pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: August 10, 2022

[redacted]
DRI/Heartis Yardley, LLC
[redacted]

RE: Heartis Yardley
255 Oxford Valley Road
Yardley, Pennsylvania 19067
License #: 147721

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection November 29, 2021, December 3, 7, and 13, 2021, February 16 and 22, 2022, April 27, 28, and 29, 2022, and May 3 and 12, 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. 2800 (relating to Assisted Living Residence), the Department hereby REVOKES your certificate of compliance 147720 dated March 15, 2022 to March 15, 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 March 15, 2022 to March 15, 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) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from August 10, 2022 to February 10, 2023.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), 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 FIRST 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 FIRST 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: *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*

Inspections / Reviews

12/13/2021 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/04/2022*

07/05/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *On-site Verification* **Follow-Up Date**: *07/07/2022*

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 [redacted]; 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 [redacted] 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 the residents room to supply electricity to recharge the oxygen concentrator.

Resident #2, support plan dated [redacted]/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 [redacted]/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 ***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

42b Abuse/Neglect (continued)

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
Completion Date: *01/31/2022* *Licensee Proposed Date* *SW 7/6/22 NOT IMPLEMENTED*

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 ***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] *degree, will be the alternative Administrator in the event of a lapse in coverage. This will be accomplished within 11 months.*
Completion Date: *11/24/2021* *Licensee Proposed Date* *SW 7/6/22 IMPLEMENTED*

60a Staffing/support plan needs

1. Requirements

2800.

60a Staffing/support plan needs *(continued)*

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 ***Accept***

The housekeeping schedule was not specific enough to identify which rooms would be cleaned on which day and 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 check list 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 by the Building Services Director for compliance.

Completion Date: *02/04/2022* *Licensee Proposed Date* *SW 7/6/22 IMPLELMENTED*

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 ***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 temperatures hourly for the duration of the outage, and residents will be moved to an alternative place in the
community or offsite (if necessary) to ensure comfort.

Completion Date: *02/03/2022* *Licensee Proposed Date* *SW 7/9/22 IMPLEMENTED*

95 Furniture & Equipment

1. Requirements

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.

95 Furniture & Equipment (continued)

The smoke detectors in rooms [redacted] 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* *Licensee Proposed Date* *SW 7/6/22 IMPLMENTED*

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 ***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* *Licensee Proposed Date* *SW 7/6/22 IMPLMENTED*

[redacted]

Violation Withdrawn

By: SLW Date: 7/6/22

[redacted]

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 ***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
HEARTIS YARDLEY 14772
107a Emergency preparedness (continued)
12/13/2021 8 of 15
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* *Licensee Proposed Date* *SW 7/6/22 IMPLEMENTED*

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 ***Accept***

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: *02/04/2022* *Licensee Proposed Date* *SW 7/6/22 IMPLEMENTED*

123c Evacuation diagrams

1. Requirements

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 ***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: *12/30/2021* *Licensee Proposed Date* *SW 7/6/22 IMPLEMENTED*

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 #[redacted]; all the rooms on the 2nd floor were not interconnected to the fire alarm monitoring station.

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

130a Smoke detector - living unit (continued)

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* *Licensee Proposed Date* *SW 7/6/22 IMPLEMENTED*

130g Proceds - 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 ***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: *01/30/2022* *Licensee Proposed Date* *SW 7/6/22 IMPLEMENTED*

[redacted]

sw 7/6/22

[redacted]

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.

162c Menus - posted *(continued)*

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: *12/28/2021* *Licensee Proposed Date* *SW 7/6/22 IMPLEMENTED*

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 [redacted] 21, does not include a plan on how the home will support the residents [redacted] oxygen usage and all of [redacted] medical needs identified by the medical evaluation dated [redacted] /21.

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: *06/27/2022* *Licensee Proposed Date* *SW 7/6/22 IMPLEMENTED*

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 ***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* *Licenseee Proposed Date* *SW 7/6/22 IMPLEMENTED*

42c Dignity/Respect

1. Requirements

2800.

42c Dignity/Respect *(continued)*

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 ***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* *Licensess Proposed Date* *SW 7/6/22 IMPLEMENTED*

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 [redacted]/21. However, the resident did not sign and date the support plan.

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

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

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* *Licensee Proposed Date* *SW 7/6/22 IMPLEMENTED*

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.

Description of Violation

Resident # 1 participated in the development of [redacted] support plan on [redacted]/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.

227h Support plan – refusal sign (continued)

Resident #2 participated in the development of [redacted] support plan on [redacted] 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 [redacted] /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 ***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* *Licensee Proposed Date* *SW 7/6/22 IMPLEMENTED*