pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **HERITAGE SPRINGS MEMORY CARE INC**
LEGAL ENTITY

To operate **HERITAGE SPRINGS MEMORY CARE**
NAME OF FACILITY OR AGENCY

Located at **327 FARLEY CIRCLE, LEWISBURG, PA 17837**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **64**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

PROVISIONAL

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 64**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **August 4, 2023** until **February 4, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **225981**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: [redacted]

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: AUGUST 4, 2023

[redacted]
Heritage Springs Memory Care Inc
[redacted]

RE: Heritage Springs Memory Care
License #: 225981

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on April 12, 2023, April 13, 2023, May 3, 2023, May 9, 2023, May 18, 2023, June 6, 2023,June 15, 2023 and June 27, 2023 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 225980) dated March 22, 2023, to March 22, 2024, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated March 22, 2023, to March 22, 2024, is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to <62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from August 4, 2023 to February 4, 2024.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 or 2800 Section:	Class of Violation	Census at Inspection	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
16c	II	30	$5	$150	5 calendar days form mailing date of this letter
42b	II	30	$5	$150	5 calendar days from mailing date of this letter
182b	II	30	$5	$150	5 calendar days from mailing date of this letter
231b	III	30	$3	$90	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary>

cc: [redacted]

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

Facility Information

Name: *HERITAGE SPRINGS MEMORY CARE* **License #**: *22598* **License Expiration**: *03/22/2024*

Addre : *327 FARLEY CIRCLE, LEWISBURG, PA 17837*

County: *UNION* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *HERITAGE SPRINGS MEMORY CARE INC*

Address: *327 FARLEY CIRCLE, LEWISBURG, PA, 17837*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *01/03/2017* **Issued By**: *Central keystone*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *60* **Waking Staff**: *45*

Inspection Information

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

Reason: *Complaint, Monitoring* **Exit Conference Date**: *06/27/2023*

Inspection Dates and Department Representative

06/27/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *30*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *30* **Capacity**: *all* **Residents Served**: *30*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *30*

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

Have Mobility Need: *30* **Have Physical Disability**: *0*

Inspections / Reviews

06/27/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/28/2023*

Inspections / Reviews *(continued)*

07/28/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/01/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/01/2023*

08/02/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/01/2023*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

60a - Staff/Support Plan

1. 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

The home currently serves 30 residents in a secured setting. 2 of these residents need assistance of 2, 1 resident needs assistance of 1 to transfer out of bed, 6 use wheelchairs, and all need cueing to evacuate during an emergency. Once the residents have evacuated, one staff person must remain with the residents at all times when not inside the locked unit.
On [redacted]/23, per the homes time sheet time, staff person A worked from 6:25pm to [redacted]/23 to 6:13am. In the event of an emergency the home does not have enough staff to meet the needs of the residents.

Plan of Correction ***Accept ([redacted] - 07/28/2023)***

Our nursing schedule has always had at least two staff members scheduled for night shift. On this particular night the med tech in charge felt it was quiet so [redacted] permitted the second staff member to go home indicating all was good. Executive Director stressed to the med tech the importance of having adequate staff on each shift in case of an emergency. Since 6/21/23 we now have 3 staff scheduled for 3rd shift to meet regulations. Executive Director alone with Resident Care Director will review schedule daily to make sure adequate staff is scheduled and if not, utilize the services of an outside agency.

Licensee's Proposed Overall Completion Date: *07/26/2023*

Not Implemented ([redacted] - 08/02/2023)

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *HERITAGE SPRINGS MEMORY CARE* **License #**: *22598* **License Expiration**: *03/22/2024*

Addre : *327 FARLEY CIRCLE, LEWISBURG, PA 17837*

County: *UNION* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *HERITAGE SPRINGS MEMORY CARE INC*

Address: *327 FARLEY CIRCLE, LEWISBURG, PA, 17837*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *01/03/2017* **Issued By**: *Central Keystone*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *62* **Waking Staff**: *47*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *06/06/2023*

Inspection Dates and Department Representative

06/06/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *31*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire Home* **Capacity**: *64* **Residents Served**: *31*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *31*

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

Have Mobility Need: *31* **Have Physical Disability**: *0*

Inspections / Reviews

06/06/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/23/2023*

Inspections / Reviews *(continued)*

06/23/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/26/2023*

Reviewer [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/28/2023*

06/26/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/26/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/02/2023*

07/31/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/26/2023*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted]/23 there was an incident in the home in which resident #1 threatened resident #2 stating that they were going to kill them and their family which frightened resident #2. The home did not report the incident to the department's regional office until [redacted]/23.

Plan of Correction ***Accept ([redacted] 06/23/2023)***

Incident report was completed on [redacted]/23. We did not report the incident because there were not any injuries. In speaking with [redacted] recommended anytime there was a resident to resident interaction, we need to submit an incident report. All staff were educated on the importance of doing just this. Resident Care Director and Executive Director will review daily report and all incidents to ensure timely reporting is completed.

Licensee's Proposed Overall Completion Date: *06/20/2023*

Not Implemented [redacted] - 07/31/2023)

57c - 2 Hours/Day

2. Requirements

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

The home had a census of 31 residents on 6/5/23, all of which have mobility needs due to residing in a secure dementia home. On 6/5/23 the home's total number of direct care hours provided was 49. The home's required minimum number of direct care hours for 6/5/23 was 62.

Plan of Correction ***Accept [redacted] - 06/26/2023)***

Staff schedule for 6/5/23 was adequate for number of residents but due to call offs and no shows, we were below required hours. We did, however utilize maintenance, admin asst, housekeeping [redacted] was on light duty) to assist with transporting residents, performing laundry, etc. but executive director was told we could not count these hours. Also, one of our residents has a caregiver for 3 days a week during dayshift as well as 7 days a week overnight which is not counted in the total as well. However, executive director and Resident Care Director will ensure staffing levels are maintained at all times.

Licensee's Proposed Overall Completion Date: *06/23/2023*

Not Implemented [redacted] - 07/31/2023)

231b - Medical Evaluation

3. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #1 was admitted to the home on [redacted]. The resident's documentation of medical evaluation (DME) form

231b - Medical Evaluation (continued)

was completed [redacted]/23 and does not indicate the resident requires a secure dementia unit. Another DME was completed on [redacted]23 which was not completed prior to the resident's admission to the home.

Plan of Correction ***Accept [redacted] - 06/26/2023)***

DME was completed prior to admission by family physician. Resident chose our in house physician which required a second DME to be completed. Resident Care Director and Executive Director will double check all paperwork for admissions to ensure all areas are completed prior to admission.

Licensee's Proposed Overall Completion Date: *06/23/2023*

Not Implemented [redacted] - 07/31/2023)

231c - Preadmission Screening

4. 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 #1 was admitted to the home on [redacted] The home did not have a cognitive screening completed until [redacted]/23.

Plan of Correction ***Accept [redacted] - 06/26/2023)***

Resident Care Director indicated assessment was done on [redacted]/23. Resident chose house physician to follow [redacted] care. PCP completed pre admission assessment and DME but house physician could not sign until [redacted] returned from vacation. Resident Care Director and Executive Director will monitor all admissions for compliance.

Licensee's Proposed Overall Completion Date: *06/23/2023*

Implemented [redacted] - 07/31/2023)

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

Facility Information

Name: *HERITAGE SPRINGS MEMORY CARE* **License #**: *22598* **License Expiration**: *03/22/2024*

Addre : *327 FARLEY CIRCLE, LEWISBURG, PA 17837*

County: *UNION* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *HERITAGE SPRINGS MEMORY CARE INC*

Address: *327 FARLEY CIRCLE, LEWISBURG, PA, 17837*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *01/03/2017* **Issued By**: *Central Keystone*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *64* **Waking Staff**: *48*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *06/20/2023*

Inspection Dates and Department Representative

05/03/2023 - On-Site: [redacted]
05/09/2023 - On-Site:
05/18/2023 - On-Site:
06/15/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *32*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *The entire home* **Capacity**: *64* **Residents Served**: *32*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *32*

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

Have Mobility Need: *32* **Have Physical Disability**: *0*

Inspections / Reviews

05/03/2023 - Partial

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *07/08/2023*

07/18/2023 POC Submi ion

Submitted By: [redacted] **Date Submitted:** *07/26/2023*

Reviewer [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *07/25/2023*

08/01/2023 Document Submi ion

Submitted By: [redacted] **Date Submitted:** *07/26/2023*

Reviewer: [redacted] **Follow Up Type:** *Enforcement*

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

Interviews with staff determined that staff person A had grabbed/patted resident #1's [redacted] and stated, "you have a [redacted] Staff person A also made sexually inappropriate statements to resident #2 and would tease resident #2 until they became very agitated and upset. It was determined that these incidents were reported to staff person D, who failed to make a mandatory abuse report to the Area Agency on Aging, as required under this regulation.

Plan of Correction ***Accept [redacted] 07/18/2023)***

1. Staff Person A was counseled immediately when the Resident Care Director learned third hand that [redacted] patted resident #1. At the time of the incident, no mention of a body part or comments made to resident was reported. During staff member #1's 90 day evaluation on [redacted]/23 a discussion was held regarding the importance of being cautious with the way they talk and behaviors around residents. Staff were inserviced by the ombudsman from Area Agency on Aging on [redacted]/23 on resident rights as well as Protective Services from Area Agency on Aging held training on [redacted]/23 on resident rights, abuse training and mandatory reporting requirements. Staff will be nserviced again every 6 months on resident rights, the importance of reporting any alleged abuse so that the Executive Director can begin an internal investigation immediately and notify AAA and DHS.

Resident #2 is known for joking with staff and has been reminded multiple times to watch what [redacted] says and does to staff. This resident is alert and oriented at times and has been redirected when [redacted] makes inappropriate comments to staff. A discussion occurred with Staff Person A during [redacted] 90 day evaluation on [redacted] 23 to be mindful of taking oking too far. At no point was Staff person D made aware that inappropriate comments were made that upset resident and caused agitation resident became agitated or upset by these incidences. AAA Protective Services and the Ombudsman conducted mandatory training sessions on [redacted] 23 and [redacted]/23 on resident abuse, resident rights and mandatory reporting to all staff. Immediately after we were notified, Executive Director and Busines Manager met with each Staff member to see if any of them were aware of inappropriate behavior or photos/videos being taken and were asked to submit a written statement regarding any knowledge. Not a single staff member acknowledged they were aware of any behaviors, photos or videos. These witness statements will be submitted after plan of correction is accepted. Staff were also reeducated on the importance of reporting allegations to both their mmediate supervisor and executive director immediately, resident rights, confidentlity and a revised cell phone policy. Staff signed each policy to acknowledge the fact these were reviewed. Resident Care Director and Executive Director will immediately report any allegations of abuse to AAA and BHS. Staff will be required to attend mandatory training every six months on the importance of reporting anything they see to their supervisor mmediately and documenting incident so it can be addressed immediately. Executive Director will be responsible for compliance with this regulation. We are planning to hire an LPN to assist in training in the near future,

Licensee's Proposed Overall Completion Date: *12/01/2023*

16c - Written Incident Report

2. Requirements

2600.

16c - Written Incident Report *(continued)*

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Interviews with staff determined that staff person A had grabbed/patted resident #1's [redacted] and stated, "you have a [redacted]". Staff person A also made sexually inappropriate statements to resident #2 and would tease resident #2 until they became very agitated and upset. It was determined that these incidents were reported to staff person D, who failed to report these alleged rights violations to the Department, as required under this regulation.

Interviews with staff also determined that staff members A, B and C were witnessed making fun of residents and acting inappropriately toward them on multiple occasions. Staff interviews determined that these incidents were brought to the attention of staff person D, who failed to report them to the Department, as required under this regulation.

Plan of Correction ***Accept [redacted] - 07/18/2023)***

Staff Person A was counseled by Resident Care Director for patting resident #1. At the time of the incident no body part or comments made to the resident was reported. Immediately after we were informed of the incident on [redacted]/23 Executive Director and Business Manager met with every staff member individually to interview them regarding any knowledge they may have had regarding behaviors or photos/videos taken by any staff member. Each member submitted a written statement and noone admitted at that time they were aware of any. These statements will be submitted once plan of correction is approved. During staff member #1's 90 day evaluation on [redacted]/23 a discussion was held regarding the importance of being cautious with the way they talk and behaviors around residents. Staff were inserviced by the ombudsman from Area Agency on Aging on [redacted]/23 on resident rights as well as Protective Services from Area Agency on Aging on [redacted]23 on resident rights, abuse training and mandatory reporting requirements. Staff will be inserviced every 6 months on resident rights, the importance of reporting any alleged abuse and Executive Director will begin an internal investigation immediately and notify AAA and DHS. Plans are in place to hire a per diem LPN to assist in staff training.

Resident #2 is known for joking with staff person A and B and has been reminded multiple times to watch what [redacted] says and does to staff. Staff Person A & B were talked with during their 90 day evaluation on [redacted]23 to be mindful of taking joking too far. At no point was Staff person D made aware that resident became agitated or upset by these incidences. AAA Protective Services and the Ombudsman conducted mandatory training sessions on [redacted] and [redacted]/23 on resident abuse, resident rights and mandatory reporting to all staff. Immediately when being notified of incident, Executive Director and Business Manager met with staff individually to determine if they had any knowledge of inappropriate behavior or photos/videos that were being taken by staff. Each member was asked to write their knowledge in a statement which will be submitted after the plan of correction is approved. At the same time Staff were re educated on the importance of reporting allegations to both their immediate supervisor and executive director immediately, right rights, confidentiality and the new cell phone policy and signed policies acknowledging they reviewed them. Resident Care Director and Executive Director will immediately report any allegations of abuse to AAA and DHS. Staff will be inserviced every six months on the importance of reporting anything they see to their supervisor immediately and documenting incident so it can be addressed immediately.

Plans are to hire an LPN per diem to assist with training.

Staff members A & B had a tendency to joke with residents to make them laugh. A discussion was held with both

16c - Written Incident Report (continued)

staff members on [redacted] 23 stressing they must be cautious and there is a fine line that cannot be crossed. Behavior was addressed with both Staff members A & B. At no time was any issues regarding Staff member C brought to the attention of the Resident Care Director nor Executive Director. Staff member A, B, & C were involved in the training provided by Area Agency on Aging Ombudsman and Protective Services regarding resident rights, abuse and mandatory reporting held on [redacted] and [redacted] 23. Staff will receive mandatory training on resident rights, abuse and mandatory training every 6 months. Executive Director will be responsible to ensure compliance with this regulation and immediately investigate any concerns brought to [redacted] attention.

Licensee's Proposed Overall Completion Date: *12/01/2023*

42b - Abuse

3. 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

An investigation by the Department determined that resident #1 was sexually abused as staff person A was witnessed to have grabbed/patted the resident's [redacted] and told them "You have a [redacted] Staff person A also made sexually inappropriate statements to resident #2, which is considered sexual harassment.

The investigation by the Department also determined that staff person A used their personal cell phone to take pictures and videos of 18 different residents (Resident [redacted] thru [redacted]) at the home while working as a direct care staff person. These photos/videos taken by staff person A included residents who were nude and being showered/toileted. They also included a picture of a staff person pinching resident [redacted]s nose. The residents involved reside in an all-secure dementia unit.

Interviews with staff also determined that staff persons A and B were verbally abusive towards residents. Residents were emotionally abused by staff persons A and B through teasing and by staff person B taking a resident #[redacted]s doll away from the resident, banging the doll's head off a table and telling the resident "You don't think this is real, do you?"

Plan of Correction ***Accept [redacted] 07/18/2023)***

Staff Person A was counseled by Resident Care Director for patting resident #1 immediately when this was reported to [redacted]. At the time of the incident, no mention of comment made to resident was reported. Immediately after we were informed of the incident on [redacted]/23 Executive Director and Business Manager met with every staff member individually to interview them regarding any knowledge they may have had regarding behaviors or photos/videos taken by any staff member. Each member submitted a written statement and noone admitted at that time they were aware of any. These statements will be submitted once plan of correction is approved. During staff member #1's 90 day evaluation on [redacted]/23 a discussion was held regarding the importance of being cautious with the way they talk and behaviors around residents. Staff were inserviced by the ombudsman from Area Agency on Aging on [redacted]/23 on resident rights as well as Protective Services from Area Agency on Aging on [redacted]5/23 on resident rights, abuse

42b - Abuse (continued)

training and mandatory reporting requirements. Staff will be inserviced every 6 months on resident rights, the mportance of reporting any alleged abuse and Executive Director will begin an internal investigation immediately and notify AAA and DHS. Plans are in place to hire a per diem LPN to assist in staff training.

Resident #2 is known for joking with staff person A and B and has been reminded multiple times to watch what [redacted] says and does to staff. Resident is alert and oriented and has been redirected on several occasions regarding comments made to staff. Discussions with Staff Person A & B were held during their 90 day evaluation on [redacted]/23 to be mindful of taking joking too far. At no point was Staff person D made aware that resident became agitated or upset by these incidences. AAA Protective Services and the Ombudsman conducted mandatory training sessions on3/23 and 5/25/23 on resident abuse, resident rights and mandatory reporting to all staff. Immediately after we were informed of the incident, Executive Director and Business Manager met with each staff member separately on [redacted]/23 to determine if they had any knowledge of behaviors or photos/videos from any staff. Staff were also asked to write a statement to any knowledge they had. No staff member indicated in their statements to any knowledge. These statements will be submitted after the plan of correction is approved. At the same time, staff were reeducated on the importance of reporting allegations to both their immediate supervisor and executive director immediately, new cell phone policy, resident rights, confidentiality and signed the policy to indicate they were aware of the policies. Resident Care Director and Executive Director will immediately report any allegations of abuse to AAA and BHS. Staff will be inserviced every six months on the importance of reporting anything they see to their supervisor mmediately and documenting incident so it can be addressed immediately. An LPN will be hired per diem to assist with staff training in the near future.

During staff member #1's 90 day evaluation on [redacted]/23 a discussion was held regarding the importance of being cautious with the way [redacted] talks and behaviors around residents. Staff were inserviced by the ombudsman from Area Agency on Aging on resident rights as well as Protective Services from Area Agency on Aging on [redacted] and [redacted]/23 on resident rights, abuse training and mandatory reporting requirements. Staff will be required to attend mandatory nservices every 6 months on the importance of reporting any alleged abuse and Executive Director will begin an nternal investigation immediately and notify AAA and DHS. Plans are to hire an LPN per diem to assist with training.

Staff Person A was immediately suspended on [redacted]/23 when Executive Director was made aware of incident regarding cell phone. An internal investigation was initiated by the Executive Director and supervisor, Business Manager. Interviews were conducted with all staff on [redacted]23 and all were asked to write a statement as to any knowledge of inappropriate behavior or photos or videos being taken by any staff member. No staff member acknowledged that they were aware of behaviors or photos being taken. AAA and DHS were both notified mmediately.

Resident #2 is known for joking with staff and has been reminded multiple times to watch what [redacted] says and does to staff. Staff Person A & B were educated during their 90 day evaluation on [redacted]23 to be mindful of taking joking too far. At no point was Staff person D made aware that resident became agitated or upset by these incidences. AAA Protective Services and the Ombudsman conducted mandatory training sessions on [redacted] and [redacted]/23 on resident abuse, resident rights and mandatory reporting to all staff. Staff were educated on [redacted]/23 on the importance of reporting allegations to both their immediate supervisor and executive director immediately and writing a witness statement if they had any knowledge of any staff member taking photos or any behavior issues. No staff member reported they had any knowledge. Staff Person A used [redacted] personal cell phone to take pictures and videos of residents which is a violation of the facility cell phone policy. This policy was updated twice since the incident and

42b - Abuse (continued)

now all staff are required to either keep their cell phone in the personal vehicle or in a locked storage cabinet located near the time clock. Resident Care Director and Executive Director will conduct rounds to ensure cell phones are not n resident areas and policy is being enforced. Staff person B was also counseled regarding treating residents with dignity and respect by both Resident Care Director and Executive Director during [redacted] 90 day evaluation on [redacted] /23. Staff who had first hand knowledge of the incident would not document the incident or come to the Resident Care Director or Executive Director so the incident could be investigated. Executive Director did speak with Staff person B regarding the incident and [redacted] told this writer that [redacted] denied hitting the baby on the table. Staff were interviewed ndividually on [redacted] 23 and all denied witnessing anything. Written statements were obtained and will be submitted once the plan of correction is approved. Staff were also educated on reporting abuse immediately to their supervisor or Executive Director, resident rights, confidentiality and new cell phone policy and signatures were obtained on policies to acknowledge they were made aware of policies. Resident Care Director and Executive Director will be responsible to report all alleged incidents to AAA and DHS immediately, whether or not it was substantiated.

Licensee's Proposed Overall Completion Date: *12/01/2023*

42c - Treatment of Residents

4. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Staff interviews determined that staff person A was witnessed calling resident #4 disgusting when they ate, for they would spit their food out. Interviews also determined staff person A told coworkers that they would ignore residents when they ask for things and would respond to resident by saying "Bah, Bah".
Interviews with staff also determined that staff members A, B and C were witnessed making fun of residents and acting inappropriately toward them on multiple occasions. Staff interviews determined that these incidents were brought to the attention of staff person D, who failed to report them to the Department, as required under Ch.2600.16c.

Plan of Correction ***Accept [redacted] - 07/18/2023)***

No reports regarding this issue were ever brought to the attention of the Executive Director. Resident #4 has a habit of spitting [redacted] food out of [redacted] mouth when [redacted] is full or does not want to eat. Staff are observed at all times and this was never brought to the Resident Care Director nor the Executive Director. There is always a dietary manager or lead cook in the dining room during meal time and at no time was this allegation reported to the ED verbally or in a written statement. Staff were educated on resident rights and the importance of treating residents with respect and dignity on [redacted] and [redacted] /23. Training was held with all managers of the importance of addressing issues like this immediately and report it to the Executive Director so that it could be reported to AAA and DHS. Executive Director has assigned a manager/supervisor to be in the dining room at meal time to overt situations like this from happening in the future. Training will continue every 6 months on resident rights, abuse and mandatory reporting. Executive Director will do walk throughs in the dining room at mealtime to ensure residents are being treated with dignity and respect.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented [redacted] 07/31/2023)

42s - Privacy

5. Requirements

42s - Privacy *(continued)*

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

An investigation by the Department determined that staff person A used their personal cell phone to take pictures and videos of 18 different residents (Resident [redacted] thru [redacted]) at the home while working as a direct care staff person. These photos/videos taken by staff person A included residents who were nude and being showered/toileted. The residents involved reside in an all-secure dementia unit.

Plan of Correction ***Accept [redacted] - 07/18/2023)***

Staff person A was immediately suspended when the Executive Director learned of this incident from the Regional police department and is still suspended pending further investigation. Staff member A will not return to work for this facility. During the investigation, Staff members B & C were also placed on suspension until the investigation is completed. A revised cell phone policy was developed to prevent staff from having access to personal cell phones while on duty. Phones must be kept in their own vehicle or locked in a cell phone storage bin which can be accessed on break or lunch only. As of 7/6/23 a camera was akso placed in the time clock area to monitor use of cell phones and ensuring stafff are following revised policy. All HS managers and Executive Director will responsible to enforce this new policy by daily walk throughs of the nursing units to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/13/2023*

Not Implemented [redacted] - 07/31/2023)

54b - Staff Under 18 Years

6. Requirements

2600.
54.b. An individual who is 16 or 17 years of age may be a staff person at a home, but may not perform tasks related to medication administration. A staff person who is 16 or 17 years of age may not perform tasks related to incontinence care, bathing or dressing of residents without supervision.

Description of Violation

Staff person A, who was [redacted] years old, was determined to have provided personal care services and was not supervised by a qualified direct care staff person. Staff person B, who is [redacted] years old but still attending High School, assisted residents with toileting and dressing along with staff person A. There was no direct supervision from a qualified DCS person.

Plan of Correction ***Accept [redacted] - 07/18/2023)***

Staff person A was [redacted] years of age but was always under the direct supervision of a charge nurse or med tech that was at least age 21. Staff member A did partner with Staff member B who was [redacted] years of age on occasions when performing cares with residents under the knowledge of the shift supervisor. Both staff member A & B were suspended immediately at the start of this investigation and will not be returning to Heritage Springs. Resident Care Director was responsible to ensure compliance with this regulation. Facility has made an internal decision not to hire those have not graduated for any position other than dietary or activities. Executive Director will work along side Administrative Assistant to ensure staff being hired as a caregiver are high school graduates or have their GED and are over the age of 18. Executive Director will audit all new employee files to ensure proper education was

54b - Staff Under 18 Years (continued)

obtained and verified by receiving a high school diploma, GED, or certificate of completion of certified nursing assistant program.

Licensee's Proposed Overall Completion Date: *07/13/2023*

Implemented [redacted] - 08/01/2023)

57c 2 Hours/Day

7. Requirements

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 5/13/23, 5/15/23 and 6/10/23 the home had a census of 31 residents. All residents in secure dementia care unit are considered to have a mobility need. The home was required to have a minimum of 62 direct care staffing hours and the home could only verify 59.5 hours on 5/13/23, 58.75 hours on 5/15/23 and 60 hours on 6/10/23.

Plan of Correction ***Accept [redacted] 07/18/2023)***

Hours counted were direct care staff only. We had ancillary staff members assisting with transferring residents to and from the dining room, laundry, cleaning and assisting with a one on one resident on 5/13 and 5/15/23. Also, on June 10, 2023 there were two staff members on duty - [redacted] who worked 10:43p-8:01a and [redacted] who worked 9:30p-6:26a. Executive Director and Resident Care Director will review the schedule on a daily basis and ensure that the correct number of staff are scheduled to ensure proper coverage based on daily census.

Licensee's Proposed Overall Completion Date: *07/13/2023*

Not Implemented [redacted] - 07/31/2023)

57d - Waking Hours

8. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 6/10 /23 the home was required to have 46.5 waking hours but was found to have 44.75 verified working hours. The home had a census of 31 residents.

Plan of Correction ***Accept [redacted] - 07/18/2023)***

On 6/10/23 payroll records indicated that there was a total of 68.57 hours worked. This was nursing staff only. We also use ancillary staff with light duty housekeeper performing tasks such as bed making, tidying up resident rooms, aundry, emptying trash and passing towels which are all included in the caregiver's job description. Our maintenance staff personnel were also utilized to do one on one supervision with residents who were required to have one to relieve the nursing staff to perform ADL's. Resident Care director and Executive Director will review nursing schedule daily to ensure staffing is adequate for each shift.

Licensee's Proposed Overall Completion Date: *07/13/2023*

Not Implemented [redacted] - 07/31/2023)

57d - Waking Hours *(continued)*

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 6/10/23 the home had 31 residents in the building. All residents are in a secure dementia care unit and are considered to have a mobility need. There was only one staff person verified to be on site on 6/10/23 during the overnight shift from 11:15 PM until 6:45 AM. This level of staffing is not adequate to safely evacuate the residents in the event of an emergency.

Plan of Correction ***Accept [redacted] - 07/18/2023)***

On 6/20/23 there were two staff members on duty on the third shift. [redacted] and [redacted] both were on the schedule. A third staff member was also instructed to stay over from the second shift and the med tech on duty that night gave [redacted] permission to leave without approval or nursing supervisor or executive director. Staff member was counseled on the mportance of not allowing staff to leave facility without permission from the nursing supervisor or executive director. Resident Service Director and Executive Director will review schedule on a daily basis to ensure staffing evels are adequate for each shift.

Licensee's Proposed Overall Completion Date: *07/13/2023*

Not Implemented ([redacted] - 07/31/2023)

182b - Prescription Medication

10. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

Description of Violation

Staff person E was asked to give medications to a resident by staff person C, who is a med tech. Staff person E is not med trained to administer medications.

Plan of Correction ***Accept[redacted] - 07/18/2023)***

Neither Resident Care Director nor Executive Director were made aware of this incident. Staff Person E was counseled regarding the fact that only certified medication technicians are permitted to administer medications. Staff Person E was suspended and will not be returning to Heritage Springs. It is the policy of this facility that noone administer medications to any resident unless they have gone through medication administration training at any time. Staff also have been reminded that noone administers medication without being properly trained. Resident Care Director will be responsible to ensure compliance. Executive Director will monitor by performing audits to ensure medications are only given by trained staff. All medication technicians were required to complete the new training program through Temple University to ensure they are all familiar with the proper way to administer medications. Training was completed by 6/30/23 to comply with state regulations. Any employeed hired as a medication technician will be required to complete this training before passing medication.

Licensee's Proposed Overall Completion Date: *07/13/2023*

Not Implemented [redacted] - 07/31/2023)

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

Facility Information

Name: *HERITAGE SPRINGS MEMORY CARE* **License #**: *22598* **License Expiration**: *03/22/2024*

Addre : *327 FARLEY CIRCLE, LEWISBURG, PA 17837*

County: *UNION* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *HERITAGE SPRINGS MEMORY CARE INC*

Address: *327 FARLEY CIRCLE, LEWISBURG, PA, 17837*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *01/03/2017* **Issued By**: *Central Keystone*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *60* **Waking Staff**: *45*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *04/13/2023*

Inspection Dates and Department Representative

04/12/2023 - On-Site: [redacted]

04/13/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *30*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire building* **Capacity**: *64* **Residents Served**: *30*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *30*

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

Have Mobility Need: *30* **Have Physical Disability**: *0*

Inspections / Reviews

04/12/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/14/2023*

05/19/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/23/2023*

Reviewer [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/24/2023*

06/02/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/23/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/07/2023*

06/13/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/23/2023*

Reviewer [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/03/2023*

07/31/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/23/2023*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted]/22, Resident #1, had an unwitnessed fall with injury that was not reported to the Department until [redacted]/22 and Resident #2 had an unwitnessed fall with injury on [redacted]22 that was not reported to the Department until [redacted]/22.

Plan of Correction ***Accept [redacted] - 05/18/2023)***

Nurses were reeducated on the importance of completing an incident report immediately. This education was completed the day of the annual inspection. Past practice was to wait until the emergency room and/or hospitalist would contact HS staff with update. Both of these instances HS nurses tried to gain information from hospital but the hospital staff would not release. We will now be submitting preliminary reports to BHS followed by an updated report when information is obtained. Education will also occur with families with regard to keeping HS updated or provide HS nursing and administration with the password to be able to obtain updated. Resident Care Director will be responsible for oversight. Executive Director will review daily reports to ensure reportable incidents are completed and submitted in a timely manner.

Licensee's Proposed Overall Completion Date: *05/30/2023*

Not Implemented [redacted] 07/18/2023)

25b - Contract Signatures

2. 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

Resident #3 was admitted on [redacted]. As of [redacted]/23, Resident #3 or responsible party did not sign the contract.

Resident # 4 was admitted on [redacted] The contract in the record for resident #4 was not signed by the resident.

Plan of Correction ***Accept [redacted] - 06/02/2023)***

he contract for Resident #3 was emailed to [redacted] who were both Power of Attorneys. The [redacted] signed all documents with the exception of the contract because the [redacted] handles the finances. Contract was reviewed with both parties by Executive Director and the [redacted] was still undecided on financial plan but gave verbal approval on admission date. Contract was returned via email with signature and date of admission of [redacted]22. Effective immediately, all new admissions will not be permitted to be admitted until all documents are signed. Resident #4 was not able to sign [redacted] name to the agreement. As recommended during survey, all attempts will be made to have resident sign the contracts the day of admission or mark it with an 'x' and witnessed by Executive Director.

Executive Director will be responsible for reviewing all preadmission forms for proper signatures before admission date is scheduled.

Licensee's Proposed Overall Completion Date: *06/01/2023*

25b - Contract Signatures *(continued)*

Implemented [redacted] ***- 07/18/2023)***

29a SOPb1- Hospice Care: Doctor Certification

3. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

Description of Violation

Resident #6, who was not evacuated during the fire drill conducted on 11/30/22, does not have a written certification from a physician that the resident is actively dying and may be injured or suffer a hastened death as the result of participating in a fire drill.

Plan of Correction ***Accept*** [redacted] ***- 06/02/2023)***

Resident #6 has since expired and is no longer in the facility.
Any resident who is admitted to hospice will have an order from their primary care physician if they feel that moving them during a fire drill or emergency would be detrimental to their condition. Resident Care Director will be responsible for working with the Hospice agency to obtain an order that the resident is too frail to be evacuated. Executive Director will review all hospice resident files to ensure compliance.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Implemented [redacted] ***- 07/18/2023)***

41e - Signed Statement

4. 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

Resident #3's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept*** [redacted] ***- 06/02/2023)***

Resident #3's Resident Rights were part of the Resident Agreement which was signed and dated [redacted]*/23 but not received until* [redacted]*/23. All new admissions will be on hold until all proper paperwork is in place. This is the responsibility of the Executive Director. Executive Director reviewed all resident files to ensure documents are signed on 5/16/23. Periodic audits will occur on a quarterly basis to ensure compliance.*

Licensee's Proposed Overall Completion Date: *06/01/2023*

Implemented [redacted] ***- 07/18/2023)***

60a - Staff/Support Plan

5. Requirements

2600.

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

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

The home currently serves 30 residents; 3 residents use wheelchairs and 8 use walkers. 3 residents required assistance of 1 to transfer and evacuate during an emergency.
Schedules were reviewed. On 4/2/23 - 2 staff persons were scheduled from 11:15 pm to 3:00am, 4/4/23 through 4/6/23, 2 staff persons were scheduled from 11:15 pm to 6:45am. The last overnight fire drill occurred on 2/18/23 at 2:15am with 29 residents in the home. The evacuation time was 7 minutes and 8 seconds with 4 staff members present. In the event of an emergency the home does not have enough staff to meet the needs of the residents.

Plan of Correction ***Accept [redacted] - 06/02/2023)***

During our annual inspection, Executive Director challenged this violation and asked for permission to show payroll logs to prove we had 3 staff members on at all times. Once the inspector reviewed the logs [redacted] agreed that this violation would be removed. Not sure why this is still showing as a violation. Executive Director creates schedule to reflect staffing needs. Resident Care Director, along with Executive Director finds proper coverage or fills voids is needed to ensure staffing levels are appropriate to meet the needs of our residents.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Not Implemented [redacted] - 07/18/2023)

65e - 12 Hours Annual Training

6. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Staff A, hired on [redacted], completed 6.5 hours of training in 2022, Staff B, hired on [redacted] completed 4 hours of training in 2022, and staff D hired on [redacted] completed 7 hours of training in 2022.

Plan of Correction ***Accept ([redacted] - 06/02/2023)***

Training for Staff A, B and D were completed by the end of May 2023. Administrative Assistant will review training records monthly to ensure all staff have completed trainings in a time manner. Executive Director will perform quarterly audits to maintain compliance. Heritage Springs uses the CARES program for 10 hours of Dementia training. This was done every two years because the certificate was valid for two years. The inspector pointed out that this has to be done yearly or 10 additional hours from another source needs to be done each year. Executive Director, Resident Care Director and Administrative Assistant will make sure each staff member completes the CARES training yearly to remain in compliance.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Implemented [redacted] - 07/18/2023)

65f - Training Topics

7. Requirements

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

65f - Training Topics *(continued)*

Description of Violation

For training year 2022:
Staff A did not receive training in infection control and safe management techniques.
Staff B did not receive training in instruction on meeting the needs (DME and RASP), care for residents with dementia & cognitive impairment, and safe management techniques.
Staff C did not receive training in safe management techniques. Staff D did not receive training in personal care service needs of the resident and safe management techniques.

Plan of Correction ***Accept [redacted] - 06/02/2023)***

Staff A B and C were required to repeat CARES training for 2023. Executive Director will perform audits on a quarterly basis to ensure staff remain in compliance. Training is held during staff meeting once a month. Staff who do not attend staff meeting will be required to review the information and sign a signature sheet to verify that they did indeed review the information. Resident Care Director and Executive Director will be responsible to make sure all staff complete the required training each month.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Not Implemented [redacted] - 07/18/2023)

65g - Annual Training Content

8. 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:

Description of Violation

For training year 2022:
Staff A and Staff B did not receive training in emergency preparedness, resident rights, and falls & accident prevention.
Staff C and Staff D did not receive training in emergency preparedness, and resident rights.

Plan of Correction ***Accept [redacted] - 06/13/2023)***

Staff A, B, C, D have been given the immediate task of completing their required trainings yearly as required. This training is to be completed by July 1st. Training is held during staff meeting once a month. Staff who do not attend staff meeting will be required to review the information and sign a signature sheet to verify that they did indeed review the information. Resident Care Director and Executive Director will be responsible to make sure all staff complete the required training each month. All training records were reviewed by Administrative Assistant and anyone who has not received their annual training will have it completed by July 1, 2023.

Within 15 days of receipt of this directed plan of correction:
Staff identified below will have required training completed by 6-28-2023.
For training year 2022:
Staff A and Staff B did not receive training in emergency preparedness, resident rights, and falls & accident prevention.
Staff C and Staff D did not receive training in emergency preparedness, and resident rights.

65g - Annual Training Content (continued)

Also, the administrator will develop a staff training plan that includes the following information:
(1) The name, position and duties of each direct care staff person, ancillary staff person, substitute personnel and regularly-scheduled volunteer
(2) The required training courses for each person identified in (1).
(3) The dates, times and locations of the scheduled training for each person identified in (1) for the upcoming year.

The training plan will include, at a minimum, the topics required by 2600.65f and 2600.65g. The administrator shall be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/26/2023*

Not Implemented [redacted] - 07/18/2023)

132c Fire Drill Records

10. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the e it route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

Fire Drill record does not include route of evacuation for any fire drill completed from 10/6/22 to 3/11/23.

Plan of Correction ***Accept [redacted] 06/02/2023)***

All Maintenance personnel were educated on the important of completing the record of drills in its entirety. Each fire drill record will now contain evacuation route used during the drill. Maintenance Director will be responsible for conducting the drill as well as completing the fire drill logs. Executive Director will conduct monthly audits on the ogs to make sure every column is completed.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Implemented [redacted] - 07/18/2023)

141a 1-10 Medical Evaluation Information

11. Requirements

2600.

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

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 initial DME, dated [redacted]/23, did not include prescribed medications.

Plan of Correction ***Accept [redacted] - 06/02/2023)***

Resident #3 medication list was attached to the DME the day of our annual survey. Medication list was still in resident chart behind the medical evaluation form. The violation was given because the medication list was not stapled to the actual form. Resident Care Director will be responsible for making sure the medication list is attached to medical evaluation. Random audits will be performed by Executive Director to ensure compliance.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Implemented [redacted] - 07/18/2023)

231c - Preadmission Screening

12. 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 on [redacted]. On [redacted]/23, a cognitive prescreen was completed by a physicians for admission to a secured unit.

Plan of Correction ***Accept [redacted] - 06/02/2023)***

Resident Care Director inadvertently wrote [redacted]/23 when completing the prescreen when the prescreen was actually completed on [redacted]23. Resident Care Director will be more careful when dating forms to be in line with regulations. Executive Director will audit all admission paperwork for accuracy. Resident Care Director wrote incorrect date on pre admission screen. All charts were reviewed by RCD to ensure all preadmission screens are completed timely and according to regulatory requirements.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Not Implemented [redacted] - 07/18/2023)

231e - No Objection Statement

13. Requirements

2600.

231e - No Objection Statement *(continued)*

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 #3 was admitted on [redacted] and resident #4 was admitted on [redacted]/22. The home did not have documentation that Resident #3 & #4, along with their designee did not object to the resident's admission to the secure dementia care home.

Plan of Correction ***Accept [redacted] 06/13/2023)***

The contract for Resident #3 was emailed to [redacted] who were both Power of Attorneys. The [redacted]r signed all documents with the exception of the contract because the [redacted] handles the finances. Contract was reviewed with both parties by Executive Director and the [redacted] was still undecided on financial plan but gave verbal approval on admission date. Contract was returned via email with signature and date of admission of [redacted]/22. Resident #5 and #6 would not sign contract. Note on contracts made by Executive Director reflecting the fact that attempt was made without success to get signature or an X on the admission paperwork, Effective immediately, all new admissions will not be permitted to be admitted until all documents are signed. All contracts were reviewed by Executive Director during the week of June 1st and any that are missing resident signatures will be reviewed with the resident to obtain either their signature or marks. Executive Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented ([redacted] - 07/18/2023)

233c Key Locking Devices

14. 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 gate located in the courtyard did not have instruction how to operate the locking device.

Plan of Correction ***Accept [redacted] 06/02/2023)***

All doors are checked daily to make sure that door codes are still attached. The sign blew off after morning rounds eaving tape still there. Maintenance immediately posted a new sign. during the annual survey. Maintenance will continue to do rounds each day to make sure signs are still visible and replace as necessary. Executive Director will also double check when rounding the facility daily.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Implemented [redacted] - 07/18/2023)

234b - Support Plan Needs Elements

15. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

Resident #5 has a bed enabler attached to the bed. Resident #5's assessment and support plan does not indicate what the resident uses this device for.

234b - Support Plan Needs Elements *(continued)*

Plan of Correction ***Accept (06/13/2023)***

Resident #5 has had an enabler for several years. Current Resident Care Director did not realize it was not listed in the plan of care. Plan of Care was updated to reflect the use of the enable bar during the survey. Physician order also obtained. Resident Care Director reviewed all resident care plans of those individuals who use an enable bar to make sure they are addressed in the plan of care. This audit was completed the last week in June 2023 by [redacted] [redacted] Resident Care Diector.

Licensee's Proposed Overall Completion Date: *06/08/2023*

Implemented [redacted] - 07/18/2023)

236 - Staff Training

16. 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

Staff B and Staff C did not complete 6 hours of dementia training for training year 2022.

Plan of Correction ***Accept [redacted] 06/13/2023)***

Staff B and C were informed they were required to completer training before July 1st. Training is held during staff meeting once a month. Staff who do not attend staff meeting will be required to review the information and sign a signature sheet to verify that they did indeed review the information. Resident Care Director and Executive Director will be responsible to make sure all staff complete the required training each month.

Licensee's Proposed Overall Completion Date: *06/28/2023*

Implemented [redacted] - 07/18/2023)

252 - Record Content

17. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

Description of Violation

Resident #3's record did not include color of eyes.

Plan of Correction ***Accept [redacted] - 06/02/2023)***

This was not discussed as a violation during exit interview. We strive hard to ensure all items on the resident face sheet are completed. Resident #3's face sheet was updated to include color of eyes and an audit was completed by the Resident Care Director for all residents to ensure that all face sheets are completed in it's entirety. Resident Care Director reviewed all face sheets to ensure all blanks are filled in. RCD will perform quarterly audits to ensure compliance.

Licensee's Proposed Overall Completion Date: *06/01/2023*

252 - Record Content *(continued)*

Implemented (07/18/2023)