pennsylvania
DEPARTMENT OF HUMAN SERVICES

Mailing Date: January 9, 2020

Mr. Kevin P. Kasseff
Manager
Evergreen Estates Holdings, LLC
2301 Rosencrans Avenue, Ste. #4170
El Segundo, California 90245

RE: Evergreen Estates Retirement Community
1300 East King Street
Lancaster, Pennsylvania 17602
Certificate #: 331930

Dear Mr. Kasseff:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on October 28, 2019 and November 12, 2019 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is:
Acceptable - All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

If you need assistance, please contact me at 717-418-9656 or email at bswanger@pa.gov.

Sincerely,

Brett Swanger
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *EVERGREEN ESTATES RETIREMENT COMMUNITY*
License Number: *33193*
Address: *1300 EAST KING STREET,, LANCASTER, PA 17602*
County: *LANCASTER* **Region:** *CENTRAL*

Administrator

Name: *Charity Cruz* **Phone:** *7173942208* **Email:**

Legal Entity

Name: *EVERGREEN ESTATES HOLDINGS LLC*
Address: *2301 ROSECRANS AVE, SUITE 4170, EL SEGUNDO, CA, 90245*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** **Issued By:**

Staffing Hours

Resident Support Staff: *81* **Total Daily Staff:** *163* **Waking Staff:** *122*

Inspection

Type: *Partial* **BHA Docket #:** **Notice:** *Unannounced*
Reason: *Complaint,Incident*

Inspection Dates and Department Representative

10/28/2019 - On-Site: Michael Showers, Hope O'Pake

11/12/2019 - On-Site: Michael Showers, Jason McCloskey

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served:** *81*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *80*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *1*
Have Physical Disability: *3*

15a - Resident Abuse Report

Regulations

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

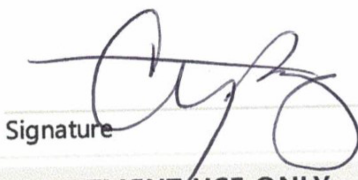
Staff Person B and Staff Person D witnessed Staff Person A yelling at Resident 1 and using excessive physical force to pry the resident's hand off the railing in the hallway and move the resident's legs against her will. Information regarding this incident was not provided to the administration of the home in a timely manner and thus not reported to the local Area Agency on Aging in accordance with the time frames designated in the Older Adult Protective Services Act

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

See attachment for Page 2A

Legal Entity Representative



Signature

Charity D. Cruz Executive Director

Printed Name and Title

11/25/19

Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 1/9/2020 (Date)

Plan of correction implementation status as of (Date)

☐ Implemented

The above plan of correction was approved by BAS (Initials)

☐ Not Implemented

Attachments for page 2:

A. Resident 1- no recall of incident, no injuries noted, normal routine for resident. Employee A as noted on page 5 & 6 was terminated from employment 10/19/19, prior to this late report on Resident # 1.

B. Staff member B and staff member D attended annual mandatory training 8/21/19 during this training review of resident abuse and abuse reporting was reviewed. (See attached signed copies of training forms.)

C. 11/18/19- Staff member B and staff member D were re-educated to the proper procedures on reporting abuse, accusations of abuse and /or other concerns related to concerns of resident treatment. (See attached signed educational forms.)

D. 11/15/19- ongoing- re-educated current staff members on proper protocol and time frame for reporting abuse, and/ or accusations of abuse or other concerns related to concerns of resident treatment. (See attached educational forms.)

E. 11/15/19- ongoing- All staff will follow proper reporting procedures for abuse, failure to follow proper procedures as outlined in the attached will result in progressive discipline, up to an including termination of employment.

F. 3/17/15- Ongoing- All incident reports are reviewed at the time reported, as well as tracked and trended. Reportable Incidents are included and reviewed in our Quality Management process, which is held quarterly. Quality Management under the regulations must be annually; Evergreen completes our quarterly to include Reportable Incidents, Violations & Plan of correction (if any), complaints, staff training and Resident monthly meetings. State inspectors review this process, policy and reports at least annually during our unannounced state inspections.

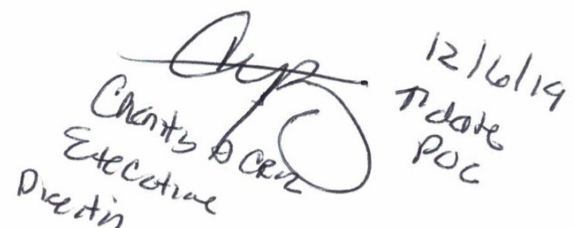
G. 5/18/2015- Ongoing- Monthly Resident Council meetings are conducted, during which time updates and reminders are given, as well as Open to residents to ask questions, ideas and /or concerns. Minutes of the meeting are completed and handed out to all residents, as well as Managers & Directors.

H. 12/11/19-ongoing- Next Resident Council meeting will be held, will review Resident Rights, and Abuse. Copies of Resident rights will be handed out with the minutes and at the meeting for any resident that would like a copy at that time. In addition will review twice more during 2020 during a regularly scheduled monthly resident council meeting.

I. 12/5/19- Next monthly nursing team meeting, Nurse Manager will review again the process for reporting abuse, please see letter C. of this plan and attachment regarding the re-education form.

J. 4/2015- Ongoing- Executive Director meeting regularly during the week, daily stand up meeting with managers and directors, at which time we share updates, and any concern. Schedule does change with holidays and vacation, however there is always a manager or director on call 24/7 should a situation rise at the community that needs immediate attention. Refer to K.

K. 5/29/15- ongoing- Manager / Director On call 24/7, should shift supervisors have any of the following issues will call the on call phone and the Manager/ Director on call will advise and / or follow up, and/or call the Executive Director if necessary. See attached posting that is in the Nurse's station, as the Charge Nurse or Lead Med tech is in charge when other Management or Directors are not in the building. Number one on that list is – Alleged or suspected abuse or neglect of a resident.



16c - Written Incident Report

Regulations

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

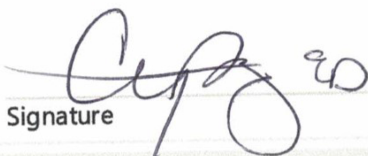
Staff Person B and Staff Person D witnessed Staff Person A yelling at Resident 1 and using excessive physical force to pry the resident's hand off the railing in the hallway and move the resident's legs against her will. Information regarding this incident was not provided to the administration of the home in a timely manner and thus not reported to the Department within 24 hours of the incident.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

(8) See attached on page 3A and 3B

Legal Entity Representative



Signature ED

Charity D. Cruz Executive Director
Printed Name and Title

11/25/19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 1/9/2020 (Date)

The above plan of correction was approved by BAS (Initials)

Plan of correction implementation status as of (Date)

☐ Implemented

☐ Not Implemented

Attachments for page 2:

A. Resident 1- no recall of incident, no injuries noted, normal routine for resident. Employee A as noted on page 5 & 6 was terminated from employment 10/19/19, prior to this late report on Resident # 1.

B. Staff member B and staff member D attended annual mandatory training 8/21/19 during this training review of resident abuse and abuse reporting was reviewed. (See attached signed copies of training forms.)

C. 11/18/19- Staff member B and staff member D were re-educated to the proper procedures on reporting abuse, accusations of abuse and /or other concerns related to concerns of resident treatment. (See attached signed educational forms.)

D. 11/15/19- ongoing- re-educated current staff members on proper protocol and time frame for reporting abuse, and/ or accusations of abuse or other concerns related to concerns of resident treatment. (See attached educational forms.)

E. 11/15/19- ongoing- All staff will follow proper reporting procedures for abuse, failure to follow proper procedures as outlined in the attached will result in progressive discipline, up to an including termination of employment.

F. 3/17/15- Ongoing- All incident reports are reviewed at the time reported, as well as tracked and trended. Reportable Incidents are included and reviewed in our Quality Management process, which is held quarterly. Quality Management under the regulations must be annually; Evergreen completes our quarterly to include Reportable Incidents, Violations & Plan of correction (if any), complaints, staff training and Resident monthly meetings. State inspectors review this process, policy and reports at least annually during our unannounced state inspections.

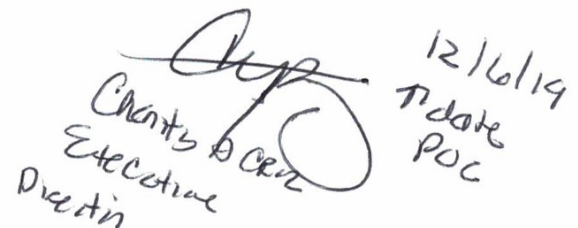
G. 5/18/2015- Ongoing- Monthly Resident Council meetings are conducted, during which time updates and reminders are given, as well as Open to residents to ask questions, ideas and /or concerns. Minutes of the meeting are completed and handed out to all residents, as well as Managers & Directors.

H. 12/11/19-ongoing- Next Resident Council meeting will be held, will review Resident Rights, and Abuse. Copies of Resident rights will be handed out with the minutes and at the meeting for any resident that would like a copy at that time. In addition will review twice more during 2020 during a regularly scheduled monthly resident council meeting.

I. 12/5/19- Next monthly nursing team meeting, Nurse Manager will review again the process for reporting abuse, please see letter C. of this plan and attachment regarding the re-education form.

J. 4/2015- Ongoing- Executive Director meeting regularly during the week, daily stand up meeting with managers and directors, at which time we share updates, and any concern. Schedule does change with holidays and vacation, however there is always a manager or director on call 24/7 should a situation rise at the community that needs immediate attention. Refer to K.

K. 5/29/15- ongoing- Manager / Director On call 24/7, should shift supervisors have any of the following issues will call the on call phone and the Manager/ Director on call will advise and / or follow up, and/or call the Executive Director if necessary. See attached posting that is in the Nurse's station, as the Charge Nurse or Lead Med tech is in charge when other Management or Directors are not in the building. Number one on that list is – Alleged or suspected abuse or neglect of a resident.



Attachment for page 3:

11/15/19- ongoing- staff will report abuse, abuse accusations and or any concerns regarding treatment of a resident. (See page 2 attachments re-education and training.)

11/15/19- ongoing- Abuse reports will be completed within the regulatory requirements for Office of Aging, and the Department of Human Services.

Please refer to page # 2 for notations for letters- A-K in addition to the attachments for page # 2.

12/16/19-3/3/20- Management will conduct confidential interviews of residents, at least 3 per week, and at least 3 staff per week over the next quarter to ensure compliance with resident rights, and to identify any concerns or possible concerns before they might arise. Copies and results of the interviews will be kept confidential and will be submitted to the Department of Human Services at the end of the quarter. Starting the week after we address with the residents during the monthly resident council meeting, as noted on page # 2, which will be held 12/11/19, resident rights and abuse will be one of the topics for discussion at that meeting, in addition in 2020 we will review this again during two regularly scheduled monthly resident council meetings, which will be soon after the 3/3/20 completion date.

*See attached copies of employee and resident surveys.

Revised 12/4/19
[signature] ED
Charity D.
Executive Director

23a - Activities of Daily Living Assistance

Regulations

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

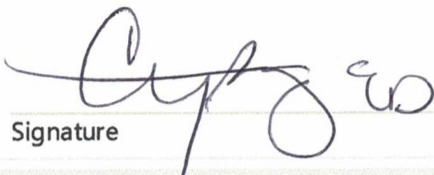
Resident 2's Resident Assessment Support Plan (RASP), dated 8/21/2019, directs staff to call 911 immediately and send the resident to the hospital for evaluation when the resident threatens self harm. On 10/9/2019 at approximately 4:30pm, Resident 2 told staff that she was going to kill herself by slicing her stomach, nose and wrist. At approximately 5:10pm, staff responded to Resident 2's call bell for assistance, whereupon the resident stated that she had attempted to cut herself with a knife. Only at this time was 911 called and the resident sent to the hospital for evaluation.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

(x) see attached on Page 4A

Legal Entity Representative



Signature

Charity D. Cruz Executive Director

Printed Name and Title

11/25/19

Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 1/9/2020 (Date)

Plan of correction implementation status as of (Date)

☐ Implemented

The above plan of correction was approved by BAS (Initials)

☐ Not Implemented

10/9/19- Resident 2 sent out to Emergency room, for evaluation after she threatened to cut herself. Resident 2 has a significant history of anxiety and mental health issues since she was a young adult. She is frequently sent out 911 due to these issues. On this date she was sent out and was not admitted to the hospital she returned a few hours later to the community. Staff followed care plan and protocol for monitoring resident. Behavioral health sees resident on a regular basis and a psych nurse also sees resident on a regular basis.

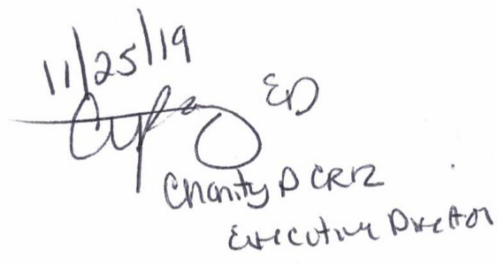
10/10/19- Nurse Manager updated Occupational Therapist as she was the person that provided the weighted utensils for the resident to the above.

11/15/19-ongoing- Staff educated that if / when resident threatens to hurt herself and / or others to remain with the resident or her private duty remain with her if there at the time of incident, and call 911 right away, and remain with her until they arrive.

(See attached educational form)

11/18/19- Resident 2 was sent out again 911 right away, after she told her private duty she wants to gouge her eyes out (meaning herself), Resident 2 was angry with her eye doctor after seeing him and made this comment when returned to the community. Resident did not act on it, however, was sent out 911 and was not admitted and returned to the community a few hours later, staff continue to follow care plan and monitor resident. Resident was angry at staff for sending her out; we reviewed with Resident 2 we must send her out each time she threatens to hurt herself or others.

12/5/19- Nurse Manger will review protocol again with care staff during the monthly nursing meeting. Any resident that threatens to harm themselves or others, staff are to stay with them and call 911 right away and send them out to hospital for an evaluation.



42b - Abuse

Regulations

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

- On 10/19/2019 at approximately 9:00pm, Resident 4 left the personal care home through a side exit door of the home in the proximity of his bedroom. The use of this exit door triggered an alert to the home's security company who contacted the staff of the home. Staff of the home checked the area near the door inside the home, but did not check the vicinity outside of the door. At approximately 10pm, while performing room checks, staff found that Resident 4 was not in his room and started a search for the resident. The resident was found face down on the ground outside the home near the front entrance at approximately 10:20pm. The resident was deceased, the death certificate stating that the cause of death being from a pulmonary embolism. Resident 4 had a diagnosis of dementia and the current Resident Assessment and Support Plan for Resident 4, finalized 12/3/2018, identified that the resident had moderate supervision and moderate mobility needs and required reminders and queuing in locating certain areas throughout the facility and required supervision outside of the facility when in unfamiliar surroundings. This RASP also assessed the resident as having a moderate problem with his orientation to time, place and person and a moderate problem with his judgement. It documented that he would have periods of confusion, his judgement was impaired, he tended to make quick irrational choices, and directed staff to re-direct the resident before a situation would escalate. The resident displayed elopement behaviors on 9/30/2019 and 10/1/2019, whereupon he was observed and able to be redirected back into the home by staff. On 10/19/2019, the home failed to provide the services necessary to address these identified behaviors of Resident 4.

- On 10/19/2019, Staff Person A forcibly grabbed Resident 3 by the arm and was yelling at her to get out of bed and get dressed against Resident 3's wishes. This treatment caused the resident to feel emotionally upset and ashamed as evidenced by her statements to Staff Person C and Staff Person E after the incident.

- Staff Person B and Staff Person D witnessed Staff Person A yelling at Resident 1 and using excessive physical force to pry the resident's hand off the railing in the hallway and move the resident's legs against her will.

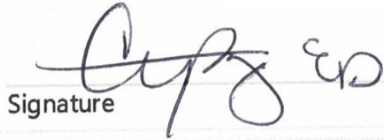
Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

(A) See attached pages 6A Pages 6A through 6E [signature] ED 11/25/19

42b - Abuse *(continued)*

Legal Entity Representative



Signature	Printed Name and Title	Date
ED	Charity A Cruz Executive Director	11/25/19

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 1/9/2020 (Date)

The above plan of correction was approved by BAS (Initials)

Plan of correction implementation status as of (Date)

- [ ] I Implemented
- [ ] Not Implemented

Attachment for page 5- Resident # 4-

10/19/19- Resident # 4- Staff reported seeing resident at the following times, approximately 7pm for medications ; approximately 8pm another staff person recalled seeing resident #4 in the community room near the couch, his caregiver provided pm care for Resident # 4 and stated that was somewhere between 8:15 and 8:30 started that care, resident was changed, cleaned up and used the bathroom, this same caregiver stated she last saw him in his room in his chair, and she turned on the TV for him. The inspectors that were on site on 10/28/19 & 11/12/19 were provided with all the staff statements in addition to when the incident occurred, when the required reportable incident and supporting information was also sent to the Department of Human Services within the time frame ; by Evergreen.

10/19/19- Select Security the 24 hour 7 days a week monitoring system for Evergreen, called in to the community to report a door breach/ alarm at approximately 9:07pm. Staff according to their written statements and interviews /updates given to Evergreen managers, and also to and by the state representatives on site 10/28/19 & 11/12/19 reported they did check the door, around the door and did not see anyone in the area or outside. At approximately 10pm staff on third shift started 2 hour rounds and checks , at which time discovered resident 4 was not in his room, in the staff reports they alerted the staff members working, they have walkie talkies and are able to communicate to each other through them as well as any resident call bells being received through this same system (resident # 4 was reported to have been wearing his pendant, however he did not press it during the time frame, we pulled the call bell reports for that evening and gave copies to the inspectors on 11/12/19 at their request the report showed there was no record of resident # 4 pressing the alert button) staff searched inside the building , did not find resident, after not finding him inside, staff searched outside, " looping " around the building finding the resident at approximately 10:20pm. At which time they call 911, nurse assessed resident, provided CPR until EMS and police arrived. As reported by coroner resident passed away from a Pulmonary Embolism.

9/19- Construction began in Pine hall at Evergreen after approval to begin renovations to convert the area into a Secured Memory Care Unit, this Secured Unit will provide care for residents that require or could benefit from a Secured Memory Care Unit, resident with cognitive impairment, residents that exit seek, wander, or have other behaviors related to cognitive impairment. The construction was completed and the approval by the township and the Department of Human Services for all the paperwork was approved on 11/5/19.

11/5/19- Approval on the final township inspections and the paperwork submitted to the Department of Human Resources received, in that communication we were informed that a state representative will call us to set up the final onsite physical inspection and approval to Secure the Unit for Memory Care.

11/13/19- Ed from the Department of Human Services contact me and set up 12/3/19 as the final inspection. Once that is completed and approved, and our license change, we will be able to provide Secured Memory Care to residents who require that care and monitoring.

11/15/19- ongoing- Staff educated when door compromised, alarm sounds (exit door in the proposed Memory Care Unit) or when select security calls regarding a door breach, that staff not only look around the area inside and outside the door , to also go outside to look around the surrounding area to ensure no one is outside. (See attached educational form.)

12/4/19 ED
Executive Director

Attachment for Page 5. Resident #4 continued.

11/15/19- ongoing- See attached created form, supervisors educated to complete when there is a door breach and / or alarm, these forms are kept on top of the medication carts. In the event that a door alarm is not able to be verified as to the cause of the breech (IE: Staff taking out trash, landscapers open the door etc.) The supervisor on duty will instruct the staff to immediately check on all residents to ensure they are all accounted for, and record on the attached form. If a resident is missing, staff will proceed to follow the procedures outlined in the Elopement/ Missing resident policy. (On 11/12/19 a copy of this policy was given to Jason state inspector at his request.)

12/5/19- Nurse Manager will review again during the monthly nursing and care staff meeting, attachments in addition to reminding staff any concerns about resident safety , any resident that exit seeks they must report to manager , to monitor resident safety & care needs , transfer resident to Secured Memory Care if appropriate . (Evergreen expected to have final approval for the unit, sometime next month.)

5/29/15- Ongoing- Director/ Manger on call 24/7, shift supervisor, Charge Nurse or Lead Med tech have access to on call phone number and list of situations to call, the on call supervisor.

12/4/19-During daily stand up meeting with Directors/ Managers, Executive Director reviewed and provided each with copies of the door alarm/ breech form and list of situations that staff are to call the on call Director / Supervisor.

*As discussed, the Nurse Manager, in conjunction with the charge nurses, will complete an audit of all residents of the home to identify the current supervision needs and risk of elopement for each resident as compared with the most recent Resident Assessment and Support Plan (RASP). The home will complete a new RASP for any resident where the current needs are not reflected in the most recent RASP. The home will provide training to its staff on all newly developed RASPs to ensure staff members are up to date on the needs of the residents. This action will be completed by 2/14/2020. (BAS 1/9/2020)

12/4/19

Charity Decker ED

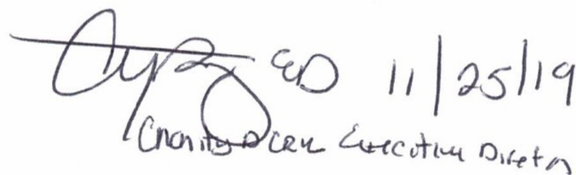
Executive Director

10/19/19- Resident # 3- Resident reported to staff member C an incident that occurred with her involving staff member A. on 10/19/19. Staff member C reported this to the Manager on duty right away, that was staff member E. Staff member E then called the Nurse Manager, and she called Executive Director. Staff member E started to collect statements, from resident, and staff member A, Nurse Manager arrived quickly to Evergreen, and continued to investigate and collect statements. Employee A was sent home, during the process, after she gave her statement to nurse manager, Employee A remained off the schedule. Upon reviewing and collecting statements, Office of Aging was called , the on call person called us back 10/19/19, we gave the verbal report to Office Of Aging, following the verbal report, we completed the Act 13 Abuse report and faxed that to Office of Aging as per protocol, following that , we made copies of the Act 13 report, and completed the required state form , and faxed those reports, the statements, our findings, hire information, training information, abuse training and a copy of employee A background check and faxed all of those to the Department of Human services 10/19/19 all reports and investigation completed day of report. This writer emailed Human Resources to inform them of the issue and that this warrants termination of employee A. Employee A did not work since we sent her home on 10/19/19 and was terminated from employment .Resident # 3 did not have any injuries from the incident, however was upset by the incident, as noted in the statements, and when she spoke with the state inspector about it on 11/12/19.

Resident # 1- Please refer to notes on pages 2 & 3 of this report, as this is the same resident. Resident # 1 does not recall incident, did not have any injuries noted and was normal self. Staff did not report this incident until after, we had already terminated employee A on 10/19/19, regarding the above incident on Resident # 3. As indicated on pages 2 & 3 and the supporting documents and educational attachments, staff will report abuse, accusations , of any concerns of treatment of a resident , immediately to a supervisor , providing written statements to supervisor that same day, failure to follow proper procedures will result in progressive discipline up to and including termination of employment. *See pages 2 & 3 and attachments for those pages.)

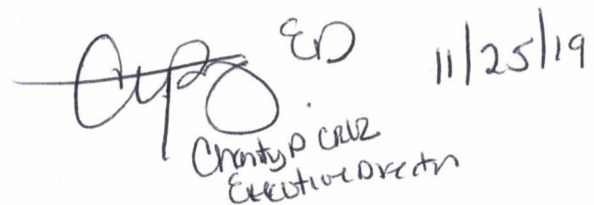
11/25/19
[signature] Executive Director
Charity D Cruz

A. Resident 1- no recall of incident, no injuries noted, normal routine for resident.
B. Staff member B and staff member D attended annual mandatory training 8/21/19 during this training review of resident abuse and abuse reporting was reviewed. (See attached signed copies of training forms.)
C. 11/18/19- Staff member B and staff member D were re-educated to the proper procedures on reporting abuse, accusations of abuse and /or other concerns related to concerns of resident treatment. (See attached signed educational forms.)
D. 11/15/19- ongoing- re-educated current staff members on proper protocol and time frame for reporting abuse, and/ or accusations of abuse or other concerns related to concerns of resident treatment. (See attached educational forms.)
E. 11/15/19- ongoing- All staff will follow proper reporting procedures for abuse, failure to follow proper procedures as outlined in the attached will result in progressive discipline, up to an including termination of employment.



11/15/19- ongoing- staff will report abuse, abuse accusations and or any concerns regarding treatment of a resident. (See page 2 attachments re-education and training.)

11/15/19- ongoing- Abuse reports will be completed within the regulatory requirements for Office of Aging, and the Department of Human Services.



183b - Meds and Syringes Locked

Regulations

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

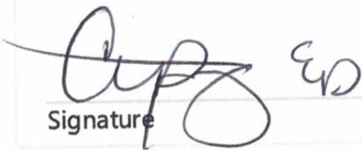
On 11/12/19, a Licensing Representative observed an unlocked and unattended medication cart in the first floor hallway of the home.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

(*) See attached Page 7A

Legal Entity Representative



ED

Signature

Charity D Case Executive Director

Printed Name and Title

11/25/19

Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 1/9/2020 (Date)

Plan of correction implementation status as of ______ (Date)

☐ Implemented

The above plan of correction was approved by BAS (Initials)

☐ Not Implemented

11/12/19- Med tech was passing medications when there was a call from out of the country from a resident's family member, wanting an update on his father, his father was in the hospital. The Med tech stepped away from the cart, to talk to the son the son was upset on the phone, the Med Tech forgot to lock the cart before she walked away. She was nearby, however not at the cart when talking.

11/12/19- Nurse Manager met with Med Tech, attached is education form and written warning for not following protocol. See attached copy

11/15/19- Ongoing- Care staff re-educated when medication carts are not in use or unattended, they must be locked at all times. See attached educational form.

12/5/19- Nurse Manager will review again with care team during the monthly care team meeting, held for all three shifts.

11/15/19- Medication carts will be locked when not in use or unattended as per regulations.

attachment on
page #7

11/25/19
[signature] ED
Charity ACRR
Executive Director