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

May 17, 2023

[redacted], ED
DRI HEARTIS YARDLEY LLC
[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 review on 02/16/2022, 02/22/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *HEARTIS YARDLEY* **License #**: *14772* **License Expiration**: *03/15/2023*

Address: *255 OXFORD VALLEY ROAD, YARDLEY, PA 19067*

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

Administrator

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

Legal Entity

Name: *DRI HEARTIS YARDLEY LLC*

Address: [redacted]

Phone: [redacted]

Certificate(s) of Occupancy

Type: *I 2* **Date**: *12/01/2020* **Issued By**: *Lower Makefield Twp*

Staffing Hours

Resident Support Staff: *101* **Total Daily Staff**: *187* **Waking Staff**: *140*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/22/2022*

Inspection Dates and Department Representative

02/16/2022 On Site: [redacted]

02/22/2022 Off Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *55*

Special Care Unit

In Home: *Yes* **Area**: *1st floor* **Capacity**: *21* **Residents Served**: *9*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *53*

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

Have Mobility Need: *31* **Have Physical Disability**: *5*

Inspections / Reviews

02/16/2022 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *03/08/2022*

Inspections / Reviews *(continued)*

03/10/2022 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/09/2022*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *03/15/2022*

06/22/2022 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/20/2022*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/02/2022*

05/17/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/06/2023*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

15a Resident abuse report

1. Requirements

2800.
15.a. The residence shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted], Resident #1 reported an allegation of abuse by direct care staff person A in which he/she described that the staff grabbed the residents call button which was around his/her neck and asking "why do you call for so much assistance" in a demeaning tone. However, this allegation of abuse was not reported to the local Area Agency on Aging.

POC Submission ***Accept***

Resident Care Director was unaware that such an incident should be reported to the Area Agency on Aging. The Resident Care Director, Memory Care Director, and Business Office Director were educated to the reporting process outlined in Act 13 by the Executive Director on 2/16/2022. Any future allegations of abuse or neglect will be immediately reported to the Area Agency on Aging and documented. Staff training was completed on 2/23/2022 regarding incident reporting requiring submission to the AAA by the resident care director an the memory care director. This will be an ongoing agenda item going forward. Next scheduled meeting is 3/23/2022. Any staff member unable to attend the training will be required to review and sign that they acknowledge the protocol.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented ([redacted] - 05/17/2023)***

Resident Care Director was unaware that such an incident should be reported to the Area Agency on Aging. The Resident Care Director, Memory Care Director, and Business Office Director were educated to the reporting process outlined in Act 13 by the Executive Director on 2/16/2022. Any future allegations of abuse or neglect will be immediately reported to the Area Agency on Aging and documented. Staff training was completed on 2/23/2022 regarding incident reporting requiring submission to the AAA by the resident care director an the memory care director. This will be an ongoing agenda item going forward. Next scheduled meeting is 3/23/2022. Any staff member unable to attend the training will be required to review and sign that they acknowledge the protocol.

Supporting Documents for POC not located within Administrative Offices of the Residence.
5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

15b Resident abuse-superv plan

2. Requirements

2800.
15.b. If there is an allegation of abuse of a resident involving a residence's staff person, the residence shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On [redacted], Resident #1 reported that staff person A grabbed the residents call bell hanging around the neck and asked the resident "why do you call for assistance so much" in a demeaning manner. Staff person A was suspended until [redacted] and continued to work but a plan of supervision was not submitted to the Department for approval.

15b Resident abuse superv plan *(continued)*

POC Submission ***Accept***

Resident Care Director was unaware that such an incident would require a plan of supervision prior to the return of the staff member to her duties. The Resident Care Director, Memory Care Director, and Business Office Director were educated on their responsibilities involved in reporting and follow up by the Executive Director on 2/16/2022 including reporting to the AAA and the department. Any future allegations of abuse or neglect will be immediately reported to the Area Agency on Aging. Any staff member that is identified with an allegation of abuse or neglect will be placed on immediate suspension pending investigation. Staff member will not be allowed to return to the community until an accepted plan of supervision is submitted to the Department.. This was also discussed with the Resident Care Director, Memory Care Director, and Business Office Director on 2/16/2022 by the Executive Director.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented ([redacted] - 05/17/2023)***

Resident Care Director was unaware that such an incident would require a plan of supervision prior to the return of the staff member to her duties. The Resident Care Director, Memory Care Director, and Business Office Director were educated on their responsibilities involved in reporting and follow up by the Executive Director on 2/16/2022 including reporting to the AAA and the department. Any future allegations of abuse or neglect will be immediately reported to the Area Agency on Aging. Any staff member that is identified with an allegation of abuse or neglect will be placed on immediate suspension pending investigation. Staff member will not be allowed to return to the community until an accepted plan of supervision is submitted to the Department.. This was also discussed with the Resident Care Director, Memory Care Director, and Business Office Director on 2/16/2022 by the Executive Director.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

16c Incident reporting

3. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted], Resident #1 reported alleged abuse by Direct Care staff A who grabbed the residents call bell pendant hanging around the neck and said "why do you call for so much assistance in a demeaning manner. The residence did not report this incident to the Department.

POC Submission ***Accept***

The Resident Care Director believed that [redacted] had faxed the reportable incident to the Department of Human Services, however, the fax did not reach the Department. Resident Care Director was educated during the survey by the Executive Director that all future reportable incidents will be emailed to the Department with a "sent receipt." Resident Care Director will educate all staff members responsible for reporting. The Resident Care Director, Memory Care Director, and Business Office Director were educated to the reporting process outlined in Act 13 by the Executive Director on 2/16/2022. Any future allegations of abuse or neglect will be immediately reported to the Area Agency on Aging and documented. Staff training was completed on 2/23/2022 regarding incident reporting requiring submission to the AAA by the resident care director an the Memory Care Director. This will be an

16c Incident reporting (continued)

ongoing agenda item going forward. Next scheduled meeting is [redacted] *Any staff member unable to attend the training will be required to review and sign that they acknowledge the protocol. incidents. Any staff member unable to attend the training will be required to review and sign acknowledgement of the protocol otherwise face removal from the schedule until completed.*

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented*** [redacted] ***- 05/17/2023)***

The Resident Care Director believed that [redacted] *had faxed the reportable incident to the Department of Human Services, however, the fax did not reach the Department. Resident Care Director was educated during the survey by the Executive Director that all future reportable incidents will be emailed to the Department with a "sent receipt." Resident Care Director will educate all staff members responsible for reporting. The Resident Care Director, Memory Care Director, and Business Office Director were educated to the reporting process outlined in Act 13 by the Executive Director on 2/16/2022. Any future allegations of abuse or neglect will be immediately reported to the Area Agency on Aging and documented. Staff training was completed on 2/23/2022 regarding incident reporting requiring submission to the AAA by the resident care director an the Memory Care Director. This will be an ongoing agenda item going forward. Next scheduled meeting is 3/23/2022. Any staff member unable to attend the training will be required to review and sign that they acknowledge the protocol. incidents. Any staff member unable to attend the training will be required to review and sign acknowledgement of the protocol otherwise face removal from the schedule until completed.*

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

18 Other laws, regs, ordins.

4. Requirements

2800.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Care Facility Carbon Monoxide Alarm Standards Act

Fossil fuel-burning devices are defined as: coal, kerosene, oil, wood, fuel gases and other petroleum or hydrocarbon products which emit carbon monoxide as a by-product of combustion. Some examples of fossil burning devices include gas stove, gas PTAC units, and gas/wood/coal burning fireplaces.
If there is not at least 15 feet between the fossil fuel burning device and the door that leads out of the enclosed area to the rest of the building, then the carbon monoxide detector should be placed just outside of the door, unless the manufacturer's instructions indicate otherwise. The additional CO detector, installed where it can be heard by the staff on duty, is not required to be interconnected. All other requirements with the Act will be enforced - i.e., if the alarm is not audible in all areas of the building, additional devices must be installed; etc. Homes should keep the manufacturer's instructions on file, especially if the home uses this information to place the detector within 15 feet from the device. (Q/A April 2017-2800.18)

18 Other laws, regs, ordins. (continued)

On 2/16/2022, the home did not have a carbon monoxide alarm. The home has gas fired hot water heaters.

POC Submission ***Accept***

Carbon Monoxide Detectors were purchased and installed by the Building Services Director. Routine Maintenance will be provided to the devices with the same schedule as the smoke detectors by the Building Services Director or designee and documented.

Licensee's Proposed Overall Completion Date: *03/08/2022*

Document Submission ***Implemented ([redacted] - 05/17/2023)***

Carbon Monoxide Detectors were purchased and installed by the Building Services Director. Routine Maintenance will be provided to the devices with the same schedule as the smoke detectors by the Building Services Director or designee and documented.
Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

25a Resident - residence contract

5. Requirements

2800.
25.a. Prior to admission, or within 24 hours after admission, a written resident-residence contract between the resident and the residence must be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #4, admitted [redacted], does not have a signed contract.

POC Submission ***Accept***

Resident #4 had signed [redacted] contract on [redacted] however was removed from his administrative file during a previous survey and misfiled. The Executive Director reached out to the Responsible Party who had a copy of the contract and provided to the community. File audit will be completed by the Executive Director and the Business Office Director to ensure that all contracts are readily available for review in the administrative office. Audit will be completed by 3/31/2022.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented [redacted] - 05/17/2023)***

Resident #4 had signed [redacted] contract on [redacted] however was removed from his administrative file during a previous survey and misfiled. The Executive Director reached out to the Responsible Party who had a copy of the contract and provided to the community. File audit will be completed by the Executive Director and the Business Office Director to ensure that all contracts are readily available for review in the administrative office. Audit will be completed by 3/31/2022.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

42c Dignity/Respect

6. Requirements

2800.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted], Resident #1 reported direct care staff person A grabbed the residents call button which was around his/her neck and asking "why do you call for so much assistance" in a demeaning tone. Resident #1 pressed the call bell on [redacted] at [redacted], the staff responded in 25 minutes 49 seconds; on [redacted] at 11:59 the resident pressed the call bell with staff responding in 44 minutes 24 seconds; [redacted] the resident pressed the call bell and staff responded in 49 minutes 46 seconds. The residents RASP dated [redacted] indicates the resident requires assistance with toileting, transferring, transportation, physical hygiene and bladder management.

Resident #2, pulled the call bell on [redacted] at 5:05am from the bathroom. It took staff 43 min and 38 seconds to respond. Resident #2 requires assistance for bladder and toileting management with standby assist for showering according to the RASP dated [redacted]

Resident #3, pulled the call bell on [redacted] at [redacted] am from the bathroom. It took the staff 41 min 22 seconds to respond. Resident #3 requires assistance with toileting, ambulating, personal hygiene and is totally immobile according to the RASP dated [redacted].

Resident #4, pushed the call bell button on [redacted] at [redacted] am. It took the staff 49 minutes 39 seconds to respond. Resident #4 is a diabetic and requires assistance according to the RASP dated [redacted].

POC Submission ***Accept***

Call bell logs are being reviewed prior to each department head stand up meeting by the Executive Director and Resident Care Director. Any call bell response times greater than 12 minutes will be investigated by the Resident Care Director and addressed immediately by the Resident Care Director or the Executive Director. Should there not be a reasonable explanation for the delay in response, the RCD or ED will take appropriate action up to and including suspension (pending investigation) or termination. Education has been provided to staff on the importance of timely response and caution with tone of voice upon answering a call on 2/23/2022. This will be a standing agenda item at staff meeting beginning 3/23/2022.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented ([redacted] - 05/17/2023)***

Call bell logs are being reviewed prior to each department head stand up meeting by the Executive Director and Resident Care Director. Any call bell response times greater than 12 minutes will be investigated by the Resident Care Director and addressed immediately by the Resident Care Director or the Executive Director. Should there not be a reasonable explanation for the delay in response, the RCD or ED will take appropriate action up to and including suspension (pending investigation) or termination. Education has been provided to staff on the importance of timely response and caution with tone of voice upon answering a call on 2/23/2022. This will be a standing agenda item at staff meeting beginning 3/23/2022.

Supporting Documents for POC not located within Administrative Offices of the Residence.

42c Dignity/Respect (continued)

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

51 Criminal background checks

7. Requirements

2800.
51.a. 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 B's date of hire was [redacted] did not have a criminal background check.

Staff person C's date of hire was [redacted] did not have a criminal background check.

POC Submission ***Accept***

FBI checks had been performed for both employees and were in their file, however, the Business Office Director was unaware that PA criminal should also be run as the two employees live out of state. The Licensing Representative educated the Business Office Director at the time of inspection and the criminal back ground check was run for both employees. Business Office Director and Executive Director will audit all employee files to ensure that the checks have been run for each employee and available in their file. Going forward, no employee will begin employment without the criminal back ground check in our possession. Business Office Director will maintain responsibility for such checks.

Licensee's Proposed Overall Completion Date: *03/08/2022*

Document Submission ***Implemented ([redacted] 05/17/2023)***

FBI checks had been performed for both employees and were in their file, however, the Business Office Director was unaware that PA criminal should also be run as the two employees live out of state. The Licensing Representative educated the Business Office Director at the time of inspection and the criminal back ground check was run for both employees. Business Office Director and Executive Director will audit all employee files to ensure that the checks have been run for each employee and available in their file. Going forward, no employee will begin employment without the criminal back ground check in our possession. Business Office Director will maintain responsibility for such checks.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

54a Direct care staff quals

8. Requirements

2800.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person B and C, does not have a high school diploma, GED, or active registry status on the

54a Direct care staff quals (continued)

Pennsylvania nurse aide registry.

POC Submission ***Accept***

Both direct care staff members had their high school diplomas, however they were unavailable at the time of inspection. Both staff members have provided their diplomas to the community and are now located in their employee files. Going forward, all newly hired direct care staff will be required to present their proof of qualification prior to beginning employment. The Business Office Director will be responsible for acquiring and maintaining documentation of qualifications for all staff. An audit will be completed by the Business Office Director and Executive Director to ensure that proper documentation of qualifications is available. Should any direct care staff be missing proper documentation, that individual will be removed from the schedule pending receipt of necessary documents.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented [redacted] - 05/17/2023)***

Both direct care staff members had their high school diplomas, however they were unavailable at the time of inspection. Both staff members have provided their diplomas to the community and are now located in their employee files. Going forward, all newly hired direct care staff will be required to present their proof of qualification prior to beginning employment. The Business Office Director will be responsible for acquiring and maintaining documentation of qualifications for all staff. An audit will be completed by the Business Office Director and Executive Director to ensure that proper documentation of qualifications is available. Should any direct care staff be missing proper documentation, that individual will be removed from the schedule pending receipt of necessary documents.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

65a Fire Safety 1st day

9. Requirements

2800.
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:

Description of Violation

Staff person B, whose first day of work was [redacted] did not receive orientation.

Staff person C, whose first day of work was [redacted] did not receive orientation.

Staff person D, whose first day of work was [redacted] id not receive orientation.

Staff person E, whose first day of work was [redacted] did not receive orientation.

POC Submission ***Accept***

There was not a sound plan in place for new hire orientation prior to the survey. A new process has been implemented beginning 2/16/2022. Staff members B,C,D, and E will be attending the new 2 day orientation program on 3/16 and 3/17. Going forward, all newly hired employees will be required to attend the 2 day

65a Fire Safety-1st day (continued)

orientation prior to working in their new roles. The Business Office Manager and Executive Director will audit all employee files to ensure proper documentation of orientation. Any other staff that have not received the orientation will be required to attend scheduled orientation. Documentation of orientation will be maintained in the business office.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented [redacted] - 05/17/2023)***

There was not a sound plan in place for new hire orientation prior to the survey. A new process has been implemented beginning 2/16/2022. Staff members B,C,D, and E will be attending the new 2 day orientation program on 3/16 and 3/17. Going forward, all newly hired employees will be required to attend the 2 day orientation prior to working in their new roles. The Business Office Manager and Executive Director will audit all employee files to ensure proper documentation of orientation. Any other staff that have not received the orientation will be required to attend scheduled orientation. Documentation of orientation will be maintained in the business office.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

65e Rights/Abuse 40 Hours

10. Requirements

2800.
65.e. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Staff person B, did not complete the initial orientation training on Resident Rights, Emergency Medical Plan, Reporting of Incidents and Safe Management Techniques within 40 hours of scheduled work.

Staff person C, did not complete any of the required initial orientation on Resident Rights/Abuse training modules as required by this regulation within 40 hours of scheduled work..

Staff D, did not complete initial orientation training on Emergency Medical Plan and Safe Management Techniques within 40 hours of scheduled work.

Staff E did not complete initial orientation training on the required Resident Rights/Abuse modules as required by this regulation within 40 hours of scheduled work.

POC Submission ***Accept***

There was not a sound plan in place for new hire orientation prior to the survey. A new process has been implemented beginning 2/16/2022. Staff members B,C,D, and E will be attending the new 2 day orientation program on 3/16 and 3/17. Going forward, all newly hired employees will be required to attend the 2 day orientation prior to working in their new roles. The Business Office Manager and Executive Director will audit all employee files to ensure proper documentation of orientation. Any other staff that have not received the orientation will be required to attend scheduled orientation. Documentation of orientation will be maintained in the business office.

65e Rights/Abuse 40 Hours *(continued)*

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented [redacted] - 05/17/2023)***

There was not a sound plan in place for new hire orientation prior to the survey. A new process has been implemented beginning 2/16/2022. Staff members B,C,D, and E will be attending the new 2 day orientation program on 3/16 and 3/17. Going forward, all newly hired employees will be required to attend the 2 day orientation prior to working in their new roles. The Business Office Manager and Executive Director will audit all employee files to ensure proper documentation of orientation. Any other staff that have not received the orientation will be required to attend scheduled orientation. Documentation of orientation will be maintained in the business office.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

65g Initial direct care training

11. Requirements

2800.
65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:
2. Successful completion and passing the Department approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person C did not complete the Department approved direct care training course and passing of the competency test. Direct care staff person C provided unsupervised assisted living services on 2/6/2022, prior to the completion of the training.

POC Submission ***Accept***

Direct Care person C had completed the direct care training course and passed the exam on 9/22/2022, however the community did not have the certificate of completion on file. Going forward, the Resident Care Director and Business Office Director will ensure that the certificate is in the employee file prior to completion of the course with proof of passing the competency test.
The Resident Care Director, Memory Care Director, and Business Office Director were educated on their responsibilities involved in reporting and follow up by the Executive Director on 2/16/2022 including reporting to the AAA and the department. Any future allegations of abuse or neglect will be immediately reported to the Area Agency on Aging. Any staff member that is identified with an allegation of abuse or neglect will be placed on immediate suspension pending investigation. Staff member will not be allowed to return to work in the community until an accepted plan of supervision is submitted to the Department.. This was also discussed with the Resident Care Director, Memory Care Director, and Business Office Director on 2/16/2022 by the Executive Director. Staff training was completed on 2/23/2022 regarding incident reporting requiring submission to the AAA by the resident care director an the Memory Care Director. This will be an ongoing agenda item going forward. Next scheduled meeting is 3/23/2022. Any staff member unable to attend the training will be required to review and sign that they acknowledge the protocol. incidents. Any staff member unable to attend the training will be required to review and sign acknowledgement of the protocol otherwise face removal from the schedule until completed.
Staff training was completed on 2/23/2022 regarding incident reporting requiring submission to the AAA by the resident care director an the Memory Care Director. This will be an ongoing agenda item going forward. Next

65g Initial direct care training (continued)

scheduled meeting is 3/23/2022. Any staff member unable to attend the training will be required to review and sign that they acknowledge the protocol. incidents. Any staff member unable to attend the training will be required to review and sign acknowledgement of the protocol otherwise face removal from the schedule until completed.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented ([redacted] - 05/17/2023)***

Direct Care person C had completed the direct care training course and passed the exam on 9/22/2022, however the community did not have the certificate of completion on file. Going forward, the Resident Care Director and Business Office Director will ensure that the certificate is in the employee file prior to completion of the course with proof of passing the competency test.
The Resident Care Director, Memory Care Director, and Business Office Director were educated on their responsibilities involved in reporting and follow up by the Executive Director on 2/16/2022 including reporting to the AAA and the department. Any future allegations of abuse or neglect will be immediately reported to the Area Agency on Aging. Any staff member that is identified with an allegation of abuse or neglect will be placed on immediate suspension pending investigation. Staff member will not be allowed to return to work in the community until an accepted plan of supervision is submitted to the Department.. This was also discussed with the Resident Care Director, Memory Care Director, and Business Office Director on 2/16/2022 by the Executive Director. Staff training was completed on 2/23/2022 regarding incident reporting requiring submission to the AAA by the resident care director an the Memory Care Director. This will be an ongoing agenda item going forward. Next scheduled meeting is 3/23/2022. Any staff member unable to attend the training will be required to review and sign that they acknowledge the protocol. incidents. Any staff member unable to attend the training will be required to review and sign acknowledgement of the protocol otherwise face removal from the schedule until completed.
Staff training was completed on 2/23/2022 regarding incident reporting requiring submission to the AAA by the resident care director an the Memory Care Director. This will be an ongoing agenda item going forward. Next scheduled meeting is 3/23/2022. Any staff member unable to attend the training will be required to review and sign that they acknowledge the protocol. incidents. Any staff member unable to attend the training will be required to review and sign acknowledgement of the protocol otherwise face removal from the schedule until completed.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

12. Requirements

2800.
65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:
3. Initial direct care staff person training to include the following:

Description of Violation

Direct care staff persons C and E did not complete 18 hours of training as required by 2800.65g (1-3).

POC Submission ***Accept***

Staff member C and E have been providing care supervised by the Memory Care Director and Resident Care Director since the survey on 2/16/2022 pending completion of the 18 hour training to be completed by the Executive Director and Business Office Director on 3/16/22 and 3/17/22. Process was not previously in place, a new orientation

65g Initial direct care training (continued)

program has been initiated and will be utilized going forward. New hire orientation will be conducted twice monthly and the RCD and Memory Care Director will be responsible to oversee compliance within 30 days of hire.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented [redacted] - 05/17/2023)***

Staff member C and E have been providing care supervised by the Memory Care Director and Resident Care Director since the survey on 2/16/2022 pending completion of the 18 hour training to be completed by the Executive Director and Business Office Director on 3/16/22 and 3/17/22. Process was not previously in place, a new orientation program has been initiated and will be utilized going forward. New hire orientation will be conducted twice monthly and the RCD and Memory Care Director will be responsible to oversee compliance within 30 days of hire.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

69 Dementia training

13. Requirements

2800.

69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Staff person C, date of hire [redacted], received only 1 hour of dementia-specific training within 30 days of hire.

Staff person E, date of hire [redacted], did not complete any dementia-specific training within 30 days of hire.

POC Submission ***Accept***

There was not a sound plan in place for new hire orientation prior to the survey. A new process has been implemented beginning 2/16/2022. Staff members B,C,D, and E will be attending the new 2 day orientation program on 3/16 and 3/17. Going forward, all newly hired employees will be required to attend the 2 day orientation prior to working in their new roles. The Business Office Manager and Executive Director will audit all employee files to ensure proper documentation of orientation. Any other staff that have not received the orientation will be required to attend scheduled orientation. Documentation of orientation will be maintained in the business office. Dementia videos have been purchased for use during the orientation and ongoing training. All staff will be required to view the videos and discuss any questions or scenarios that may require further training or support from the Memory Care Director.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented [redacted] - 05/17/2023)***

There was not a sound plan in place for new hire orientation prior to the survey. A new process has been implemented beginning 2/16/2022. Staff members B,C,D, and E will be attending the new 2 day orientation program on 3/16 and 3/17. Going forward, all newly hired employees will be required to attend the 2 day orientation prior to working in their new roles. The Business Office Manager and Executive Director will audit all employee files to ensure proper documentation of orientation. Any other staff that have not received the orientation will be required to

69 Dementia training (continued)

attend scheduled orientation. Documentation of orientation will be maintained in the business office. Dementia videos have been purchased for use during the orientation and ongoing training. All staff will be required to view the videos and discuss any questions or scenarios that may require further training or support from the Memory Care Director.
Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

82a Poisons original containers

14. Requirements

2800.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

According to the tube of [redacted] toothpaste, unlocked in SDCU room 10, the label noted to "call poison control, immediately, if more is used for brushing and accidentally swallowed." The residents of the SDCU are unable to safely handle poisonous material.

POC Submission ***Accept***

The [redacted] toothpaste was removed from the resident's room on the day of inspection. All other rooms were checked for any other potentially harmful items. The Memory Care Director purchased small bins for storage of the resident's personal items. Each bin is labeled with the resident's name and locked in a storage area that is not accessible to residents. Staff are using the items while providing personal care, and returning to the locked storage area. Additionally, staff survey each resident's room daily to identify if any potentially hazardous materials appear in resident rooms and removal if discovered. Weekly room checks will also be completed by the Memory Care Director to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/08/2022*

Document Submission ***Implemented [redacted] - 05/17/2023)***

The Sensodyne toothpaste was removed from the resident's room on the day of inspection. All other rooms were checked for any other potentially harmful items. The Memory Care Director purchased small bins for storage of the resident's personal items. Each bin is labeled with the resident's name and locked in a storage area that is not accessible to residents. Staff are using the items while providing personal care, and returning to the locked storage area. Additionally, staff survey each resident's room daily to identify if any potentially hazardous materials appear in resident rooms and removal if discovered. Weekly room checks will also be completed by the Memory Care Director to ensure compliance.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

91 Telephone Numbers

15. Requirements

91 Telephone Numbers *(continued)*

2800.

91. Emergency Telephone Numbers Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and assisted living residence complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire Department on or by the telephone in room 116.

POC Submission ***Accept***

The resident in room 116 had removed the phone numbers in her room unbeknownst to staff. Previously the community had been placing the phone numbers in a small frame near the phone. Going forward, the community will implement the numbers laminated and attached to the phone with zip ties to prevent removal of the numbers. Building Services Coordinator will be responsible for maintaining compliance by tasking the Housekeeping staff to add the new tags to the phone cords and monitor new residents telephones and adding the tags as needed.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented ([redacted] - 05/17/2023)***

The resident in room 116 had removed the phone numbers in [redacted] room unbeknownst to staff. Previously the community had been placing the phone numbers in a small frame near the phone. Going forward, the community will implement the numbers laminated and attached to the phone with zip ties to prevent removal of the numbers. Building Services Coordinator will be responsible for maintaining compliance by tasking the Housekeeping staff to add the new tags to the phone cords and monitor new residents telephones and adding the tags as needed.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

96a First aid kit

16. Requirements

2800.

96.a. The residence shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers. The residence shall have an automatic external defibrillation device located in each building on the premises.

Description of Violation

The first aid kit located in the Wellness Center does not include scissors and band aides.

POC Submission ***Accept***

The missing items were added to the first aid kit at the time of inspection. Monthly audits will be completed by the Wellness team to ensure all items remain in place for ongoing compliance. The Resident Care Director or designee will be responsible to maintain oversight of the audits.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented ([redacted] - 05/17/2023)***

The missing items were added to the first aid kit at the time of inspection. Monthly audits will be completed by the Wellness team to ensure all items remain in place for ongoing compliance. The Resident Care Director or designee will be responsible to maintain oversight of the audits.

96a First aid kit (continued)

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

103e Leftovers

17. Requirements

2800.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There were unlabeled, undated numerous cupcakes, plus a bottle of red and yellow juice in the SDCU refrigerator.

POC Submission ***Accept***

Unlabeled items were removed and disposed of at the time of inspection. The Memory Care Director implemented a labeling and dating process with the Memory Care Program assistant on 2/21/2022. The Program Assistant takes primary responsibility to monitoring items in the SDCU refrigerator to ensure ongoing compliance. The Memory Care Director will continue to monitor while in the community for ongoing compliance and report any issues or concerns to the Executive Director. Should the Memory Care Director not be in the community the Program Assistant will report to the Executive Director any issues or concerns. Program Assistant was educated to this protocol on 2/21/2022. The Memory Care Director will continue to monitor for compliance.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented ([redacted] - 05/17/2023)***

Unlabeled items were removed and disposed of at the time of inspection. The Memory Care Director implemented a labeling and dating process with the Memory Care Program assistant on 2/21/2022. The Program Assistant takes primary responsibility to monitoring items in the SDCU refrigerator to ensure ongoing compliance. The Memory Care Director will continue to monitor while in the community for ongoing compliance and report any issues or concerns to the Executive Director. Should the Memory Care Director not be in the community the Program Assistant will report to the Executive Director any issues or concerns. Program Assistant was educated to this protocol on 2/21/2022. The Memory Care Director will continue to monitor for compliance.
Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

105g Dryer lint removal

18. Requirements

2800.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On [redacted] at [redacted], there was an approximate 1/4 inch accumulation of lint in the lint trap of the commercial dryer. There were no clothes in the dryer at the time.

105g Dryer lint removal *(continued)*

POC Submission ***Accept***

The lint was removed from the commercial dryer at the time of inspection. The Building Services Director has implemented a process for removal of the lint twice daily by housekeeping/laundry team members. The Building Services Director has in serviced staff responsible for maintaining the dryer and will continue to monitor for compliance and report any concerns to the Executive Director.

Licensee's Proposed Overall Completion Date: *03/08/2022*

Document Submission ***Implemented ([redacted] - 05/17/2023)***

The lint was removed from the commercial dryer at the time of inspection. The Building Services Director has implemented a process for removal of the lint twice daily by housekeeping/laundry team members. The Building Services Director has in serviced staff responsible for maintaining the dryer and will continue to monitor for compliance and report any concerns to the Executive Director.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

107b Emergency procedures

19. 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 measures the home will implement for residents not connected to the emergency generator when the home is without electricity.

POC Submission ***Accept***

The emergency procedures had been updated after the previous survey to include evacuation procedures in the event of a power outage, however the update did not include the location of additional supplies purchased to ensure resident comfort if the heat is compromised (laser thermometers, blankets). The emergency procedures have been updated again by the Executive Director and will be submitted to the emergency management agency for approval by the Executive Director by 3/25/2022. Staff will be in-serviced to the procedures on 3/23/2022 at scheduled staff meeting. Any employee unable to attend the training will be required to review the protocol and sign for acknowledgement of review.
Completion Date: 03/31/2022

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented [redacted] - 05/17/2023)***

The emergency procedures had been updated after the previous survey to include evacuation procedures in the event of a power outage, however the update did not include the location of additional supplies purchased to ensure resident comfort if the heat is compromised (laser thermometers, blankets). The emergency procedures have been updated again by the Executive Director and will be submitted to the emergency management agency for approval by the Executive Director by 3/25/2022. Staff will be in-serviced to the procedures on 3/23/2022 at scheduled staff meeting. Any employee unable to attend the training will be required to review the protocol and sign for acknowledgement of review.

107b Emergency procedures (continued)

Completion Date: 03/31/2022

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

141a Medical evaluation

20. Requirements

2800.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

Description of Violation

The medical evaluation for resident #6, does not include the date the physician completed the medical evaluation. This area of the form is blank.

POC Submission ***Accept***

The Resident Care Director contacted the physician of resident #6 for clarification of the date of completion of the medical evaluation. A chart audit was performed on [redacted] by the Resident Care Coordinator and Resident Care Director to ensure that all medical evaluations are dated appropriately. The Resident Care Director is responsible to ensure all medical evaluation accuracy and completion. Audits will take place monthly by the Resident Care Coordinator.

Licensee's Proposed Overall Completion Date: *03/09/2022*

Document Submission ***Implemented ([redacted] - 05/17/2023)***

The Resident Care Director contacted the physician of resident #6 for clarification of the date of completion of the medical evaluation. A chart audit was performed on [redacted] by the Resident Care Coordinator and Resident Care Director to ensure that all medical evaluations are dated appropriately. The Resident Care Director is responsible to ensure all medical evaluation accuracy and completion. Audits will take place monthly by the Resident Care Coordinator.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

183f Discontinued medications

21. Requirements

2800.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the residence 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 residence, 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 residence.

183f Discontinued medications *(continued)*

Description of Violation

Resident # 7 is prescribed [redacted] and expired[redacted]. Resident #7's expired medication was still on the medication cart available for administration.

POC Submission ***Accept***

The expired medication was removed from the medication cart at the time of inspection. Cart audit was performed to ensure that no other expired medication remained in the cart. The Resident Care Director and Wellness team will perform weekly audits beginning 3/10/2022 for one month, then move to bi weekly audits if there are no further concerns. The Resident Care Director will re educate all med techs to the process for disposal of expired medication to avoid potential hazard to the resident.
Med Techs were verbally educated to this requirement on 2/18/2022, and will be re educated at team meeting on 3/23/2022.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented ([redacted] - 05/17/2023)***

The expired medication was removed from the medication cart at the time of inspection. Cart audit was performed to ensure that no other expired medication remained in the cart. The Resident Care Director and Wellness team will perform weekly audits beginning 3/10/2022 for one month, then move to bi-weekly audits if there are no further concerns. The Resident Care Director will re-educate all med techs to the process for disposal of expired medication to avoid potential hazard to the resident.
Med Techs were verbally educated to this requirement on 2/18/2022, and will be re-educated at team meeting on 3/23/2022.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

224a2 30 days prior to admission

22. Requirements

2800.
224.a.2. An individual shall have a written initial assessment that is documented on the Department's assessment form within 30 days prior to admission unless one of the conditions contained in paragraph (3) apply.

Description of Violation

Resident #1 was admitted on [redacted]. The resident's initial assessment was not completed until [redacted].

POC Submission ***Accept***

The Resident Care Director and Resident Care Coordinator performed a chart audit on[redacted] to ensure that all other residents had an initial assessment documented in their chart within 30 days of admission. Going forward, the Resident Care Coordinator will be responsible for ensuring that the initial assessment is completed and signed by all parties involved within 30 days. Additional chart audit is being performed on 3/9 and 3/10 to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented ([redacted] - 05/17/2023)***

The Resident Care Director and Resident Care Coordinator performed a chart audit on 2/18/2022 to ensure that all other residents had an initial assessment documented in their chart within 30 days of admission. Going forward,

224a2 30 days prior to admission (continued)

the Resident Care Coordinator will be responsible for ensuring that the initial assessment is completed and signed by all parties involved within 30 days. Additional chart audit is being performed on 3/9 and 3/10 to ensure ongoing compliance.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

224a5 Written initial assessment

23. Requirements

2800.
224.a.5. The written initial assessment must, at a minimum include the following:

Description of Violation

Resident #4 requires the use of oxygen. Resident #4's assessment, dated [redacted], does not include: the use of oxygen due to the [redacted] diagnosis.

POC Submission ***Accept***

Resident #4's assessment was updated to include the use of oxygen. A chart audit was performed on [redacted] by the Resident Care Coordinator and Resident Care Director to ensure that all assessments and support plans document each of the needs outlined in the Medical Evaluation. The Resident Care Director is responsible to ensure all assessment accuracy and completion. Audits will take place monthly by the Resident Care Coordinator.

Licensee's Proposed Overall Completion Date: *03/08/2022*

Document Submission ***Implemented ([redacted] - 05/17/2023)***

Resident #4's assessment was updated to include the use of oxygen. A chart audit was performed on 2/18/2022 by the Resident Care Coordinator and Resident Care Director to ensure that all assessments and support plans document each of the needs outlined in the Medical Evaluation. The Resident Care Director is responsible to ensure all assessment accuracy and completion. Audits will take place monthly by the Resident Care Coordinator.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

224c1 Initial SP 30 days prior/adm

24. Requirements

2800.
224.c.1. An individual requiring services shall have a written preliminary support plan developed within 30 days prior to admission to the residence unless one of the conditions contained in paragraph (2) applies.

Description of Violation

Resident #1 was admitted on [redacted]; however, the resident's written preliminary support plan was not completed until [redacted].

224c1 Initial SP-30 days prior/adm (continued)

Resident #6 was admitted on 4/14/2021, however, the resident's written support plan was not completed until 5/4/2021.

POC Submission ***Accept***

The Resident Care Director and Resident Care Coordinator performed a chart audit on 2/18/2022 to ensure that all other residents had an initial assessment documented in their chart within 30 days of admission. Going forward, the Resident Care Coordinator will be responsible for ensuring that the initial assessment is completed and signed by all parties involved within 30 days. An additional chart audit is being done by the Resident Care Coordinator on 3/9 and 3/10 to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented (- 05/17/2023)***

The Resident Care Director and Resident Care Coordinator performed a chart audit on 2/18/2022 to ensure that all other residents had an initial assessment documented in their chart within 30 days of admission. Going forward, the Resident Care Coordinator will be responsible for ensuring that the initial assessment is completed and signed by all parties involved within 30 days. An additional chart audit is being done by the Resident Care Coordinator on 3/9 and 3/10 to ensure ongoing compliance.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

224c8 Preliminary support plan - participants' signatures

25. Requirements

2800.
224.c.8. Individuals who participate in the development of the preliminary support plan shall sign and date the preliminary support plan.

Description of Violation

Resident # 4 and a licensed staff participated in the development of his/her preliminary support plan; however, the licensed staff did not sign and date the preliminary support plan.

POC Submission ***Accept***

The Resident Care Director and Resident Care Coordinator performed a chart audit on 2/18/2022 to ensure that all other residents had an initial assessment documented in their chart within 30 days of admission. Going forward, the Resident Care Coordinator will be responsible for ensuring that the initial assessment is completed and signed by all parties involved within 30 days.
Resident #4's assessment was reviewed and signed by the Resident Care Coordinator on The Resident Care Director verbally reviewed the importance of signing the RASP upon completion. RCC will be formally re-educated on .

Licensee's Proposed Overall Completion Date: *03/23/2022*

Document Submission ***Implemented - 05/17/2023)***

The Resident Care Director and Resident Care Coordinator performed a chart audit on 2/18/2022 to ensure that all other residents had an initial assessment documented in their chart within 30 days of admission. Going forward, the Resident Care Coordinator will be responsible for ensuring that the initial assessment is completed and signed by all parties involved within 30 days.

224c8 Preliminary support plan - participants' signatures (continued)

Resident #4's assessment was reviewed and signed by the Resident Care Coordinator on [redacted]. The Resident Care Director verbally reviewed the importance of signing the RASP upon completion. RCC will be formally re-educated on 3/23/2022.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

225a2 Assessment – significant change

26. Requirements

2800.
225.a.2. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

On [redacted], resident #1 was evaluated for hospice due to a decline in condition and on [redacted] nursing reports an increase in confusion. An additional written assessment was not completed despite the change in condition.

POC Submission ***Accept***

Resident #1 and [redacted] family declined hospice care when referred and evaluated, however there was not a follow up note to support that decision. The resident's support plan had been updated to reflect her current condition. A chart audit was performed on 2/18/2022 by the Resident Care Coordinator and Resident Care Director to ensure that all assessments and support plans document each of the needs outlined in the Medical Evaluation. The Resident Care Director is responsible to ensure all assessment accuracy and completion. Audits will take place monthly by the Resident Care Coordinator.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented ([redacted] - 05/17/2023)***

Resident #1 and [redacted] family declined hospice care when referred and evaluated, however there was not a follow up note to support that decision. The resident's support plan had been updated to reflect her current condition. A chart audit was performed on 2/18/2022 by the Resident Care Coordinator and Resident Care Director to ensure that all assessments and support plans document each of the needs outlined in the Medical Evaluation. The Resident Care Director is responsible to ensure all assessment accuracy and completion. Audits will take place monthly by the Resident Care Coordinator.
Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

225b Assessment content

27. Requirements

2800.
225.b. The assessment must, at a minimum include the following:

Description of Violation

Resident # 4's assessment, dated [redacted], does not include the residents use of oxygen.

POC Submission ***Accept***

Resident #4's assessment was updated to include the use of oxygen. A chart audit was performed on 2/18/2022 by the Resident Care Coordinator and Resident Care Director to ensure that all assessments and support plans document each of the needs outlined in the Medical Evaluation. The Resident Care Director is responsible to ensure all assessment accuracy and completion. Audits will take place monthly by the Resident Care Coordinator.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented ([redacted] - 05/17/2023)***

Resident #4's assessment was updated to include the use of oxygen. A chart audit was performed on [redacted] by the Resident Care Coordinator and Resident Care Director to ensure that all assessments and support plans document each of the needs outlined in the Medical Evaluation. The Resident Care Director is responsible to ensure all assessment accuracy and completion. Audits will take place monthly by the Resident Care Coordinator.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

227g Support plan - signatures

28. 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 # 5 participated in the development of his/her support plan dated [redacted] However, the resident did not sign and date the support plan.

POC Submission ***Accept***

A chart audit was performed on 2/18/2022 by the Resident Care Coordinator and Resident Care Director to ensure that all assessments and support plans document each of the needs outlined in the Medical Evaluation and that each participant has signed the support plan. The Resident Care Director is responsible to ensure all assessment accuracy and completion, including signatures. Audits will take place monthly by the Resident Care Coordinator to ensure completion.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented [redacted] - 05/17/2023)***

A chart audit was performed on 2/18/2022 by the Resident Care Coordinator and Resident Care Director to ensure that all assessments and support plans document each of the needs outlined in the Medical Evaluation and that each participant has signed the support plan. The Resident Care Director is responsible to ensure all assessment accuracy and completion, including signatures. Audits will take place monthly by the Resident Care Coordinator to ensure completion.

227g Support plan signatures (continued)

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*

252 Records – content

29. Requirements

2800.
252. Content of Resident Records - Each resident's record must include the following information:
25. A copy of the resident-home contract.

Description of Violation

Resident # 4's record does not include a copy of the contract.

POC Submission ***Accept***

Resident #4's contract had been removed from [redacted] file during a previous survey and misfiled. The contract could not be located at the time of inspection. The resident's niece was able to provide the residence with a copy of the contract and is now in the resident's administrative file. A file audit of all resident contracts will be completed by the Executive Director and Business Office Director to ensure that all contracts are in the administrative file.
File audit was completed by the ED and BOD on [redacted] File audits will be conducted monthly by the ED or BOD. Resident contracts will be reviewed and accepted by the ED upon admission effective immediately,
A new filing system has been implemented by the ED and BOD to ensure that all administrative files are in full compliance including resident contracts with all appropriate signatures.

Licensee's Proposed Overall Completion Date: *03/31/2022*

Document Submission ***Implemented [redacted] - 05/17/2023)***

Resident #4's contract had been removed from [redacted] file during a previous survey and misfiled. The contract could not be located at the time of inspection. The resident's niece was able to provide the residence with a copy of the contract and is now in the resident's administrative file. A file audit of all resident contracts will be completed by the Executive Director and Business Office Director to ensure that all contracts are in the administrative file.
File audit was completed by the ED and BOD on 2/22/2022. File audits will be conducted monthly by the ED or BOD. Resident contracts will be reviewed and accepted by the ED upon admission effective immediately,
A new filing system has been implemented by the ED and BOD to ensure that all administrative files are in full compliance including resident contracts with all appropriate signatures.

Supporting Documents for POC not located within Administrative Offices of the Residence.

5/6/2023

Licensee's Proposed Overall Completion Date: *05/06/2023*