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

November 14, 2023

[redacted], REGIONAL CLINICAL SERVICE DIRECTOR
JENNER'S POND INC
[redacted]

RE: RUSTON RESIDENCE
100 SYCAMORE DRIVE
WEST GROVE, PA, 19390
LICENSE/COC#: 13889

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/17/2023, 08/18/2023, 08/21/2023 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: *RUSTON RESIDENCE* **License #**: *13889* **License Expiration**: *07/04/2024*

Address: *100 SYCAMORE DRIVE, WEST GROVE, PA 19390*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *JENNER'S POND INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/06/1998* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *87* **Waking Staff**: *65*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *08/17/2023*

Inspection Dates and Department Representative

08/17/2023 - On-Site: [redacted]

08/18/2023 - Off-Site: [redacted]

08/21/2023 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *70* **Residents Served**: *47*

Special Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *12* **Residents Served**: *11*

Hospice

Current Residents: *NM*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *48*

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

Have Mobility Need: *40* **Have Physical Disability**: *0*

Inspections / Reviews

08/17/2023 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/08/2023*

Inspections / Reviews *(continued)*

09/22/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/04/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *10/22/2023*

11/14/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/04/2023*

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

16c Incident reporting

1. 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] at [redacted], a resident fell and was sent to a trauma center. The residence did not report this incident to the Department until [redacted] at [redacted].

On [redacted] at [redacted], a resident was sent to ER. The residence did not report this incident to the Department until [redacted] at [redacted].

On [redacted] at [redacted], a resident passed away. The residence did not report this incident to the Department until [redacted] at [redacted].

On [redacted] at [redacted], a resident passed away. The residence did not report this incident to the Department until [redacted] at [redacted].

On [redacted] at [redacted], a resident passed away. The residence did not report this incident to the Department until [redacted] at [redacted].

On [redacted] at [redacted], a resident passed away. The residence did not report this incident to the Department until [redacted] at [redacted].

On [redacted] at [redacted], a resident was sent to ER. The residence did not report this incident to the Department until [redacted] at [redacted].

On [redacted] at [redacted], a resident passed away. The residence did not report this incident to the Department until [redacted] at [redacted].

On [redacted] at [redacted], a resident was sent to ER. The residence did not report this incident to the Department until [redacted] at [redacted].

On [redacted] at [redacted], an LPN did not follow provider's order as written. The residence did not report this incident to the Department until [redacted] at [redacted]

On [redacted] at [redacted], a resident did not receive adequate incontinence care during the 11-7 shift. The residence did not report this incident to the Department until [redacted] at [redacted] pm.

On [redacted] at [redacted], four residents did not receive adequate incontinence care during the 11-7 shift. The residence did not report this incident to the Department until [redacted] at [redacted] pm.

Repeat Violation Date: 9/14/22, 11/02/22.

Plan of Correction ***Accept ([redacted] - 09/22/2023)***

On 9/1/2023, the Administrator educated additional designated staff on the requirements set within 2600.16c and

16c Incident reporting (continued)

directed them to report timely in the Administrators absence. (Exhibit 00 In service)
Beginning 9/4/2023, the Administrator or designee will review DHS reportable incident reports weekly x 4 weeks, then bi weekly x 4 weeks, then monthly x 1 to validate they were sent to the department within the regulated submission timeframe. (Exhibit 00 Audit Tool)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
On 9/1/23, the Administrator educated additional designated staff on the requirements set within 2800.16c and directed them to report timely in the Administrators absence. (Exhibit A1 In service)
Beginning 9/4/2023, the Administrator or designee will review DHS reportable incident reports weekly x 4 weeks, bi weekly x 4 weeks, then monthly x 1 to validate they were sent to the department within the regulated submission timeframe. (Exhibit A2 Audit Tool)
The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented [redacted] - 11/14/2023)

23a ADL assistance

2. Requirements

2800.
23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The current assessment and support plan for Resident 1, indicates that the resident requires assistance with incontinence care. On [redacted] the resident did not receive this assistance as required.

The current assessment and support plans for Resident 2, Resident 3, Resident 4, and Resident 5, indicate that residents each require assistance with incontinence care. On [redacted], the residents did not receive this assistance as required.

Plan of Correction ***Accept ([redacted] - 09/22/2023)***

On 8/10/2023, a Certified Registered Nurse Practioner (CRNP) assessed Resident #1 due to, as a result of not receiving assistance with incontinence care as detailed in their support plan and determined Resident #1 did not sustain a negative effect related to this finding.
On 8/10/2023, a CRNP assessed Residents #2, #3, #4, and #5 due to not receiving assistance with incontinence care as detailed in their support plan and determined Residents #2, #3, #4, and #5 did not sustain a negative effect related to this finding. Resident #2, #3, #4, and #5 as a result of not receiving assistance with incontinence as detailed in their support plan and determined Residents #2, #3, #4, and #5 did not sustain a negative effect related to this finding.
On 9/1/2023, the Administrator educated currently direct care staff on the requirements set within 2800.23a. (Exhibit 00 In service)
On 8/18/2023, the Administrator, a licensed nurse, observed direct care staff providing assistance with incontinence care for a sample of five residents, to ensure the care being provided was consistent with the documented level and need of assistance in the resident's support plans. The Administrators observations validated compliance.
Beginning 9/1/2023, the Administrator or direct care designee, will observe three staff members providing resident assistance with incontinence care, weekly x 4 weeks, the bi weekly, x 4 weeks, the monthly x 1 to validate sustained compliance. (Exhibit 00 Audit tool)

23a ADL assistance (continued)

Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
On 9/6/2023, the Administrator educated current direct care staff on the requirements set within 2800.23a. (Exhibit B1 – In-service)
On 9/6/2023, the Administrator, a licensed nurse, observed direct care staff assisting with incontinence care for a sample of five residents to ensure the care being provided was consistent with the documented level and need of assistance in the resident's support plans. The Administrator's observations validated compliance.
Beginning 9/8/2023, the Administrator or direct-care designee will observe a sample of three residents being assisted with incontinence care weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit B2- Audit tool)
The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented (- 11/14/2023)

24 Personal hygeine

3. Requirements

2800.
24. Personal Hygiene - A residence shall provide the resident with assistance with personal hygiene as indicated in the resident's assessment and support plan. Personal hygiene includes one or more of the following:

Description of Violation

The current assessment and support plan for Resident 1, indicates that the resident requires assistance with personal hygiene. On the resident did not receive this assistance as required.

The current assessment and support plans for Resident 2, Resident 3, Resident 4, and Resident 5, indicate that residents each require assistance with personal hygiene. On , the residents did not receive this assistance as required.

Plan of Correction ***Accept (09/22/2023)***

On 8/10/2023, a CRNP assessed Resident #1 due to, as a result of not receiving assistance with personal hygiene as detailed in their support plan and determined Resident #1 did not sustain a negative effect related to this finding.
On 8/10/2023, a CRNP assessed Residents #2, #3, #4, and #5 due to not receiving assistance with personal hygiene as detailed in their support plan and determined Residents #2, #3, #4, and #5 did not sustain a negative effect related to this finding. Resident #2, #3, #4, and #5 as a result of not receiving assistance with personal hygiene as detailed in their support plan and determined Residents #2, #3, #4, and #5 did not sustain a negative effect related to this finding.
On 9/5/2023, the Administrator educated currently direct care staff on the requirements set within 2800.24. (Exhibit 00 – In-service)
On 9/8/2023, the Administrator, a licensed nurse, observed direct care staff providing assistance with personal hygiene for a sample of five residents, to ensure the care being provided was consistent with the documented level and need of assistance in the resident's support plans. The Administrators observations validated compliance.
Beginning 9/8/2023 the Administrator or direct-care designee, will observe three staff members providing resident assistance with personal hygiene, weekly x 4 weeks, the bi-weekly, x 4 weeks, the monthly x 1 to validate sustained compliance. (Exhibit 00- Audit tool)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued

24 Personal hygeine (continued)

auditing is necessary based on three consecutive months of compliance.
On 9/6/2023, the Administrator educated current direct care staff on the requirements set within 2800.24. (Exhibit C1 – In-service)
On 9/8/2023, the Administrator, a licensed nurse, observed direct care staff assisting with personal hygiene for a sample of five residents to ensure the care provided was consistent with the documented level and need for assistance in the resident's support plans. The Administrator's observations validated compliance. (Exhibit C2 – Audit tool)
Beginning 9/8/2023, the Administrator or direct-care designee will observe a sample of 3 residents being assisted by staff with personal hygiene weekly x 4 weeks, bi-weekly, x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit C3- Audit tool)
The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented [redacted] - 11/14/2023)

25b Contract signatures and renewal

4. Requirements

2800.
25b . The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days notice or by the residence with 30 days notice in accordance with § 2800.228 (relating to transfer and discharge).

Description of Violation

Resident 2's contract dated [redacted] was not signed by the resident.

Plan of Correction ***Accept ([redacted] - 09/22/2023)***

On 1/4/2022, the Administrator presented Resident #2's contract to the Responsible Party and resident for signing. (Exhibit – Signed contract)
On 8/21/2023, the admissions Coordinator audited the residency contracts belonging to current residents to validate the contracts were signed in accordance with regulation 2800.225b. For instances where signature omissions were identified, the contract was presented to the appropriate party for signing. (Exhibit 00 – Audit Tool)
On 9/6/2023, the Administrator in-serviced the Sales Director on the requirements set within regulation 2800.225.b. (Exhibit- In-service)
Beginning 9/8/2023, the Administrator or designee will audit the contracts belonging to newly admitted residents weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit 00- Audit Tool)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
On 8/21/2023, the Administrator presented Resident #2's contract to Resident #2 and their Responsible Party for signing. (Exhibit D1– Signed contract)
On 8/21/2023, the admission coordinator audited the residency contracts belonging to current residents to validate the contracts were signed in accordance with regulation 2800.225b. For instances where signature omissions were identified, the contract was presented to the appropriate party for signing. (Exhibit D2 – Audit Tool)
On 9/6/2023_the Administrator in-serviced the Sales Director on the requirements set within regulation

25b Contract signatures and renewal (continued)

2800.225.b. (Exhibit D3- In-service)
Beginning 9/8/2023, the Administrator or designee will audit the contracts belonging to newly admitted residents weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit D4- Audit Tool) The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented [redacted] - 11/14/2023)

42b Abuse/Neglect

5. Requirements

2800.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted] into [redacted], during the 11p-7a shift, Resident 1 did not receive incontinence care from Staff person A. The resident was double-briefed and was saturated with urine to the extent that their bed sheets were also soiled. This incident has resulted in the deprivation of necessary services by the staff person to maintain the resident's physical and mental health.

On [redacted] into [redacted], during the 11p-7a shift, Resident 2, Resident 3, Resident 4, and Resident 5 did not receive incontinence care from Staff person B. The residents were double-briefed and were found soiled with urine and feces to the extent that their bed sheets were also soiled. These incidents have resulted in the deprivation of necessary services by the staff person to maintain the residents' physical and mental health.

On [redacted], at approximately [redacted], Resident 1 was discovered fully unclothed on the floor, seated on the left side of their bed. Staff person C and Staff person D placed one arm under each of Resident 1' arms and lifted them to a sitting position on the lower left part of their mattress. While the staff members were lifting them up, Resident 1 became agitated and bit Staff person D's right upper arm. Frustrated by this, Staff person C forcefully pushed Resident 1 on their chest, deliberately causing mental anguish, which resulted in them falling backward into the urine-saturated sheets. Staff person C then lifted the resident's legs, which were over the sides of the mattress, into the bed and covered them with a white blanket. Without changing the resident's sheets or dressing them, Staff person C left the resident in urine-saturated sheets and exited the room, neglecting the resident's care needs.

Plan of Correction ***Accept ([redacted] - 09/22/2023)***

On 8/10/2023, a CRNP assessed Resident #1, as a result of not receiving incontinence care as detailed in their support plan and determined Resident #1 did not sustain a negative effect related to this finding.
On 8/10/2023, a CRNP assessed Residents #2, #3, #4, and #5, as a result of not receiving incontinence care as detailed in their support plan and determined Residents #2, #3, #4, and #5 did not sustain a negative effect related to this finding.
On 8/7/2023, the Administrator placed Staff person C on administrative leave pending the alleged incidents investigation.
On 8/31/2023, Staff person C and D were educated on the requirements set within 2800.42b pertaining to abuse and neglect. (Exhibit 00 – In-service)
On 8/10/2023, the Administrator queried current residents, asking them if they have experienced abuse or neglect while residing at the facility. (Exhibit Resident Interview)

42b Abuse/Neglect (continued)

On 9/6/2023, the Administrator in-serviced the facilities currently employed staff as to the requirements set within regulation 2800.42b. (Exhibit 00 – In-Service)
Beginning 9/8/2023, Administrator or designee will query three residents weekly x 4 weeks, then bi-weekly x 4 weeks, and then monthly x 1, asking if they have experienced or been subject to abuse or neglect while residing within the facility to validate sustained compliance.?(Exhibit 00– Audit tool)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
On 8/10/2023, a CRNP assessed Resident #1 due to not receiving incontinence care as detailed in their support plan and determined Resident #1 did not sustain a negative effect related to this finding.
On 8/10/2023, a CRNP assessed Residents #2, #3, #4, and #5, due to not receiving incontinence care as detailed in their support plan and determined Residents #2, #3, #4, and #5 did not sustain a negative effect related to this finding.
On 8/7/2023, the Administrator placed Staff person C on administrative leave pending the alleged incidents investigation.
On 8/31/2023, the Administrator educated Staff persons C and D on the requirements set within 2800.42b pertaining to abuse and neglect. (Exhibit E1 – In-service)
On 8/10/2023, the Administrator queried current residents, asking them if they had experienced abuse or neglect while residing at the facility. (Exhibit E2 – Audit tool)
On 9/6/2023, the Administrator in-serviced the facility's currently employed staff as to the requirements set within regulation 2800.42b. (Exhibit E3 – In-Service)
Beginning 9/8/2023, the Administrator or designee will query three residents weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 1, asking if they have experienced or been subject to abuse or neglect while residing within the facility to validate sustained compliance. (Exhibit E4– Audit tool)
The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented [redacted] - 11/14/2023)

42c Dignity/Respect

6. Requirements

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

Description of Violation

On [redacted] at approximately [redacted] Resident 1 was discovered fully unclothed seated on the floor, on the left side of their bed. Resident's bed linens were soaked with urine. Staff person C and Staff person D placed one arm under each of Resident 1's arms and lifted them to a sitting position on the lower left part of their mattress, that was not saturated. While the staff members were lifting them up, Resident 1 became agitated and bit Staff person D's right upper arm. Frustrated by this, Staff person C forcefully pushed Resident 1 on their chest, which resulted in them falling backward onto the urine-saturated sheets. Staff person C then lifted the resident's legs, which were over the sides of the mattress, into the bed and covered them with a white blanket. Without changing the resident's sheets or dressing them, Staff person C left the resident in urine-saturated sheets and exited the room. These actions illustrate a profound lack of respect for Resident 1's dignity and well-being, causing them both physical and emotional distress during a vulnerable moment.

42c Dignity/Respect *(continued)*

Plan of Correction ***Accept ([redacted] - 09/22/2023)***

On 8/10/2023, a CRNP assessed Resident #1, as a result of this alleged finding and determined Resident #1 did not sustain a negative effect related to this finding.
On 8/7/2023, the Administrator placed Staff person C on administrative leave pending the alleged incidents investigation.
On 8/10/2023, the Administrator queried a sample of 5 residents who have also been assigned to staff persons C and D, inquiring if they experienced or were subject to disrespectful behavior. No additional instances of disrespectful behavior were noted. (Exhibit 00 Audit tool)
On 8/31/2023, the Administrator re educated Staff person C and D on the requirements set within regulation 2800.42.c (Exhibit 00 In service)
By 9/6/2023, the Administrator or designee will re educate currently employed staff members on the requirements set within regulation 2800.42c. (Exhibit 00 In service)
Beginning 9/8/2023, the Administrator or designee will query three residents weekly x 4 weeks, then bi weekly x 4 weeks, and then monthly x 1, asking if they have experienced or been subject staff to resident disrespectful behavior while residing within the facility to validate sustained compliance. For further instances identified, the Administrator or designee will report the allegation per the requirements set within 2800.15.a. (Exhibit 00 Audit Tool)
Beginning 9/8/2023, the Administrator or designee will briefly observe three direct care staff members interacting with residents weekly x 4 weeks, then bi weekly x 4 weeks, the monthly x 1 to validate sustained compliance (Exhibit 00 Audit Tool)
Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
On 8/10/23, a CRNP assessed Resident #1 due to this alleged finding and determined Resident #1 did not sustain a negative effect related to this finding.
On 8/7/2023, the Regional Director of Clinical Services (RDCS) placed Staff person C on administrative leave pending the alleged incidents investigation.
On 8/10/2023, the Administrator queried a sample of 5 residents who have also been assigned to staff persons C and D, inquiring if they experienced or were subject to disrespectful behavior. No additional instances of disrespectful behavior were noted. (Exhibit F1 Audit tool)
On 8/31/2023, the Administrator re educated Staff person C and D on the requirements set within regulation 2800.42.c (Exhibit F2 In service)
By 9/6/2023, the Administrator or designee will re educate currently employed staff members on the requirements set within regulation 2800.42c. (Exhibit F3 In service)
Beginning 9/8/2023, the Administrator or designee will query three residents weekly x 4 weeks, then bi weekly x 4 weeks, and then monthly x 1, asking if they have experienced or been subject to disrespectful behavior while residing within the facility to validate sustained compliance. For further instances identified, the Administrator or designee will report the allegation per the requirements set within 2800.15.a. (Exhibit F4 Audit Tool)
Beginning 9/8/2023, the Administrator or designee will briefly observe three direct care staff members interacting with residents weekly x 4 weeks, bi weekly x 4 weeks, then monthly x 1 to validate sustained compliance (Exhibit F5 Audit Tool)
The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented [redacted] - 11/14/2023)

65a Fire Safety-1st day

7. 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:

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 B, whose first day of work was [redacted], did not receive orientation on the following topics:

1. Evacuation procedures.

2. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.

3. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.

4. The location and use of fire extinguishers.

5. Smoke detectors and fire alarms.

6. Telephone use and notification of emergency services.

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

1. Evacuation procedures.

2. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.

3. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.

4. The location and use of fire extinguishers.

5. Smoke detectors and fire alarms.

6. Telephone use and notification of emergency services.

Plan of Correction ***Accept [redacted] - 09/22/2023)***

The facility no longer employs staff person B.

On 8/31/2023_the Administrator met with Staff person C and collaboratively reviewed the facility-specific orientation checklist, which encompasses fire safety topics, evacuation procedures, the designated meeting place outside of the building or within the fire-safe area in the event of an actual fire, smoking safety procedures and policy, location of fire extinguishers, smoke detectors and fire alarms and telephone use, and notification of emergency services, both signing off on its' completion. (Exhibit G1 – Completed checklist)

On 8/23/2023, the HR dept. audited the personnel files of currently employed direct-care staff to ensure their facility-specific orientation checklist was completed. For instances identified of incomplete or missing employee checklists, the Administrator or designee collaboratively reviewed the orientation checklist with the employee, completing their checklist to satisfy the requirements detailed within 2800.65a. (Exhibit G2 – Audit tool)

On 9/6/2023, the Administrator in-serviced Human Resource Personnel on the requirements set within regulation 2800.65.a. (Exhibit G3 – In-Service)

Beginning 8/31/2023, the Administrator or designee will audit the orientation checklists of newly hired direct-care employees weekly x 4 weeks, then bi-weekly x 4 weeks, and then monthly x 1 to validate sustained compliance.

65a Fire Safety-1st day (continued)

(Exhibit G4 – Audit tool)

The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented [redacted] - 11/14/2023)

65e Rights/Abuse 40 Hours

8. 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.

Description of Violation

Staff person B did not complete training in the following topics within 40 scheduled working hours:

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. Core competency training that includes the following:

i.Person-centered care.

ii.Nutritional support according to resident preference.

Staff person C did not complete training in the following topics within 40 scheduled working hours:

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. Core competency training that includes the following:

i.Person-centered care.

ii.Nutritional support according to resident preference.

Plan of Correction ***Accept [redacted] - 09/22/2023)***

The facility no longer employs staff person B.

On 8/31/2023_the Administrator met with Staff person C and collaboratively reviewed the facility-specific

65e Rights/Abuse 40 Hours (continued)

orientation checklist, which encompasses Resident Rights, Emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, reporting of reportable incidents and conditions, care competency training that includes person centered care and nutritional support as per the resident's preference, both signing off on its' completion. (Exhibit H1 Completed checklist)

On 8/23/2023, the HR dept. audited the personnel files of currently employed direct care staff to ensure their facility specific orientation checklist was completed. For instances identified of incomplete or missing employee checklists, the Administrator or designee collaboratively reviewed the orientation checklist with the employee, completing their checklist to satisfy the requirements detailed within 2800.65e. (Exhibit H2 Audit tool)

On 9/6/2023, the Administrator in serviced Human Resource Personnel on the requirements set within regulation 2800.65.e. (Exhibit H3 In Service)

Beginning 9/8/2023, the Administrator or designee will audit the orientation checklists of newly hired direct care employees weekly x 4 weeks, bi weekly x 4 weeks, and then monthly x 1 to validate sustained compliance. (Exhibit H4 Audit tool)

The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented ([redacted] - 11/14/2023)

81b Resident equip – good repair

9. Requirements

2800.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On [redacted], Room 212 had an uncovered enabler bar, measuring approximately 11 inches, tethered to the bed by a strap wrapped around the mattress, which posed a possible hazardous condition for the resident.

Plan of Correction ***Accept [redacted] - 09/22/2023)***

On 8/17/2023, the RDCS removed the uncovered enabler bar from the bed in room #212.

On8/17/2023, the RDCS and Administrator audited current residents' beds for uncovered enablers. Enabler bars noted uncovered were then immediately covered.

On 9/6/2023, the Administrator in serviced the facility's current direct care staff as to the requirements set within regulation 2800.81b. (Exhibit I1 In service)

Beginning 9/8/2023, the Administrator or designee will audit three resident beds with enablers weekly x 4 weeks, bi weekly x 4 weeks, and then monthly x 1 to validate sustained compliance. (Exhibit I2 Audit Tool)

The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented [redacted] - 11/14/2023)

82c Locked poisons

10. Requirements

2800.

82c Locked poisons *(continued)*

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

A [redacted], an [redacted] deodorant body spray, a [redacted] shampoo, and an [redacted] dandruff 2 in 1 shampoo & conditioner, all with a manufacturer's label indicating, "If swallowed, get medical help or contact a Poison Control Center immediately," were unlocked, unattended, and accessible to Resident 1's bathroom sink and cabinet. Not all the residents of the home, including Resident 1, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept ([redacted] - 09/22/2023)***

On 8/17/2023, a Licensed Practical Nurse (LPN) secured Resident#1's [redacted] toothpaste, [redacted] shampoo, and [redacted] 2 in 1 shampoo and conditioner in a locked cabinet.
On 8/17/2023, an LPN audited the currently occupied memory care unit apartments to ensure poisonous materials, including toiletries, were appropriately secured and inaccessible to the residents. No additional instances of unlocked poisons were noted.
On 9/6/2023, the Administrator in-serviced the facility's current direct care staff on the requirements set within 2800.82c. (Exhibit J1 – In-service)
Beginning 9/8/2023, the Administrator or designee will audit three resident apartments weekly x four weeks, bi-weekly x 4 weeks, and then monthly x 1 to validate sustained compliance. (Exhibit J2- Audit Tool)
The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented ([redacted]S - 11/14/2023)

85a Sanitary conditions

11. Requirements

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

Description of Violation

On [redacted], Room 208 had a very strong odor of urine at 9:00am and which was still present at 12:40pm.

Plan of Correction ***Accept ([redacted] - 09/22/2023)***

On 8/17/2023, housekeeping staff cleaned and deodorized Room 208's bathroom, eliminating the odor.
On 8/17/2023, the Administrator audited current resident apartments to ensure no additional apartments were malodorous. No additional instances were identified. (Exhibit K1 – Audit tool)
On 9/6/2023, the Administrator in-serviced the facility's current direct care, maintenance, and housekeeping staff as to the requirements set within regulation 2800.85a. (Exhibit K2 – In-service)
Beginning 9/8/2023, the Administrator or designee will audit three resident apartments weekly x four weeks, bi-weekly x 4 weeks, and then monthly x 1 to validate sustained compliance. (Exhibit K3 – Audit Tool)
The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented [redacted] - 11/14/2023)

88a Floors, walls, ceilings, windows, doors

12. 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 8/17/23, carpets had extensive stains in the hallways, near Room 204 and Room 212.

Plan of Correction ***Accept ([redacted] - 09/22/2023)***

On 8/17/2023, facility maintenance staff extracted the carpet stains in the hallway near rooms 204 and 212.
On 8/17/2023, the Administrator audited the facility halls for additional stains and relayed findings to housekeeping and building maintenance for further remediation.
On 8/29/2023, Servpro professionally extracted the stains identified by the Administrator's audit. (Exhibit L1 -Work order/invoice)
On 9/6/2023, the Administrator in-serviced the facility's current direct care, maintenance, and housekeeping staff as to the requirements set within regulation 2800.88a. (Exhibit L2– In-Service)
Beginning 9/8/2023, the Administrator or designee will audit three of the facility's carpeted hallways weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 1 to validate sustained compliance. (Exhibit L3 – Audit Tool)
The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented [redacted] - 11/14/2023)

101j7 Lighting/operable lamp

13. 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 2 does not have access to a source of light that can be turned on/off at bedside.

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

Plan of Correction ***Accept ([redacted] - 09/22/2023)***

On 8/17/2023, the Administrator provided Resident #2 and Resident #3 with an operable lamp at their bedside.
On 8/17/2023, the RDCS and Administrator audited occupied resident apartments for operable light sources accessible from the resident's bedside. Lightbulbs, either missing or burnt out, were replaced at the time of finding.
On 9/6/2023, the Administrator in-serviced the facility's current direct care, maintenance, and housekeeping staff as to the requirements set within regulation 2800.101j7 (Exhibit M1 – In-service)
Beginning 9/8/2023, the Administrator or designee will audit three resident apartment lights weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance (Exhibit M2 – Audit Tool)
The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented ([redacted] - 11/14/2023)

141a Medical evaluation

14. 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:

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], does not include the following; This area of the form is blank.

1. A general physical examination by a physician, physician's assistant or nurse practitioner.

2. Special health or dietary needs of the resident.

3. Immunization history.

4. Body positioning and movement stimulation for residents, if appropriate.

5. 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.

Plan of Correction ***Accept [redacted] - 09/22/2023)***

On 8/17/2023, a CRNP thoroughly completed a new Medical Evaluation for Resident #1, which captured previously omitted sections. (Exhibit N1 – New DME)

On 8/18/2023, the Administrator, also an LPN, audited current residents DMEs. Residents with DMEs that contained omitted entries were updated in collaboration with the resident's designated healthcare provider. (Exhibit N2 – Audit tool)

On 8/17/2023, the Administrator educated the facility's primary healthcare providers on the requirements set within regulation 2800.141.a. (Exhibit N3 – In-service)

Beginning 8/20/2023, the Administrator or designee will audit DMEs belonging to newly admitted residents or residents that experienced a recent significant change weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit N4 – Audit tool)

The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented [redacted] 11/14/2023)

225a2 Assessment – significant change

15. 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 3 was using a bed enabler. However, the resident's assessment, dated [redacted] does not include the need for bedside mobility devices.

Plan of Correction ***Accept [redacted] - 09/22/2023)***

On 8/21/2023, the Administrator updated Resident #3's Assessment and Support Plan (ASP) to include the utilization of a bed enabler. (Exhibit 01– Updated ASP)
On 8/25/2023, the Administrator audited the ASPs belonging to current residents that utilize bed enablers to validate that the enabler was documented on the ASP. For omissions noted, the Administrator updated the ASP accordingly. (Exhibit 02 – Audit tool)
Beginning 9/8/2023, the Administrator or designee will audit the ASPs of three residents utilizing bed enablers weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 1 to validate sustained compliance. (Exhibit 03 – Audit tool)
The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented [redacted] - 11/14/2023)

227c Final support plan - revision

16. Requirements

2800.
227.c. The final support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. The residence shall review each resident's final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

Description of Violation

Resident 1 was admitted to the secured care unit on [redacted] from the assisted living. However, the resident's support plan was not revised following the change in the resident's needs.

Plan of Correction ***Accept [redacted] - 09/22/2023)***

On [redacted], the Administrator completed Resident #1's final support plan (Exhibit P1 – ASP)
On 8/18/2023, the Administrator audited current resident support plans to validate that a final support plan was completed. For additional instances of an omitted final support plan, the Administrator or LPN completed the final support plan accordingly. (Exhibit P2 – Audit tool)
On 8/23/2023, the Administrator educated the LPN on the requirements set within regulations 2800.227.c. (Exhibit P3 – In-service)
Beginning 8/20/2023, the Administrator or designee will audit newly admitted residents' support plans weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit P4 – Audit tool)
The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

227c Final support plan - revision *(continued)*

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented [redacted] - 11/14/2023)

231d No objection statement

17. Requirements

2800.
231.d. Resident admission to special care unit. Each resident record must have documentation that the resident or potential resident and, when appropriate, the resident's designated person or the resident's family have agreed to the resident's admission or transfer to the special care unit.

Description of Violation

Resident 1 was admitted to the special care unit on [redacted]. However, the resident's record does not include documentation that the resident and the resident's designated person or the resident's family have agreed to the resident's admission to the special care unit.

Plan of Correction ***Accept ([redacted] - 09/22/2023)***

On 9/1/2023, the Administrator presented Resident #1 and their responsible party with the document titled "Secured Memory Care Acknowledgment" for signing, which reflects the secured unit in which Resident#1 resides. (Exhibit Q1 – Signed Addendum)
On 9/1/2023, the Administrator audited the contracts of current residents who reside in the secured unit to ensure their "Secured Memory Care Acknowledgment" was executed. For additional instances of unsigned Acknowledgments, the Administrator will present the Acknowledgment to the corresponding resident and their responsible party for signing. If a resident cannot sign the Acknowledgement secondary to cognitive deficits, the Administrator will document attempts made. (Exhibit Q2- Audit Tool)
On 8/18/2023, the Administrator educated the Sales Director on the requirements set with 2600.231g and the "Secured Memory Care Acknowledgment." (Exhibit Q3 – In-Service)
Beginning 8/20/2023, the Administrator or designee will audit the "Secured Memory Care Acknowledgment" for newly admitted residents assigned to the secured unit weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit Q4 – Audit Tool)
The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented ([redacted] - 11/14/2023)

231g Resident-residence contract

18. Requirements

2800.
231.g. Disclosure of services. The resident-residence contract specified in § 2800.25 (relating to resident-residence contract) must also include a disclosure of services, admission and discharge criteria, change in condition policies, special programming and costs and fees.

Description of Violation

Resident 1 was admitted to the special care unit on [redacted]. However, the resident's record does not include the resident-residence contract related to the admission to the special care unit, including disclosure of services, admission and discharge criteria, change in condition policies, special programming, and costs and fees.

Plan of Correction ***Accept ([redacted] - 09/22/2023)***

231g Resident residence contract (continued)

On 9/1/2023, the Administrator presented Resident #1 and their responsible party with the document titled "Addendum to Residency Contract" for signing, which reflects the secured unit in which Resident#1 resides. (Exhibit R1 Signed Addendum)

On 8/20/2023, the Administrator audited the contracts of current residents who reside in the secured unit to ensure their "Addendum to Residency Contract" was executed. For additional instances identified of unsigned addendums, the Administrator will present the addendum to the corresponding resident and their responsible party for signing. If a resident cannot sign the addendum secondary to cognitive deficits, the Administrator will document attempts made. (Exhibit R2 Audit Tool)

On 8/18/2023, the Administrator educated the Sales Director on the requirements set with 2600.231g, and the "Addendum to Residency Contract." (Exhibit R3 In Service)

Beginning 8/20/2023, the Administrator or designee will audit the "Addendum to Residency Contract" for newly admitted residents who reside in the secured unit weekly x 4 weeks, bi weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit R4 Audit Tool)

The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented [redacted] - 11/14/2023)

252 Records – content

19. Requirements

2800.

252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. A language, speech, hearing or vision need which requires accommodation or awareness of during oral or written communication.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the residence, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.

252 Records – content *(continued)*

20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the residence, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2800.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.
27. A record relating to any exception request under § 2800.229 (relating to excludable conditions; exceptions).
28. Ongoing resident progress notes.

Description of Violation

Resident 1's record does not include their color of hair, color of eyes, religious affiliation, if any, and identifying marks.

Plan of Correction ***Accept [redacted] - 09/22/2023)***

On [redacted], the Administrator updated Resident #1's face sheet to include their hair color, eye color, religious affiliation, and identifying marks. (Exhibit S1 – updated face sheet)

On 8/24/2023, the admissions coordinator audited current resident face sheets to ensure identifying marks are notated. For instances identified where an omission is noted, the residents face sheet was updated accordingly.

On 9/1/2023, the Administrator educated the admissions coordinator as to the requirements set within regulations 2800.252 (Exhibit S2 – In-service)

Beginning 9/8/2023, the Administrator or designee will audit three resident face sheets weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 1 to validate sustained compliance. (Exhibit S3 – Audit tool)

The results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented ([redacted] - 11/14/2023)