Department of Human Services
Bureau of Human Service Licensing

June 1, 2021

[redacted] WELLNESS DIRECTOR
AB DRESHER OPERATOR LLC
525 FELLOWSHIP ROAD, SUITE 360
MOUNT LAUREL, NJ 8054

RE: BRANDYWINE SENIOR LIVING AT DRESHER ESTATES
1405 NORTH LIMEKILN PIKE
DRESHER, PA, 19025
LICENSE/COC#: 14424

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/22/2021, 03/23/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Mia Johnson

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *BRANDYWINE SENIOR LIVING AT DRESHER ESTATES* **License #**: *14424* **License Expiration Date**: *07/02/2021*
Address: *1405 NORTH LIMEKILN PIKE, DRESHER, PA 19025*
County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: *2155914000* **Email**: [redacted]

Legal Entity

Name: *AB DRESHER OPERATOR LLC*
Address: *525 FELLOWSHIP ROAD, SUITE 360, MOUNT LAUREL, NJ, 8054*
Phone: *2155914000* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/25/2001* **Issued By**: *Commonwealth of PA, L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *111* **Waking Staff**: *83*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *03/23/2021*

Inspection Dates and Department Representative

03/22/2021 - On-Site: [redacted]
03/23/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *112* **Residents Served**: *77*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *25* **Residents Served**: *19*

Hospice

Current Residents: *7/23*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *75*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *34* **Have Physical Disability**: *0*

Inspections / Reviews

03/22/2021 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *04/25/2021*

4/30/2021 POC Submi ion

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

6/1/2021 - Document Submission

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

20b8 - Quarterly Account

1. Requirements

2600.

20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:

8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident s behalf on a quarterly basis.

Description of Violation

Residents are not provided a quarterly account of financial transactions.

Plan of Correction **Accept**

20b: Business Office Manager updated resident fund accounts and sent out the quarterly statements on 3/29/2021 for the first quarter of 2021. This will be monitored on a quarterly basis during Quality Management by the Business Office Manager or designee. An example of one of the quarterly statements is attached.
Completed: 3/29/2021 and ongoing quarterly

Completion Date: *03/29/2021*

Document Submission **Implemented**

20b: Business Office Manager updated resident fund accounts and sent out the quarterly statements on 3/29/2021 for the first quarter of 2021. This will be monitored on a quarterly basis during Quality Management by the Business Office Manager or designee. An example of one of the quarterly statements is attached.
Completed: 3/29/2021 and ongoing quarterly

63a - First Aid/CPR Training

1. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 03/07/21, 03/09/21, 03/10/21, 03/12/21, 03/16/21, 03/17/21 and 03/20/21, from 11:30 pm to 7:00 am, approximately 77 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

Plan of Correction **Accept**

63a: On 3/23/2021 the Wellness Director provided CPR re certification training to direct care staff who work the overnight shift so the community could remain in compliance with the regulation. Wellness Director or designee will review list of CPR trained staff during Quarterly Quality Management Meetings to assist with further compliance. The training sheet, CPR cards and Wellness Director s CPR credentials are attached.
Completed: 3/23/2021 and ongoing quarterly

Completion Date *03/23/2021*

63a - First Aid/CPR Training *(continued)*

Document Submission **Implemented**

63a: On 3/23/2021 the Wellness Director provided CPR re-certification training to direct care staff who work the overnight shift so the community could remain in compliance with the regulation. Wellness Director or designee will review list of CPR trained staff during Quarterly Quality Management Meetings to assist with further compliance.
The training sheet, CPR cards and Wellness Director's CPR credentials are attached.
Completed: 3/23/2021 and ongoing quarterly

65a - FS Orientation 1st Day

1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

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

Description of Violation

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

Plan of Correction **Accept**

65a: On 3/26/2021, staff person "A" has since received training on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.
Business office manager or designee will audit staff files by 5/7/2021 to check for compliance with orientation training and topics. Business office manager or designee will utilized a tickler to track orientation training and topics for new staff.
Files for newly hired staff each quarter, will be reviewed by Business Office Manager or designee at Quality Management.
n service sheet is attached, as well as copy of the tickler file.
Completed: 3/26 /2021; 5/7/2021; quarterly

Completion Date: *03/26/2021*

65a - FS Orientation 1st Day *(continued)*

Document Submission **Implemented**

65a: On 3/26/2021, staff person "A" has since received training on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Business office manager or designee will audit staff files by 5/7/2021 to check for compliance with orientation training and topics. Business office manager or designee will utilized a tickler to track orientation training and topics for new staff.

Files for newly hired staff each quarter, will be reviewed by Business Office Manager or designee at Quality Management.

n service sheet is attached, as well as copy of the tickler file.

Completed: 3/26 /2021; 5/7/2021; quarterly

65b - Rights/Abuse 40 Hours

1. **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 A completed [redacted] 40th scheduled work hour in November 2019. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Plan of Correction **Accept**

65b: On 3/ 26 /2021, staff person "A" has since received training on the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Business office manager or designee will audit staff files by 5/7/2021 to check for compliance with orientation training and topics. Business office manager or designee will utilized a tickler to track orientation training and topics for new staff.

Files for newly hired staff each quarter, will be reviewed by Business Office Manager or designee at Quality Management.

In service sheet is attached, as well as copy of the tickler file.

Completed: 3/ 26 /2021; 5/7/2021; quarterly

Completion Date: *03/26/2021*

65b - Rights/Abuse 40 Hours *(continued)*

Document Submission **Implemented**

65b: On 3/ 26 /2021, staff person "A" has since received training on the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.
Business office manager or designee will audit staff files by 5/7/2021 to check for compliance with orientation training and topics. Business office manager or designee will utilized a tickler to track orientation training and topics for new staff.
Files for newly hired staff each quarter, will be reviewed by Business Office Manager or designee at Quality Management.
In service sheet is attached, as well as copy of the tickler file.
Completed: 3/ 26 /2021; 5/7/2021; quarterly

65e - 12 Hours Annual Training

1. **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.

Description of Violation

Direct care staff person B received only 9.75 hours of annual training in training year 2019.

Plan of Correction **Accept**

65e: The remaining training hours for staff person B were conducted and documented on 4/6 /2021. The administrator or designated staff person will monitor all direct care staff training through the quality management review process to ensure all staff persons receive the required amount of hours in accordance with regulation 2600.65(e) during each established training year.
The training sheet is attached.
Completed:4/6/2021 and ongoing quarterly through Quality Management

Completion Date: *04/06/2021*

Document Submission **Implemented**

65e: The remaining training hours for staff person B were conducted and documented on 4/6 /2021. The administrator or designated staff person will monitor all direct care staff training through the quality management review process to ensure all staff persons receive the required amount of hours in accordance with regulation 2600.65(e) during each established training year.
The training sheet is attached.
Completed:4/6/2021 and ongoing quarterly through Quality Management

65f - Training Topics

1. **Requirements**

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.

65f - Training Topics *(continued)*

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 B 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 during training year 2019.

Plan of Correction **Accept**

65f: Staff person B received training on Med Self Administration and Meeting the needs of the Resident as described in the RASP and DME on 4/6/2021. The administrator or designated staff person will monitor all direct care staff training through the quality management review process to ensure all staff persons receive the required trainings in accordance with regulation 2600.65(f) during each established training year.
The training sheet is attached.
Completed: 4/6/2021 and ongoing quarterly through Quality Management

Completion Date: *04/06/2021*

Document Submission **Implemented**

65f: Staff person B received training on Med Self Administration and Meeting the needs of the Resident as described in the RASP and DME on 4/6/2021. The administrator or designated staff person will monitor all direct care staff training through the quality management review process to ensure all staff persons receive the required trainings in accordance with regulation 2600.65(f) during each established training year.
The training sheet is attached.
Completed: 4/6/2021 and ongoing quarterly through Quality Management

82c - Locking Poisonous Materials

1. **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

Pronamel and Colgate Toothpaste, Selan plus diaper rash cream and Moisture barrier Antifungal cream, with a manufacture's label indicating "if swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to residents in the secured unit (Reflections). Not all the residents of the home, have been assessed capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials *(continued)*

Plan of Correction **Accept**

82c: The items found during the inspection walkthrough were immediately removed. On the same day, all apartments in memory care were checked by the Assistant Wellness Director for compliance. All items in question were locked in a separate room.
Staff were in serviced on 3/24/2021 regarding locking and monitoring for poisonous materials. By 4/20/2021 all of the apartments in memory care were re-fitted with locks on the vanity cabinets under the bathroom sinks, to assist with further compliance. Assistant Wellness Director or designee will make routine rounds to monitor for ongoing compliance.
The training sheet is attached.

Completed: 3/24/2021, by 4/20/2021; ongoing routinely.

Completion Date: *03/24/2021*

Document Submission **Implemented**

82c: The items found during the inspection walkthrough were immediately removed. On the same day, all apartments in memory care were checked by the Assistant Wellness Director for compliance. All items in question were locked in a separate room.
Staff were in serviced on 3/24/2021 regarding locking and monitoring for poisonous materials. By 4/20/2021 all of the apartments in memory care were re-fitted with locks on the vanity cabinets under the bathroom sinks, to assist with further compliance. Assistant Wellness Director or designee will make routine rounds to monitor for ongoing compliance.
The training sheet is attached.

Completed: 3/24/2021, by 4/20/2021; ongoing routinely.

89b - Hot Water Temperature

1. **Requirements**

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 03/23/21, the hot water temperature at the bathroom sink in room [redacted] of the Reflections unit measured 124.3 degrees Fahrenheit.
On 03/23/21, the hot water temperature at the bathroom sink in room [redacted] of the Reflections unit measured 122.3 degrees Fahrenheit.
On 03/23/21, the hot water temperature at the bathroom sink in room [redacted] of the Reflections unit measured 128.3 degrees Fahrenheit.
On 03/23/21, the hot water temperature at the bathroom sink in rooms [redacted] and [redacted] measured 125.6 degrees Fahrenheit.

89b - Hot Water Temperature *(continued)*

Plan of Correction **Accept**

89b: Beginning the week of 3/22/2021, the Maintenance Director or designee instituted weekly water temperatures. These readings are documented in the TELS system. Additionally, the mixing valve for the boiler was replaced on 4/9/2021 to assist with further compliance on the regulation of the water temperatures.
A weekly log from the TELS system is attached.
Completed: Week of 3/23/2021 and 4/9/2021, ongoing weekly

Completion Date: *03/23/2021*

Document Submission **Implemented**

89b: Beginning the week of 3/22/2021, the Maintenance Director or designee instituted weekly water temperatures. These readings are documented in the TELS system. Additionally, the mixing valve for the boiler was replaced on 4/9/2021 to assist with further compliance on the regulation of the water temperatures.
A weekly log from the TELS system is attached.
Completed: Week of 3/23/2021 and 4/9/2021, ongoing weekly

91 - Telephone Numbers

1. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in room [redacted].

Plan of Correction **Accept**

91a: The emergency telephone numbers were placed on the resident's phone on 3/23/2021. The Maintenance Director did a walkthrough of all residents' apartments checking for emergency telephone numbers and ensuring they were all compliant. Director of Community Relations will provide emergency telephone numbers to residents upon their move into the community. Maintenance Director or designee will check apartments for emergency telephone numbers as a part of quarterly Quality Management.
Quarterly monitoring tool attached
Completed: 3/23/2021; time of move in; quarterly ongoing

Completion Date: *03/23/2021*

Document Submission **Implemented**

91a: The emergency telephone numbers were placed on the resident's phone on 3/23/2021. The Maintenance Director did a walkthrough of all residents' apartments checking for emergency telephone numbers and ensuring they were all compliant. Director of Community Relations will provide emergency telephone numbers to residents upon their move into the community. Maintenance Director or designee will check apartments for emergency telephone numbers as a part of quarterly Quality Management.
Quarterly monitoring tool attached
Completed: 3/23/2021; time of move in; quarterly ongoing

141b1 - Annual Medical Evaluation

1. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #1's most recent medical evaluation was completed on 10/20/20 due to a status change. The resident's annual medical evaluations were completed on 05/14/19 and 06/18/20.

Plan of Correction **Accept**

141b1: Although DME in question was annual; the resident has a current DME for change of condition. The Wellness Director or designee will audit all DME's by 5/7/2021 for completeness and accuracy. On an ongoing basis, the Wellness Director or designee will audit DME's monthly using an audit tool. Also ongoing, Wellness Director or designee will communicate with appropriate PCP and make notation in the resident's file for any DME's that are affected by this suspended regulation.
Audit tool attached. Completed: 5/7/2021; ongoing monthly

Completion Date: *05/07/2021*

Document Submission **Implemented**

141b1: Although DME in question was annual; the resident has a current DME for change of condition. The Wellness Director or designee will audit all DME s by 5/7/2021 for completeness and accuracy. On an ongoing basis, the Wellness Director or designee will audit DME s monthly using an audit tool. Also ongoing, Wellness Director or designee will communicate with appropriate PCP and make notation in the resident s file for any DME s that are affected by this suspended regulation.
Audit tool attached. Completed: 5/7/2021; ongoing monthly

171b5 First Aid Kit

1. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

There was no first aid kit in the Lincoln Town Car used to transport residents.

Plan of Correction **Accept**

171b5: The first aid kit for the Town Car was placed back in the vehicle on 3/23/2021. The vehicle will be checked weekly by the Chauffer or designee to assist in ensuring the first aid kit remains in the vehicle and contains all the required items.
Competed: 3/23/2021 and ongoing weekly

Completion Date *03/23/2021*

171b5 - First Aid Kit *(continued)*

Document Submission **Implemented**

171b5: The first aid kit for the Town Car was placed back in the vehicle on 3/23/2021. The vehicle will be checked weekly by the Chauffer or designee to assist in ensuring the first aid kit remains in the vehicle and contains all the required items.
Competed: 3/23/2021 and ongoing weekly

187a - Medication Record

1. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #2's PRN medication Hydrocortisone 1% Cream was discontinued on 11/24/20. However, the medication is listed on the resident's March 2021 medication administration record.

Plan of Correction **Accept**

187a: All nurses were in serviced on Regulations 181a through 191 relating to medication record and medication administration on 3/24, 3/25, and 3/26/2021. The medication is no longer listed on the MAR as of 4/18/2021. Overnight Wellness Nurses or designee will audit the Medication Administration Record and medication carts on a monthly basis to assist with ongoing compliance. Training sheet, copy of the MAR , and audit tool attached. Completed: 3/24, 3/25, 3/26, and 4/18/2021; ongoing on a monthly basis

Completion Date: *04/18/2021*

Document Submission **Implemented**

187a: All nurses were in serviced on Regulations 181a through 191 relating to medication record and medication administration on 3/24, 3/25, and 3/26/2021. The medication is no longer listed on the MAR as of 4/18/2021. Overnight Wellness Nurses or designee will audit the Medication Administration Record and medication carts on a monthly basis to assist with ongoing compliance. Training sheet, copy of the MAR , and audit tool attached. Completed: 3/24, 3/25, 3/26, and 4/18/2021; ongoing on a monthly basis

225a - Assessment 15 Days

1. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for resident #3, who was admitted to the home on [redacted]

Plan of Correction **Accept**

225a: Resident Assessment and Support Plan for resident #3 was completed and reviewed with resident on 3/25/2021. Chart audit will be completed by Wellness Director or designee by 5/7/2021 to ensure each chart has an up to date RASP. All new residents' charts will be audited for RASP compliance during that quarter's Quality Management Meeting.
Audit tool attached

Completed: 3/25/2021 and 5/7/2021 and quarterly at Quality Management

Completion Date: *03/25/2021*

Document Submission **Implemented**

225a: Resident Assessment and Support Plan for resident #3 was completed and reviewed with resident on 3/25/2021. Chart audit will be completed by Wellness Director or designee by 5/7/2021 to ensure each chart has an up to date RASP. All new residents' charts will be audited for RASP compliance during that quarter's Quality Management Meeting.
Audit tool attached

Completed: 3/25/2021 and 5/7/2021 and quarterly at Quality Management

227a - Support Plan 30 Days

1. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #3 was admitted on [redacted]*; however, the resident's initial support plan has not been completed.*

227a - Support Plan 30 Days *(continued)*

Plan of Correction **Accept**

227a: Resident Assessment and Support Plan for resident #3 was completed and reviewed with resident on 3/25/2021. Chart audit will be completed by Wellness Director or designee by 5/7/2021 to ensure each chart has an up to date RASP. All new residents' charts will be audited for RASP compliance during that quarter's Quality Management Meeting.
Audit tool attached
Completed: 3/25/2021 and 5/7/2021 and quarterly at Quality Management

Completion Date: *03/25/2021*

Document Submission **Implemented**

227a: Resident Assessment and Support Plan for resident #3 was completed and reviewed with resident on 3/25/2021. Chart audit will be completed by Wellness Director or designee by 5/7/2021 to ensure each chart has an up to date RASP. All new residents' charts will be audited for RASP compliance during that quarter's Quality Management Meeting.
Audit tool attached
Completed: 3/25/2021 and 5/7/2021 and quarterly at Quality Management

233c - Key-Locking Devices

1. **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 four emergency exit doors in the Secure Dementia Care Unit (SDCU).

Plan of Correction **Accept**

233c: The directions/code for operating the locked doors in memory care was posted on 3/24/2021. This will be monitored by the Assistant Wellness Director or designee through routine rounds of the neighborhood.
A picture of the posted direction(s) is attached.
Completed: 3/24/2021 and ongoing quarterly

Completion Date: *03/24/2021*

Document Submission **Implemented**

233c: The directions/code for operating the locked doors in memory care was posted on 3/24/2021. This will be monitored by the Assistant Wellness Director or designee through routine rounds of the neighborhood.
A picture of the posted direction(s) is attached.
Completed: 3/24/2021 and ongoing quarterly

236 - Staff Training

1. **Requirements**

2600.

236 - Staff Training *(continued)*

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 B, who works in the Secure Dementia Care Unit (SDCU) had only 1.75 hours of training in dementia care during the 2019 training year.

Plan of Correction **Accept**

236: Staff person "B" will receive 6 hours of Memory Care training by 5/7/2021. The administrator or designated staff person will monitor all direct care staff training through the quality management review process to ensure all staff persons receive the required trainings in accordance with regulation 2600.236, during each established training year.
Completed: 5/7/2021, ongoing quarterly

Completion Date: *05/07/2021*

Document Submission **Implemented**

236: Staff person "B" will receive 6 hours of Memory Care training by 5/7/2021. The administrator or designated staff person will monitor all direct care staff training through the quality management review process to ensure all staff persons receive the required trainings in accordance with regulation 2600.236, during each established training year.
Completed: 5/7/2021, ongoing quarterly

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.
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.

252 - Record Content *(continued)*

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.

Description of Violation

Resident #3's record does not include the initial intake assessment or a support plan.

Plan of Correction **Accept**

252: Resident Assessment and Support Plan for resident #3 was completed and reviewed with resident on 3/25/2021.
Chart audit will be completed by Wellness Director or designee by 5/7/2021 to ensure each chart has an up to date RASP. All new residents' charts will be audited for RASP compliance during that quarter's Quality Management Meeting.
Audit tool attached
Completed: 3/25/2021 and 5/7/2021 and quarterly at Quality Management

Completion Date: *03/25/2021*

Document Submission **Implemented**

252: Resident Assessment and Support Plan for resident #3 was completed and reviewed with resident on 3/25/2021.
Chart audit will be completed by Wellness Director or designee by 5/7/2021 to ensure each chart has an up to date RASP. All new residents' charts will be audited for RASP compliance during that quarter's Quality Management Meeting.
Audit tool attached
Completed: 3/25/2021 and 5/7/2021 and quarterly at Quality Management