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	ASL510474	A. BUILDING: _____ B. WING _____	07/15/2025

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A 000	Initial Comment Annual Survey conducted from 7/9/25 - 7/15/25 Violations: 295.2040: a) b) 5) 295.4010: a) b) i) 3) c) d) g) 1) 2) 3) 5) 295.4060: i) 2) A) B) 295.5000: h) 1) 2) j) 5)	A 000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: General Violation Section 295.2040 Disaster Preparedness a) For the purpose of this Section, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the establishment. b) Each establishment shall: 5) Orient each resident to the emergency and evacuation plans within 10 days after the resident's arrival. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative. This requirement was not met as evidenced by:	A2040		

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A2040	Continued From page 1 Based on record review and interview, the establishment failed to ensure that 4 residents (R1, R2, R3, R4) and their responsible party received orientation on emergency evacuation and obtained signature and dates when orientation was completed. This failure has the probability to affect all residents who reside in assisted living and both memory care units (Bridge and Evergreen). Findings include: On 7/10/25, the records for R1 (move in date 4/25/25), R2 (move in date 4/24/25) were reviewed. On 7/9/25 at 3:40pm E10 (resident service director) was asked to present the resident orientation for R1 and R2. On 7/10/25 at 7:48 am, the same information was requested on R3 and R4. On 7/10/25, E10 presented the establishment's New Resident Orientation Guide. This guide does not address resident orientation, emergency evacuation nor does it include the signature of the resident or the resident's responsible party. On 7/11/25 at 2:13pm via email, E10 wrote, the new resident orientation packet has information needed for safety and includes the map for exits. Also, E11 (maintenance director) meets with the new resident/and the family if present, to show them the fire safety instructions sheet which is affixed in a acrylic picture holder on the inside of their apartment on the wall next to the door as they exit.	A2040		

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A2040	Continued From page 2 On 7/12/25 up until time of exit, the establish was not able to present documentation of the orientation signed and dated by R1, R2, R3 and R4 or these resident's responsible representatives or POA (power of attorney).	A2040		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General Violation Section 294.4010 a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; 3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care. c) The service plan shall be signed and dated by all individuals involved in its development.	A4010		

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A4010	Continued From page 3 d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) g) Service plans shall address: 1) The level of service the resident is receiving, including: 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; 5) Whether the resident requires medication reminders, supervision of self-administered medication, or medication administration. These requirements were not met as evidenced by: Based on record review and interview the establishment failed to: -revise the service plan with interventions to address the unwitnessed fall incidents for two residents (R2, R4) out of 4 residents reviewed for falls; -include the amount, type and frequency of an outside service, physical therapy, as well as addressing a change in therapy agencies for one resident (R2); -ensure the service plans were signed and dated	A4010		

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A4010	Continued From page 4 by for 4 resident residents (R1, R2, R3, R4) or their POA (power of attorney). These failures have the probability to effect the residents who reside in assisted living and both memory care units. Findings include: 1. R2 is 84 year old who moved into the establishment 4/25/25. R2 resides in Assisted Living. R2 has diagnoses including Dementia, Major depressive disorder, Delirium, Anxiety, agitation, Essential HTN Myocardial infarction, Malignant neoplasm of Uterus, and Age related macular degeneration. The progress note dated 5/1/25 shows at approximtely 9:15pm, RA (resident aide) called NOD (nurse on duty) to R2's room. RA was still in the hallway when she heard R2's door open. RA found R2 on the floor in her doorway. NOD observed R2 sitting on the floor in her doorway, leaning back on the kitchen floor and supporting herself with her forearms against the floor. R2 said she was trying to use her belt to open the door. R2 complained of lower back pain on a scale of 2 out of 10. Bruising observed to lower back and redness to both forearms. NOD spoke to Z1 who was in agreement to send R2 to the hospital. It is also noted R2 is receiving PT (physical therapy). The service plan dated 4/25/25 was not revised with interventions to address the unwitnessed fall incident that occurred on 5/1/25. PT (SOC start of care) 5/20/25 is not addressed, as well as the change to another therapy agency is not mentioned.	A4010		

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A4010	Continued From page 5 On 7/11/25 at 2:13pm via email E10 wrote: yes R2 is on therapy. R2 was receiving services through home health, then R2 decided that she didn't want a male therapist anymore, so we switched R2 to (alternate home care) who has seen R2 either 2 or 3 times, as they had to get the Medicare approval first then assess and set up R2's schedule. On 7/14/25 during telephone meeting at 3:30pm, E10 admitted that she had this information in her notes but did not carry this information over to the service plan. 2. R4 is a 93 year old who moved into the establishment on 9/18/24. R4 has diagnoses including Vascular dementia, Type 2 diabetes mellitus, Essential HTN, Pulmonary nodule, Supraventricular tachycardia, Hypothyroidism, Generalized edema, Hydronephrosis, Traumatic subdural, Hemorrhage with loss of Consciousness, Cerebral ischemia, Respiratory failure with hypoxia, and UTI (urinary tract infection). The progress notes from December 2024 through June 2025 were reviewed and show the following related to falls: -12/7/24: at approximately 10:0pm, nurse was called to R4's room, R4 was observed trying to get up from the floor. R4 said she slipped out of bed. R4 complained of slight shoulder pain. -12/12/24: at approximately 8:05pm, nurse was called to R4's room. R4 observed in the floor by the bathroom and was trying to stand up. Walker was by the bed and R4 only wearing 1 sock. R4	A4010		

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A4010	Continued From page 6 said she was trying to get to the bathroom -1/20/25: RA hear R4 calling for help through R4's door. R4 observed sitting on the floor with the walker standing nearby -1/26/25: RA (resident aide) notified writer to come to Res room due to Res on the floor. Observed R4 sitting on the floor in the bathroom by the toilet, walker next to R4, incontinent of bowel -6/4: around 7pm RA came to R4's room, R4 was observed sitting on the floor outside her bathroom, wheelchair and walker in front of her, R4's right leg was bent and left leg was extended. When asked what happened, R4 stated, "I was trying to go to the bathroom, can you get me up?" -6/12/25: Writer (nurse) called to R4's room by her RA around 7:35pm. Writer noted R4 sitting on the floor next to her bed, walker was behind her, R4's right leg was bent underneath her, extended left leg with both arms touching the ground. R4 a & o (alert and oriented) x1. R4 stated, "I wanted to use the restroom then I slipped fell." R4 also stated that she bumped her head on her way down, The POA (power of attorney) didn't want R4 to go to hospital and be waiting a long time. The order summary sheet dated 9/11/24 shows orders for Tylenol oral tablet 325mg, give 2 tablets by mouth every 6 hours as needed for pain and Tylenol extra strength oral tablet 500mg, 1 tablet by mouth two times a day for pain. R4 expressed shoulder pain after several of the falls and was given Tylenol to relieve the pain. The service plan dated 5/1/25 was not revised	A4010		

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A4010	Continued From page 7 with new interventions after each unwitnessed fall incident. The service plan does not address R4's shoulder pain and medication prescribed for pain. 3. The service plans for R1, R2 and R3 were not signed and dated by these residents nor their POA (power of attorney).	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: General Violation Section 295.4060 Alzheimer's and Dementia Programs i) Training requirements for individuals working in a special program: 2) Staff training: A) All staff members must receive, in addition to the training required in Section 295.3020, four hours of dementia-specific orientation prior to assuming job responsibilities without direct supervision within the Alzheimer's/dementia program. Training must cover, at a minimum, the following topics: i) basic information about the causes, progression, and management of Alzheimer's disease and other related dementia disorders; ii) techniques for creating an environment that minimizes challenging behavior;	A4060		

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A4060	Continued From page 8 iii) identifying and alleviating safety risks to residents with Alzheimer's disease; iv) techniques for successful communication with individuals with dementia; and v) residents' rights. B) Direct care staff must receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Training must cover: i) encouraging independence in and providing assistance with the activities of daily living; ii) emergency and evacuation procedures specific to the dementia population; iii) techniques for creating an environment that minimizes challenging behaviors; iv) resident rights and choice for persons with dementia, working with families, caregiver stress; and v) techniques for successful communication These requirements were not met as evidenced by: Based on record review and interview, the establishment failed to ensure five newly hired direct care employees (E1 E2, E3, E4, E6,)	A4060		

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A4060	Continued From page 9	A4060		

completed the required 4 hours and 16 hours of dementia-specific orientation and one newly hired non direct employee (E5) completed the required four hours of the same training prior to assuming their job responsibilities.

This failure has the probability to affect future direct care non direct care newly hired employees.

Findings include:

On 7/10/25 surveyor reviewed the personnel files of 8 newly hired employees with E13 (human resources manager). The personnel files showed the following:

-E1 (resident aide), DOH (date of hire) 10/16/24

-E2 (resident aide), DOH 11/27/24

-E3 (resident aide), DOH 4/30/25

-E4 (resident aide), DOH 1/23/25

-E5 (engagement coordinator), DOH 11/3/24

-E6 (licensed practical nurse) DOH 5/28/25

There is no documentation to show that E1, E2, E3, E4 and E6 completed the required 4 and 16 hours of dementia-specific orientation prior to assuming job responsibilities without direct supervision. There is no documentation to show that E5 completed the required 4 hours of dementia-specific orientation prior to assuming job responsibilities without direct supervision as a engagement (activities) coordinator .

On 7/10/25 E13 could not give an explanation

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A4060	Continued From page 10 why this these new hires did not complete the required hours of dementia-specific training.	A4060		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: General Violation Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage h) Any medication stored by the establishment shall meet the following requirements: 1) Medication shall be stored in a locked container, cabinet, or area that is inaccessible to residents; 2) Medication shall not be left unattended by an employee; j) A separate medication record shall be maintained for each resident receiving medication administration and shall include: 5) Signature or initials of the employee administering medication. Based on record review and interview, the establishment failed to: Ensure oral medications were stored in a locked medication cart that is inaccessible to other	A5000		

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A5000	Continued From page 11 residents for 2 residents (R5, R6) reviewed for medication errors. After investigation it was determined that the nurse (E12) left several medications unattended and did not administer the medications as ordered. Findings include: 1. R5 is a 91 year old resident who resides in Assisted Living. R5 has diagnoses including Essential hypertension, Hyperlipidemia, Coronary angioplasty, Chronic kidney disease, Peripheral vascular disease, Peripheral arty disease, Right lower extremity cellulitis, Glaucoma, and Anemia. The incident and accident report dated 3/17/25 shows that a medication error occured on 3/16/25. R5's medications in unit dose pack where found left on top of the medication cart. They were unopened and not given to R5 as scheduled at 5pm medpass. Electronic eMAR (electronic medical administration) verified as not given. PCP (primary care physician) notified. No new orders but to monitor resident and notifiy if there is a change in the resident's status. The medications due at 5pm that were not given: -Carvedilol 3.125mg, by mouth -Ferrous sulfate 325mg, by mouth -Isosorbide mono10mg, by mouth -Simvastatin 20mg, by mouth -Tramadol 50mg, by mouth -Ammonium lac lotion, 12% apply to bilateral lower extremities, twice a day (6pm not given) Review of the eMAR for R5 shows that the above medications were not initialed as given at 5pm by E12 (LPN).	A5000		

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A5000	Continued From page 12 2. R6 is a 68 year old resident who resides in Assisted Living. R6 has diagnoses including Depression, Hypertension, Asthma and Hypothyroidism. The incident and accident report dated 3/17/25 shows that a medication error occured on 3/16/25. R6's medications in unit dose pack where found left on top of the medication cart. They were unopened and not given to R6 as scheduled at 8pm medpass. Electronic eMAR verified as not given. PCP notified. No new orders but to monitor resident and notifiy if there is a change in the resident's status. The medications due at 8pm that were not given: Rosuvastatin 20mg by mouth at 8pm Trazodone 50mg by mouth at 8pm R6's PCP notified of medications not given as ordered. No new medication orders given but instructions to monitor R6 and notify him if there was a change in status. E10 (RN/Resident Care Director) included in the investigation: investigated E12's (LPN) action. The decision was made to terminate employment. Nature of medications could have had adverse effects on resident.	A5000		