pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail [redacted]
May 31, 2023

[redacted]
Wyndmoor Assisted Living Company, LLC
551 East Evergreen Avenue
Wyndmoor, Pennsylvania 19038

RE: Springfield Senior Living Community
License #: 14484

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on September 19, 2022 and December 21, 2022, and January 12, 2023, February 21, 2023, and May 5 and 16, 2023 of the above facility, we have determined that your submitted plans of correction for the July 27, 28, and 29, 2022, and August 1 and 4, 2022 inspection and the November 17 and 18, 2022 and December 7, 2022 inspection are not fully implemented. Correction of these violations in accordance with the specified plans of correction are required. Continued compliance must be maintained.

Sincerely,

[redacted]

[redacted]

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *SPRINGFIELD SENIOR LIVING COMMUNITY* **License #:** *14484* **License Expiration:** *05/12/2023*

Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA 19038*

County: *MONTGOMERY* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *WYNDMOOR ASSISTED LIVING COMPANY LLC*

Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA, 19038*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *11/16/1987* **Issued By:** *Commonwealth of PA, L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *66* **Waking Staff:** *50*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *08/01/2022*

Inspection Dates and Department Representative

07/27/2022 - On-Site: [redacted]
07/28/2022 - On-Site:
07/29/2022 - On-Site:
08/01/2022 - On-Site:
08/04/2022 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *103* **Residents Served:** *36*

Special Care Unit

In Home: *Yes* **Area:** *MC-3rd Floor* **Capacity:** *34* **Residents Served:** *7*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *36*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *30* **Have Physical Disability:** *2*

Inspections / Reviews

07/27/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/26/2022*

08/30/2022 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/11/2022*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/04/2022*

09/19/2022 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/11/2022*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/02/2022*

02/22/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *10/11/2022*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

18 Other laws, regs, ordins.

1. 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

There were no Carbon Monoxide detectors for the 1st floor kitchen or the basement kitchen which used gas in their equipment. Per the Care Facility Carbon Monoxide Alarms Standards Act of Jun. 23, 2016; Carbon Monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance.

POC Submission ***Accept [redacted] - 09/19/2022)***

Maintenance Director/Designee installed 3 carbon monoxide detectors in the basement kitchen and installed 1 in the first floor kitchen on 8/20/2022
The kitchen carbon monoxide detectors will be monitored by maintenance director/designee monthly for the next 3 months and then semiannually there after to make sure they are in working order.
08/20/2022 Maintenance Director/Designee

Licensee's Plan Completion Date: *09/02/2022*

Implemented [redacted] - 12/21/2022)

2. 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

On Saturday, 07/30/2022 and on Monday 08/01/2022 from 7:00 AM to 9:00 AM, no staff present in the kitchen were ServSafe certified.
The PA Department of Agriculture Food Employee Certification Act, 3 Pa C.S.A. 6501 – 6510, effective January 22, 2011, requires one employee per licensed food facility to obtain a nationally recognized food manager certification. National exam programs are those that have been approved by ANSI using the Conference of Food Protection certified food protection manager standards. The Food Employee Certification Act requires one supervisory employee per food facility to obtain a food safety certification by taking an ANSI-CFP nationally recognized food safety class. The certified employee must be available during all hours of operation. The certified employee is the Person-in-Charge (PIC) when in the facility.

POC Submission ***Accept[redacted] 09/19/2022)***

The staff person that was in the kitchen at the time of the survey allowed the serv safe to expire.That staff person received the serv safe certification on August 12, 2022.The facility will have serv safe certified employees in the kitchen at all times. Dining Director/Designee will audit all serv safe certifications for the kitchen staff to make sure they get renewed before expiration. Dining Director/Designee will audit schedule weekly for the next 3 months to make sure there is always at least one serv safe employee on the schedule when the kitchen is open.
08/12/2022 Dining Director/Designee

Licensee's Plan Completion Date: *09/02/2022*

Implemented[redacted] - 12/21/2022)

22a1 Medical Eval - time frames

3. Requirements

22a1 Medical Eval - time frames *(continued)*

2800.
22.a. Documentation. The following admission documents shall be completed for each resident:
1. Medical evaluation completed within 60 days prior to admission on a form specified by the Department. The medical evaluation may be completed within 15 days after admission if one of the following conditions applies

Description of Violation

- Resident #1 was admitted on [redacted]/2022. The resident's medical evaluation was completed on 09/09/2021.

- Resident #2 was admitted on [redacted]/2021. The resident's medical evaluation was not completed until 12/30/2021.

POC Submission ***Accept ([redacted] - 09/19/2022)***

Medical Evaluations will be completed 60 days prior to an admission or within 15 days of an admission if it meets the requirements. Director of Nursing/Designee will audit all New Admission paperwork for next 3 months to make sure the ADME is completed in a the correct amount of time..
08/17/2022 Director of Nursing/Designee

Licensee's Plan Completion Date: *09/02/2022*

Not Implemented [redacted] - 12/21/2022)

25c2 Fee schedule

4. Requirements

2800.
25.c. At a minimum, the contract must specify the following:
2. A fee schedule that lists the actual amount of allowable resident charges for each of the home's available services.

Description of Violation

The resident-residence contract, dated 03/25/2022, for resident # 1 does not include a fee schedule that list the actual amount of charges for each of the assisted living services that are include in the resident's core service package.

POC Submission ***Accept ([redacted]J - 09/19/2022)***

The residence resident contract will be updated to include a fee schedule that lists the actual amount of charges for all services that are included in the resident's core service package.
The fee schedule is with the contract in the business office file. We do not put the fee schedule in the resident's health record file.
Administrator/Designee will monitor all Residence resident contract to ensure all fee schedules are included with the contract.
09/08/2022 Administrator/Designee

Licensee's Plan Completion Date: *09/08/2022*

Not Implemented [redacted] - 12/21/2022)

25l Core package/supplemental

5. Requirements

2800.

25l Core package/supplemental *(continued)*

25.l. The resident-residence contract shall identify the assisted living services included in the core service package the individual is purchasing and the total price for those services. Supplemental health care services shall be packaged, contracted and priced separately from the resident-residence contract. Services provided by or contracted for by the residence other than supplemental health care services must be priced separately from the service package in the resident-residence contract.

Description of Violation

The resident-residence contract shall identify the assisted living services included in the core service package the individual is purchasing and the total price for those services. The resident-residence contract did not identify the total price for the core services.

POC Submission ***Accept [redacted] - 09/19/2022)***

The residence resident contract will be updated to include a fee schedule that lists the actual amount of charges and the total price for the core services.
Administrator/Designee will monitor all Residence resident contract to ensure all fee schedules are included with the contract.
09/08/2022 Administrator/Designee

Licensee's Plan Completion Date: *09/08/2022*

Not Implemented ([redacted] 12/21/2022)

42m Right - leave/return

6. Requirements

2800.
42.m. A resident has the right to leave and return to the residence at times consistent with the residence rules and the resident's support plan.

Description of Violation

On 08/01/2022, licensing representative was conducting resident interviews. During these interviews, it was stated that the front doors are locked after 6:00 PM and no one is available to answer the doorbell when rung. On at least one occasion, residents were forced to walk around the building until an open door was found. The interviewee stated the door continues to be locked and residents continue to have problems when trying to reenter the residence.

POC Submission ***Accept [redacted] - 09/19/2022)***

The facility staff was educated to answer the phone when it is rung to allow the residents the right to leave & return.
Administrator/Designee will conduct random audits after 6:00pm when the doors are locked to ensure the bell is answered in a timely manner. There is also the phone number listed on the door in the event the resident can't get in.
09/08/2022 Administrator/Designee

Licensee's Plan Completion Date: *09/08/2022*

Not Implemented [redacted] 12/21/2022)

51 Criminal background checks

7. Requirements

2800.
51. Criminal background checks
    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).

51 Criminal background checks *(continued)*

b. The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site.

Description of Violation

Staff person A's date of hire was [redacted]/2017. Staff person A's criminal background check was not completed until 07/28/2022.

POC Submission ***Accept [redacted] - 09/19/2022)***

HR will be educated to ensure background checks are obtained for all staff prior to them starting employment.
Administrator/Designee will audit all new hire files to ensure all preemployment checks are done for the next 3 months.
09/08/2022 Administrator/Designee

Licensee's Plan Completion Date: *09/08/2022*

Implemented [redacted] - 12/21/2022)

52 OAPSA hiring

8. Requirements

2800.
52. Staff Hiring, Retention and Utilization - Hiring, retention and utilization of staff persons 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) and other applicable regulations

Description of Violation

Staff member A's date of hire is [redacted]/2017, staff member A's criminal background check request was not completed until 07/28/2022. The Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) requires the home to determine if the applicant has held permanent residency in a state other than Pennsylvania within the past two years and request the appropriate criminal background checks from the Pennsylvania State Police and FBI on or before the first day of work.

POC Submission ***Accept [redacted] - 09/19/2022)***

HR will be educated to verify if the employee has held permanent residency in a State other then PA and to obtain the correct State or FBI background check prior to starting employment.
Administrator/Designee will audit all new hire files to ensure all preemployment checks are done for the next 3 months.
09/08/2022 Administrator/Designee

Licensee's Plan Completion Date: *09/08/2022*

Not Implemented [redacted] - 12/21/2022)

53c Administrator duties

9. Requirements

2800.
53.c. The administrator shall be responsible for the administration and management of the residence, including the health, safety and well-being of the residents, implementation of policies and procedures and compliance with this chapter.

Description of Violation

53c Administrator duties (continued)

Staff person B, the Administrator, has not been responsible for the administration and management of the residence, including the health, safety and well being of the residents since the previous administrator left in Mid-April. The residence has a sign posted on the receptionist desk stating The Administrator Designee is staff person C, who is not a licensed administrator. When staff was questioned about who was the acting administrator, several replied "we don't have an administrator". When asked who was in charge, staff referred to staff person C.

POC Submission ***Accept [redacted] - 09/19/2022)***

The facilities Administrator will be responsible for the administration & management of the residence and will make sure policies and procedures are being followed.
09/16/2022 Administrator/Designee

Licensee's Plan Completion Date: *09/16/2022*

Implemented [redacted] - 12/21/2022)

53d Admin direct care ability

10. Requirements

2800.
53.d. The administrator shall have the ability to provide personal care services or to supervise or direct the work to provide assisted living services.

Description of Violation

The administrator has not been present in the home to provide assisted living services or to supervise or direct the work to provide assisted living services.

POC Submission ***Accept [redacted] - 09/19/2022)***

The Administrator will be present in the facility to provide and or supervise the assisted living services being provided.
09/16/2022 Administrator/Designee

Licensee's Plan Completion Date: *09/16/2022*

Implemented [redacted] - 12/21/2022)

53e Admin knowledge of regs

11. Requirements

2800.
53.e. The administrator shall have knowledge of this chapter.

Description of Violation

Staff person B, the Administrator, does not exhibit sufficient knowledge of this chapter. At several points during this inspection, staff person B raised questions regarding these regulations (I.E.: overnight fire drills, description of services, fire alarm connections to fire panel...) that an informed administrator should understand.

POC Submission ***Accept [redacted] 09/19/2022)***

The Administrator will review the 2800 regulations and will have the knowledge of the 2800 regulations. Administrator will take required educations to ensure that they have knowledge of required regulations.
09/16/2022 Administrator/Designee

Licensee's Plan Completion Date: *09/16/2022*

Implemented [redacted] - 12/21/2022)

53f Admin ability to comply

12. Requirements

2800.
53.f. The administrator shall have the ability to comply with applicable laws, rules and regulations, including this chapter.

Description of Violation

Based on the findings in this inspection, the residence and staff person B, the Administrator, do not have the ability to comply with applicable laws, rules and regulations, including this chapter.

POC Submission ***Accept [redacted] - 09/19/2022)***

The Administrator will have the ability to comply with applicable laws, rules and regulations, including this chapter. Administrator will take required educations to ensure that they have knowledge of required regulations. 09/16/2022 Administrator/Designee

Licensee's Plan Completion Date: *09/16/2022*

Implemented [redacted] - 12/21/2022)

56a Admin 36 hrs/week

14. Requirements

2800.
56.a. Except for temporary absences under subsection (b), the administrator shall be present in the residence an average of 36 hours or more per week, in each calendar month. At least 30 hours per week must be during normal business hours.

Description of Violation

During calendar months April 2022, May 2022, June 2022 and July 2022, staff person B, the Administrator, was not present in the residence an average of 36 hours or more per week or at least 30 hours per week during normal business hours.

POC Submission ***Directed [redacted] 09/19/2022)***

The Administrator will be present in the residence an average of 36 hours per week in each calendar month. 09/16/2022 Administrator/Designee

In addition to the above plan of correction: The administrator's work hours will be documented on a scheduled. The schedule will include the name of the administrator and intended hours of work. The schedule will be maintained for Department review. [redacted] 9/19/22

Directed Completion Date: *09/16/2022*

Implemented [redacted] - 12/21/2022)

56b Designee present

15. Requirements

2800.
56.b. If the administrator is unavailable to meet the hourly requirements in subsection (a) due to a temporary absence, the administrator shall assign an administrator designee in writing to supervise the residence during the administrator's temporary absence. The administrator designee shall meet the following requirements:
1. Have 3,000 hours of direct operational responsibility for a senior housing facility, health care facility, residential care facility, adult daily living facility or other group home licensed or approved by the Commonwealth.

56b Designee present *(continued)*

2. Pass the Department-approved competency-based administrator training test under § 2800.64(a)(3) (relating to administrator training and orientation.)
3. Meet the qualification and training requirements of a direct care staff person under § § 2800.54 and 2800.65 (relating to qualifications for direct care staff persons; and staff orientation and direct care staff person training and orientation).

Description of Violation

Staff person C, who is listed as the Administrator Designee in a sign on the receptionist's desk has not passed the Department-approved competency-based administrator training test under 2800.64(a)(3) (relating to administrator training and orientation).

POC Submission ***Directed [redacted] - 09/19/2022)***

If the Administrator is unavailable to meet the hourly requirements due a temporary absence the administrator shall assign an administrator designee in writing who has passed the Departments approved competency-based administrator training test. In the event that this happens the Administrator /Designee will audit to make sure that the designee has the proper credentials.
08/22/2022 Administrator/Designee

Within 15 days of receipt of the accepted plan of correction: The administrator will hire a designee that has the qualification required by this regulation. The administrator will in writing submit the name and qualifications of the assigned designee to the Department. [redacted] 9/19/22

Directed Completion Date: *09/02/2022*

Not Implemented [redacted] - 12/21/2022)

60c Housekeeping/maintenance

16. Requirements

2800.
60.c. Additional staff hours, or contractual hours, shall be provided as necessary to meet the transportation, laundry, food service, housekeeping and maintenance needs of the residents.

Description of Violation

On Saturday, July 30th, residents were forced to eat dinner in their rooms. According to staff interviews, the service was not provided due to a lack of staff to have full service in the dining area. According to the interviewee, the kitchen staff was working with only "one tray line".

POC Submission ***Accept [redacted] - 09/19/2022)***

Staffing call outs and not having enough staff to run the kitchen has led to this violation. The facility will have enough staff to meet the food service needs of the residents and to keep the dining room open. Currently hiring 2 new staff members to be in compliance with 2800.60.c. The Dining Director/Designee will continue to interview and hire staff to stay in compliance.
Dining Director/Designee
Dining Director/designee will audit the schedule weekly to ensure dining room will be open at meal times.

Licensee's Plan Completion Date: *09/24/2022*

Implemented [redacted] - 12/21/2022)

65a Fire Safety-1st day

17. Requirements

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

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:

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

Description of Violation

Staff person E, whose first day of work was [redacted]/2022, did not receive orientation on the following topics: Evacuation procedures, Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, The designated meeting place outside the building or within the fire-safe area in the event of an actual fire, Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, The location and use of fire extinguishers, Smoke detectors and fire alarms, Telephone use and notification of emergency services until 01/24/2022.

POC Submission ***Accept [redacted] - 09/19/2022)***

The Administrative staff will be educated to ensure employees are educated on: Evacuation procedures.
Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location, if applicable. The designated meeting place outside the building or within the firesafe area in the event of an actual fire. Smoking safety procedures, the residence's smoking policy and location of smoking areas, if applicable. The location and use of fire extinguishers, Smoke detectors and fire alarms, Telephone use and notification of emergency services.
Administrator/Designee will audit all new hires for the next 3 months to ensure they were properly oriented.
Administrator/Designee

Licensee's Plan Completion Date: *09/27/2022*

Not Implemented [redacted] - 12/22/2022)

65e Rights/Abuse 40 Hours

18. 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:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.
5. Safe management techniques.
6. Core competency training that includes the following:
   i. Person-centered care.
   ii. Communication, problem solving and relationship skills.
   iii. Nutritional support according to resident preference.

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

Description of Violation

Staff person E completed [redacted]r 40th scheduled work hour on 01/21/2022. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions, safe management techniques, core competency training that includes the following: person-centered care , core competency training that includes the following: communication, problem solving and relationship skills , core competency training that includes the following: nutritional support according to resident preference until 01/28/2022.

POC Submission ***Accept ([redacted] - 09/19/2022)***

The Administrative staff will be educated to ensure employees are educated on the following topics within the first 40 scheduled working hours. Resident rights, emergency medical plan, mandatory reporting of abuse & neglect, reporting of reportable incidents and conditions, safe management techniques, core competency training including person centered care, communication problem solving and relationship skills, nutritional support according to resident preference.
Administrator/Designee will audit all new hires within the first 40 hours for the next 3 months to ensure they were properly oriented.
Administrator/Designee

Licensee's Plan Completion Date: *09/27/2022*

Not Implemented [redacted] - 12/21/2022)

82c Locked poisons

19. Requirements

2800.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

Description of Violation

- On 07/27/2022, a storage room containing resident toiletries with several items labeled "If swallowed, get medical help or contact a Poison Control Center right away" was unlocked, unattended and accessible to residents. The storage room is located behind the nurse's station on the Special Care Unit (SCU). On 08/01/2022, this storage room was again found to be unlocked, unattended and accessible to residents of the SCU.

- A container of Men Degree Antiperspirant, with a manufacture's label indicating "if swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to residents in the bathroom of room C301-303 of the SCU.

- On 07/27/2022, shadow boxes, containing multiple straight push pins, were found outside several bedroom units on the SCU.

Not all the residents of the residence, including residents in the Special Care Unit, have been assessed capable of recognizing and using poisons safely.

POC Submission ***Accept [redacted] - 09/19/2022)***

The storage room located behind the nursing station on the special care unit had the lock replaced. The container of mens degree antiperspirant was removed from roomc301-c303. The push pins were removed from the shadow

82c Locked poisons (continued)

boxes on the SCU.
Family and staff educated on not leaving hygiene products in resident room and who they should give the products to when they bring them in. Staff educated to check resident's rooms for any poisonous materials and to where to keep them locked. All third floor residents will be assessed on recognizing and using poisonous materials.
DON/Designee will monitor all poisonous materials to make sure they are locked and audit resident rooms for any poisonous materials that are unlocked for the next 3 month
DON/Designee

Licensee's Plan Completion Date: *09/16/2022*

Not Implemented [redacted] - 12/21/2022)

85a Sanitary conditions

20. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

Description of Violation

- On 07/27/2022, at 11:05 AM, a pair of used gloves were found inside the linen closet on the second floor, "B" wing.

- On 07/28/2022, at 4:20 PM, a hose was protruding from the front of the building draining water from the ice machine out into the lawn and down into the parking lot.

- On 08/01/22, at 11:48 AM, streaks of a brown substance, presumed to be feces, were found on the toilet seat of the first floor guest bathroom closest to the entrance. Staff was asked to have housekeeping have the bathroom cleaned.

POC Submission ***Accept [redacted] - 09/19/2022)***

The used gloves in the linen wing were disposed of. The first floor guest bathroom was cleaned.
Housekeeping staff to check and disinfect guest bathrooms several times a day to make sure they are clean and to also clean linen closets before restocking.
Hose was diverted to the right of the wall to drain in a drain below the wall.
Housekeeping Director/Designee will audit for the next 3 months to ensure the sanitary conditions are being maintained.
Housekeeping Director/Designee

Licensee's Plan Completion Date: *09/18/2022*

Not Implemented [redacted] 12/21/2022)

85d Trash cans – kitchen/bath

21. Requirements

2800.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 07/29/2022, at 12:45 PM, there were uncovered trash cans in both of the first floor guest bathrooms.

POC Submission ***Accept [redacted] - 09/19/2022)***

Both trash cans were replaced with trash cans with lids.

85d Trash cans – kitchen/bath (continued)

Housekeeping Director/Designee will audit for the next 3 months to ensure lids are on all trash cans in kitchen and bathrooms.

Licensee's Plan Completion Date: *09/18/2022*

Implemented [redacted] 12/21/2022)

88a Floors, walls, ceilings, windows, doors

22. Requirements

2800.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

- On 07/27/2022, at 10:00 AM, several ceiling tiles were noted to have water damage. Some of the ceiling tiles had been repainted but the water stains remain visible.

- On 07/27/2022, at 10:08 AM, the floor leading from the dining area to the kitchen was dirty, missing pieces of tile and brick.

- On 07/27/2022, at 10:14 AM, a potato chip was found on the dining area floor indicating the floor had not been swept or mopped at least since before supper on 07/26/2022. When questioned, staff stated the floor is to be mopped after every meal.

- On 07/27/2022, at 12:21 PM, the ceiling in the first floor public bathroom on "B" wing was in considerable disrepair from water damage and had drywall tape hanging from the ceiling.

- On 07/27/2022, at 12:37 PM, several pieces of flooring between "B" and "C" wing were sticking up or missing causing several tripping hazards.

- On 08/01/2022, at 3:53 PM, the wall under the shower control knob in room A102 was in disrepair due to water damage.

POC Submission ***Accept [redacted] 09/19/2022)***

The flooring leading from the dining area to the kitchen was cleaned and repaired. Staff has been reeducated mop the floor after every meal. Spackled and painted first floor public bathroom. Replaced the tiles between B and C wings. Spackled the drywall behind the plate and painted.
Maintenance Director/Designee will audit for the next 3 months to ensure that the floors, walls, ceilings and doors are clean, in good repair and free of hazards.

Licensee's Plan Completion Date: *09/27/2022*

Not Implemented [redacted] - 12/21/2022)

100a Exterior – free of hazards

23. Requirements

2800.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

100a Exterior – free of hazards (continued)

- The residence maintains an exterior walking path for independent and assisted living residents. This area includes a smoking area. On 07/27/2022 at 10:29 AM, there was a large area of caked on mud and dirt that covered a large part of the path by the smoking area and beyond. This is considered a tripping hazard, especially for residents with assisted walking devices.

- The same walking path was littered with a large piece of packing material in the middle of a flower bed.

- By the grill on this path there was a patio roof that had fallen or been taken down. The roof had dozens of nails protruding up ward presenting another hazard.

- Another walking path, which was gated for residents of the special care unit to use, was littered with overgrown weeds and fallen branches presenting several tripping hazards.

- The electrical connection to the sump pump, using what appeared to be a standard extension cord spliced and connected to an exterior electrical line, was uncovered and open to the elements. Directly above this is a small roof where water collects and drips down the wall next to the open electrical connection.

POC Submission ***Accept [redacted] - 09/19/2022)***

The walking area was cleaned, and the mud was removed. The packing material was removed from the flower bed. The patio roof was removed and placed in the dumpster. The landscaping company cleaned the area that was overgrown and had fallen branches. The area of the electrical connection was sealed.
The gated walking path that had overgrown weeds and fallen branches was cleaned by the landscape company on 08/02/2022. Maintenance Director/Designee will monitor grounds daily to make sure the grounds are free of debri. Maintenance Director/Designee placed a cover over the wires to protect from the elements. Maintenance Director/Designee will audit additional electrical connections to make sure they are covered.

Licensee's Plan Completion Date: *09/02/2022*

Not Implemented ([redacted] - 12/21/2022)

101j7 Lighting/operable lamp

24. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident # 3 does not have access to a source of light that can be turned on/off at bedside.

POC Submission ***Accept [redacted] - 09/19/2022)***

Resident #3 was provided with an operable lamp that could be turned on / off at bedside.
Administrator/Designee will audit to ensure that every resident has an operable lamp at the bedside for the next 3 months.
Administrator/Designee

Licensee's Plan Completion Date: *09/17/2022*

Not Implemented [redacted] - 12/21/2022)

103i Outdated food

25. Requirements

2800.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was an unlabeled, undated bag of bar-b-que riblets and another bag of chicken tenders, also unlabeled and undated, in the downstairs walk in freezer.

POC Submission ***Directed [redacted] - 09/19/2022)***

The unlabeled and undated items were discarded. Dietary staff will ensure that all food is labeled and dated. Dining Director/Designee will audit for the next 3 months to ensure all food is labeled and dated.

Within 15 days of receipt of the plan of correction: All staff persons handling, preparing or storing food items shall be educated regarding the safe storage of food items including labeling and dating. Documentation of education shall be kept. A designee shall check all food storage areas daily including refrigerators and freezers to ensure all food items are labeled and dated. Any outdated or spoiled food will be disposed of.[redacted] 9/19/22

Directed Completion Date: *09/17/2022*

Not Implemented [redacted] - 12/21/2022)

121a Unobstructed egress

26. Requirements

2800.
121.a. Stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed.

Description of Violation

On 07/27/2022, at 12:33 P.M., an exit sign was posted above a "Fire Door" leading to the enclosed special care unit's walkway. The exit gate from this area is locked with a padlock meaning there is no immediate egress from this "exit".

POC Submission ***Directed [redacted] - 09/19/2022)***

Dining Director/Designee will audit for the next 3 months to ensure all food is labeled and dated. Maintenance Director/Designee to audit all egress routes to ensure they are unlocked and unobstructed. Maintenance Director/Designee

Within 15 days of receipt of the plan of correction: A designated staff person will check the home daily on each shift to ensure all stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed. The administrator will conduct a weekly check of the home to ensure all stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed. Any malfunctioning locks will be immediately repaired.[redacted] 9/19/22

Directed Completion Date: *09/17/2022*

Not Implemented ([redacted] - 12/21/2022)

123c Evacuation diagrams

27. Requirements

123c Evacuation diagrams *(continued)*

2800.
123.c. For a residence serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

On 07/27/2022, at 11:12 A.M., the fire evacuation diagram posted outside room B-219 has a hand written notice on it stating "You Are Here" in red marker and points to an area in the "A" Section of the home.

POC Submission ***Accept [redacted] - 09/19/2022)***

Fire evacuation diagram has been replaced with correct signage.
Maintenance Director/Designee to audit for the next 3 months to make sure fire evacuation diagrams are correctly posted.
07/29/2022 Maintenance Director/Designee

Licensee's Plan Completion Date: *09/02/2022*

Not Implemented [redacted] - 12/21/2022)

123d Mobility need – FS area

28. Requirements

2800.
123.d. If the residence serves one or more residents with mobility needs above or below grade level of the home, there shall be a fire-safe area, as specified in writing within the past year by a fire safety expert, on the same floor as each resident with mobility needs.

Description of Violation

The second and third floors are accessible to residents who have mobility needs. These levels of the residence do not have a fire safe area specified in writing within the past year by a fire safety expert.

POC Submission ***Directed [redacted] - 09/19/2022)***

The fire safety expert will be contracted to designate the fire safe areas for the second and third floors.
Maintenance Director/Designee

Within 15 days of receipt of the plan of correction: The administrator shall develop and implement a system to ensure the home has fire safe areas specified in writing by a fire safety expert at least annually if the home is serving any residents with mobility needs. Documentation will be kept. [redacted] 9/19/22

Directed Completion Date: *09/27/2022*

Implemented [redacted] - 12/21/2022)

132a Monthly fire drill

29. Requirements

2800.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

During the fire drills held in January and February 2022, it is documented that no residents were evacuated.

132a Monthly fire drill *(continued)*

POC Submission ***Directed [redacted] - 09/19/2022)***

The outside company that performs the fire drills will be educated that the residents need to be evacuated during the fire drills.
Maintenance Director/Designee will audit to ensure that residents are being evacuated properly for the next 3 months.
Maintenance Director/Designee

Within 15 days of receipt of the plan of correction: All staff persons will be educated on the fire drill requirements of 2800.132a and the required documentation of fire drills in 2800.132c. Documentation shall be kept in the staff records. All residents will be educated on the requirements of the home to conduct a fire drill at least once a month, a fire drill in conducted during sleeping hours every 6 months, all residents are evacuated to a public thoroughfare or to a fire-safe area within the time specified in writing by a fire safety expert within the past year. Documentation of education shall be kept. The administrator will audit all fire drill records monthly to ensure all residents are being evacuated. [redacted] 9/19/22

Directed Completion Date: *09/27/2022*

Not Implemented [redacted] - 12/21/2022)

132b Safety inspection/fire drill

30. Requirements

2800.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The residence does not have documentation of an annual fire drill and fire safety inspection conducted by a fire safety expert.

POC Submission ***Directed [redacted] - 09/19/2022)***

The fire safety expert will be contracted to perform the annual fire drill and fire safety inspection.
Maintenance Director/Designee will make sure they are in contact with the fire safety expert annually to ensure the annual inspections are complete

Within 15 days of receipt of the plan of correction: The administrator or designated staff person will contact a fire safety expert and schedule a fire drill and fire safety inspection. Document will be kept.
Within 10 days receipt of the plan of correction: The administrator will develop and implement a process and procedure to ensure a fire drill and fire inspection is conducted by a fire safety expert at least annually. [redacted] 9/19/22

Directed Completion Date: *09/27/2022*

Implemented ([redacted] - 12/21/2022)

132c Fire drill records

31. Requirements

132c Fire drill records *(continued)*

2800.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the residence at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on January, February, March, April, May and June 2022 do not include the exit route used.

POC Submission ***Directed [redacted] - 09/19/2022)***

The outside company that performs the fire drills will be educated to include the exit route that was used on the fire drill documentation.
Maintenance Director/Designee will audit to ensure that residents are being evacuated properly for the next 3 months to include the evacuation route that was used.
Maintenance Director/Designee

Within 15 days receipt of the plan of correction: The administrator will monitor all fire drills and the fire drill record to ensure an unannounced fire drill is conducted at least once a month and is documented in the home's fire drill record which includes; the date, time, amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was activated.[redacted]/19/22

Directed Completion Date: *09/27/2022*

Not Implemented [redacted] - 12/22/2022)

132d Evacuation

32. Requirements

2800.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the residence.

Description of Violation

- The residence does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The residence exceeded an evacuation time of 2 minutes 30 seconds during the following drills: March, April, May and June 2022.

POC Submission ***Directed [redacted] - 09/19/2022)***

The fire safety expert will be coming out to do an inspection and provide a maximum safe evacuation time.
Maintenance Director/Designee will make sure they are in contact with the fire safety expert annually to ensure the annual inspections are complete and include the safe evacuation time.
Maintenance Director/Designee

132d Evacuation (continued)

Within 15 days of receipt of the plan of correction: The administrator or designated staff person will contact a fire safety expert and schedule a fire drill and fire safety inspection. Document will be kept. [redacted] *9/19/22*

Directed Completion Date: *09/27/2022*

Implemented [redacted] ***- 12/21/2022)***

132g Fire drills – days/times

33. Requirements

2800.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The fire drills conducted on 01/08/2022, 02/22/2022 and 03/15/2022 were all completed on a Tuesday.

POC Submission ***Directed*** [redacted] ***- 09/19/2022)***

The outside company that performs the fire drills will be educated that fire drills need to be held on different days of the week.
Maintenance Director/Designee will audit to ensure that fire drills are being conducted on different days of the week for the next 3 months.
Maintenance Director/Designee

Within 15 days of the receipt of the plan of correction: The administrator will develop and implement a policy and procedure to ensure fire drills are held on different days and times of the week. [redacted] *9/19/22*

Directed Completion Date: *09/27/2022*

Not Implemented [redacted] ***- 12/21/2022)***

141a Medical evaluation

34. 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:
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.

Description of Violation

- The medical evaluation for resident #1, dated [redacted] */2022, does not include the resident's ability to self-administer medications, This area of the form is blank.*

- The medical evaluation for resident #4, dated [redacted] */2021, does not include an indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days*

141a Medical evaluation (continued)

after admission. This area of the form is blank.

POC Submission ***Accept [redacted] - 09/19/2022)***

The medical evaluation for resident #1 was updated to include the resident's ability to self-administer medications.
Resident #4 was provided with TB test and the medical evaluation form was updated to include that it was provided, and the results were negative.
DON/Designee will audit all residents over the next 3 months to ensure all ADME are completed appropriately.
DON/Designee

Licensee's Plan Completion Date: *09/27/2022*

Not Implemented [redacted] - 12/21/2022)

141b2 Medical evaluation changes

35. Requirements

2800.
141.b. A resident shall have a medical evaluation:
2. If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

Resident # 2's medical condition changed on 03/21/2022 when the resident was switched from a normal diet to a "diabetic diet - low carbohydrate" and the home failed to have a medical evaluation conducted prior to the annual medical evaluation.

POC Submission ***Accept ([redacted] - 09/19/2022)***

Resident #2 had a medical evaluation completed. The Administrative staff will be educated for residents to have a medical evaluation if the medical condition of a resident changes prior to the annual medical evaluation.
DON/Designee will audit all residents that have a change of condition and require a new ADME are completed, at he time of the change of condition.
DON/Designee

Licensee's Plan Completion Date: *09/27/2022*

Not Implemented [redacted] - 12/21/2022)

144c1 Smoking area guidelines

36. Requirements

2800.
144.c. A residence that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the residence, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The residence's designated smoking area does not contain fire resistant furniture.

POC Submission ***Accept [redacted] - 09/19/2022)***

The non-fire-resistant furniture was removed from the residents designated smoking area.
Maintenance Director/Designee will monitor the smoking areas monthly to ensure that all furniture in that area is fire resistant.

144c1 Smoking area guidelines (continued)

07/29/2022 Maintenance Director/Designee

Licensee's Plan Completion Date: *09/02/2022*

Implemented [redacted] - 12/21/2022)

144d Smoking outside

37. Requirements

2800.
144.d. Smoking outside of the smoking room is prohibited.

Description of Violation

- On 07/27/2022, at 12:29 P.M., a large metal ashtray and a sign stating "Please Do Not Throw Cigarettes On Ground" were found in the enclosed secure care unit walkway. This is not the residence's designated smoking area. The residence's designated smoking area is in courtyard north area.

- On 07/29/2022, at 9:00 AM, staff person C was smoking in the delivery area which is not the residence's designated smoking area. The residence's designated smoking area is in courtyard north area.

POC Submission ***Accept [redacted] - 09/19/2022)***

A sign was hung outside the enclosed secure area that it is not a smoking area and the metal ashtray was removed.
Staff person c will be educated to only smoke in the designated smoking area.
Administrator/Designee will monitor and ensure there is no smoking outside of the designated smoking area.

Licensee's Plan Completion Date: *09/02/2022*

Implemented [redacted] - 12/21/2022)

162c Menus - posted

38. 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.

POC Submission ***[redacted] - 09/19/2022)***

The weekly menus were posted in a conspicuous area. The Dietary director will ensure the weekly menus are posted.
Dining Director/Designee will audit weekly to ensure for 3 months to ensure the menus are posted correctly.
08/08/2022 Dining Director/Designee

Licensee's Plan Completion Date: *09/02/2022*

Implemented [redacted] 12/21/2022)

185a Storage procedures

39. Requirements

2800.
185.a. The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

185a Storage procedures *(continued)*

Description of Violation

On 08/01/2022, resident #4's Lispro Injection KwikPen did not have an open date. Per manufacturer's instructions, once you start using this product, it should be stored at room temperature and must be used within 28 days or be discarded.

POC Submission ***Accept [redacted] - 09/19/2022)***

Resident #4's Lispro injection kwikpen was discarded. A new one was obtained and dated. Nursing staff will be educated on dating upon opening the kwikpen.
DON/Designee will audit all residents monthly for the next 3 months, with a Lispro injection kwikpen, to ensure there is an open date.
DON/Designee

Licensee's Plan Completion Date: *09/21/2022*

Not Implemented ([redacted] - 12/21/2022)

185b Medication procedures

40. Requirements

2800.
185.b. At a minimum, the procedures must include:
1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his living unit.

Description of Violation

Resident #2's Enema Disposable, which is a PRN medication, was not available on 08/01/2022 in the home's medication cart.

POC Submission ***Accept [redacted] - 09/19/2022)***

Nursing staff will be educated on proper procedures to obtain medications that are unavailable. PRN medication enema disposable was obtained for resident #2 and is in the med cart.
DON/Designee will conduct random audits for the next 3 months to ensure that all medications are available.
DON/Designee

Licensee's Plan Completion Date: *09/27/2022*

Not Implemented [redacted] - 12/21/2022)

187a Medication record

41. Requirements

2800.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

- Resident #1 is prescribed three medications daily. However, the resident's August 2022 medication administration record does not include diagnosis or purpose for the medications, including pro re nata (PRN).

187a Medication record (continued)

- Resident #2 is prescribed multiple medications daily. However, not all of medications on the resident's August 2022 medication administration record include the diagnosis or purpose for the medications, including pro re nata (PRN).

- Resident #5 is prescribed multiple medications daily. However, not all of medications on the resident's August 2022 medication administration record include the diagnosis or purpose for the medications.

POC Submission ***Accept (09/19/2022)***

The medication administration record was updated to include diagnose for residents # 1, 2 &5.
DON/Designee will conduct monthly audits to ensure that all medication administration records have a proper diagnosis.
DON/Designee

Licensee's Plan Completion Date: *09/27/2022*

Implemented - 12/22/2022)

187d Follow prescriber's orders

42. Requirements

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

Description of Violation

Resident # 6 is prescribed Melatonia 4MG-take one tab by mouth on Mon & Thurs Evening according to the resident's August 2022 MAR. However, the residence is substituting CVSHealth Melatonin 10MG Sleep Aid for this order. The home is not able to provide a copy of the doctor's order to verify the correct dosage.

POC Submission ***Accept - 09/19/2022)***

Received TVO from Primary care Physician and is now properly documented. Nursing staff will be educated on obtaining and following physicians orders.
DON/Designee will audit for the next 3 months to ensure all orders are obtained and followed.
DON/Designee

Licensee's Plan Completion Date: *09/27/2022*

Not Implemented (- 12/22/2022)

43. Requirements

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

Description of Violation

- Resident #2 is prescribed Docusate Sod Cap 100MG. However, this medication was not available in the residence on 08/01/2022 at 4:10 P.M. during a medication audit.

- Resident #5 is prescribed Senna Tab 8.6MG. However on 07/29/2022 at 9:00 PM, this medication was not administered because the medication was not available in the residence. Additionally, this medication and Docusate Sod Cap 100MG were not available during a medication audit on 08/01/2022 at 3:00 P.M.

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

POC Submission ***Accept (- 09/19/2022)***

Met with pharmacy to ensure that when a medication needs a refill the pharmacy will contact the physician to obtain the refill order.
DON/Designee will audit for the next 3 months to ensure all medications are available per physicians orders.
DON/Designee

Licensee's Plan Completion Date: *09/27/2022*

Not Implemented (- 12/22/2022)

190a Completion of course–meds

44. Requirements

2800.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

- Staff person D has not successfully completed the annual practicums for the Department-approved medications administration course,

- Staff person F has not successfully completed the annual practicums for the Department-approved medications administration course,

POC Submission ***Accept - 09/19/2022)***

Staff person D & F are no longer passing medication until we can have the annual practicums completed.
DON/Designee will audit monthly to ensure all med techs are current and up to date with their trainings and practicums.
DON/Designee

Licensee's Plan Completion Date: *09/27/2022*

Implemented - 12/22/2022)

223a Description of service

45. Requirements

2800.
223.a. The residence shall have a current written description of services and activities that the home provides including the following:
3. Specific services that the residence does not provide, but will arrange or coordinate.

Description of Violation

The residence's current written description of services and activities provided by the residence does not include specific services that the residence does not provide, but will arrange or coordinate.

POC Submission ***Accept - 09/19/2022)***

The residents written description of services will be updated to include specific areas that the residence does not provide.
Administrator /Designee will update the description of services annually to ensure all services are listed, including those we do not provide but can arrange for someone else to provide.

223a Description of service (continued)

Administrator /Designee

Licensee's Plan Completion Date: *09/27/2022*

Implemented (- 12/22/2022)

225b Assessment content

46. Requirements

2800.
225.b. The assessment must, at a minimum include the following:
6. The resident's need for special diet or meal requirements.

Description of Violation

Resident # 2's assessment, dated /2021, does not include the resident's need for special diet or meal requirements.

POC Submission ***Accept - 09/19/2022)***

The assessment for resident #2 has been updated to include the residents needs for a special diet or meal requirements.
DON/designee will audit monthly for the next 3 months to ensure resident's dietary needs are included on the resident's assessment.
DON/designee

Licensee's Plan Completion Date: *09/27/2022*

Not Implemented - 12/22/2022)

233a Lock approval

47. Requirements

2800.
233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The residence does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the magnetic locking devices that prevent immediate egress used on the exit doors located in the special care unit.

POC Submission ***Accept - 09/19/2022)***

The facility will reach out to the Dept of Labor & Industry, Dept of Health or local building authority for written approval permitting the use of the magnetic locking system that are on the exit doors on the special care unit.
Maintenance Director/Designee

Licensee's Plan Completion Date: *09/12/2022*

Implemented (- 12/22/2022)

233b Lock manufact. statement

48. Requirements

2800.

233b Lock manufact. statement *(continued)*

233.b. A residence shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:

Description of Violation

The magnetic locking system on the "C" stairwell of the special care unit (SCU) does not disengage when inputting the code on the key pad. Using the key pad or not, there is a 15 second delay, with alarm, and the door will open. The other doors on the SCU open when using a code and do not have a 15 second delay. The key pad only serves to "reset" the alarm.

POC Submission ***Accept [redacted] - 09/19/2022)***

Amp Tech was out and repaired the locking system and it now disengages when entering the code.
Maintenance Director/Designee will audit monthly to ensure that doors are disengaging when entering the code.
Maintenance Director/Designee

Licensee's Plan Completion Date: *09/12/2022*

Implemented [redacted] - 12/22/2022)

233d Electronic/magnetic system

49. Requirements

2800.
233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

The gate door opening into the driveway from the secures care unit's walking path is not locked with an electronic or magnetic locking system. The gate door is locked with a key operated padlock.

POC Submission ***Accept [redacted] - 09/19/2022)***

The Residence will contract with qualified vendor to install a magnetic/electronic lock system.
Once installed the Maintenance Director/Designee will audit monthly to ensure that the lock is working appropriately.
Maintenance Director/Designee

Licensee's Plan Completion Date: *09/12/2022*

Implemented [redacted] 12/22/2022)

233e Fire alarm systems

50. Requirements

2800.
233.e. Fire alarm systems shall be interconnected to the local fire department, when available, or a 24-hour monitoring service approved by the local fire department.

Description of Violation

The residence has fire alarms in the resident rooms and in the hallways. Some of the hallway fire alarms are not hard wired to the home's fire alarm system, therefore these alarms are not connected to the local fire Department or to a 24-hour monitoring service approved by the local fire Department.

POC Submission ***Accept [redacted] - 09/19/2022)***

The Residence has reached out to our life safety company to come out and hard wire the fire alarms in the

233e Fire alarm systems (continued)

hallways that are not connected to the system. Currently waiting for them to come out.
Maintenance Director/Designee

Licensee's Plan Completion Date: *10/01/2022*

Not Implemented [redacted] - 12/22/2022)

251b Record entries - legible

51. Requirements

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

Description of Violation

Correction fluid was used on resident # 2's residency agreement and assorted move-in documents, dated 12/10/2021.

POC Submission ***Accept ([redacted] - 09/19/2022)***

Resident #2's resident agreement was updated with a new form and the correction fluid was removed.
Administrator/Designee will audit all new resident records for the next 3 months to ensure they written in permanent, legible, dated and signed by the staff person making the entry.
Administrator/Designee

Licensee's Plan Completion Date: *09/27/2022*

Not Implemented [redacted] - 12/22/2022)

252 Records – content

52. Requirements

2800.
252. Content of Resident Records - Each resident's record must include the following information:
3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident # 2's record does not include a photograph of the resident that is no more than 2 years old.

POC Submission ***Accept [redacted] - 09/19/2022)***

All residents who had pictures dated for 2020 have been retaken and added to their chart.
Administrator/Designee will audit all current resident charts to ensure they have a current photo and audit all new admissions for the next 3 months.
Administrator/Designee

Licensee's Plan Completion Date: *10/01/2022*

Not Implemented [redacted] - 12/22/2022)

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

Facility Information

Name: *SPRINGFIELD SENIOR LIVING COMMUNITY* **License #:** *14484* **License Expiration:** *05/12/2023*

Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA 19038*

County: *MONTGOMERY* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *WYNDMOOR ASSISTED LIVING COMPANY LLC*

Address: *551 EAST EVERGREEN AVENUE, WYNDMOOR, PA, 19038*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *11/16/1987* **Issued By:** *Commonwealth of Pa L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *72* **Waking Staff:** *54*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *12/07/2022*

Inspection Dates and Department Representative

11/17/2022 - On-Site: [redacted]
11/18/2022 - On-Site:
12/07/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *103* **Residents Served:** *50*

Special Care Unit

In Home: *Yes* **Area:** *SDCU* **Capacity:** *33* **Residents Served:** *6*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *50*
Diagnosed with Mental Illness: *1*
Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *22*
Have Physical Disability: *11*

Inspections / Reviews

11/17/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/01/2023*

01/06/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/30/2022*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/11/2023*

01/12/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/10/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/12/2023*

05/31/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *02/17/2023*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

42c Dignity/Respect

1. Requirements

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

Description of Violation

On 12/6/2022, resident 1 came out of the dining area and approached staff person A to ask for assistance getting to their room. Staff person A responded with "can't you see I'm doing something?" Staff person A then proceeded to tell the person to "wait their turn" and to "do as I say". Resident 1 was then assisted by the Department Representative to their room. Resident 1 was in need of a bathroom visit.

Plan of Correction ***Directed [redacted] - 01/12/2023)***

Staff person A will be given additional dignity and respect training. Jada Peace Director of nursing will provide this training via video from YouTube https://youtu.be/HVF0273iHus and https://youtu.be/fZyRl23bIy8 on 1/10/2023. A counseling form will be placed in [redacted] employee file. This training will be done annually and upon new hire orientation.

Responsible Party: Director of Nursing

Directed

Within 30 calendar days of receipt of the accepted plan of correction: All direct care staff, ancillary staff persons, substitute personnel, volunteers and management staff including the administrator shall receive training in mandatory abuse reporting, resident rights, and the prevention of resident abuse by an outside source approved by the department such as the Area Agency on Aging.

Within 10 calendar days of receipt of the accepted plan of correction: The administrator will develop and implement a system to ensure residents are treated with dignity and respect. The administrator will provide continual reinforcement and emphasis on these goals through discussions at staff meetings and any staff training sessions. The administrator will privately interview two residents a week for three months and monthly thereafter to ensure residents are treated with dignity and respect. Documentation of interviews shall be kept.

Directed Completion Date: *02/11/2023*

Not Implemented [redacted] 02/21/2023)

42s Privacy - self/possessions

2. Requirements

2800.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

42s Privacy - self/possessions *(continued)*

Description of Violation

On 11/17/2022, there were cameras pointing towards residents rooms and doorways in the memory care unit.

Plan of Correction ***Accept [redacted]/12/2023)***

Cameras pointing towards residents rooms and doorways in the memory care unit have been deactivated and were removed by maintenance on 1/09/2023.

Responsible Party: Maintenance Director

Licensee's Proposed Overall Completion Date: *01/10/2023*

Implemented ([redacted] - 02/21/2023)

82c Locked poisons

3. Requirements

2800.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

Description of Violation

Mouthwash with a manufacturer's label indicating "contact poison control if swallowed, was unlocked, unattended, and accessible to residents in the storage room.

Plan of Correction ***Accept [redacted] - 01/12/2023)***

Storage room on the memory care unit is to be locked at all times when no one is in there. Staff was reeducated on keeping the door locked with poisonous materials at all times when no one is in there. The training was completed in the staff meeting on 1/5/2023. Director of Nursing / designee will audit daily for the next month starting 1/06/2023 to ensure this is being done.

Responsible Party: Director of Nursing / Designee

Licensee's Proposed Overall Completion Date: *02/06/2023*

Not Implemented [redacted] - 05/16/2023)

85a Sanitary conditions

4. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 11/17/22, at 2:00 pm, the ice machine was leaking water and there was a puddle.

On 11/17/22, there was a brown substance on the floor of room B319.

On 11/17/22, there was a brown substance on the inside of the toilet in the guest bathroom on the first floor.

85a Sanitary conditions (continued)

Plan of Correction ***Accept [redacted] - 01/12/2023)***

Ice machine has been fixed and Maintenance Director will audit weekly starting the week of 1/9/2023 for any leaks for the next 3 months.

Responsible Party: Maintenance Director

The brown substance on the floor of room B319 was due to the resident having just had an episode of coffee ground emesis and was being sent out to the hospital. Room B319 is now empty.

Responsible Party: Housekeeping Director

The guest bathroom toilet has been cleaned and will be cleaned at least once a day and monitored throughout the day by Housekeeping Director will audit daily for the next 30days to make sure it stays clean starting on 1/10/2023

Responsible Party: Housekeeping Director/Designee

Licensee's Proposed Overall Completion Date: *02/09/2023*

Implemented [redacted] - 02/21/2023)

85e Trash outside

5. Requirements

2800.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 11/17/2022, the trash can in the Memory care courtyard did not have a lid.

Plan of Correction ***Accept [redacted] - 01/12/2023)***

Trash can in the memory care courtyard will be replaced with a can with a lid on it. The can is on order with our vendor as of 1/05/2023. Maintenance Director will audit weekly for the next 3 months to make sure the trash can has a lid on it. As soo as the trash can is received. Old can has been removed on 12/30/2022

Responsible Party: Maintenance Director

Licensee's Proposed Overall Completion Date: *02/06/2023*

Implemented [redacted] - 02/21/2023)

88a Floors, walls, ceilings, windows, doors

6. Requirements

2800.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

88a Floors, walls, ceilings, windows, doors *(continued)*

Description of Violation

On 11/17/2022, there was an exposed cable in the first floor kitchen wall.

Plan of Correction ***Accept [redacted] - 01/12/2023)***

Cable has been covered today 1/6/2023 (please see picture attached) and Maintenance Director will audit weekly starting 1/6/2023 for the next 3 months to verify it stays covered.

Responsible Party: Maintenance Director

Licensee's Proposed Overall Completion Date: *01/06/2023*

Implemented [redacted] 02/21/2023)

95 Furniture & Equipment

7. Requirements

2800.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 11/17/2022, and 12/6/2022, the toilet seat in the guest bathroom was in disrepair and loose causing a hazard to residents.

Plan of Correction ***Directed ([redacted] - 01/12/2023)***

The toilet seat has been replaced on 1/06/2023 in the guest bathroom and is in working order. No more hazard to residents. We have hired a maintenance director that worked here a few years back and is familiar with building. He started on 01/03/2023 and will be able to keep up with repairs in a timely manner.

Responsible Party: Maintenance Director

Directed

In addition to the above plan of correction: Within 30 calendar days of receipt of the accepted plan of correction: All staff persons shall be educated on the requirements of regulation 2600.95 and reporting or repairing furniture and equipment that is not in good repair, not clean or is hazardous. Any hazards will be immediately reported to the administrator and corrected. If furniture or equipment is in disrepair and cannot be repaired immediately, it will be immediately removed from service. Documentation of education shall be kept.

Directed Completion Date: *02/11/2023*

Not Implemented [redacted] - 02/21/2023)

100a Exterior – free of hazards

8. Requirements

2800.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

100a Exterior – free of hazards *(continued)*

Description of Violation

On 11/17/2022, there was a snow shovel in the Memory care courtyard in front of the door.

Plan of Correction ***Accept [redacted] - 01/12/2023)***

The shovel has been removed from the memory care courtyard. Maintenance director will audit weekly for the next 3 months to make sure area is free and clear of any hazards. Starting on the week of 1/9/2023

Responsible Party: Maintenance Director

Licensee's Proposed Overall Completion Date: *04/09/2023*

Implemented [redacted] 05/05/2023)

102a Functioning toilet

9. Requirements

2800.
102.a. There must be one functioning flush toilet in the bathroom in the living unit.

Description of Violation

The bathroom in living unit #B319 does not have a functioning flush toilet in the bathroom.

Plan of Correction ***Directed [redacted] - 01/12/2023)***

Toilet in B319 has been fixed and is in working order. We have hired a maintenance director that worked here a few years back and is familiar with building.[redacted] started on 01/03/2023 and will be able to keep up with repairs in a timely manner.

Responsible Party: Maintenance Director

Directed

In addition to the above plan of correction: Within 30 calendar days of receipt of the accepted plan of correction: All staff persons shall be educated on the requirements of regulation 2600.102a and reporting or repairing non working equipment that is not in good repair, not clean or is hazardous. Any hazards will be immediately reported to the administrator and corrected. If furniture or equipment is in disrepair and cannot be repaired immediately, it will be immediately removed from service. Documentation of education shall be kept.

Directed Completion Date: *02/11/2023*

Not Implemented [redacted] 02/21/2023)

103i Outdated food

10. Requirements

2800.
103.i. Outdated or spoiled food or dented cans may not be used.

103i Outdated food *(continued)*

Description of Violation

On 11/17/2022, there was an unlabeled, undated tater tot potatoes in the first floor kitchen.

On 11/17/2022, there was an unlabeled, undated block of cheese in the main kitchen.

On 11/17/2022, there was an unlabeled, undated mozzarella cheese in the main kitchen.

On 11/17/2022, there was a tray of molded pasta in the main kitchen.

Plan of Correction ***Accept [redacted] - 01/12/2023)***

The unlabeled and undated items were discarded. Dietary staff will ensure that all food is labeled and dated. Dining Director/Designee will audit for the next 3 months to ensure all food is labeled and dated.
Within 15 days of receipt of the plan of correction: All staff persons handling, preparing or storing food items shall be educated regarding the safe storage of food items including labeling and dating. Documentation of education shall be kept. A designee shall check all food storage areas daily including refrigerators and freezers to ensure all food items are labeled and dated. Any outdated or spoiled food will be disposed of. All education and audits will start on 1/09/2023 and continue for the next 3 months.

Responsible Party: Dining Director

Licensee's Proposed Overall Completion Date: *04/09/2023*

Implemented [redacted] - 05/05/2023)

125a Combustible storage

11. Requirements

2800.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 11/17/2022, there were combustible materials that included cardboard and a bag of trash located inside the boiler room.

Plan of Correction ***Accept [redacted] - 01/12/2023)***

All combustible materials including cardboard and trash have been removed from the boiler room and disposed of properly. Maintenance Director will audit boiler room weekly for the next 3 months to ensure there are no combustible materials stored in the boiler room. Audits will begin the week of 01/09/2023

Responsible Party: Maintenance Director

Licensee's Proposed Overall Completion Date: *04/09/2023*

Implemented [redacted] - 05/05/2023)

141a Medical evaluation

12. Requirements

141a Medical evaluation *(continued)*

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:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.
11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.
12. Information about a resident's day-to-day assisted living service needs.

Description of Violation

The medical evaluation for resident #1, dated [redacted]/2022, does not include dementia information and head injury or trauma. This area of the form is blank and not checked off with a selection.

The medical evaluation for resident #2, dated [redacted]/2022, does not include TB Information. This area of the form is blank.

Plan of Correction ***Accept [redacted] - 01/12/2023)***

Resident #1 and resident #2 have been updated to have all areas filled in. Director of nursing was educated to never have any blank areas on the form. Education was completed on 12/20/2023. If the information of vaccinations is unknown, then they have to put unknown. Administrator will audit all new resident ADMEs to make sure all information is filled in for the next 3 months. Administrator will start the audits with the next admission and thereafter for the next 3 months. Please see attached ADME instructions used for Education.

Responsible Party: DON and Administrator

Licensee's Proposed Overall Completion Date: *04/09/2023*

Implemented [redacted] - 05/05/2023)

183e Storing Medications

13. Requirements

2800.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 12/6/2022, Insulin Lispro belonging to Resident 3 was opened on 10/26/2022 and remained in the cart after 28

183e Storing Medications (continued)

days. This medication also states to refrigerate and was not being stored in a refrigerator.

Plan of Correction ***Accept (- 01/12/2023)***

Expired medications were discarded appropriately and new medication were delivered by the pharmacy that same day. Med techs and nursing were educated on refrigeration of required medications and expiration dates of medication and proper disposal. A pharmacy expiration date sheet was placed in all the MARs on the med carts. This list gives the name of the medication and the expiration time after opened. This education was completed on 1/03/2023. DON will audit medication carts weekly starting the week of 01/03/2023 for the next 3 months to ensure there are no expired medications on the carts.

Responsible Party: DON

Licensee's Proposed Overall Completion Date: *04/03/2023*

Implemented (- 05/05/2023)

185a Storage procedures

14. Requirements

2800.
185.a. The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 12/6/2022, Glargine Insulin belonging to Resident 3 was opened on 10/20/2022 and remained in the cart after 28 days.

On 12/6/2022, Insulin Lispro belonging to Resident 3 was opened on 10/26/2022 and remained in the cart after 28 days. This medication also states to refrigerate and was not being stored in a refrigerator.

Plan of Correction ***Accept - 01/12/2023)***

Expired medications were discarded appropriately and new medication were delivered by the pharmacy that same day. Med techs and nursing were educated on refrigeration of required medications and expiration dates of medication and proper disposal. A pharmacy expiration date sheet was placed in all the MARs on the med carts. This list gives the name of the medication and the expiration time after opened. This education was completed on 1/03/23. DON will audit medication carts weekly starting the week of 1/03/2023 for the next 3 months to ensure there are no expired medications on the carts.
Responsible Party: DON

Licensee's Proposed Overall Completion Date: *04/03/2023*

Implemented (- 05/05/2023)

226a Mobility – assessment

15. Requirements

2800.
226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

226a Mobility – assessment *(continued)*

Description of Violation

Resident #2's assessment, dated [redacted] 2022, does not include a correct assessment of the resident's mobility needs. The Resident's Annual Medical Evaluation shows the Resident is immobile.

Plan of Correction ***Accept [redacted] - 01/12/2023)***

Resident #2's assessment was updated and all resident assessments were audited starting on 11/21/2022 to verify that all mobility needs are accurate. This was completed on 11/28/2022 by [redacted] DON.

Responsible Party: DON

Licensee's Proposed Overall Completion Date: *01/10/2023*

Implemented [redacted] - 02/21/2023)

251b Record entries - legible

17. Requirements

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

Description of Violation

The date was scribbled and written over on resident #4's support plan, dated 8/31/2022.

Plan of Correction ***Accept [redacted] - 01/12/2023)***

Resident #4's support plan was corrected and the DON was educated on how to properly cross off an error, by putting one line through the error, marking it as an error and initialing it. [redacted] Administrator will audit any support plans new admission and annual for the next 3 months, starting 01/10/2023.

Responsible Party: Administrator and DON

Licensee's Proposed Overall Completion Date: *01/10/2023*

Implemented [redacted] - 02/21/2023)