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

May 15, 2024

[redacted], ADMINISTRATOR
NORTH WALES 1089 MC BG OPCO LLC
[redacted]

RE: PARK CREEK PLACE - MEMORY CARE
1089 HORSHAM ROAD
NORTH WALES, PA, 19454
LICENSE/COC#: 14256

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/15/2024, 02/22/2024 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: *PARK CREEK PLACE - MEMORY CARE* **License #**: *14256* **License Expiration**: *10/02/2024*

Address: *1089 HORSHAM ROAD, NORTH WALES, PA 19454*

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

Administrator

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

Legal Entity

Name: *NORTH WALES 1089 MC BG OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/19/1996* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *56* **Waking Staff**: *42*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/22/2024*

Inspection Dates and Department Representative

02/15/2024 - On-Site: [redacted]

02/22/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *28*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire Home* **Capacity**: *48* **Residents Served**: *28*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *28*

Diagnosed with Mental Illness: *3*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *28*

Have Physical Disability: *0*

Inspections / Reviews

02/15/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/14/2024*

03/20/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/14/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/25/2024*

Inspections / Reviews *(continued)*

05/15/2024 POC Submission

Submitted By: [redacted]
Date Submitted: *03/25/2024*
Reviewer: [redacted]
Follow Up Type: *Bypass Document Submission*

05/15/2024 Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *05/15/2024*
Reviewer: [redacted]
Follow Up Type: *Not Required*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 2/15/24 the home's current violation report dated 1/25/2023 was not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept ([redacted] - 04/04/2024)***

The Executive Director has obtained a copy of the current violation report dated 1/25/2023 and has placed it at the front desk in a labeled binder as of 3/1/23.
The Executive Director or designee will verify weekly that a copy of the most recent violation reported is posted and a available in a public place for residents and visitors . Started by 3/31/2024
Ongoing compliance will be maintained by auditing monthly during community corporate compliance audits (CERT). Audit will be completed by the Business Office Manager. This will begin 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] - 05/15/2024)

18 - Compliance With Laws

2. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Under Act 106 of 2010: The Retail Food Facility Safety Act (3Pa.C.S.A.§§5701-5714) and The Food Safety Act (3Pa.C.S.A. §§5721-5737) and the Local Health Administration Law Act 315 approved August 24, 1951, P.L. 1304, as amended, as found in 16 P.L. §12001 et seq, a person may not operate a food facility, food establishment, retail food establishment, mobile vending unit, a temporary or otherwise transient food establishment without a valid permit to operate issued by the Montgomery County Health Department. The home's license to operate a food establishment expired 11/30/23.

On 2/15/24, the staff person present in the kitchen was not 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.

Repeat Violation: 1/25/23 et al.

Plan of Correction ***Accept ([redacted] - 03/20/2024)***

The Executive Director will ensure that staff member D has completed the Serve Safe certification by 03/14 and a copy of the safe serve certificate will be placed in the employee file .
Business Office Manager will complete an audit for current applicable dietary staff to verify that they are serve safe

18 Compliance With Laws (continued)

certified, any discrepancies will be reported to the Executive Director. Completion date 3/31/2024
Executive Director or Designee will verify that applicable newly hired employees are provided with serve safe training. Ongoing

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

24 - Personal Hygiene

3. Requirements

2600.
24. Personal Hygiene - A home 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

On [redacted], resident 1 was not permitted to attend morning activities because the resident had not been showered that morning. In an interview, it was revealed that direct care staff were "behind" on doing showers that morning.

Plan of Correction ***Accept ([redacted] - 04/04/2024)***

Health and Wellness Director will provide training to current staff on resident rights by 3/31/24
Health and Wellness director will provide training to current staff on the company's ADL expectation & standards . Completion by 3/31/2024
The Health and Wellness Director or designee will review the current shower schedule and preference with the current staff and changes to the shower schedule will be made per resident preference . Completed by 3/31/2024
Community will maintain appropriate staffing levels based on the needs of the residents. This will ensure the community will continue to honor residents daily choices while ensuring needs are met. This will occur by training staff on strategic planning, staff adhering to primary assigned sections and assignment of pre assigned breaks/lunches. Additionally, staffing levels will be reviewed with residents change of condition. Ongoing monitoring will be provided by Health and Wellness Director.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

25b - Contract Signatures

4. Requirements

2600.
25.b. 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.

Description of Violation

The resident home contract, dated [redacted] for resident 2 was not signed by the resident.

The resident home contract, dated [redacted], for resident 3 was not signed by the resident.

Repeat Violation: 1/25/23 et al.

25b Contract Signatures (continued)

Plan of Correction ***Accept (- 03/20/2024)***

The Business Office Manager will communicate with the resident's POA for resident 2 and 3 to obtain a signature on the current contract by 3/31/24.
Business Office Manager will audit current resident files for contract completion by 3/31/24. Any discrepancies found will be reported the Executive Director and adressed immediatley.
The Business Office Manager will receive training by the Executive Director on regulation 2600.25(b) regarding contract expectations by 3/31/24.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented (- 05/15/2024)

26a - Quality Management Plan

5. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home has not implemented it's quality management plan as it has not conducted a quality management review since 4/6/23. According to the home's policy, meetings are to be held quarterly.

Plan of Correction ***Accept (- 03/20/2024)***

Executive Director and leadership team will complete a Quality Assurance Review by 3/31/24
Executive Director will educate leadership team on the Quality Assurance Review expectations by 3/31/24
Executive Director will provide training to current management staff on the company's Quality Assurance Review guidelines and Quality Assurance Review will be conducted quarterly and as needed. Training will be completed by 3/20/24.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented (- 05/15/2024)

41e - Signed Statement

6. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Records for residents 2, 3, and 4 did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Repeat Violation: 1/25/23 et al.

41e - Signed Statement (continued)

Plan of Correction ***Accept [redacted] - 03/20/2024)***

Business Office Manager will audit resident files for compliance of the signed statement by 3/29/24. Any discrepancies found will be reported to the Executive Director and addressed immediately .
Ongoing the Executive Director will audit all new contracts for completion during the admission process.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

51 - Criminal Background Check

7. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A hired [redacted] did not have a criminal background check completed until [redacted].

Staff person B hired [redacted], has not lived in Pennsylvania within the last 2 years and does not have and FBI background check.

Staff person C hired [redacted], has not lived in Pennsylvania within the last 2 years and does not have and FBI background check.

Repeat Violation: 1/25/23 et al.

Plan of Correction ***Accept [redacted] - 03/20/2024)***

Business Office Manager has completed the FBI background check on staff person B and C
The Executive Director will provide training for the Business Office Manager on regulation 2600.51 as it pertains to background checks . Completion by 3/31/2024
Business Office Manager will audit current staff files for compliance by 3/31/23. Any discrepencies found will be reported to the Executive Director and addressed immediatley.
Business Office Manager will audit all newly hired files prior to all new hires first day for compliance. Ongoing

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

53a - Qualifications

8. Requirements

2600.

53a - Qualifications *(continued)*

53.a. The administrator shall have one of the following qualifications:
1. A license as a registered nurse from the Department of State.
2. An associate's degree or 60 credit hours from an accredited college or university.
3. A license as a licensed practical nurse from the Department of State and 1 year of work experience in a related field.
4. A license as a nursing home administrator from the Department of State.
5. For a home serving 8 or fewer residents, a general education development diploma or high school diploma and 2 years direct care or administrative experience in the human services field.

Description of Violation

On [redacted], the home was serving 28 residents. Staff persons B and C, the administrators, do not have a license from the Pennsylvania Department of State as a registered nurse, or a licensed practical nurse with one year of work experience in a related field, an associate's degree, 60 or more credits from an accredited college or university, or a license.

Plan of Correction ***Accept [redacted] - 03/20/2024)***

Interim Executive Director will provide community with a copy of the Bachelor and Masters degree by 3/11/2 to ensure that compliance is met.
Staff member B and C will obtain a Personal Care Home administrators license by 5/30/24

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

60a - Staff/Support Plan

9. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On [redacted], resident 1 was not permitted to attend morning activities because the resident had not been showered that morning. According to staff interviews, these services could not be provided due to lack of available direct care staffing in the home.

Plan of Correction ***Accept ([redacted] - 04/04/2024)***

Health and Wellness Director will educate staff on Resident Rights for current staff .Completed by 3/31/2024
Health and Wellness director will provide training to current staff on the company's ADL expectation & standards . Completion by 3/31/2024
The Health and Wellness Director or designee will review the current shower schedule and preference with the current staff and changes to the shower schedule will be made per resident preference . Completed by 3/31/2024
Health and Wellness Director will educate current staff on assignment sheets and proper reporting protocol by 3/31/24.
Community will maintain appropriate staffing levels based on the needs of the residents. This will ensure the community will continue to honor residents daily choices while ensuring needs are met. This will occur by training staff on strategic planning, staff adhering to primary assigned sections and assignment of pre assigned breaks/lunches. Additionally, staffing levels will be reviewed with residents change of condition. Ongoing monitoring will be provided by Health and Wellness Director.

60a - Staff/Support Plan *(continued)*

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] - 05/15/2024)

65b - Rights/Abuse 40 Hours

10. Requirements

2600.
65.b. 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.

Description of Violation

Staff person D completed his/her 40th scheduled work hour on on or around 10/11/23. 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).

Staff person E completed his/her 40th scheduled work hour on on or around 11/20/23. 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).

Plan of Correction ***Accept ([redacted] - 03/20/2024)***

Health and Wellness Director or Designee will educate staff D and E on resident rights, emergency medical plan and mandatory reporting of abuse and neglect by 3/13/24
Business Office Manager will audit current staff files for training requirements. Any discrepancies found will be reported to the Executive Director and addressed immediately. Completion by 3/31/2024
The Executive Director will provide training to current managers including the Business Office Manager on the training requirements 2600.65(b) by 3/31/24. The Executive Director will discuss training requirements at the next Quality Assurance Review by 3/31/24. Training requirements will be discussed during the Quality Assurance review by the Executive Director with current managers in attendance . Completion by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

65e - 12 Hours Annual Training

11. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

65e 12 Hours Annual Training *(continued)*

Description of Violation

Direct care staff person A received 0 hours of annual training in training year January 2023 to December 2023.

Plan of Correction ***Accept (- 03/20/2024)***

Staff person A will receive 12 hours of annual job related training by the HWD or designee by 3/13/24
Type text here
Business Office Manager will audit current staff files to verify that all annual training requirements are met by 3/13/24. Any discrepencies found will be reported to the Executive Director and addressed immediately and training will be set up for completion by 3/31/2024
The Executive Director will educate the current managment staff on annual training hours 2600.65(e) by 3/31/24.
Training requirements will be discussed during the Quality Assurance review by the Executive Director with current managers in attendance . Completion by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented (- 05/15/2024)

65f - Training Topics

12. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in medication self administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques , care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year January 2023 to December 2023.

Plan of Correction ***Accept (- 03/20/2024)***

Staff person A will received required training by the Health and Wellness Director by 3/13/24
Business Office Manager will audit current staff files for direct care training requirements. Any discrepencies found will be reported to the Executive Director and addressed immediately and required training will be completed by 3/31/2024
Executive Director will provide training to current managers on training requirements. Completion by 3/31/2024
Training requirements will be discussed during the Quality Assurance review by the Executive Director with current

65f - Training Topics (continued)

managers in attendance . Completion by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] - 05/15/2024)

65g - Annual Training Content

13. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person A did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention during training year January 2023 to December 2023.

Plan of Correction ***Accept [redacted] - 03/20/2024)***

Staff person A receives fire saftey training by a fire saftey expert by 3/13/24
Executive Director or designee will conduct a audit by 3/31/24 to ensure that current and newly hired staff have met the regulation 2600.65g training requirements . Any discrepencies found will be addressed by the Executive Director immediately and training will be completed by 3/31/2024
Execuitve Director will verify that current staff are educated on fire saftey by a fire safety expert by 3/31/24
Training requirements will be discussed during the Quality Assurance review by the Executive Director with current managers in attendance . Completion by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] - 05/15/2024)

81a - Accomodation

14. Requirements

2600.
81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Description of Violation

Resident 2's bed was equipped with a bedside mobility device that had an opening of approximately 12 inches wide

81a - Accomodation (continued)

by 6 inches high, which exceeds the FDA guidelines for areas of entrapment. The device was not covered.

Resident 3's bed was equipped with a bedside mobility device that had an opening of approximately 6 inches between the device and mattress, which exceeds the FDA guidelines for areas of entrapment. There were no guards or bumpers in the opening.

Plan of Correction ***Accept (- 04/04/2024)***

Executive Director or Designee will provide staff education on proper use, storage and set up of mobility devices by 3/31/24.
Health and Wellness Director replaced resident 2's mobility device cover on 2/15/24
Health and Wellness Director completed a audit of current resident bed mobility devices for compliance on 2/15/24. Audit has been reported to the Executive Director.
Executive Director with current managers in attendance will discuss Mobility Devices and expectations at the next Quality Assurance Review by 3/31/24
An ongoing weekly audit will be completed during the weekly manager rounds by the Health & Wellness Director or Memory Care Director or designee . Any discrepancy will be reported to the Executive Director immediately . Started by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented (- 05/15/2024)

81b - Resident Personal Equipment

15. Requirements

2600.
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 2/15/24, a bedside mobility device was being utilized by resident 2. The device was slid under the mattress. It was not attached securely to the bed frame.

On 2/15/24, a bedside mobility device was being utilized by resident 3. The device was slid under the mattress. It was not attached securely to the bed frame.

Plan of Correction ***Accept (- 04/04/2024)***

Executive Director or Designee will provide staff education on proper use, storage and set up of mobility devices by 3/31/24
Health and Wellness Director verified that resident 2 and 3 mobility devices are attached securely on 2/23/2024
Health and Wellness Director will audit current bed mobility devices for compliance and continued need of the mobility device by 3/29/24. Any discrepancies found will be reported to the Executive Director and addressed immediately.
Executive Director with current managers in attendance will discuss Mobility Devices and expectations at the next Quality Assurance Review by 3/31/24.
An ongoing weekly audit will be completed during the weekly manager rounds by the Health & Wellness Director

81b - Resident Personal Equipment (continued)

or Memory Care Director or designee . Any discrepancy will be reported to the Executive Director immediately . Started by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] - 05/15/2024)

82c - Locking Poisonous Materials

16. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 2/15/24 Tom's antiperspirant, with a manufacturer's label indicating "if swallowed, get medical help or contact a Poison Control Center", was unlocked, unattended, and accessible to residents in room E6. Not all the residents of the home, have been assessed capable of recognizing and using poisons safely.

On 2/15/24 several unlocked poisons including mouthwash, toothpaste, and body cream, with manufacturer's labels indicating "if swallowed, get medical help or contact a Poison Control Center", were unlocked, unattended, and accessible to residents in the bathroom cabinet room A6. Not all the residents of the home, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 03/20/2024)***

Health and Wellness Director has removed all poisonous materials from E6 and A6 as of 2/15/24
Health and Wellness Director or Memory Care Director will complete a audit of all poisonous materials and storage by 2/15/24. Any discrepencies found will be reported to the Executive Director and addressed immediatley.
Weekly management rounds will be completed by a current manager or designee to verify that all poisonous materials are locked and inaccessible to residents as of 2/15/24.
Health and Wellness Director or Memory Care Director will provide training for current staff on the companies Safe Haven policy which includes the storing of potential poisonous materials by 3/31/24
Executive Director with current managers in attendance will discuss the Safe Haven standard and expectations at the next Quality Assurance Review by 3/31/24.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] - 05/15/2024)

85a - Sanitary Conditions

17. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 2/15/24 at 10:51 am, the dry storage pantry has cereal spilled on the floor.

85a - Sanitary Conditions (continued)

On 2/15/24 at 11:23 am, resident 5's bed had a mattress cover that had resident 2's name written on it.

On 2/15/24 at 11:25 am, the bathroom in room B2 had a strong odor of urine.

Plan of Correction ***Accept ([redacted] - 03/20/2024)***

Dinning Service Director has completed a deep clean of dry storage area as of 2/23/24
Health and Wellness Director has removed mattress cover from resident 5's bed as of 2/23/24
Plant Operations Director completed a deep clean of B2 bathroom on 2/23/24
Dining Service Director will educate dinning staff on companies' sanitation policy by 3/31/24
Health and Wellness Director will educate to staff on the proper reporting protocol and the companies' soiled incontinence products standards. Staff are to report to their direct supervisor for any soiled incontinence products discrepencies. Completion by 3/31/2024
Management rounds will be completed weekly, and the Executive Director will review the management rounds checklist weekly and address areas of discrepancies immediately . Starting by 3/31/2024
Executive Director with current managers in attendance will discuss the sanitary condition and reporting expectations at the next Quality Assurance Review by 3/31/24.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

88a - Surfaces

18. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 2/15/24, on the north side, there was peeling paint and water damage behind the sink in the kitchenette area.

Both kitchenettes have electric stoves that are accessible to residents.

On 2/15/24, there was an unattended and accessible electric razor plugged in and sitting on the sink in the bathroom in room A6.

Plan of Correction ***Accept ([redacted] - 03/20/2024)***

The Plant Operations Director completed the paint and water damage correction on the north side kitchenette area on 3/8/24.
The Health and Wellness Director removed electric razor from the bathroom sink and stored it correctly as of 2/23/24
The Health and Wellness Director or Designee will provide training with current staff on the importance of storing resident personal items including electrical items and on the companies Safe Haven policy. Completion by 3/31/2024
Management rounds will be completed weekly, and the Executive Director will review the management rounds checklist weekly and address areas of discrepancies immediately . Starting by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

88a - Surfaces *(continued)*

Implemented ([redacted] - 05/15/2024)

89a - Water Pressure

19. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 2/15/24, the home did not have sufficient hot water in the bathroom sink in rooms B2 and A6.

Plan of Correction ***Accept ([redacted] - 03/20/2024)***

Executive Director and leadership team will complete Quality Assurance Review by 3/31/24
Plant Operations Director completed an audit of all water temps on 2/29/24. All water temperatures will be within range by 3/31/24. Plant Operations Director has communicated with vendor to repair the circulating motor by 3/15/24..
Plant Operations Director audit water temps weekly for compliance. Any discrepencies will be reported to the Executive Director and addressed immediately. Executive Director will educate Plant Operations director on the companies Environmental Health and Safety policy by 3/31/24.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

95 - Furniture and Equipment

20. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The cabinet above the washer in Laundry E is in disrepair. The shelf is damaged and falling.

The cabinet above the washer in Laundry C is in disrepair. The shelf is damaged and falling.

Plan of Correction ***Accept [redacted] - 03/20/2024)***

Shelfs identified during the survey were repaired by the Plant Operations Director on 3/8/24
Executive Director will educate staff on proper reporting protocol for maintenance work orders to be completed by 3/31/24. Staff will report all maintenance request to their direct supervisor.
Executive Director with current managers in attendance will discuss maintenance repair and reporting expectations at the next Quality Assurance Review by 3/31/24.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

101j1 - Mattress Fire Retardant

21. Requirements

101j1 Mattress Fire Retardant *(continued)*

2600.
101.j. Each resident shall have the following in the bedroom:
1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

On 2/15/24, resident 2's bed had plastic on the mattress.

Plan of Correction ***Accept (- 03/20/2024)***

Health and Wellness Director removed plastic cover on resident 2's mattress as of 2/16/24.
Current management staff will complete weekly management rounds to ensure compliance requirements are met. Any discrepancies found will be reported to the Executive Director and corrected immediately Completion by 3/31/2024.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented (- 05/15/2024)

101j3 Bed/Linens/Pillows/Blankets

22. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 2/15/24, the bed for resident 5 did not have sheets.

Plan of Correction ***Accept (- 03/20/2024)***

Resident 5 is independent with bed making as per the serivce plan. Per residents' preference, prefers not to have a top sheet on bed. Resident's Support plan will be updated by the the Health and Wellness Director or Designee . Completed by 3/31/2024
Health and Wellness Director will educate staff on the importance of bed making and following the resident's support plan by 3/31/24
Health and Wellness or designee will update the resident's support plan to reflect the resident's preference .Completion by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented (- 05/15/2024)

101j5 Bedside Table/Shelf

23. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf beside resident 3's bed in bedroom E6.

101j5 - Bedside Table/Shelf (continued)

There is no bedside table or shelf beside resident 6's bed in bedroom F6.

Plan of Correction ***Accept (- 03/20/2024)***

Executive Director has provided resident 3 and 6 with a bedside table as of 2/15/24.
Executive Director or Designee will audit for compliance of regulation 2600.101j5 by 3/31/24. Any discrepencies found will be addressed immediatley.
Executive Director or Designee will provide training to current managers on regulation 2600.101j5 . Completion by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented - 05/15/2024)

101j7 - Lighting/Operable Lamp

24. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Residents 3, 6, and 7 do not have access to a source of light that can be turned on/off at bedside.

Repeat Violation: 1/25/23 et al.

Plan of Correction ***Accept (- 03/20/2024)***

Executive Director and Plant Operations Director have provided resident 3, 6 and 7 with operable lighting at their bedside as of 2/16/24
Health and Wellness Director will educate staff on regulation 2600.1017j and to report if any lighting is inoperable as soon as it is discovered. Completion by 3/31/2024
Plant Operations Director will audit monthly for compliance. Any discrepencies will be reported to the Executive Director and addressed immediatley. Starting by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented - 05/15/2024)

103e - Left Overs

25. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 2/15/24, there was an unlabeled, undated sandwich on a plate in the refrigerator.

Plan of Correction ***Accept (- 03/20/2024)***

Dining Service Director will educate dining staff on proper food handling practices and regulation 2600.103e by 3/31/23
Dining Service Director or designee will complete daily food storage audits beginning on 3/1/24 for compliance.

103e - Left Overs (continued)

Any discrepencies found will be reported to the Executive Director and corrected immediately.
Food storage compliance will be reviewed during the quality management meeting by the Executive Director and current management staff . Completion by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] - 05/15/2024)

103i - Outdated Food

26. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 2/15/24 in the kitchen, there was a large tub of sugar that was not labeled and dated, and a large tub of flour dated 6/19/22.

Plan of Correction ***Accept ([redacted] - 03/20/2024)***

Dining Service Director has removed all outdated items as of 2/23/24
Dining Service Director will educate current dining staff on the companies' proper food handling standard policy and regulation 2600.103e by 3/31/23
Dining Service Director or designee will complete daily food storage audits weekly for compliance. Any discrepancies found will be reported to the Executive Director and corrected immediately .Started by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

105f - Labeling/Return of Clothes

27. Requirements

2600.
105.f. Measures shall be implemented to ensure that residents' clothing are not lost or misplaced during laundering or cleaning. The resident's clean clothing shall be returned to the resident within 24 hours after laundering

Description of Violation

The home does not have a system to safeguard resident laundry from loss. On 2/15/24, there were unlabeled clothes in Laundry E. Staff indicate that they do not know who the clothes belong to.

Plan of Correction ***Accept ([redacted] - 03/20/2024)***

Health and Wellness Director has removed all unlabeled clothing from laundry area E as of 3/8/34
Health and Wellness Director will educate staff on a magnet labeling system for all clothing in the laundry area while being washed or dried by 3/31/24. Staff will place a magent with the resident name on the washer or dryer to identify residents belongings. Current staff will be trained by the Health and Wellness Director or designee on the labeling system by 3/31/2024
Health and Wellness Director and Memory Care Director will audit weekly for compliance. Any discrepencies will be reported to the Executive Director and corrected immediatley. Started by 3/31/2024.

Licensee's Proposed Overall Completion Date: *03/31/2024*

105f Labeling/Return of Clothes *(continued)*

Implemented ([redacted] - 05/15/2024)

107c Food/Water 3 Day Supply

28. Requirements

2600.
107.c. The home shall maintain at least a 3 day supply of nonperishable food and drinking water for residents.

Description of Violation

On 2/15/24, the home served 28 residents, requiring 84 gallons of emergency drinking water. However, the home had only 50 gallons.

Plan of Correction ***Accept ([redacted] - 03/20/2024)***

Executive Director completed an additional order of emergency water supplies on 3/8/24. Community is in compliance with the required amount of 84 gallons of emergency drinking water.
Executive Director or designee will audit monthly for compliance. Any discrepancies found will be corrected immediately.
The Dining Service Director provided education for current dinning staff on 2600.107(c) by 3/13/24 Regulation 2600.107c regarding the 3 day supply expectations at the next Quality Assurance review by the Executive Directors with current management team in attendance . Completion by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

107d Procedure Emergency Management Agency Submission

29. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency management agency since 2021.

Plan of Correction ***Accept ([redacted] - 04/04/2024)***

Executive Director has submitted and received approval of home's written emergency procedure via the management agency as of 3/8/24.
Community will add review, update and submission of written emergency procedures to the local emergency management agency to the corporate required December audit schedule to ensure compliance annually on or before the beginning of each year. This will be completed by the Executive Director.

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented [redacted] - 05/15/2024)

132d Evacuation

30. Requirements

2600.
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 home.

Description of Violation

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during all fire drills in the past 12 months.

Plan of Correction ***Accept (- 03/20/2024)***

Executive Director will communicate with the fire safety expert to receive a written specified period time designating a maximum evacuation time by 4/5/24.
Executive Director will utilize the community fire safety expert to educate all current staff on 2600.132 (d) by 4/5/24
Executive Director or Designee will audit fire safety evacuation time monthly for compliance. Any discrepancies found will be corrected immediately.

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented - 05/15/2024)

141a 1 10 Medical Evaluation Information

31. Requirements

2600.
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.

Description of Violation

Resident 3's medical evaluation dated did not include height, weight, allergies, health status, cognitive functioning.

Plan of Correction ***Accept (- 04/04/2024)***

Health and Wellness Director or designee will complete an audit of current resident medical evaluation for compliance of regulation 2600.141a by 3/31/24. Any discrepancies found will be reported to the Executive Director and corrected immediately.
The medical evaluation and expectations will be discussed by the Executive Director with current management in staff at the next Quality Assurance review by 3/31/2024
The Executive Director or Designee will audit the medical evaluations -10% weekly for one month and then monthly thereafter of the current or newly admitted medical evaluation for the required information . Started by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented - 05/15/2024)

141a 1-10 Medical Evaluation Information *(continued)*

162c - Menus Posted

32. Requirements

2600.
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

On 2/15/24, the home's menu for the week of 2/11/24 to 2/17/24 was posted. However, the menu for the week in advance was not posted.

Plan of Correction ***Accept ([redacted] - 03/20/2024)***

Director of Dining Service has placed the week in advance menu in the dining room as of 2/23/24
Dining Service Director will educate current dining staff on regulation 2600.162c by 3/29/24
Dining Service Director will review menu posting weekly to ensure compliance is met. Any discrepencies found will be reported to the Executive Director and corrected immediatley. Ongoing

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

183e - Storing Medications

33. Requirements

2600.
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 2/15/24[redacted] with an open date of 1/2/24, was on the medication cart. According to the manufacturer's instructions they should be discarded after 28 days.

Plan of Correction ***Accept ([redacted] - 03/20/2024)***

Health and Wellness Director or Designee will audit all medication cart by 3/31/24. Any discrepancies found will be reported to the Executive Director and corrected immediately.
Health and Wellness Director will educate staff on the companies' medication labeling standard and dating open medication, reviewing the open date expectations by 3/31/2024
Health and Wellness Director or Designee will complete a 10% weekly audit for one month then monthly thereafter. Started by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

185a - Implement Storage Procedures

34. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

185.a. The home 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

The glucometer for resident 2 is not calibrated for the correct date and time. On [redacted], the glucometer reads [redacted].

The following transcription errors were found while auditing resident 2's glucometer:

[redacted]

Plan of Correction ***Accept ([redacted] - 04/04/2024)***

Health and Wellness Director has discontinued the glucometer for resident 2 per the resident's primary care physician request on 3/8/24.
Health and Welness Director will educate current staff on companies' Blood Glucose Policy by 3/31/24
The Health and Wellness Director or designee will verify weekly that the current glucometers in use are calibrated. Started by 3/31/2024
The Health & Wellness Director or designee will audit the glucometer readings weekly and will complete a MAR audit weekly to verify there are no transcription errors for one month or until compliance is established . Started by 3/31/2024.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

187b - Date/Time of Medication Admin.

35. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

On [redacted], resident 2 was administered [redacted]. Staff person A did not initial the medication administration record.

Plan of Correction ***Accept ([redacted] - 03/20/2024)***

Health and Wellness Director will educate current Med. Techs on the company's Medication Administration policy and 2600.187(b) by 3/31/24
A weekly audit of the current Mars will be completed by the Health and Wellness Director or designee to verify that medication documentation is in compliance . Any discrepancies will be reported to the executive Director and followed up for compliance . Started by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

187d - Follow Prescriber's Orders

36. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 2 is prescribed [redacted], 1 drop in left eye every 12 hours, [redacted], 1 can by mouth twice daily, and [redacted], inject 10 units subcutaneously at bedtime. However, resident 2 was not administered these medications on [redacted].

Plan of Correction ***Accept ([redacted] - 03/20/2024)***

Health and Wellness Director will educate medication technicians on the company's Medication Administration policy and the regulation 2600.187(d) by 3/29/24.
A weekly audit of the current Mars will be completed by the Health and Wellness Director or designee to verify that medication documentation is in compliance . Any discrepancies will be reported to the executive Director and followed up for compliance . Started by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

190a - Completion Medication Course

37. Requirements

2600.
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 A, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:

[redacted]

Plan of Correction ***Accept [redacted] - 04/04/2024)***

Staff member A has successfully completed the department approved medication administration course as of 5/11/22. Staff member A certification has been placed in her file as of 3/7/24
The BOM or designee will audit current med Tech files to verify that up to date training is present and in compliance , any discrepancies will be reported to the Executive Director for follow up and to provide training by a qualified Medication trainer . Started by 3/31/2024.
The BOM or designee will audit the current Med Tech employee file and newly hired Med tech files for compliance monthly x3 months or until compliance is met. Started by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] - 05/15/2024)

191 - Resident Right to Refuse

38. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident 2, admitted [redacted], has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident 3, admitted [redacted], has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident 4, admitted [redacted] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Repeat Violation: 1/25/23 et al.

Plan of Correction ***Accept [redacted] - 04/04/2024)***

Health and Wellness Director will educate resident 2, 3, and 4 on 2600.191 by 3/13/24
Health and Wellness Director will educate current residents on 2600.191 by 3/31/24
Current staff will receive education on regulation 2600.191 by the Health and Wellness Director or designee . Completion by 3/31/2024
The Business Office Manager or designee will complete an audit to verify that the right to refuse medication form is present in each current resident's file and any discrepancies will be reported to the Executive Director for follow up . Started by 3/31/2024
The Execuitve Director or designee will monitor each new admission for 3 months or until compliance is established . Started by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

227d - Support Plan Medical/Dental

39. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident 2, dated [redacted] indicates the resident has a need for transferring. The resident's support plan, dated [redacted] does not mention the resident's bedside mobility device.

The assessment for resident 3, dated [redacted], indicates the resident has a need for transferring. The resident's support plan, dated [redacted] does not mention the resident's bedside mobility device.

The assessment for resident 4, dated [redacted], indicates the resident has a need for transferring. The resident's

227d - Support Plan Medical/Dental (continued)

support plan, dated [redacted] mentions the resident's bedside mobility device but does not mention the specific need for the device, intended use and any risks associated with the use, resident's ability to use the device safely for the purpose it was intended, and identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Plan of Correction ***Accept ([redacted] - 04/04/2024)***

Health and Wellness Director completed an audit of the RASP for resident 2, 3 and 4 to verify resident RASP are current. Health and Wellness Director verified RASP addendum in resident 2, 3 and 4 chart to verify that RASP did include mobility information on 3/8/24.
Health and Wellness Director completed audit on 3/8/24 to verify that all current residents RASP are in compliance. The Executive Director will provide training to the Health & wellness Director on the regulation 2600.227d. Completion by 3/31/2024
The Health & Wellness Director or designee will complete an audit of 10% of currentresident's RASP weekly x 1 month and then 10% monthly thereafter for compliance for 3 months or until compliance is established . Any discrepancies will be reported to the Executive Director . Started by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

231e - No Objection Statement

40. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident 2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Resident 4 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Repeat Violation: 1/25/23 et al.

Plan of Correction ***Accept ([redacted] - 03/20/2024)***

The Business Office Manager will commuincate with the resident's POA for resident 2 and 4 to obtain a signature of resident and POA non-objection to the admission of a secured unit by [redacted]
Business Office Manager will audit current resident files for secured unit admission completion by [redacted]. Any discrepencies found will be reported the Executive Director and adressed immediatley.
The Business Office Manager will receive training by the Executive Director on regulation 2600.231(e) regarding contract expectations by 3/31/24.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

233c - Key-Locking Devices

41. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the entrance doors to the Secure Dementia Care Unit (SDCU) on both the north and south sides.

Plan of Correction ***Accept ([redacted] - 03/20/2024)***

The Memory Care Director has completed and added directions for operating the locking mechanism is conspicuously
posted near the entrance of all doors on both north and sides of the community as of 2/20/24. The Executive Director will complete a training on regulation 2600.233c with the current leadership team . Completed 3/31/2024 . During the weekly management rounds the Memory Care Director or designee will verify that the directions are present and in conspicuous viewer the regulation . Starting by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

234a - Admission Support Plan

42. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident 3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was completed on [redacted]

Plan of Correction ***Accept [redacted] - 03/20/2024)***

Health and Wellness Director will audit current resident RASP by [redacted] Any discrepencies will be reported to the Executive Director and corrected immediatley.
Health and Wellness Director will review new admission support plans within 72 hours of admission. Any discrepencies found will be corrected immediatley.
The Executive Director will educate the Health and Wellness Director on 260.234(a) by [redacted]

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] - 05/15/2024)

236 - Staff Training

43. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person A, who works in the Secure Dementia Care Unit (SDCU) had 0

236 - Staff Training (continued)

hours of training in dementia care during the 1/1/23 to 12/31/23 training year.

Plan of Correction ***Accept [redacted] - 03/20/2024)***

Health and Wellness Director and Memory Care Director will provide staff member A with required 6 hours of Dementia care training by 3/13/24.
Executive Director or Designee will verify that current and newly hired staff will receive the required # hours of dementia care and annual training . Completion by 3/31/2024

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)

252 - Record Content

44. Requirements

2600.
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. Language or means of communication spoken or used by the resident.
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 home, 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.
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 home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

252 - Record Content *(continued)*

Description of Violation

Resident 4's record does not include a photograph of the resident that is no more than 2 years old.

Plan of Correction ***Accept ([redacted] - 03/20/2024)***

Health and Wellness Director will update resident 4 chart with a current photograph with including the date of photo of resident 4 by 3/13/24

Health and Wellness Director will audit current resident charts for 2600.252 compliance. Any discrepancies will be corrected immediately . Health and Wellness Director will educate current staff on 2600.252 by 3/31/24

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented ([redacted] - 05/15/2024)