/2025)***

Immediately: The administrator shall develop and implement a training plan and a tracking system that ensures each direct care staff person working in a secured dementia care unit receives 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) during each training year.

Directed Completion Date: *06/12/2025*

Evidence of Completion ***Not Implemented (- 06/20/2025)***

HR manager to be re-educated on annual training plan by Interim Executive Director by 6/20/2025. Tracking to be developed for all new employees, to be maintained in employee records. HR manager or designee to monitor compliance.