Department of Human Services
Bureau of Human Service Licensing

January 8, 2021

SAM FUERER, MANAGER
WYNDMOOR ASSISTED LIVING COMPANY LLC
551 EAST EVERGREEN AVENUE
WYNDMOOR, PA 19038

RE: SPRINGFIELD SENIOR LIVING COMMUNITY
551 EAST EVERGREEN AVENUE
WYNDMOOR, PA, 19038
LICENSE/COC#: 14484

Dear Mr. Fuerer,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 08/03/2020, 08/07/2020, 08/10/2020, 08/11/2020, 08/12/2020, 08/17/2020, 08/19/2020, 08/24/2020, 08/28/2020, 08/31/2020 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,
Claire Mendez

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *SPRINGFIELD SENIOR LIVING COMMUNITY* **License #**: *14484* **License Expiration Date**: *11/15/2020*
Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA 19038*
County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: *Michele Adams* **Phone**: *2152336300* **Email**: *michele.adams@springfieldal.com*

Legal Entity

Name: *WYNDMOOR ASSISTED LIVING COMPANY LLC*
Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA, 19038*
Phone: *2152336300* **Email**: *sfeuer@gardenhc.com*

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *84* **Waking Staff**: *63*

Inspection

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Complaint,Incident* **Exit Conference Date**: *08/31/2020*

Inspection Dates and Department Representative

08/03/2020 - Off-Site: Youn Hie Chung
08/07/2020 - Off-Site: Youn Hie Chung
08/10/2020 - Off-Site: Youn Hie Chung
08/11/2020 - Off-Site: Youn Hie Chung
08/12/2020 - Off-Site: Youn Hie Chung
08/17/2020 - Off-Site: Youn Hie Chung
08/19/2020 - Off-Site: Youn Hie Chung
08/24/2020 - Off-Site: Youn Hie Chung
08/28/2020 - Off-Site: Youn Hie Chung
08/31/2020 - Off-Site: Youn Hie Chung

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *103* **Residents Served**: *58*

Special Care Unit

In Home: *Yes* **Area**: *3rd floor* **Capacity**: *34* **Residents Served**: *17*

Resident Demographic Data as of Inspection Dates *(continued)*

Hospice

Current Residents: *x*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *58*
Diagnosed with Mental Illness: *20*
Diagnosed with Intellectual Disability: *22*
Have Mobility Need: *26*
Have Physical Disability: *14*

Inspections / Reviews

08/03/2020 - Partial

Lead Inspector: *Youn Hie Chung* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/06/2020*

1/8/2021 - POC Submission

Lead Reviewer: *Claire Mendez* **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/15/2021*

15a Resident abuse report

1. Requirements

2800.

15.a. The residence shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 05/13/2020, there was a verbal and physical altercation between resident #1 and staff A, witnessed by staff B. This incident was reported to staff person C same day. However, the residence did not report this incident to the local Area Agency on Aging.

On 06/11/2020, there was a physical altercation between residents #1 and #2. Resident #1 pushed resident #2, who fell and hit the back of [redacted] head. The resident was sent out to a hospital and diagnosed with [redacted]. The residence did not report this incident to the local Area Agency on Aging.

Plan of Correction **Accept**

The Wellness Staff were re-educated on the requirement to notify local Area Agency on Aging on 9/28 and 9/29/20 (see attached). To ensure compliance is maintained the Administrator and/or designee will review each reportable incident.

Completion Date: *11/03/2020*

16c Incident reporting

1. Requirements

2800.

16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Repeat Violation

On 05/13/2020 at 12:30 PM, there was a physical altercation between resident #1 and staff A. On 06/11/2020, there was a physical altercation between residents #1 and #2 resulting in a [redacted]. The residence reported these incidents to the Department headquarter's office. The Regional Office did not receive this report.

Repeat Violation: 1/9/2020

Plan of Correction **Accept**

The Nursing Supervisor's will be re-educated to notify the Regional Office by 11/20/20. The phone, fax and email address will also be posted as a reminder. To ensure compliance is maintained, the Administrator and/or designee will review each reportable incident.

Completion Date: *11/20/2020*

16d Final Incident report

1. Requirements

2800.

16.d. The residence shall submit a final report, on a form prescribed by the Department, to the Department's assisted living residence office immediately following the conclusion of the investigation.

16d Final Incident report *(continued)*

Description of Violation

On 06/11/2020, there was a physical altercation between residents #1 and #2. Resident #2 suffered [redacted]. The residence submitted an initial incident report on 06/12/2020. However, the residence did not submit a final report to the Department.

Plan of Correction **Accept**

The nursing supervisor's will be re-educated on the requirement to submit a final report by 11/20/20. To ensure compliance is maintained, the Administrator and/or designee will review each initial report and ensure a final report is submitted.

Completion Date: *11/20/2020*

23a ADL assistance

1. **Requirements**

2800.

23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plans, dated 07/16/2019 for resident #1 and 05/15/2020 for resident # 2, indicate the residents require 24 hour direct supervision. On 06/11/2020, the residents did not receive this assistance as required.

The assessment and support plan, dated 05/14/2019 for resident #3, indicates the resident is on [redacted] continuously. The ASP indicates that Direct Care Staff will assist when needed. On 08/06/2020 during the return trip from a nearby skilled nursing facility from a temporary relocation, which was due to flooding, the resident was transported without the [redacted]. Upon arrival to [redacted] room, the resident requested assistance with [redacted] in the room. The request was unanswered. The resident was able to independently connect the [redacted]

Plan of Correction **Accept**

Direct care staff will be re-educated to make sure they are providing the care as outlined in the Assessment and Support Plan by 11/30/20. To ensure compliance is maintained, the Administrator and/or designee will speak with random residents monthly to ensure they are receiving the appropriate care.

Completion Date: *11/30/2020*

42b Abuse/Neglect

1. **Requirements**

2800.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

42b Abuse/Neglect *(continued)*

Description of Violation

Resident #1 and resident #2 both require 24 hour supervision. On 06/11/2020 around 07:00 PM, staff D heard fighting in the hallway and checked the camera to see what was going on. Before she could get to the scene, resident #2 put her hand on resident #1's face, at which time resident #1 pushed resident #2, who [redacted]. *After the resident* [redacted] *Resident #2 was sent out to a hospital, where* [redacted]

On 07/31/2020 early in the morning, resident #1 approached staff E and said [redacted] *wanted to go home. Staff E told resident #1 that this was where* [redacted] *lived now and resident #1 started yelling and swung* [redacted] *arm to hit the staff. Staff E grabbed* [redacted] *hand, which resulted in pain and swelling of the resident's right middle finger.*

Plan of Correction **Accept**

Direct care staff were re-educated on Abuse and Safe Management Techniques on 9/28 and 9/29/20 (see attached). Staff Member E was put on investigatory suspension on [redacted]*20 and terminated on* [redacted]*20. Resident #1 finger has healed.*

Completion Date: *09/29/2020*

42c Dignity/Respect

1. **Requirements**

2800.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 08/04/2020 during an emergency evacuation, staff F and a hospice aid were having a hard time trying to persuade resident #3 to transfer to [redacted] *wheelchair so that they could help* [redacted] *evacuate safely. As the resident refused physical assistance from the firefighter on scene, Staff F stood next to the resident and rolled* [redacted] *eyes, and said "We can't leave you here [resident name] stop saying that." After the firefighter left the room, the hospice aid said "ain't nobody got time for this, this is serious." Both the Staff member and Hospice aid stood on either side of the resident attempting to assist* [redacted] *to transfer again. When the resident continued to refuse assistance, both the staff member and hospice Aid yelled at the resident simultaneously. Staff F got frustrated with the resident, raised* [redacted] *voice, and said"* [redacted]

Plan of Correction **Accept**

Staff Member F was placed on investigatory suspension on 8/10/20, and was given permission from Local Area Agency on Aging to return with additional training on 8/24/20. Staff Member F, decided not to return. Direct care staff were re-educated on Abuse on 9/28 and 9/29/20 (see attached). Direct care staff were also instructed to notify supervisor if a resident was not participating with the evacuation protocol.

Completion Date: *09/29/2020*

65a Fire Safety-1st day

1. **Requirements**

2800.

65a Fire Safety-1st day *(continued)*

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

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

Description of Violation

The residence could not provide a document showing that staff E, whose first day of work was [redacted]/2020, received orientation on the topics listed above on or prior to [redacted]/2020.

Staff D's first day of work was [redacted]2020. The training log for these topics is not dated. It can not be determined if these training topics were covered on the first day.

Plan of Correction **Accept**

Staff Member E was terminated on [redacted]/20. Staff Member D will re-educated on Fire Safety by 11/30/20. An Audit of 1st day training will be completed by 12/15/20. To ensure compliance is maintained, the Administrator and/or designee will meet with direct care staff at the end of their first day.

Completion Date: *12/15/2020*

65e Rights/Abuse 40 Hours

1. 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:

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 E completed her 40th scheduled work hour early February 2020. However, this staff person did not complete training in the topics listed above.

Plan of Correction **Accept**

Staff Member E was terminated on [redacted]/20. An audit will be completed by 12/15/20 to ensure that direct care staff, ancillary staff, substitute personnel and volunteers, received orientation within 40 working hours. To ensure compliance is maintained, the Administrator and/or designee will meet with staff by the end of their 5th day.

Completion Date: *12/15/2020*

65i Training topics

1. Requirements

2800.

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

1. Medication self-administration training.
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.

Description of Violation

Direct care staff person G did not receive training in medication self-administration and infection control during 2019 training year.

Plan of Correction **Accept**

An Audit will be completed by 12/15/20 to ensure that direct care staff meet the annual training requirements. To ensure compliance is maintained, and audit will be completed annually at the beginning of the 3rd quarter. Employees who do not meet requirement by the end of year, will be removed from schedule.

Completion Date: *12/15/2020*

141a Medical evaluation

1. Requirements

2800.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.

Description of Violation

The medical evaluation for resident #1, dated 06/24/2020, does not include [redacted] *date. The medical evaluation for resident #2, dated 04/02/2020, does not include* [redacted] *date. This area of the form is blank.*

Plan of Correction **Accept**

Resident #2 no longer resides at the home. Resident #1 received a [redacted] */20. An audit of Medical Evaluations has been completed (see attached). The facility is working on obtaining new medical evaluations, as appropriate by 12/31/20. To ensure compliance is maintained, the nursing department will use audit tool to schedule medical evaluations. The Administrator and/or designee will also use audit tool to spot check medical evaluations for completion.*

Completion Date: *12/31/2020*

141b1 Annual medical evaluation

1. Requirements

2800.

141.b. A resident shall have a medical evaluation:

1. At least annually.

Description of Violation

Resident #2's most recent medical evaluation was completed on 04/02/2020. The resident's previous medical evaluation was completed on 01/11/2019.

141b1 Annual medical evaluation *(continued)*

Plan of Correction **Accept**

Resident #2 no longer resides at The Home. An audit of Medical Evaluations was completed (see attached).The facility is working on obtaining new medical evaluations, as appropriate by 12/31/20. To ensure compliance is maintained, the nursing department will use audit tool to schedule medical evaluations. The Administrator and/or designee will also use audit tool to spot check medical evaluations for completion.

Completion Date: *12/31/2020*

141b2 Medical evaluation changes

1. **Requirements**

2800.

141.b. A resident shall have a medical evaluation:

2. If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

Resident #3's medical condition changed and [redacted] went on a hospice on [redacted]/2020, but the residence failed to have a medical evaluation conducted prior to the annual medical evaluation.

Plan of Correction **Accept**

Resident #3no longer resides at The Home. An audit of Medical Evaluations was completed (see attached).The facility is working on obtaining new medical evaluations, as appropriate by 12/31/20. To ensure compliance is maintained, the nursing department will use audit tool to schedule medical evaluations. The Administrator and/or designee will also use audit tool to spot check medical evaluations for completion.

Completion Date: *12/31/2020*

185b Medication procedures

1. **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.

Description of Violation

The residence could not explain the discrepancy on resident #2's [redacted] receipt and disposition log. 05/26/2020 receipt count was 56 and one pill was signed out on 05/30/2020, with a remaining count of 55. On 06/16/2020, the residence destroyed 29, which leaves 26 pills unaccounted for.

Plan of Correction **Accept**

The narcotic policy was revised 9/20 (see attached). The Administrator and/or designee must always sign disposition record to ensure accurate count. If count is not accurate, an investigation will be initiated, and authorities notified, if appropriate.

Completion Date: *09/30/2020*

187a Medication record

1. **Requirements**

2800.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

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

187a Medication record *(continued)*

Description of Repeat Violation

Resident #1 is prescribed [redacted], [redacted], and [redacted] However, [redacted] June medication administration record (MAR) does not include the diagnoses for these medications. Resident #2 is prescribed [redacted]. However, [redacted] June MAR does not include the diagnosis for this medication.

Repeat Violation: 1/9/2020

Plan of Correction **Accept**

The Wellness staff were re-educated on9/28 and 9/29/20 to have a diagnosis listed for each medication(see attached). To ensure compliance is maintained a medication audit is completed monthly to ensure a diagnosis is listed for each medication (see attached).

Completion Date: *09/29/2020*

187b Date/time of med admin

1. **Requirements**

2800.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1 is prescribed [redacted] every eight hours as needed. [redacted] MAR does not include the initials of the staff person who administered it on 05/16, 20, 22, 06/12,16, 26, 07/3, 14, 26, and 08/02, 05, 06, 15.
Resident #2 was prescribed [redacted] as needed. [redacted] MAR does not include the initials of the staff person who administered it on 05/13 and 05/30.

Plan of Correction **Accept**

The wellness staff were re-educated on 9/28 and 9/29/20 on the importance of initialing the medication administration record after the medication is administered (see attached). An audit is completed monthly to ensure the medication administration record is initialed, and to maintain compliance (see attached).

Completion Date: *09/29/2020*

187d Follow prescriber's orders

1. **Requirements**

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On 05/09/2020, resident #1 was not administered [redacted] and [redacted] at [redacted] and [redacted], [redacted] at [redacted]. On 07/08/2020, the same resident was prescribed [redacted] and [redacted] once daily for two weeks. [redacted] and [redacted] were not taken on 07/10/2020 and 07/12/2020.
Resident #2 was prescribed [redacted] for seven days starting on 07/12/2020 but was administered this medication for five more days.

Resident #2 has an order for [redacted], take [redacted]) by [redacted] twice daily as needed for [redacted] On 5/30/20 at [redacted] was administered.

187d Follow prescriber's orders *(continued)*

Plan of Correction **Accept**

The wellness staff were re-educated on the importance of following directions of the prescriber on 9/28 and 9/29/20 (see attached). To ensure compliance is maintained an audit is completed monthly (see attached).

Completion Date: *09/29/2020*

201 Positive interventions

1. **Requirements**

2800.

201. Safe Management Techniques - The residence shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident #1 tends to behave aggressively when agitated. The residence has not implemented positive interventions to modify or eliminate the behavior. On 06/11/2020, resident #1 pushed resident #2, who [redacted]

On 07/31/2020, resident #1 tried to hit staff E, who grabbed the resident's hands to avoid being hit, rather than attempting to redirect the resident.

Resident #1's ASP does not define how to address the resident's aggressive behaviors.

Plan of Correction **Accept**

The wellness staff were re-educated in Safe Management techniques on 9/28 and 9/29/20 (see attached). An audit of ASP's has been completed and The Home is currently in the process of completing new ASP's as appropriate (see attached). To maintain compliance, the Administrator and/or designee will spot check ASP's to make sure appropriate interventions are listed for residents.

Completion Date: *12/31/2020*

225a Assessment - RN/form

1. **Requirements**

2800.

225.a. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows:

Description of Violation

Resident #1's assessment, dated 07/31/2020, was completed by staff C, an LPN. Resident #2's assessment, dated 05/15/2020, was completed by staff I, an LPN. There is no indication that either staff was supervised by an RN at the time of the assessment.

Plan of Correction **Accept**

The home has a RN who is supervising the LPN's with assessments (see attached). To ensure compliance is maintained, the Administrator and/or designee will spot check assessments to ensure a RN signature is present.

Completion Date: *09/30/2020*

225a1 Assessment – annually

1. Requirements

2800.

225.a.1. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: Annually.

Description of Violation

Resident #3's most recent assessment was completed on 08/11/2020. The resident's previous assessment was completed on 05/14/2019.

Plan of Correction **Accept**

An audit of assessments is in the process of being completed. The Home will use the audit to schedule completion of assessments, as appropriate. To maintain compliance, the Administrator and/or designee will use the audit tool to spot check assessments for compliance.

Completion Date: *12/31/2020*

225b Assessment content

1. Requirements

2800.

225.b. The assessment must, at a minimum include the following:

4. The resident's medical history, medical conditions, and current medical status and how these impact or interact with the individual's service needs.

Description of Violation

Resident #3's assessments, dated 05/14/2019 and 08/11/2020, do not include [redacted] medical diagnoses.

Plan of Correction **Accept**

An audit of assessments is in the process of being completed. The Home will use the audit to schedule completion of assessments, as appropriate. To maintain compliance, the Administrator and/or designee will use the audit tool to spot check assessments for compliance.

Completion Date: *12/31/2020*

227b Final support plan – RN

1. Requirements

2800.

227.b. A residence may use its own support plan form if it includes the same information as the Department's support plan form. An LPN, under the supervision of an RN, shall review and approve the final support plan.

Description of Violation

The support plan for resident #3, dated 08/11/2020, was finalized by staff C, an LPN. There is no indication that the staff was supervised by an RN.

Plan of Correction **Accept**

The home has a RN who is supervising the LPN's with assessments (see attached). To ensure compliance is maintained, the Administrator and/or designee will spot check assessments to ensure a RN signature is present.

Completion Date: *09/30/2020*

227c Final support plan - revision

1. Requirements

227c Final support plan - revision *(continued)*

2800.

227.c. The final support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. The residence shall review each resident's final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

Description of Violation

Resident #3's support plan has not had a quarterly review since 08/14/2019.

Plan of Correction **Accept**

Resident #3 no longer resides at the home. The home is in process of completing an audit of ASP's and completing new and/or quarterly as appropriate (see attached). To maintain compliance, the administrator and/or designee will use audit tool to spot check ASP's for timeliness.

Completion Date: *12/31/2020*

231e Additional assessments

1. **Requirements**

2800.

231.e.1. In addition to the requirements in § 2800.225 (relating to additional assessments), residents of a special care unit for Alzheimer's disease or dementia shall also be assessed quarterly for the continuing need for the special care unit for Alzheimer's disease or dementia.

Description of Violation

Residents #1 and #2 were assessed for the need for special care unit on 08/16/2019 and 05/11/2019 and were not assessed again until 05/06/2020 and 05/15/2020.

Plan of Correction **Accept**

Resident #1 assessment was completed on 10/16/20 (see attached). The Home is currently auditing assessments and completing as appropriate. To maintain compliance, the administrator and/or designee will use the audit tool to spot check for timeliness. Resident #2 no longer resides at The Home.

Completion Date: *10/16/2020*

234b Support plan - elements

1. **Requirements**

2800.

234.b.1. The support plan and if applicable, the rehabilitation plan, must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated 07/31/2020, for resident #1 does not address [redacted] medical need.
The support plan, dated 05/15/2020, for resident #2 does not address [redacted] medical or psychological need.

Plan of Correction **Accept**

Resident #1 assessment was completed on 10/16/20 (see attached). The Home is currently auditing assessments and completing as appropriate. To maintain compliance, the administrator and/or designee will use the audit tool to spot check for medical and psychological needs. Resident #2 no longer resides at The Home.

Completion Date: *10/16/2020*

234d Support plan - review

1. **Requirements**

2800.

234d Support plan - review *(continued)*

234.d.1. The support plan for a resident of a special care unit for residents with Alzheimer's disease or dementia shall be reviewed, and if necessary, revised at least quarterly and as the resident's condition changes.

Description of Violation

A support plan for resident #1 was completed on 07/16/2019; however, the plan was not reviewed quarterly. A support plan for resident #2 was completed on 01/11/2019; however, the last quarterly review was on 05/11/2019.

Plan of Correction **Accept**

Resident #1 support plan was updated on 10/16/20 (see attached). Resident #2 no longer resides at The Home. The Home is currently auditing support plans and completing as appropriate. To maintain compliance, the administrator and/or designee will use audit tool to spot check for timeliness.

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Completion Date: *10/16/2020*

236a Staff training

1. 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 G, who works in the special care unit, had only 6 hours of training related to dementia care during the 2019 training year.

Plan of Correction **Accept**

An audit of annual training will be completed by 12/15/20. Training will be offered to direct care who have not met the requirement. Failure to meet requirement will result in removal from schedule. To maintain compliance, an audit will be completed annually at the beginning of 3rd quarter.

Completion Date: *12/16/2020*

2. 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 E, date of hire [redacted]/2020, worked in the special care unit, but the residence could not provide any documentation of [redacted] initial training related to dementia care within the first 30 days of the date of hire. Direct care staff person D, date of hire [redacted] 2020, works in the special care unit, but [redacted] had only 4 hours of dementia related training.

Plan of Correction **Accept**

Staff Member E is no longer employed at The Home. An audit of initial and annual training will be completed by 12/15/20. The administrator and/or designee will review new employee dementia training within their first 30 days.

Completion Date: *12/15/2020*

236b Training topics

1. 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:
3. Effective communications.
4. Assistance with ADLs.
5. Creating a safe environment.

Description of Violation

Direct care staff person G, who works in the special care unit, did not complete training in the following topics; effective communications, assistance with ADLs, and creating a safe environment.

Plan of Correction **Accept**

An audit of direct care training for employees who work in a special care will be completed by 12/15/20. To maintain compliance, the administrator and/or designee will ensure that topics listed in 2800.236(b) are covered in the initial training, as well as annually.

Completion Date: *12/15/2020*

251b Record entries - legible

1. Requirements

2800.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

On the cognitive prescreening form for resident #2, the participation date of Part IV was written over. The date on the orientation training record for staff D was written over.

Plan of Correction **Accept**

The managers will be re-educated in the appropriate way to correct a mistaken entry by 11/20/20. To maintain compliance, the administrator and/or designee will spot check items in the medical record, to make sure legible.

Completion Date: *11/20/2020*