Department of Human Services
Bureau of Human Service Licensing

February 3, 2022

[redacted]
RAPPS SENIOR CARE LLC
[redacted]

RE: WOODBRIDGE PLACE
1191 RAPPS DAM ROAD
PHOENIXVILLE, PA, 19460
LICENSE/COC#: 14359

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/25/2021, 03/02/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Shawn Parker

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *WOODBRIDGE PLACE* **License #:** *14359* **License Expiration:** *11/19/2020*

Address: *1191 RAPPS DAM ROAD, PHOENIXVILLE, PA 19460*

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

Administrator

Name: [redacted] **Phone:** *4843020005* **Email:** [redacted]

Legal Entity

Name: *RAPPS SENIOR CARE LLC*

Address: *1000 LEGION PLACE, SUITE 1600, ATTN BILL SNOW, ORLANDO, FL, 32801*

Phone: *4843020005* **Email:** [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff:** *113* **Waking Staff:** *85*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *03/25/2021*

Inspection Dates and Department Representative

03/25/2021 - On-Site: [redacted]

03/02/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served:** *85*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *SDCU* **Capacity:** *21* **Residents Served:** *19*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *86*

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

Have Mobility Need: *28* **Have Physical Disability:** *0*

Inspections / Reviews

03/25/2021 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/08/2021*

Inspections / Reviews *(continued)*

05/19/2021 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/01/2021*

02/03/2022 - Document Submission

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

24 - Personal Hygiene

1. 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:
8. Skin care.

Description of Violation

Resident #1 is prescribed Triad Wound PST Dressing apply topically to open areas of skin every shift. Documentation is noted the treatment was provided morning and evening only on the following dates: 2/1/21, 2/3/21, 2/5/21, 2/8/21, 2/9/21, 2/10/21, 2/12/21, 2/15/21, 2/16/21, 2/17/21, and 2/19/21. There was no Triad Wound PST Dressing applied during any shift on the following dates: 2/2/21, 2/4/21, 2/6/21, 2/7/21, 2/11/21, 2/13/21, 2/14/21, 2/18/21, 2/20/21, 2/21/21, and 2/22/21. Resident was sent to hospital for increased wound pain with bi-lateral cellulitis and confusion on [redacted].

Plan of Correction ***Accept***

2600.24
Resident #1 was admitted with multiple stage II wounds on [redacted] *buttocks and BLE. A referral was made to* [redacted] *skilled nursing to manage wound care. Wound care orders were faxed to the pharmacy provider who entered the orders on the eMAR but did not indicate treatments were to be completed by the home care nurse. Med techs inadvertently signed off on the Triad Wound PST Dressing which was managed by* [redacted] *skilled nurse.*

Pharmacy provider was contacted to review the process of wound care order entry on the eMAR to assure the directions specify administration by the skilled home care nurse so the order will not pop for the med tech to administer. D.O.N or designee will monitor and approve all orders on the eMAR.

All med techs will be retrained in proper medication administration procedures related to 2600.187c; 187d; and 188b. by 6.1.21.
As of 4.6.21 a CRNP Wound Care specialist meets with D.O.N. on Tuesdays to completes weekly wound care rounds on all residents with wounds. The number of residents with wounds has decreased from 13 to 2 since implementing weekly wound rounds.

Documentation of weekly wound care rounds will be maintained for Department review in the wound care binder.

Executive Director will review residents with wound-care at the monthly QA Meeting.

Document Submission ***Implemented***

Monthly QA Meeting held. (See Attached May 2021)

42b - Abuse

1. Requirements

2600.
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

Resident #1 was admitted into the home on [redacted] *with stage 2 open area on buttocks and both legs are weeping. Resident #1 is prescribed Triad Wound PST Dressing apply topically to open areas of skin every shift. Documentation is*

42b - Abuse (continued)

noted the treatment was provided morning and evening only on the following dates: 2/1/21, 2/3/21, 2/5/21, 2/8/21, 2/9/21, 2/10/21, 2/12/21, 2/15/21, 2/16/21, 2/17/21, and 2/19/21. There was no Triad Wound PST Dressing applied during any shift on the following dates: 2/2/21, 2/4/21, 2/6/21, 2/7/21, 2/11/21, 2/13/21, 2/14/21, 2/18/21, 2/20/21, 2/21/21, and 2/22/21. Resident #1 was sent to hospital for increased wound pain with bi-lateral cellulitis and confusion on [redacted]. Home care visit notes from 2/23/21 report that Resident #1 was upset, crying, and needed to be cleaned up. Resident #1's wound dressing was removed on the lower legs, resident observed crying out in pain due to increased pain in right lower leg. Resident #1's Bilateral lower leg was bright red, tender to the touch, more red and painful then normal. Resident #1's buttocks was bleeding and purple.

Resident #3 was admitted into the home on [redacted] and moved into the secure dementia unit on [redacted]. On [redacted], Resident #3 choked on a large piece of meat resulting in his death. Resident #3's support plan dated [redacted] shows the resident had a dietary need for minced to moisten food. Resident #3 has a history of choking and swallowing concerns. On 5/19/20, progress notes report that resident #3 choked on a whole shrimp, and it required the Heimlich maneuver. Resident #3 had physician's orders for small to bite sized foods on 5/22/20, and speech therapy evaluations for swallowing/dysphasia 9/18/20 and 12/18/20. EMT reports on [redacted] at 16:54 that excessive food was in airway and large chunks of food were removed manually and at 17:05 additional large pieces of food were removed from the airway. Pieces approximately 1 inch in size were suctioned from the airway. Police report states the officer observed on a large piece of meat was removed out of resident #3's Airway. Staff reported on 3/25/21 that there is a list of special diets in the secure dementia unit. However, during a physical site walk through during lunch at 11:30 am on 3/25/21 the list was unavailable in the secure dementia unit. In addition to not following dietary needs, the resident was not immediately attended to upon choking. There were three staff members in the secure dementia unit during dinner on [redacted] Staff member C and D fed residents in their rooms while staff member E administered medications to the rest of the memory care residents eating in the dining area. Resident #3 was eating in the dining area unattended. It is unknown how long Resident #3 was choking, as they were not identified as unresponsive and choking until Staff member C re-entered the dining area after feeding a resident in their room. At that point, Staff member C alerted Staff member E, who was with the residents in the dining area. Then, Staff member C alerted Staff member D, who was also feeding a resident in their room. Staff member D then went to Resident #3 and started the Heimlich. Shortly after, the staff put resident #3 on the floor to start CPR.

Plan of Correction ***Accept***

42b – Abuse
Residents at Woodbridge Place will not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or discipline in any way.
Resident #1 was discharged from the home on [redacted].
Woodbridge Place is using a new skilled nursing home care provider, [redacted], to improve clinical support for residents requiring skilled nursing. A wound care CRNP and the D.O.N. or designee completes weekly rounds on for all residents with wounds to assure all orders are followed as prescribed.
Resident #3 was discharged on 1[redacted].
The speech therapist from [redacted] in-serviced direct care staff, and med-techs on emergency procedures related to dysphagia and response to choking. (Attachment #1)
A new daily resident diet list was posted in the SDU kitchen as of 4.30.21 . (See attachment #2) Ongoing, the dietary manager or designee is responsible to update the daily resident diet list and post in the SDU kitchen. The chef prepares resident meals according to their diet. Servers and care managers check off the resident diet list at each

42b - Abuse (continued)

All SDU direct care staff will be re-educated on CPR and choking procedures by 6.1.21. A "Choking and heimlich maneuver procedures poster was hung in the SDU kitchenette for reference.
Resident #1 no longer resides in the home as of [redacted] .
Policy 41 Description of Services was reviewed by the new Executive Director. (Attachmenyt #3) On 5.6.2021 the new Executive Director re-educated the management team on the home's Policy 42 – Description of Services. (Attachment #4) Going forward all residents admitted with wound-care will be reviewed and approved for admission by the Executive Director, Director of Nurses or designee to assure that the home can meet the clinical needs of the resident.

Document Submission ***Implemented***

See attachments #1, 2, 3, 4, CPR Training Attachment

161d - Dietary Needs

1. Requirements

2600.
161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

On 12/19/20, resident #3 was prescribed a minced to moisten diet. However, on 1[redacted] for dinner, resident #3 was served large pieces of meat.

Plan of Correction ***Accept***

161d – Dietary Needs
All resident diets were reviewed by the D.O.N., Dietary Director and Speech Therapist to assure all resident diets were accurate and being followed. A daily resident diet form was implemented (Attachment #2) to be completed by the server/care manager. The Dietary Director or designee maintains the completed daily resident diet form in a binder for the Department review. The D.O.N. or designee is responsible to obtain diet orders from the resident's physician and complete a diet form (Attachment #5) and give to the dietary department.
A diet manual was created in collaboration with Speech Therapy for staff to reference definitions of various diets and consistencies. The diet manuals are located in the both PC and SDU kitchen for reference.
On 3/25/21; 4/5/21; 4/7/21; and 4/8/21[redacted] Speech Therapist in-serviced all cooks, servers and Care Managers who work 1st and 2nd shifts on various diet types, food consistencies and definitions for each and the daily resident diet and meal preferences checklist. (Attachment #1). The Dining Director or designee maintains the completed daily resident diet in a binder for the Department Review.
Executive Director or designee will review resident diets at the Monthly Q.A. Meeting.

Document Submission ***Implemented***

See Attachment 1 - completion 4/8/21 & Monthly QA Meeting Attachment 5/19/21. Ongoing monthly QA meeting documentation will be maintained for Department Review

187c - Refusal of Medication

1. Requirements

2600.

187c - Refusal of Medication *(continued)*

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #1 refused prescribed medications on 2/20/21 and 2/21/21 that included Hydralazine 25mg Prosource, Triad Wound Dressing, Atenolol 50 mg, Docusate 100mg, Ferrous Sulfate 325mg, Furosemide 40mg, and Magnesium Oxide 400mg. The resident's physician was not contacted.

Plan of Correction ***Accept***

187d Following Prescriber's Orders
Resident #1 was admitted on [redacted] with multiple stage II wounds on [redacted] buttocks and BLE. A referral was made to [redacted] skilled nursing to manage wound care. Wound care orders were faxed to the pharmacy provider who entered the orders on the eMAR but did not indicate treatments were to be completed by the home care nurse. Med techs inadvertently signed off on the Triad Wound PST Dressing which was managed by skilled nurse.
Pharmacy provider, [redacted] was contacted to review the process of wound care order entry on the eMAR to assure the directions specify administration by the skilled home care nurse so the order will not pop for the med tech to administer. D.O.N or designee will monitor and approve all orders on the eMAR.
All med techs will be retrained in proper medication administration procedures related to 2600.187c; 187d; and 188b. by 6.1.21
A CRNP Wound Care specialist meets with D.O.N. to completes weekly wound care rounds on all residents with wounds. The number of residents with wounds has decreased from 13 to 2 since implementing weekly wound rounds.
Documentation of weekly wound care rounds will be maintained for Department review.
Executive Director will review residents with wound-care at the monthly QA Meeting.

Document Submission ***Implemented***

See Medication Administration Retraining 5.13.21 and May QA Meeting

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #1 is prescribed Triad Wound PST Dressing apply topically to open areas of skin every shift. Documentation is noted the treatment was provided morning and evening only on the following dates: 2/1/21, 2/3/21, 2/5/21, 2/8/21, 2/9/21, 2/10/21, 2/12/21, 2/15/21, 2/16/21, 2/17/21, and 2/19/21. There was no Triad Wound PST Dressing applied during any shift on the following dates: 2/2/21, 2/4/21, 2/6/21, 2/7/21, 2/11/21, 2/13/21, 2/14/21, 2/18/21, 2/20/21, 2/21/21, and 2/22/21. Resident #1 was sent to hospital for increased wound pain with bi-lateral cellulitis and confusion on 2/23/21

Plan of Correction ***Accept***

2600.187d
Resident #1 was admitted with multiple stage II wounds on [redacted] buttocks and BLE. A referral was made to [redacted] skilled nursing to manage wound care. Wound care orders were faxed to the pharmacy provider who entered the orders on the eMAR but did not indicate treatments were to be completed by the home

187d - Follow Prescriber's Orders (continued)

care nurse. Med techs inadvertently signed off on the Triad Wound PST Dressing which was managed by skilled nurse.

Pharmacy provider, [redacted], was contacted to review the process of wound care order entry on the eMAR to assure the directions specify administration by the skilled home care nurse so the order will not pop for the med tech to administer. D.O.N or designee will monitor and approve all orders on the eMAR.

All med techs will be retrained by the medication administration train the trainer in proper medication administration procedures related to 2600.187c; 187d; and 188b. by May 28, 2021.

A CRNP Wound Care specialist meets with D.O.N. to completes weekly wound care rounds on all residents with wounds. The number of residents with wounds has decreased from 13 to 2 since implementing weekly wound rounds.

Documentation of weekly wound care rounds will be maintained for Department review.

Executive Director will review Med Error Reporting at the Monthly QA Meeting

Document Submission ***Implemented***

See Medication Administration Retraining attachment and May QA Meeting attachment

188b - Medication Error Reporting

1. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

On 2/10/21 and 2/11/21 Triad wound dressing was not available for administration as it was on backorder for resident #1. The home did not report this medication error.

Plan of Correction ***Accept***

188b – Med Error Reporting
Resident #1 was admitted on [redacted] with multiple stage II wounds on [redacted] buttocks and BLE. A referral was made to [redacted] skilled nursing to manage wound care. Wound care orders were faxed to the pharmacy provider who entered the orders on the eMAR but did not indicate treatments were to be completed by the home care nurse. Med techs inadvertently signed off on the Triad Wound PST Dressing which was managed by skilled nurse.
Pharmacy provider, [redacted], was contacted to review the process of wound care order entry on the eMAR to assure the directions specify administration by the skilled home care nurse so the order will not pop for the med tech to administer. D.O.N or designee will monitor and approve all orders on the eMAR.
All med techs will be retrained in proper medication administration procedures related to 2600.187c; 187d; and 188b. by 6.1.21
D.O.N. or designee will monitor the eMAR daily for med errors. All med errors will be reported within 24 hours as required.

188b - Medication Error Reporting (continued)

A CRNP Wound Care specialist meets with D.O.N. to completes weekly wound care rounds on all residents with wounds. The number of residents with wounds has decreased from 13 to 2 since implementing weekly wound rounds.
Documentation of weekly wound care rounds will be maintained for Department review.
Executive Director will review Med Error Reporting at the Monthly QA Meeting

Document Submission ***Implemented***

See Medication Administration Retraining attachment and May QA Meeting attachment. Ongoing monthly QA Meeting Documentation will be maintained for Department Review.

224a - Preadmission Screen Form

1. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #3's preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept***

224a – PreAdmission Screen Form
Resident #3's no longer resides at the home so the preadmission screen cannot be corrected.
On 4.5.21 An audit of all resident records was completed by the D.O.N and Resident Care Director to assure that the needs of the resident can be met by the services provided by the home. (Attachment #7)
The wellness nurse or designee is responsible to complete the admissions checklist within 30 days of admission to assure that all documentation is accurate and completed according to 2600.224a.(Attachment #8)
On 5.6.21 the new Executive Director re-educated the D.O.N., Resident Care Director, and Memory Care Director on the requirements of 2600.224a and 2600.231c related to preadmission screening form and written cognitive screen. (Attachment # 4)
Going forward the D.O.N. or designee is responsible for completing the preadmission screen which includes documentation that the needs of the resident can be met by the services provided by the home.
By 6.1.21 the home will begin using [redacted], an electronic health record (E.H.R.) which will streamline the documentation and communication process and allow staff to spend more direct time for resident observations and assessments. The Preadmission screening form will be completed on the [redacted] H.R system which has programming that prohibits the prescreen from being saved if all required items are not completed. The home will request a waiver from the Department for the use of Department Required Forms on the [redacted] E.H.R. An in-service will be held by 6.1.21 to train staff in the use of [redacted].
The new Executive Director or designee will review all preadmission screening forms prior to filing in the resident chart.

Document Submission ***Implemented***

See attachments #4, 7, TabulaPro Staff Training Sheet; Department Waiver for [redacted]

225c - Additional Assessment

1. Requirements

2600.

225c - Additional Assessment *(continued)*

225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]; however, the resident did not have a assessment completed for significant changes.

Plan of Correction ***Accept***

225c – Additional Assessment
Resident #3 no longer resides in the home so an additional assessment could not be completed.
On 5.6.21 the new Executive Director re-educated the D.O.N., Resident Care Director, wellness nurse and Memory Care Director on the requirements of 2600.225c related to the RASP and additional assessments annually. If the condition of the resident significantly changes prior to the annual assessment and/or at the request of the Department upon cause to believe than an update is required. (Attachment #4)
By 6.1.21 the home will begin using [redacted] an electronic health record (E.H.R.) which will streamline the documentation and communication process and allow staff to spend more direct time for resident observations and assessments. The home will request a waiver from the Department for the use of Department Required Forms on the [redacted] E.H.R. An in-service will be held by May 31st to train staff in the use of [redacted].

Document Submission ***Implemented***

See attachments #4, 7, [redacted] Staff Training Sheet; Department Waiver for [redacted]

227d - Support Plan Medical/Dental

1. 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

Resident #1's RASP, dated [redacted] identifies the need for wound care, upon admission, but does not indicate a plan for the wound care of the stage 2 weeping wounds.

Plan of Correction ***Accept***

227d – Support Plan Medical/Dental – RASP re: wounds
Resident #1 has been discharged from the home.
An audit was completed by the D.O.N. for all residents with wound-care to assure the RASP was updated to include wound-care by the home care skilled nurse and frequency.
On 5.7.21 the new Executive Director re-educated the D.O.N., Resident Care Director, wellness nurse and Memory Care Director on the requirements of 2600.227d related to the RASP and additional assessments annually. If the condition of the resident significantly changes prior to the annual assessment and/or at the request of the Department upon cause to believe than an update is required.
By 6.1.21 the home will begin using [redacted] an electronic health record (E.H.R.) which will streamline the documentation and communication process and allow staff to spend more direct time for resident observations and assessments. The home will request a waiver from the Department for the use of Department Required Forms on the [redacted] E.H.R. An in-service will be held by May 31st to train staff in the use of [redacted].

227d - Support Plan Medical/Dental *(continued)*

Document Submission ***Implemented***

See attachments #4, 7, [redacted] Staff Training Sheet; Department Waiver for [redacted]

231c - Preadmission Screening

1. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, resident #3 did not have a written cognitive preadmission screening was completed.

Plan of Correction ***Accept***

231c – Preadmission Screening – Cog screen
Resident #3's no longer resides at the home so the preadmission screen cannot be corrected.
On 4.5.21 An audit of all resident records was completed by the D.O.N and Resident Care Director to assure that the needs of the resident can be met by the services provided by the home. (Attachment #7)
The wellness nurse or designee is responsible to complete the admissions checklist within 30 days of admission to assure that all documentation is accurate and completed according to 2600.224a.(Attachment #8)
On 5.6.21 the new Executive Director re-educated the D.O.N., Resident Care Director, and Memory Care Director on the requirements of 2600.224a and 2600.231c related to preadmission screening form and written cognitive screen. (Attachment # 4)
Going forward the D.O.N. or designee is responsible for completing the preadmission screen which includes documentation that the needs of the resident can be met by the services provided by the home.
By 6.1.21 the home will begin using [redacted], an electronic health record (E.H.R.) which will streamline the documentation and communication process and allow staff to spend more direct time for resident observations and assessments. The Preadmission screening form will be completed on the [redacted] E.H.R system which has programming that prohibits the prescreen from being saved if all required items are not completed. The home will request a waiver from the Department for the use of Department Required Forms on the [redacted] E.H.R. An in-service will be held by 6.1.21 to train staff in the use of [redacted].
The new Executive Director or designee will review all preadmission screening forms prior to filing in the resident chart.

Document Submission ***Implemented***

See attachments #4, 7, [redacted] Staff Training Sheet; Department Waiver for TabulaPro

231e - No Objection Statement

1. 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 SDCU on [redacted]. The documentation the resident and family have not objected to the admission was not signed by the resident.

231e - No Objection Statement *(continued)*

Plan of Correction ***Accept***

2600.231e
Resident #2 no longer resides in the home so the SDU no objection could not be corrected.

An audit will be completed by 6.1.21 to assure each resident record contains documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secure dementia care unit.

The Director of Community relations or designee is responsible to obtain the signatures from the respective parties that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secure dementia care unit. The Memory Care Director, Wellness Nurse or designee will complete the Admissions Checklist (Attachment 8) to assure the no objection documentation was completed for resident admitted or transferred to the SDU unit.

The Executive Director will review documentation for SDU admissions, no objection, at the monthly QA Meeting.

Document Submission ***Implemented***

See attachments # 8 and May QA Meeting

234a - Admission Support Plan

1. 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 #2 was admitted to the SDCU on [redacted] There is no RASP completed to identify the residents needs and services upon [redacted] admission.

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident did not have an initial support plan completed for admission to the SDCU.

Plan of Correction ***Accept***

234a – Admission Support Plan SDU 72 hours
Resident #3 no longer resides in the home so an additional assessment could not be completed.
On 5.6.21 the new Executive Director re-educated the D.O.N., Resident Care Director, Wellness Nurse and Memory Care Director on the requirements of 2600.234a related to the RASP and additional assessments annually. If the condition of the resident significantly changes prior to the annual assessment and/or at the request of the Department upon cause to believe than an update is required.
By 6.1.21 the home will begin using [redacted] an electronic health record (E.H.R.) which will streamline the documentation and communication process and allow staff to spend more direct time for resident observations and assessments. The home will request a waiver from the Department for the use of Department Required Forms on the [redacted] E.H.R. An in-service will be held to train staff in the use of [redacted]
The Memory Care Director or designee is responsible to complete the RASP within 72 hours for residents admitted or transferred to the SDU.
The Executive Director will review all new SDU RASPS at the monthly QA Meeting to assure completion within 72 hours.

234a - Admission Support Plan *(continued)*

Document Submission ***Implemented***

See attachments [redacted] Manager Training, Waiver for [redacted] May QA Meeting

251e - Records Availability

1. Requirements

2600.
251.e. Resident records shall be made available to the resident and the resident's designated person during normal working hours.

Description of Violation

Resident #3's designated person requested [redacted] record from staff member B. However the staff person refused to make the resident record available.

Plan of Correction ***Accept***

251e – Records Availability
The records for Resident #3 have been made available to the designated person as requested.
On 5.6.21 The new Executive Director re-educated all managers of regulation 2600.251e and the policy of Woodbridge Place related to records availability. (Attachment #4)
The Executive Director will be responsible to assure compliance with 2600.251e.

Document Submission ***Implemented***

See attachment #4

252 - Record Content

1. 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.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.

Description of Violation

Resident 1's record does not include color of hair, color of eyes, and identifying marks.

Resident 2's record does not include the assessment and support plan.

Plan of Correction ***Accept***

252 – Record Content – Face Sheet
Resident #1 has been discharged from the home.
An audit will be completed by 6.1.21 to assure that each resident face sheet contains all of the requirements of 2600.252.
Resident #2 no longer resides in the home.
On 4.5.21 an audit of all resident records was completed by the Resident Care Manager to assure that each resident's RASP is current and available. (Attachment #7)
By 6.1.21 the home will begin using [redacted] an electronic health record (E.H.R.) which will streamline the documentation and communication process and allow staff to spend more direct time for resident observations and assessments. The home will request a waiver from the Department for the use of Department Required Forms on the [redacted] E.H.R. An in-service will be held to train staff in the use of [redacted]

252 - Record Content *(continued)*

Document Submission ***Implemented***

See attachments #7, [redacted] Manager Training, Waiver for [redacted]

253a - Record 3 Years

1. Requirements

2600.
253.a. The resident's entire record shall be maintained for a minimum of 3 years following the resident's discharge from the home or until any audit or litigation is resolved.

Description of Violation

Resident #3 was discharged from the home on 12/19/20. However, the home is unable to provide the resident's DME's and preadmission screening.

Plan of Correction ***Accept***

253a – Records Maintained 3 Years
Resident #3 was discharged from the home on [redacted].
By 6.1.21 the home will begin using [redacted] an electronic health record (E.H.R.) which will streamline the documentation and communication process and allow staff to spend more direct time for resident observations and assessments. The home will request a waiver from the Department for the use of Department Required Forms on the [redacted] E.H.R. An in-service will be held to train staff in the use of [redacted]
The Business Office Coordinator or designee will be responsible to complete the Discharge Checklist upon resident discharge and maintain discharged resident records.
The Executive Director will complete random audits of discharged resident records.

Document Submission ***Implemented***

See attachments for [redacted] Manager Training and Waiver for TabulaPro