pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: April 12, 2022

[redacted]
Columbia Wegman Southampton LLC
[redacted]

RE: The Landing of Southampton
1160 Street Road
Southampton, Pennsylvania 18966
License #: 145381

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection September 16 and 30, 2021, October 1, 5, 7, and 8, 2021, and December 20, 2021 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 145380 dated February 10, 2022 to February 10, 2023 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated February 10, 2022 to February 10, 2023 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3); (4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from April 12, 2022 to October 12, 2022.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

[redacted]

If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Jeanne Parisi, Bureau Director
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Jamie L. Buchenauer

Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *THE LANDING OF SOUTHAMPTON* **License #:** *14538* **License Expiration:** *02/10/2022*

Address: *1160 STREET ROAD, SOUTHAMPTON, PA 18966*

County: *BUCKS* **Region:** *SOUTHEAST*

Administrator

Name: [redacted] **Phone:** *2064367796* **Email:** [redacted]

Legal Entity

Name: *COLUMBIA WEGMAN SOUTHAMPTON LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *58* **Waking Staff:** *44*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *10/08/2021*

Inspection Dates and Department Representative

09/16/2021 - On-Site: [redacted]

09/30/2021 - On-Site: [redacted]

10/01/2021 - Off-Site: [redacted]

10/05/2021 - On-Site: [redacted]

10/07/2021 - On-Site: [redacted]

10/07/2021 - On-Site: [redacted]

10/08/2021 - On-Site: [redacted]

Inspection Dates and Department Representative *(continued)*

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *106* **Residents Served**: *42*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *OPAL* **Capacity**: *36* **Residents Served**: *12*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *40*

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

Have Mobility Need: *16* **Have Physical Disability**: *1*

Inspections / Reviews

09/16/2021 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/05/2021*

11/04/2021 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/22/2021*

02/16/2022 - Document Submission

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

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On 9/16/21 at 9:00am then again at 2:00pm, an agent of the Department, requested access to internal investigation documentation regarding abuse. The home denied access both times.

Plan of Correction ***Directed***

Community staff misunderstood the importance/definition of "immediate" access and completed other tasks before providing Agents of the Department with access to the requested documentation. Representatives from the corporate office will review the requirements of this regulation with the General Manager (GM) and individuals who are designated as the manager-on-duty to ensure Agents of the Department are provided immediate access.
A properly credentialled representative from the corporate office has been appointed as the interim Administrator of the community (GM). Upon the appointment of a new GM, the community's Operations Leader will ensure this requirement and the provisions of this plan of correction are reviewed with the individual.

DPOC - SP - 11-04-2021
Within 10 business days receipt of this Plan of Correction (POC), management will ensure the executive director, administrator, business office staff, and any other staff responsible for providing records to agents of the Department are educated on providing immediate access. Documentation of education will be maintained by home and made available for Department review.

Document Submission Licensee's Proposed Date for POC Implementation -11/14/21 03-01-22 SP - ***Implemented***

Current Administrator is licensed and very familiar with Personal Care Home Regulations in PA. Future requests for records will not be denied by staff in the home. Additionally, staff that are present in the home have been trained on this requirement, see attached training document.

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home 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

During staff interviews it was reported that on [redacted]/21 or [redacted]/21, a staff member witnessed sexual assault involving resident #1 and resident #2. However, this was not reported in accordance with the Older Adult Protective Services Act.

During staff interviews it was reported that on [redacted]/21, a staff member witnessed sexual assault involving resident #1 and resident #3. However, this was not reported in accordance with the Older Adult Protective Services Act.

During staff interviews it was reported that on [redacted]/21, staff members witnessed sexual assault involving resident #1 and resident #4. However, this was not reported in accordance with the Older Adult Protective Services Act.

Plan of Correction ***Directed***

It has been determined that community staff were not sufficiently trained to recognize/differentiate between

15a - Resident Abuse Report (continued)

"behaviors associated with dementia" and the reportable crime of sexual assault.
Representatives from the corporate office have completed re-training for all staff on the community's applicable policies and the requirements of 2600.15.a. Community policies and the Older Adults Protective Services Act identify all staff as mandatory reporters who must comply with company policy and applicable laws if they have knowledge of abuse, have witnessed abuse or reasonably suspect that abuse has occurred. If an employee witnesses physical or sexual abuse or threats of abuse, employees must call 911 immediately. Each staff member is also responsible for:
• Reporting these occurrences to the appropriate jurisdictional authorities by calling the statewide elder abuse hotline,
• Verbally reporting the incident to the community's GM or designee,
• Completing an incident report in the community's electronic documentation platform.
The GM or designee is responsible for ensuring all reporting requirements are met in the timeframe specified by applicable laws. The GM will ensure this training is a component of the community's annual continuing education plan for each employee. Representatives from the corporate office conduct a review of staff continuing education as a component of the community's periodic clinical audits.
The individual designated as the GM on the dates identified in this violation is no longer employed by the community. The interim GM has will ensure continued compliance with this plan of correction. Upon the appointment of a new GM, the community's Operations Leader will ensure this requirement and the provisions of this plan of correction are reviewed with the individual.

DPOC - SP - 11-04-2021 Licensee's Proposed Date for POC Implementation -11/14/21 SP - Not Implemented 03-01-22
Education to be completed within 10 business days receipt of this POC and made available for Department review.

15d - Resident Abuse-Notification

1. Requirements

2600.
15.d. The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

Description of Violation

On [redacted]21, the home received a report of suspected abuse involving resident #3. The home did not notify resident #3's designated person.

Plan of Correction ***Accept***

It has been determined that staff were not sufficiently trained to recognize/differentiate between "behaviors associated with dementia" and abuse. A review of community records indicates that staff did not consistently report and document incidents in accordance with community policies and regulatory requirements.
Training for all staff has been conducted on the requirements of abuse reporting. See attached documentation of training.
A component of the training referenced in violation 2600.15.a. above includes the requirement to notify a resident's designated person of a report of suspected abuse. The interim GM will ensure compliance with this requirement until a new GM is appointed and oriented to this plan of correction. As indicated above, representatives from the corporate office conduct periodic clinical audits to monitor ongoing compliance.

Licensee's Proposed Date for POC Implementation -11/14/21 SP - Not Implemented 03-01-22

16c - Written Incident Report

1. Requirements

16c - Written Incident Report *(continued)*

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

During staff interviews it was reported that on [redacted]/21 or [redacted]/21, a staff member witnessed sexual assault involving resident #1 and resident #2. However, The home did not report this incident to the department.

During staff interviews it was reported that on [redacted]/21, a staff member witnessed sexual assault between resident #1 and resident #3. However, The home did not report this incident to the department.

During staff interviews it was reported that on [redacted]/21, staff members witnessed sexual assault involving resident #1 and resident #4. However, The home did not report this incident to the department.

Repeat et al 02-25-2021

Plan of Correction ***Accept***

As determined in the plan of correction for violation 2600.15.d. above, staff did not consistently report and document incidents in accordance with community policies and regulatory requirements.
A component of the training referenced in violation 2600.15.a. above includes the requirement to notify the Department of incidents of sexual assault within 24 hours. The interim GM will ensure compliance with this requirement until a new GM is appointed and oriented to this plan of correction.

Licensee's Proposed Date for POC Implementation -11/14/21 SP - Implemented 03-01-22

42b - Abuse

1. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted]/21, Resident #1 was witnessed sexually assaulting resident #3 during an activity. Resident #1's hand was [redacted] resident #3. Resident #1 and resident #3 were separated. Resident #1 had noticeable [redacted]. About 10 minutes later, Resident #1's hand was once again [redacted] resident #3. At that point resident #1 was removed from the area.

On [redacted]/21 or [redacted]/21, Resident #1 was witnessed sexually assaulting resident #2 on the floor in the living room area of OPAL. Resident #2's [redacted]. Resident #2's [redacted] and resident #1's hand was on resident #2's [redacted]. Resident #2 was yelling "What's happening to me? What's going on?"

On [redacted]/21, Resident #1 was witnessed sexually assaulting Resident #4. Resident #1's hand was [redacted] Resident #4, while resident #1's other hand [redacted] resident #1's [redacted]. Resident #1 had undressed Resident #4 and [redacted] Resident #4's [redacted]. Staff members separated Resident #1 and Resident #4. While redressing Resident #4, Resident #1 then went to kiss Resident #3.

The home did not take action to prevent the sexual assaults involving Resident #1 from recurring.

Plan of Correction ***Directed***

As indicated in the plan of correction for the related violations above, staff were not sufficiently trained to identify

42b - Abuse (continued)

sexual assaults and respond appropriately to prevent the potential recurrence of incidents.
Representatives from the corporate office have completed re-training for all staff on the provisions of the community's Suspected Resident Abuse Policy and Resident Rights Policy-see attached record of training. Aggressive Resident or Individual Policy training will occur. Provisions of the policies include:
• An employee must call 911 immediately if they witness sexual abuse and/or if the safety of any individual is in jeopardy,
• Staff should intervene to protect the safety of residents in the area and remove the aggressive individual from the situation,
• The GM shall be notified immediately to direct the implementation of protective protocols to prevent further potential for abuse.
The GM will ensure this training is a component of the community's annual continuing education plan for each employee.
Resident #1 was discharged from the community on [redacted]/21.
The interim GM will ensure compliance with this requirement until a new GM is appointed and oriented to this plan of correction. The periodic clinical and operational audits conducted by representatives from the corporate office include a review of the continuing education plans and timelines for staff.

DPOC - SP - 11-04-2021
Within 10 business days receipt of this POC, the exact resident rights training that was provided to staff will be made available for Department review. Training should heavily enforce mitigating and eliminating the neglect and abuse of residents.

Licensee's Proposed Date for POC Implementation -11/14/21 SP - Not Implemented 03-01-22

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 was hired on [redacted]/20 and did not have a PA STATE criminal background check completed until [redacted]/21

Staff person B was hired [redacted]/20 and did not have a PA STATE criminal background check completed until [redacted]/21

[redacted]

Plan of Correction ***Accept***

The company's Volunteer Policy does not permit the use of volunteers without the prior approval of the community's Operations Leader. The Operations Leader did not approve the use of volunteers at the community. Staff person C has been restricted from volunteering, is not employed by the community and is no longer subject to the PA State criminal background check requirement.
The community did conduct background checks and have them on file for both Staff member A and B, however the checks did not comply with all the elements identified in 2600.51. In accordance with the plan of correction for a previous violation of this requirement, the community re-processed background checks for all staff according to the Background Check Policy established for the community that complies with the requirements of 2600.51.
The company has developed an Onboarding Checklist (attached) to guide Department Heads through employee onboarding and references the alpha-numeric identifier for the Background Check Policy to ensure compliance.

51 - Criminal Background Check (continued)

Corporate office staff have reviewed the checklist and background check policy with community Department Heads. The GM is responsible for reviewing each employee's onboarding checklist within 30 days following employment to ensure the conditions of employment have been met. Upon the appointment of a new GM, the community's Operations Leader will ensure this requirement and the provisions of this plan of correction are reviewed with the individual.
Corporate office staff conduct periodic operational audits and will verify compliance with the onboarding/background check process.

Licensee's Proposed Date for POC Implementation -11/14/21 SP - Not Implemented 03-01-22

58a - Awake Staff 16 or More

1. Requirements

2600.
58.a. If a home serves 16 or more residents, all direct care staff persons on duty in the home shall be awake at all times one or more residents are present in the home.

Description of Violation

On 10/7/21, more than 16 residents were present in the home. Staff member D was on duty for 1:1 supervision of resident #1. However, at 12:03am Staff member D was asleep in a chair outside the room of resident #1.

Plan of Correction ***Directed***

In addition to the provision of this requirement, the community's Employee Handbook identifies that sleeping on the job is prohibited and a violation of the community's standards of conduct. Failure to demonstrate immediate and sustained improvement with this standard of conduct and/or other violations will result in further disciplinary action, up to and including termination of Staff member D's employment.
The interim GM is responsible for monitoring and reviewing the Corrective Action Plan as documented.
Representatives from the corporate office have reviewed this requirement and this provision of the Employee Handbook and Employee Incident Report Policy with employee. All staff are responsible for documenting and reporting violations of workplace behavior as a conduct incident. Conduct incident reports are to be reviewed by the GM who is identified as the community's impartial investigator. The interim GM has will ensure compliance with this plan of correction. Upon the appointment of a new GM, the community's Operations Leader will ensure this requirement and the provisions of this plan of correction are reviewed with the individual.*
** Exception: If the General Manager is alleged to have been involved in a conduct incident or may not be considered to be an impartial investigator, the incident report will be given to the GM's designee with a report made directly to the Operations Leader and/or Corporate Senior HR Director.*

DPOC - SP - 11-04-2021
Provider will ensure there are awake, alert staff members in the residence at all times residents are present in the facility.

Document Submission Licensee's Proposed Date for POC Implementation -11/14/21 SP - 03-01-22 ***Implemented***

Since the appointment of a new GM, the community's Operations Leader has ensured this requirement and the provisions of this plan of correction were reviewed with the GM and will be maintained.

65a - FS Orientation 1st Day

1. Requirements

2600.

65a - FS Orientation 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

Staff person C, whose first day of volunteering was [redacted]/21, did not receive orientation on the following topics:

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.

Plan of Correction ***Directed***

Had the Operations Leader approved the use of volunteers at the community, the GM must comply with all requirements of the local governance, including the topics identified in this requirement, prior to permitting access to the community or its residents. Additionally, volunteers would not be permitted to perform the duties or responsibilities of employees. As identified in 2600.51 above, Staff person C is no longer providing services as a volunteer, employee, or other role subject to the provision of this requirement and the GM who violated the company's Volunteer Policy is no longer employed by the community.
Representatives who conduct the periodic clinical audits and operational audits review staff onboarding records and will verify the community is not utilizing volunteers in lieu of staff.

DPOC - SP - 11-04-2021
Within 10 business days receipt of this POC, the administrator will audit the files of all Direct Care Staff to ensure they received 1st day orientation trainings specified in regulation 2600.65a. Documentation will be kept in staff files and made available for Department review.

Document Submission Licensee's Proposed Date for POC Implementation -11/14/21 SP - ***Implemented*** 03-01-22

Employee files were only returned to the home last week. Each file is currently being audited by Interim Administrator and Business Office Manager for record compliance. In the event that any staff , volunteer, or substitute personnel records are found to be missing the initial training specified in 2600.65a, this training will occur immediately. All individuals will be trained on this requirement by 11/24/21, or next scheduled work day thereafter.

65d - Initial Direct Care Training

1. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

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

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   i. Safe management techniques.
   ii. ADLs and IADLs
   iii. Personal hygiene.
   iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.

Description of Violation

Direct care staff person A, hired on [redacted]/20, began providing unsupervised ADL services before [redacted]21. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test until [redacted]21.

Plan of Correction ***Directed***

A previous statement of deficiencies issued by the Department identified that Staff person A began providing unsupervised ADL services prior to complying with the requirements of 2600.65.d. Direct care staff person A is licensed as a nurse in the State of [redacted] Although Pennsylvania has passed the Nursing Licensure Compact exempting licensed nurses from the Department-approved training and competency test, [redacted] is not a participating state. The affected staff member completed the required course/test and a note regarding the discrepancy of the training/test date and provision of unsupervised ADL services was noted in the employee record by the indicated completion date (which was [redacted]/21 and accepted by the Department but was not present in the employee's file at the time of this inspection).

The corporate office staff provided the GM who was employed at the time of Staff person A's hiring with a link to the multi-state nursing compact site to verify whether a licensed nurse is exempt from this requirement. Staff person A is currently on a leave of absence and upon completion of [redacted] will not be returning to work.

The GM, in conjunction with the HWD, are responsible for ensuring proper supervision is provided as specified in this section. The interim GM will ensure compliance with this requirement until a new GM is appointed and oriented to this plan of correction.

Representatives who conduct the periodic clinical audits and operational audits review staff onboarding records and will verify the community is compliant with the provisions of this plan of correction.

Going forward, Interim Administrator will verify compliance of all newly hired staff, to make certain all have successfully passed the Department approved direct care training course and competency test prior to performing unsupervised ADLs with residents.

DPOC - SP - 11-04-2021

Within 10 business days receipt of this POC, the administrator will audit the files of all Direct Care Staff to ensure they received Initial Direct Care trainings specified in regulation 2600.65d. Documentation will be kept in staff files and made available for Department review.

Document Submission Licensee's Proposed Date for POC Implementation -11/14/21 SP - ***Implemented*** 03-01-22

All staff records were returned to the home last week. Direct Care staff training is on file as completed for all applicable individuals. See attached for verification.

85a - Sanitary Conditions

1. Requirements

85a - Sanitary Conditions *(continued)*

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 10/8/21 at 10:00am, there was a metal kitchen dish holding a fruit cup in the OPAL medication cart. There was a layer of dried fruit juice covering the bottom of the kitchen dish.

Plan of Correction ***Accept***

Community staff have cleaned the dish.
Representatives from the corporate office have reviewed medication cart standards for organization and cleanliness with staff who have access to and are responsible for the carts and supervisors who are responsible for conducting periodic/ongoing monitoring of the community's medication services program, including cart standards.
Said representatives will oversee the community's medication services program until the new GM and HWD are appointed and oriented to this requirement and plan of correction.

Document Submission Licensee's Proposed Date for POC Implementation -11/14/21 SP - ***Implemented*** 03-01-22

completed

183a - Original Containers and Injections

1. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

Resident #7 is prescribed Lorazepam .5MG Tabs, however there are 5 pills taped over on the back of the blister pack.

Resident #12 is prescribed Oxycod/apap tab 10-325MG, however pill #30 of the is taped over on the back of the blister pack.

Resident #13 is prescribed Tramadol HCL tab 50mg. however pill #6 of the is taped over on the back of the blister pack.

Resident #14 is prescribed Alprazolam tab .25mg. However, pill #30 of the is taped over on the back of the blister pack.

Plan of Correction ***Accept***

Community staff have reported that the blister packaging is cracking due to the storage of the blister cards. Staff have stated that the punch-able barrier/foil breaks and they have used tape to secure the medication.
Representatives from the corporate office requested assistance from the pharmacy provider to review the affected medications that were still available to audit. The pharmacy representative confirmed the remaining affected medications had the identifier codes that matched the medication that was ordered. The audit will extend to other blister packs that have been taped. The compromised medication from affected blister packs have been destroyed. The community's Operations Leader has authorized reimbursement of uncompensated resident expenses related to this violation.
Storage has been modified to allow more room to store blister card in the designated secured area, to prevent future bending of cards. The interim GM will ensure compliance with this plan of correction. Upon the appointment of a new GM, the community's Operations Leader will ensure this requirement and the provisions of this plan of

183a - Original Containers and Injections (continued)

correction are reviewed with the individual.
Representatives from the corporate office will conduct an in-service for all staff who are associated with the community's medication services program (properly credentialed direct care staff, Department Supervisors and the GM) to review the requirements identified in 2600.183.a. and will monitor the community's compliance with the Medication Services Policy as a component of the periodic clinical audit.

Licensee's Proposed Date for POC Implementation -11/14/21 SP - Not Implemented 03-01-22

183d - Prescription Current

1. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 10/8/21 at 10:00am, Sertraline tab 25MG prescribed for resident 1, was in the OPAL medication cart; however, the medication was discontinued. The medication was not listed on the medication administration record and the home could not verify the discontinue date.

Plan of Correction ***Accept***

Community staff assigned to provide medication services and responsible for overseeing medication services did not appear to provide services/oversight consistent with this requirement. The Health and Wellness Director (HWD), who was designated as the person responsible for managing the medication services program at the time of this violation, is no longer an employee of the community.
Representatives from the corporate office have ensured this medication has been removed from the community both because it was discontinued and because Resident #1 has been discharged from the community.
Representatives from the corporate office have conducted an audit of medications and confirmed that any medications that do not have current orders are removed from the community. Said representatives will ensure compliance until a new HWD is appointed and oriented to this plan of correction. Reviewing the community's compliance with the community's Medication Services Policy is a component of the periodic clinical audits conducted by the corporate office.

Licensee's Proposed Date for POC Implementation -11/14/21 SP - Not Implemented 03-01-22

183f - Discontinued Medications

1. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

On 10/8/21 at 10:00am, Sertraline tab 25MG prescribed for resident #1, was in the OPAL medication cart; however, the medication expired 9/30/2021.

Plan of Correction ***Accept***

Please see related plan of correction for 2600.183.d. above.

183f - Discontinued Medications *(continued)*

Document Submission Licensee's Proposed Date for POC Implementation -11/14/21 SP- Not ***Implemented*** 03-01-22

completed

184a - Labeling OTC/CAM

1. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #8 is prescribed Alprazolam Tab .25mg take one tablet by mouth 3 times daily as needed. However, the medication label and narcotic log read take one tablet three times a day. The home couldn't determine if it was a straight order or a PRN.

Plan of Correction ***Directed***

The HWD responsible for monitoring the accuracy of the community's medication services program did not effectively manage the program and is no longer employed by the community.
Representatives from the corporate office will reviewed the order/label/narcotic log to confirm all items are consistent. Said representatives will ensure compliance until a new HWD is appointed and oriented to this plan of correction. As referenced in related violations identified above, the community's compliance with the community's Medication Services Policy is a component of the periodic clinical audits conducted by the corporate office.
Corporate staff will retrain all staff responsible for medication assistance to assure they understand the difference with pharmacy labels and PRN medications.

DPOC - SP - 11-04-2021
Within 10 business days receipt of this POC, the administrator will ensure all medication administration staff or med techs are educated on medication and pharmacy labeling. All of the requirements specified in regulation 2600.184a will be on residents medication labels.

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Staff responsible for assistance with Medication Administration have been re-trained on the provisions of regulation 2600.184a, Labeling OTC/CAM. See attached training content.

187b - Date/Time of Medication Admin.

1. 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 #6 is prescribed Zolpidem tab 5MG take 1 tablet by mouth daily at bedtime. Resident #6's Narcotic Log does not include the initials of the staff person who administered the medication on 9/30/21, 10/1/21, 10/4/21, 10/6/21, and 10/7/21.

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

Resident #9 is prescribed Oxycod/apap tab 2.5-325 take one tablet by mouth three times a day. However on 10/5/21, the time of the evening administration was not documented.

Resident #11 is prescribed pregabalin cap 50MG take twice a day for Nerve Pain. However, resident #11's narcotic log does not include the staff initials and time of administration for the second dose from 9/21/21 to 10/7/21.

Resident #15 is prescribed Tramadol HCL tab 50MG take one tablet by mouth daily in the morning. However, on 9/29/21 the time of the administration was not documented.

Plan of Correction ***Directed***

The HWD responsible for monitoring the accuracy of the community's medication services program did not effectively manage the program and is no longer employed by the community.
Representatives from the corporate office will provide in-service training to all staff who assist with the community's medication services program to ensure they understand this requirement and how to properly document medication administration in the electronic medication administration record and narcotic logs and will oversee the community's medication services program until a new HWD is appointed and oriented to this plan of correction. The new GM will also be oriented to this plan of correction and is responsible for the overall operational oversight of the community.
The community's compliance with the community's Medication Services Policy is a component of the periodic clinical audits conducted by the corporate office.

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Within 10 business days receipt of this POC, the administrator will ensure all medication administration staff or med techs are educated on initialing the Medication Administration Record (MAR) at the date and time medication is administered. Documentation of training to be maintained by home and made available for Department review.

187c - Refusal of Medication

1. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 9/6/21 at 9:00pm, resident #2 refused to take a scheduled dose of Symbicort 160/4.5MCG inhale 2 puffs by mouth twice a day. The home did not report the refusal to the prescriber within 24 hours.

Plan of Correction ***Accept***

Representatives from the corporate office have provided training referenced in 2600.18.b. above which includes a review of this requirement and that staff document and communicate refusals properly so they can be identified in the electronic platform, prompting staff to notify the prescriber. Please see attached training documentation.
Representatives from the corporate office will oversee the medication services program until a new HWD is appointed and oriented to this plan of correction. The new GM will also be oriented to this plan of correction and is responsible for the overall operational oversight of the community.
The community's compliance with the community's Medication Services Policy is a component of the periodic clinical audits conducted by the corporate office.

187c - Refusal of Medication *(continued)*

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Staff responsible for assistance with Medication Administration have been re-trained on the provisions of regulation 2600.187c, Refusal of Medication. See attached training content.

187d - Follow Prescriber's Orders

1. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 is prescribed Memantine HC Cap 14 MG take 1 cap daily for dementia. However, resident #2 was not administered this medication from 8/1/21 to 8/11/21.

Plan of Correction ***Accept***

Resident #2 was discharged from the community on [redacted]/21, so it is not practical to complete a medication error incident report and report these errors to Resident #2, Resident #2's authorized representative or physician in arrears.
Training conducted by representatives from the corporate office has included a review of medication errors and related processes (see attached training documentation). A Medication Error Incident Report it to be completed, which will generate an electronic notification to both the GM and HWD that an error has occurred and requires action.
Representatives from the corporate office will receive notices of Medication Error Incident Reports and enact the appropriate action until a new HWD and GM are appointed and oriented to this plan of correction.
The community's compliance with the community's Medication Services Policy is a component of the periodic clinical audits conducted by the corporate office.

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2. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 is prescribed MCT Oil take 3ml by mouth once daily . However, this medication was not administered to resident #2 on 7/15/21, 7/16/21, 7/20/21, and 7/21/21 because the medication was not available in the home.

Resident #2 is prescribed Celecoxib Cap 100mg take 1 capsule by mouth twice a day. However, this medication was not administered to resident #2 on 8/4/21 at 5:00pm and 8/5/21 at 9:00am because the medication was not available in the home.

Resident #5 is prescribed Metoprolol Tar tab 50MG take one tab by mouth three times a day. However, this medication was only given twice on 9/28/21 because the medication was not available in the home.

Plan of Correction ***Directed***

Resident #2 was discharged from the community on [redacted]/21. Representatives from the corporate office have verified the medication is on hand for Resident #5 and had no missed doses in October.
The unavailability of an ordered medication in the home is a medication error. The training and plan of correction noted in 2600.187.d. above would apply to this violation's plan of correction. Please see attached training documentation.

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Within 10 days receipt of this POC, the administrator shall engage the contracted pharmacy to review and audit and correct all of the resident's medication administration records for accuracy and completeness. The administrator will update the medication administration policy requiring medication availability. Policy should include method to audit compliance on an on-going basis and all staff administering medications should be trained of the policy development/update and as necessary. Documentation of the policy and staff training shall be provided to the Department for review within 10 business days of receipt of this POC.

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202 - Prohibitions

1. Requirements

2600.
202. The following procedures are prohibited:
4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

Description of Violation

Resident #10 is prescribed Lorazepam .5MG Tab take one tablet every 6 hours as needed for anxiety. According to Staff Member A, Lorazepam is administered to resident #10 with the residents morning medications to control behaviors. Staff member A stated that if the Lorazepam is not given with the rest of the morning medications, than resident #10 will refuse it.

Plan of Correction ***Accept***

Representatives from the corporate office completed a Medication Error Incident Report and have notified Resident #10, Resident #10's authorized representative and physician. The physician discontinued the order on 10/21/21.
Staff member A is on a leave of absence from the community and upon [redacted] completion of [redacted] will not be returning to work.
The training and plan of correction attached would apply to this violation's plan of correction as these practices were medication errors. Representatives from the corporate office also included additional in-service training related to this requirement and the community's Resident Rights Policy (right to refuse medication). Aggressive Resident-Individual Policy (prohibiting chemical restraints) will occur.
Representatives from the corporate office will supervise the community's medication services until a new HWD and GM are appointed and oriented to this plan of correction.
The community's ongoing compliance with violations of this nature are reviewed as components of both the clinical and operational audits conducted periodically by representatives from the corporate office.

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Aggressive Resident - Individual training is scheduled to be reviewed with staff next week.

227g -Support Plan Signatures

1. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1 participated in the development of [redacted] support plan on [redacted] /21. However, the resident and assessor did not sign and date the support plan.

227g -Support Plan Signatures (continued)

Resident #1 participated in the development of [redacted] support plan on [redacted]/21. However, the resident and assessor did not sign and date the support plan.

Repeat et al 02-25-2021 and 10-05-2020

Plan of Correction ***Accept***

Resident #1 has been discharged from the community.
Representatives from the corporate office will review the support plans of all residents to ensure they are properly executed by the required parties and will supervise the assessment and service planning paperwork until the new HWD and GM are appointed and oriented to this requirement and plan of correction.
Representatives from the corporate office review support plans during the periodic clinical audits and will verify documents are properly executed.

Document Submission Licensee's Proposed Date for POC Implementation -11/14/21 SP - 03-01-22 ***Implemented***

Resident/family meetings are continuing to take place in order to achieve compliance with Regulation 227g, Support Plan Signatures. After which, another audit will be conducted by the Interim administrator to verify all RASPs are current and up to date with participant signatures.

231b - Medical Evaluation

1. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/20; however, the resident's medical evaluation does not indicate the need for Secure Dementia Care in section 4.

Plan of Correction ***Accept***

Resident #4 was discharged from the community on [redacted]/21.
Representatives from the corporate office who are reviewing the assessment and service plans for each resident will ensure that residents who reside in the SDCU have documented medical evaluations that indicate the need for placement in a secured dementia care unit. Should there not be such documentation, the resident will either be transferred from the SDCU or an updated medical evaluation will be obtained that documents the need for placement in the SDCU. Corporate staff will conduct an audit of DMEs for SDCU residents by 11/15/21.
Representatives from the corporate office will oversee the community's admissions to the SDCU until the new HWD and GM are appointed and oriented to this requirement, the community's Resident Agreement Policy (SDCU admission requirements), Health Care Practitioner's Statement Policy (medical evaluations), Assessment Policy and Service Plan Policy, and this plan of correction.
Representatives from the corporate office will review the process for proper admissions to the SDCU as a component of the periodic clinical audits.

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completed 03-01-22

231c - Preadmission Screening

1. Requirements

231c - Preadmission Screening *(continued)*

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/21. However, the resident #2's written cognitive preadmission screening was completed on [redacted]/21.

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/21. However, the resident #3's written cognitive preadmission screening was completed on [redacted]/21.

Plan of Correction ***Accept***

These deficient occurrences cannot be corrected. Resident #2 has been discharged from the community. A note acknowledging this discrepancy will be reflected in Resident #3's record. Should the review of other residents' records identify additional violations, a note will be documented in each affected record. Corporate staff will conduct an audit to determine if any other PreScreens are non-compliant by 11/30/21.
As indicated above, admissions to the SDCU will be overseen by representatives from the corporate office until the new HWD and GM are appointed and oriented to this requirement, the community's electronic assessment scheduling tool, Move In Checklist/Move In Process Policy, (specifying that assessments must be completed prior to move in), and plan of correction.
Reviewing the Move In Checklists is a component of the periodic operational audit. Reviewing the timing of assessment dates is a component of the periodic clinical audit.

Document Submission Licensee's Proposed Date for POC Implementation -11/30/21 SP - 03-01-22 ***Implemented***

Audit of Pre-screens is currently underway, with expected completion by 11/30/21.

234b - Support Plan Needs Elements

1. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

Resident #1 was deemed to need 1 to 1 supervision on [redacted] 2021. The Resident Assessment Support Plan (RASP) dated [redacted] 2021 fails to address how this supervision need will be met and implemented. The RASP states the resident only needs "moderate" supervision.

During staff interviews it was reported that resident #2 is known for undressing and disrobing in the common areas of the home. This is noted in resident #2's progress notes on the following days: 6/8/21, 7/7/21, 7/21/21, 7/26/21, 7/27/21, 7/29/21, 8/11/21, 8/13/21. Resident #2's most recent support plan dated [redacted]/21 has not been updated to address disrobing or a plan to meet this need.

The support plan, dated [redacted]/21, for resident #4 does not address anxiety, however the resident is prescribed clonazepam for anxiety.

234b - Support Plan Needs Elements *(continued)*

Plan of Correction ***Accept***

The support pans for the residents affected by these deficient practices cannot be corrected/updated as they all have been discharged from the community.
Representatives from the corporate office are reviewing all residents' support plans. If additional discrepancies are identified, they will revise the support plan in conjunction with the respective resident and resident's authorized representative, if applicable. Said representatives will supervise the support planning for residents until the new HWD and GM are appointed, oriented to this requirement, the community's Medication Services Policy (RN/Pharmacy review of medications), Non-Resident Incident Report Policy (change of condition/incidents that warrant re-assessment/possible support plan revision), Assessment Policy, Service Plan Policy (changes in service provision that indicate change of condition/need), and this plan of correction.
Both the periodic corporate clinical and operational audits review the community's ongoing compliance with these policies and practices.

Document Submission Licensee's Proposed Date for POC Implementation -11/14/21 SP - 03-01-22 ***Implemented***

Resident/family meetings are continuing to take place in order to achieve compliance with Regulation 234b, Support Plan Needs Elements. After which, another audit will be conducted by the Interim administrator to verify all RASPs are current and up to date with needs elements properly identified.

252 - Record Content

1. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
10. A record of incident reports for the individual resident.

Description of Violation

Resident #2's record does not include an incident dated [redacted]/21.

Plan of Correction ***Accept***

The community did document the incident in the electronic chart, and also completed a 2600 reportable report. However this state reportable was not also placed in the resident chart per regulation. All staff were retrained as to the reportable incident regulations, see attached training documentation.
Both the periodic corporate clinical and operational audits review the community's ongoing compliance with incident reports.

Document Submission Licensee's Proposed Date for POC Implementation -11/14/21 SP - 03-01-22 ***Implemented***

completed