

Department of Human Services
Bureau of Human Service Licensing

January 18, 2022

[REDACTED]
DRI HEARTIS YARDLEY LLC
[REDACTED]
[REDACTED]

RE: HEARTIS YARDLEY
255 OXFORD VALLEY ROAD
YARDLEY, PA, 19067
LICENSE/COC#: 14772

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 12/13/2021, 11/29/2021, 12/03/2021, 12/07/2021 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,
Sandi Wooters

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: HEARTIS YARDLEY License #: 14772 License Expiration: 03/15/2022
Address: 255 OXFORD VALLEY ROAD, YARDLEY, PA 19067
County: BUCKS Region: SOUTHEAST

Administrator

Name: [REDACTED] Phone: 267-521-1032 Email: [REDACTED]

Legal Entity

Name: DRI HEARTIS YARDLEY LLC
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: Total Daily Staff: 74 Waking Staff: 56

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Complaint Exit Conference Date: 12/13/2021

Inspection Dates and Department Representative

12/13/2021 - On-Site: [REDACTED]
11/29/2021 - Off-Site: [REDACTED]
12/03/2021 - Off-Site: [REDACTED]
12/07/2021 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 115 Residents Served: 47

Special Care Unit

In Home: Yes Area: Generatios Capacity: 21 Residents Served: 8

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 47
Diagnosed with Mental Illness: 18 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 27 Have Physical Disability: 2

Inspection Dates and Department Representative (*continued*)

Inspections / Reviews

12/13/2021 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/03/2022*

01/10/2022 - POC Submission

Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/15/2022*

01/18/2022 - POC Submission

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *01/23/2022*

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.

Description of Violation

On 10/29/21 at 9:38pm through 10/30/21 there were 29 residents in rooms 101-106: 111-133; all the rooms on the 2nd floor were without electricity, heat and interconnected smoke detectors. The exterior temperature on these days was between 54 degrees Fahrenheit and 59 degrees Fahrenheit in Yardley. Residents reported feeling chilly and no blankets were made available to the residents. No fire watch was conducted during the outage despite the inoperable/interconnected smoke detectors.

Resident #1 is on oxygen for Chronic Hypoxic Respiratory Failure and was unable to use the oxygen concentrator for fear it would run out from 10/29/21 through 10/30/21. There was no emergency electrical outlet near [REDACTED] room to supply electricity to recharge the oxygen concentrator.

Resident #2, support plan dated 5/3/21 indicates the staff will provide assistance for transfers in and out of bed, transfer with toileting and assistance with ambulation. On 10/29/21 at 8:15am the resident used [REDACTED] call bell for assistance and it took the staff a total of 65 minutes to respond to [REDACTED] needs. On 10/30/21 at 12:5pm it took the staff 29minutes 10 seconds to respond to the residents needs. All call bells were operable via WIFI.

Resident #3, support plan dated 8/16/21 indicates [REDACTED] requires a two person assist for transfers and toileting. On 10/29/21 at 8:16am it took the staff 17 minutes 35 seconds to respond to the call bell for assistance. All call bells were operable via WIFI,

Plan of Correction**Do Not Accept**

Disaster plan is being updated to reflect additional safeguards to be implemented in the event of an emergency such as a power outage. Updated disaster plan will be forwarded to the Emergency Management Coordinator for approval once complete. Staff will be serviced by the ED or designee on updates to the disaster plan.

Evacuation procedures are being updated to ensure appropriate and safe accommodations for residents in the event of a power outage, including relocation within the Community or to an off-site location if necessary. Residents who are on Oxygen will be relocated immediately to a safe area within the community with the ability to utilize a generator powered outlet.

Additional blankets have been purchased to ensure that there is ample supply in the community if the heat source in Resident rooms is compromised due to a power outage. A temperature gun has been purchased so staff are able to check room temperatures in the event that the power is out and the heat source is compromised. A log will be kept monitoring room temperature for the duration of the outage, and residents will be moved to an alternative place in the community to ensure comfort. Emergency light source has been placed in every resident's room on the Assisted Living portion of the building.

Call bell reports will be generated daily by the concierge and provided to the ED or Designee. Reports of any call bells longer than 12 minutes will be highlighted, and the RCD/RSS will be responsible to follow up with staff to

42b Abuse/Neglect (continued)

determine reason for length of delay and take action accordingly.

Staff will be in-serviced on the abuse and neglect policy to ensure full understanding of the very specific guidelines and expectations on the care of the Residents, and their role in providing that care and treatment always. Inservice is scheduled with an outside provider at the community on January 10th.

Completion Date: 02/03/2022

Plan of Correction**Accept**

The Disaster plan was not specific enough to identify what steps would need to be taken upon the loss of power to the community. Disaster plan is being updated to reflect additional safeguards to be implemented in the event of an emergency such as a power outage. Executive Director will forward the updated disaster plan to the local Emergency Management Coordinator for approval once complete no later than 1/31/2022. All staff will be in serviced by the ED or designee on updates to the disaster plan no later than 2/4/2022. Annual review of the disaster plan will be provided to all staff by the ED or designee.

Evacuation procedures are being updated to ensure appropriate and safe accommodations for residents in the event of a power outage, including relocation within the Community to areas of the building that are powered by the generator or to an off-site location if necessary. Mutual aid agreements are in place for two other communities in the event that relocation off the premises becomes necessary. In the event of a power outage, residents who are on Oxygen will be relocated immediately to a safe area within the community with the ability to utilize a generator powered outlet for the oxygen concentrator.

Additional blankets have been purchased to ensure that there is ample supply in the community if the heat source in Resident rooms is compromised due to a power outage. The blankets are kept in the laundry storage area. The Building Services Director and Resident Care Director will be responsible to ensure distribution of the additional blankets to all residents affected by the loss of power. A temperature gun has been purchased so that the Building Services Director or designee are able to check room temperatures in the event of a power outage and the heat source is compromised. An hourly log will be kept monitoring room temperature for the duration of the outage, and residents will be moved to an alternative location in the community to ensure comfort. Emergency light source has been purchased and placed in every resident's room on the Assisted Living portion of the building.

Call bell reports will be generated daily by the concierge and provided to the ED or Designee. Reports of any call bells longer than 12 minutes will be highlighted, and the RCD/RSS will be responsible to follow up with staff to determine reason for length of delay and take action accordingly.

Fire watch procedures have been updated and will be implemented immediately upon loss of power to the building. Staff will be trained on the fire watch procedures no later than 1/31/22 by the Building Services Director or designee.

Staff have been in-serviced on the abuse and neglect policy to ensure full understanding of the very specific guidelines and expectations on the care of the Residents, and their role in providing that care and treatment always. Inservice was scheduled with an outside provider at the community on January 10th. Any staff members unable to attend on that date are being in serviced no later than 1/21/22. Failure to complete the in service will result in non-compliant staff to be removed from the schedule until complete.

Completion Date: 02/04/2022

Update: 01/18/2022

The administrator will discuss the disaster plan at monthly staff meetings for the next six months to ensure staff are aware of the procedures, starting immediately. SW 1.18.22

53a Admin. qualifications

1. Requirements

2800.
53.a. The administrator shall have one of the following qualifications:

Description of Violation

The home was without a qualified administrator from 9/15/21 to 10/26/21.

Plan of Correction

Do Not Accept

The home did have an administrator covering the community between 9/15/2021 and 10/26/2021, however this administrator was from another state so did not have a PA Certificate. This administrator has held the position of Executive Director in communities in many other states. [redacted] was a constant presence in the community to ensure appropriate coverage until a new administrator was hired on [redacted]/2021. Going forward, the plan is to have another member of the leadership team within the community obtain the ALR certificate to be sure that in the absence of the ED, there is not a lapse in coverage of a State Certified Administrator.

Completion Date: 02/03/2022

Plan of Correction

Accept

The home did have an administrator covering the community between 9/15/2021 and 10/26/2021, however this administrator was from another state so did not have a PA Certificate. This administrator has held the position of Executive Director in communities in many other states. [redacted] was a constant presence in the community to ensure appropriate coverage until a new administrator was hired on [redacted]/2021. Going forward, the plan is to have another member of the leadership team within the community obtain the ALR certificate to be sure that in the absence of the ED, there is not a lapse in coverage of a State Certified Administrator. The Business Office Director has been designated as the most suitable team member to complete the 100 hour course. BOD will be scheduled to attend the training, and upon completion of [redacted] associates degree, will be the alternative Administrator in the event of a lapse in coverage. This will be accomplished within 11 months.

Completion Date: 11/24/2022

60a Staffing/support plan needs

1. Requirements

2800.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan. Residence staff or service providers who provide services to the residents in the residence shall meet the applicable professional licensure requirements.

Description of Violation

The home has two housekeeping staff for 47 residents. Many residents reported not receiving housekeeping services that included cleaning their rooms, changing their sheets and vacuuming the rooms on a regular basis.

Plan of Correction

Do Not Accept

The housekeeping schedule has been evaluated and updated by the Building Services Director to ensure appropriate and consistent services to each resident. A checklist has been created for housekeepers which will be filled out by the housekeeper each time a resident's room is cleaned to be sure that all surfaces. This binder will be kept on each housekeeping cart and evaluated periodically by the Building Services Director for compliance.

Completion Date: 02/03/2022

Plan of Correction

Accept

The housekeeping schedule was not specific enough to identify which rooms would be cleaned on which day, and

60a Staffing/support plan needs (continued)

what alternative means of follow up would take place in the event that a room's scheduled day is missed. The housekeeping schedule has been evaluated and updated by the Building Services Director to ensure appropriate and consistent services to each resident. A checklist has been created for housekeepers which will be filled out by each housekeeper at the time a resident's room is cleaned to be sure that all surfaces have been appropriately tended to. This binder will be kept on each housekeeping cart and evaluated weekly by the Building Services Director for compliance.

Completion Date: 02/04/2022

Update: 01/18/2022

The administrator will conduct interviews with random residents to determine if the housekeeping meets the residents needs, at least monthly, starting immediately
SW 1.18.22

83a Indoor temperature

1. Requirements

2800.

83.a. The indoor temperature, in areas used by the residents, must be at least 70°F when residents are present in the home.

Description of Violation

On 10/29/21 at 9:38pm through 10/30/21 at 6:44pm, when residents were present in the residence 29 resident rooms were without electricity and heat. The exterior temperature was 54 degrees Fahrenheit in the evening and on Oct 30 was 59 Fahrenheit with rain in the morning and 66 during the day. The home did not have heat in the rooms on these dates and did not offer any blankets to keep the residents warm. Many residents reported feeling chilly when they had no heat in their rooms.

Plan of Correction

Do Not Accept

Additional blankets have been purchased to ensure that there is ample supply in the community if the heat source in Resident rooms is compromised due to a power outage. A temperature gun has been purchased so staff are able to check room temperatures in the event that the power is out and the heat source is compromised. A log will be kept to monitor room temperature for the duration of the outage, and residents will be moved to an alternative place in the community to ensure comfort.

Completion Date: 02/03/2022

Plan of Correction

Accept

Additional blankets have been purchased to ensure that there is ample supply in the community if the heat source in Resident rooms is compromised due to a power outage. A temperature gun has been purchased so staff are able to check room temperatures in the event that the power is out. Temperatures will be checked hourly, and a log will be

1. Requirements

95 Furniture & Equipment (continued)

2800.

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

Description of Violation

On 10/29/21 through 10/30/21 the home was without electricity due to a transfer switch malfunction from the generator to the main electrical breaker box of the residence.

The smoke detectors in rooms 101-106: 111-133; all the rooms on the 2nd floor were not interconnected to the fire monitoring station.

Plan of Correction**Accept**

The team in the community at the time of the outage contacted an electrical service provider who came to address the problem and fixed the faulty transfer switch. A generator maintenance company contract will be established with the community to ensure scheduled routine maintenance and safety checks to the generator.

The smoke detectors in each resident room is battery operated. In any future loss of power, the Building Services Director will maintain a log of battery checks for each room that is not connected to the generator. Additionally, the Building Services Director will complete bi-annual battery changes to the detectors and document completion. Fire watch will be implemented for the duration of loss of power.

Completion Date: 02/03/2022

104c Condiments**1. Requirements**

2800.

104.c. Condiments shall be available at the dining table.

Description of Violation

At meal time, on 12/13/21, at 5:45, condiments were not available at the dining table(s). Meatloaf was served at this meal.

Plan of Correction**Do Not Accept**

Condiments are readily available in the dining and offered to residents at each meal. Staff have been educated to ask about condiment preference when taking resident orders and provide them at the table when meal is delivered.

Completion Date: 02/03/2022

Plan of Correction**Accept**

Condiments are readily available in the dining and offered to residents at each meal. Culinary staff were educated on 12/17/2021 to inquire about condiment preference when taking resident orders and provide them at the table when meal is delivered. Director of Culinary Services or ED will monitor compliance weekly through dining room visits, and monthly at the Food For Thought meeting.

Completion Date: 02/04/2022

107a Emergency preparedness**1. Requirements**

2800.

107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the residence is located.

107a Emergency preparedness (continued)

Description of Violation

Staff person A, the Administrator, did not fully implement the homes the emergency preparedness plan by not contacting the local law enforcement, local emergency management agency, the fire department and local housing agency on 10/29/21 through 10/30/21 when the home was without electricity, heat and operable smoke detectors.

Plan of Correction

Do Not Accept

Staff person A is no longer employed with the company. The new administrator has become fully familiar with the emergency plan and will fully implement emergency procedures in the event of a situation that requires notification of local emergency management personnel.

Completion Date: 02/03/2022

Plan of Correction

Accept

Staff person A is no longer employed with the company. The new administrator has become fully familiar with the emergency plan and will fully implement emergency procedures in the event of a situation that requires notification of local emergency management personnel. All department heads will also be in serviced to the updated disaster plan to ensure clear instruction in the event that the disaster plan must be initiated.

Completion Date: 02/04/2022

107b Emergency procedures

1. Requirements

2800.

107.b. The residence shall have written emergency procedures that include the following:

Description of Violation

The residence's written emergency procedures do not include how they will meet the needs of 50% of the residents during an utility outage when the generator only supplies electricity to 50% of the resident rooms.

Plan of Correction

Do Not Accept

Disaster plan is being updated to reflect additional safeguards to be implemented in the event of an emergency such as a power outage. Updated disaster plan will be forwarded to the Fire Marshal for approval once complete. Staff will be in serviced by the ED or designee on updates to the disaster plan.

Evacuation procedures are being updated to ensure appropriate and safe accommodations for residents in the event of a power outage, including relocation within the Community or to an off-site location if necessary. Residents who are on Oxygen will be relocated immediately to a safe area within the community with the ability to utilize a generator powered outlet.

Completion Date: 02/03/2022

Plan of Correction

Accept

The Disaster plan was not specific enough to identify what steps would need to be taken upon the loss of power to the community. Disaster plan is being updated to reflect additional safeguards to be implemented in the event of an emergency such as a power outage. Executive Director will forward the updated disaster plan to the local Emergency Management Coordinator for approval once complete no later than 1/31/2022. All staff will be in serviced by the ED or designee on updates to the disaster plan no later than 2/4/2022. Annual review of the disaster plan will be

107b Emergency procedures (continued)

provided to all staff by the ED or designee.

Evacuation procedures are being updated to ensure appropriate and safe accommodations for residents in the event of a power outage, including relocation within the Community to areas of the building that are powered by the generator or to an off-site location if necessary. Mutual aid agreements are in place for two other communities in the event that relocation off the premises becomes necessary. In the event of a power outage, residents who are on Oxygen will be relocated immediately to a safe area within the community with the ability to utilize a generator powered outlet for the oxygen concentrator.

Additional blankets have been purchased to ensure that there is ample supply in the community if the heat source in Resident rooms is compromised due to a power outage. The blankets are kept in the laundry storage area. The Building Services Director and Resident Care Director will be responsible to ensure distribution of the additional blankets to all residents affected by the loss of power. A temperature gun has been purchased so that the Building Services Director or designee are able to check room temperatures in the event of a power outage and the heat source is compromised. An hourly log will be kept monitoring room temperature for the duration of the outage, and residents will be moved to an alternative location in the community to ensure comfort. Emergency light source has been purchased and placed in every resident's room on the Assisted Living portion of the building.

Call bell reports will be generated daily by the concierge and provided to the ED or Designee. Reports of any call bells longer than 12 minutes will be highlighted, and the RCD/RSS will be responsible to follow up with staff to determine reason for length of delay and take action accordingly.

Fire watch procedures have been updated and will be implemented immediately upon loss of power to the building. Staff will be trained on the fire watch procedures no later than 1/31/22 by the Building Services Director or designee. Staff have been in-serviced on the abuse and neglect policy to ensure full understanding of the very specific guidelines and expectations on the care of the Residents, and their role in providing that care and treatment always. Inservice was scheduled with an outside provider at the community on January 10th. Any staff members unable to attend on that date are being in serviced no later than 1/21/22. Failure to complete the in service will result in non-compliant staff to be removed from the schedule until complete.

Completion Date: 02/04/2022

107d Procedure EMA submission

1. Requirements

2800.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The residence's written emergency procedures had not been sent to the local emergency management agency as of 11/29/21.

Plan of Correction

The emergency management plan had not been submitted by the original administrator. Staff person A submitted the plan on 11/29/2021. The plan was approved by the Emergency Management Coordinator on 12/3/2021, however the letter noted 55PA Code Chapter 2600. The current administrator re-submitted and is now approved under 55 PA Code Chapter 2800 as of 12/21/2021.

Completion Date: 02/03/2022

Accept

123c Evacuation diagrams

1. Requirements

123c Evacuation diagrams (*continued*)

2800.

123.c. For a residence serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The residence currently serves 47 residents. However, the emergency evacuation diagram posted near the elevator on the first floor did not have a line of travel noted.

Plan of Correction

Do Not Accept

Emergency evacuation diagrams have been updated to reflect evacuation lines of travel noted. New signs have been posted.

Completion Date: 01/06/2022

Plan of Correction

Accept

Emergency evacuation diagrams have been updated to reflect evacuation lines of travel noted. New signs have been posted by the Building Services Coordinator as of 12/30/2021.

Completion Date: 12/31/2021

130a Smoke detector - living unit

1. Requirements

2800.

130.a. There shall be an operable automatic smoke detector located in each living unit.

Description of Violation

On 10/29/21 at 9:38pm through 10/30/21 at 6:44pm the smoke detectors in living units #101-106: 111-133; all the rooms on the 2nd floor were not interconnected to the fire alarm monitoring station.

Plan of Correction

Do Not Accept

The smoke detectors in each resident room is battery operated. In any future loss of power, the Building Services Director will maintain a log of battery checks for each room that is not connected to the generator. Additionally, the Building Services Director will complete bi-annual battery changes to the detectors and document completion. Fire watch will be implemented for the duration of loss of power.

Completion Date: 02/03/2022

Plan of Correction

Accept

The smoke detectors in each resident room is battery operated. In any future loss of power, the Building Services Director will maintain a log of daily battery checks for each room that is not connected to the generator for the duration of the outage. Additionally, the Building Services Director will complete bi-annual battery changes to the detectors and document completion. All batteries changes in resident rooms were completed by 12/27/2021. Going forward, batteries will be changed twice annually (March and November) by the Building Services Director. Fire watch will be implemented for the duration of loss of power. Fire watch procedures have been updated and will be implemented immediately upon loss of power to the building. Staff will be trained on the fire watch procedures no later than 1/31/22 by the Building Services Director or designee.

Completion Date: 02/04/2022

130c Interconnected and audible smoke detector

1. Requirements

2800.

130.c. If the residence serves nine or more residents, there shall be at least one smoke detector on each floor interconnected and audible throughout the residence or an automatic fire alarm system that is interconnected and audible throughout the residence.

Description of Violation

On 10/29/21 and 10/30/21, the residence served 47 residents. The residence did not have smoke detectors interconnected in 29 resident rooms when the home was without electricity.

Plan of Correction

Accept

We respectfully request revocation of this violation. The regulation states "that there should be at least one smoke detector on each floor interconnected and audible throughout the residence or an automatic fire alarm system that is interconnected and audible throughout the residence." The community does have an interconnected fire alarm system that is connected to the generator. There are audible, interconnected smoke detectors throughout the community's hallways and common areas on both floors of the building.

Completion Date: 01/03/2022

130g Proceeds - inop. smoke det.

1. Requirements

2800.

130.g. The residence's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

The residence's emergency procedures do not indicate what procedures will be implemented when a smoke detector or fire alarm is inoperable.

Plan of Correction

Do Not Accept

Disaster plan is being updated to reflect additional safeguards to be implemented in the event of an emergency such as a power outage that could affect smoke detectors in resident rooms. Fire watch protocols will be immediately implemented and monitored by the Building Services Coordinator for the duration of the affected time. Updated disaster plan will be forwarded to the Emergency Management Coordinator for approval once complete. Staff will be in serviced by the ED or designee on updates to the disaster plan.

Completion Date: 02/03/2022

Plan of Correction

Accept

Disaster plan is being updated to reflect additional safeguards to be implemented in the event of an emergency such as a power outage that could affect smoke detectors in resident rooms. Fire watch protocols will be immediately implemented and monitored by the Building Services Coordinator for the duration of the affected time. Updated disaster plan will be forwarded to the Emergency Management Coordinator for approval once complete. Staff will be in serviced by the ED or designee on updates to the disaster plan by 2/4/2022. Fire watch procedures have been updated and will be implemented immediately upon loss of power to the building. All staff will be trained on the fire watch procedures no later than 1/31/22 by the Building Services Director or designee.

Completion Date: 02/04/2022

161c Additional portions

1. Requirements

2800.

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

Description of Violation*On 12/13/21, at the evening meal, there were no additional portions of chicken noodle soup available for residents.***Plan of Correction****Do Not Accept***The soup choice on that particular day was enjoyed by many. The culinary team ran out of the soup unexpectedly despite thinking that they had enough prepared. Culinary staff has been in serviced on ensuring that there are enough portions of all menu items offered during each meal service. ED or designee will monitor for compliance.***Completion Date:** 02/03/2022**Plan of Correction****Accept***The soup choice on that particular day was enjoyed by many. The culinary team ran out of the soup unexpectedly despite thinking that they had enough prepared. Culinary staff has been in serviced by the ED on 12/17/2021 on ensuring that there are enough portions of all menu items offered during each meal service. ED or designee will monitor for compliance weekly and at monthly Resident Council Meeting.***Completion Date:** 12/17/2021

162c Menus - posted

1. Requirements

2800.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation*Weekly menus were not posted in a conspicuous and public place in the residence.***Plan of Correction****Accept***Menus had been posted in the dining room and removed by culinary staff for reference on that particular day. New menus were posted at the time of inspection. ED or designee will be responsible to ensure that the 2-week menu cycles always remain posted . ED has purchased a menu frame that can be mounted to the wall to prevent menus from being removed from the dining area.***Completion Date:** 02/03/2022

225b Assessment content

1. Requirements

2800.

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

Description of Violation*Resident # 1's assessment, dated 4/28/21, does not include a plan on how the home will support the residents COPD, oxygen usage and all of [REDACTED] medical needs identified by the medical evaluation dated 4/12/21.*

225b Assessment content (continued)

Plan of Correction**Do Not Accept**

Resident #1's assessment was updated to include how his oxygen usage and all medical needs identified will be managed and supported. The RCD will be responsible for the audit of all resident assessments to ensure that all resident needs identified in the medical evaluation are captured and supported.

Completion Date: 02/03/2022

Plan of Correction**Accept**

Resident #1's assessment has been updated to include how [REDACTED] oxygen usage and all medical needs identified will be managed and supported. Resident #1's oxygen usage and needs are evaluated and daily by RCD or designee. Any concerns will be addressed immediately. The RCD will be responsible for the audit of all resident assessments to ensure that all resident needs identified in the medical evaluation are captured and supported.

Completion Date: 01/17/2022

233c Key-locking devices

1. Requirements

2800.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the residence's locking mechanism are not conspicuously posted near the door nearest the ARL dining room, nearest room 133, at the entrance to the SDCU and from the outdoor patio area in the special care unit.

Plan of Correction**Do Not Accept**

Directions for operations of the locking system was posted at the time of inspection. Routine checks of the doors will be completed by the Generations Director, Building Services Director, or the Executive Director.

Completion Date: 02/03/2022

Plan of Correction**Accept**

Directions for operating the locking devices had been posted but removed by an unknown source on the door nearest room 133. Directions for operations of the locking system was posted at the time of inspection. Weekly checks of the doors will be completed by the Generations Director, Building Services Director, or the Executive Director. Should any of the directions be removed, new directions will be posted immediately.

Completion Date: 02/04/2022

42c Dignity/Respect

1. Requirements

2800.

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

Description of Violation

Resident #4 reported that the staff did not check on [REDACTED] during the utility outage on 10/29/21 and 10/30/21 despite [REDACTED] needing assistance to ambulate to the dining room for meals. On 10/30/21 at 8:34am it took the staff 30 minutes 30 seconds to respond to the call bell and 36 minutes 29 seconds at 12:09pm to transport [REDACTED] to the dining room. All call bells were operable during the utility outage.

Plan of Correction**Do Not Accept**

Call bell reports will be generated daily by the concierge and provided to the ED or Designee. Reports of any call

42c Dignity/Respect (continued)

bells longer than 12 minutes will be highlighted, and the RCD/RSS will be responsible to follow up with staff to determine reason for length of delay and take action accordingly.

Completion Date: 02/03/2022

Plan of Correction

Accept

Call bell reports will be generated daily by the concierge and provided to the ED or Designee. Reports of any call bells longer than 12 minutes will be highlighted, and the RCD/RSS will be responsible to follow up daily with staff to determine reason for length of delay and take action accordingly.

Completion Date: 02/04/2022

Update: 01/18/2022

227g Support plan - signatures

1. Requirements

2800.

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 4/28/21. However, the resident did not sign and date the support plan.

Resident #2 participated in the development of [redacted] support plan on 5/3/21. However, the resident did not sign and date the support plan.

Resident #3 participated in the development of [redacted] support plan on 8/16/21. However, the resident did not sign and date the support plan.

Plan of Correction

Do Not Accept

File audit has been completed for all resident support plans to ensure proper documentation of review of the plan complete with the resident's signature and date. Should the resident be unable to sign or date the support plan, a notation will be made by the reviewer of the refusal to sign

Completion Date: 02/03/2022

Plan of Correction

Accept

File audit has been completed for all resident support plans to ensure proper documentation of review of the plan complete with the resident's signature and date. All residents have signed the support plan at this time. Should the resident be unable to sign or date the support plan, a notation will be made by the reviewer of the refusal to sign. Resident Care Director will be responsible to ensure ongoing compliance. Audits will be completed within 30 days of move in and development of updated support plan.

Completion Date: 02/04/2022

227h Support plan – refusal sign

1. Requirements

2800.

227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

227h Support plan – refusal sign (continued)

Description of Violation

Resident # 1 participated in the development of [REDACTED] support plan on 4/28/21. However, the resident did not sign and date the support plan. The residence did not make a notation regarding the resident's refusal to sign.

Resident #2 participated in the development of [REDACTED] support plan on 5/3/21. However, the resident did not sign and date the support plan. The residence did not make a notation regarding the resident's refusal to sign.

Resident #3 participated in the development of [REDACTED] support plan on 8/16/21. However, the resident did not sign and date the support plan. The residence did not make a notation regarding the resident's refusal to sign.

Plan of Correction

Do Not Accept

File audit has been completed for all resident support plans to ensure proper documentation of review of the plan complete with the resident's signature and date. Should the resident be unable to sign or date the support plan, a notation will be made by the reviewer of the refusal to sign

Completion Date: 02/03/2022

Plan of Correction

Accept

File audit has been completed for all resident support plans to ensure proper documentation of review of the plan complete with the resident's signature and date. All residents have signed the support plan at this time. Should the resident be unable to sign or date the support plan, a notation will be made by the reviewer of the refusal to sign. Resident Care Director will be responsible to ensure ongoing compliance. Audits will be completed within 30 days of move in and development of updated support plan.

Completion Date: 02/04/2022