pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail hmiller2@5ssl.com
Sent via e-mail shaines@5ssl.com
May 28, 2020

Ms. Jennifer F. Francis
President and COO
SNH Penn Tenant, LLC
Two Newton Place
255 Washington Street, Suite 300
Newton, Massachusetts 02458

RE: Glen Mills Senior Living
242 Baltimore Pike
Glen Mills, Pennsylvania 19342
License #: 145110

Dear Ms. Francis:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on January 13 and 14, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Mia Johnson

Mia Johnson
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *Glen Mills Senior Living* **License Number:** *14511*
Address: *242 Baltimore Pike, Glen Mills , Pa 19342*
County: *Delaware* **Region:** *Southeast*

Administrator

Name: *Heather Miller* **Phone:** *6103584900* **Email:** *HMiller2@5SSL.COM*

Legal Entity

Name: *SNH PENN TENANT LLC*
Address: *TWO NEWTON PLACE , 255 WASHINGTON STREET, SUITE 300, NEWTON , MA, 02458*

Certificate(s) of Occupancy

Type: *I-2* **Date:** *03/19/2010* **Issued By:** *Concord Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *52* **Waking Staff:** *39*

Inspection

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

Inspection Dates and Department Representative

01/13/2020 - On-Site: Natasha Braswell, Christina Eberhart , Evelyn Perez

01/14/2020 - On-Site: Natasha Braswell, Christina Eberhart , Evelyn Perez

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served:** *52*

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: *52*
Diagnosed with Mental Illness: *1*
Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *0*
Have Physical Disability: *0*

5a1 - DHS Access

Regulations

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

1. Agents of the Department.

Description of Violation

On 1/13/20, at 9:15 am, an agent of the Department, requested access to resident records. The Department did not receive the records until 12:15 pm.

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.)

Effective 1/14/2020:

The Executive Director or Designee will ensure that records are provided to The Department in a timely manner.

Legal Entity Representative

Heather Miller — Heather Miller Executive Director 4/2/2020

Signature | Printed Name and Title | Date

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

The above plan of correction is approved as of 5/26/20 (Date)

Plan of correction implementation status as of 5/26/20 (Date)

☒ Implemented

☐ Not Implemented

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

42s - Privacy

Regulations

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

On 1-13-20, at 10:00 am, mailbox numbers 201, 214, 215, 302 and 327 were full of mail and left opened and unsecured.

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.)

Resident mailboxes are secured and accessed by the postal service and the resident.

Mailboxes will be checked no less than 3 times week x 4 weeks by personnel to ensure locking mechanisms are functional and that mailboxes are closed and secured. Results of the audit will be reviewed weekly by the Executive Director. If at that time there is further evidence of non-compliance, a plan for further monitoring will be established.

We will notify residents if their mailbox is found unlocked and opened during the audit. If we deem that a resident is not able to manage their personal mail and/or mailbox, we will contact their responsible party and ask that the resident's mail be delivered to the responsible party's address versus the Community. Resident's RASPS will be updated to reflect this change, if applicable.

The USPS will be notified to replace any mailbox locks that are defective.

Legal Entity Representative

Heather Miller — Signature

Heather Miller Executive Director — Printed Name and Title

4/2/2020 — Date

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☐ Not Implemented

60c - Housekeeping/Maintenance

Regulations

2600.
60.c. Additional staff hours, or contractual hours, shall be provided as necessary to meet the laundry, food service, housekeeping and maintenance needs of the home.

Description of Violation

On 1-14-20, the Department conducted a staff interview. According to the administrator of the home , laundry services are often put to the side to focus on the priority of completing resident care. The service was not provided due to a lack of staff to complete the laundry task.

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.)

In order to complete resident laundry, duties are assigned to 1st, 2nd and 3rd shift direct care staff.

The DRC or Designee will re-train all direct care staff on the laundry process by 4/15/20.

If a resident is designated to have their laundry serviced and direct care staff is unable to complete it, direct care staff will be required to notify their shift supervisor prior to two hours of their shift end time to allow for reassignment to another direct care staff member during the shift.

Direct care staff will be required to sign their assignment sheet showing completion of laundry service during their shift. The Nurse on duty each shift will be required to sign the assignment sheet after ensuring the laundry has been done by the staff member. Laundry services will be monitored weekly x 4 weeks by the DRC or Designee. If at the end of 4 weeks there is further evidence of non-compliance, a plan for further monitoring will be established.

The laundry service process will be reviewed for effectiveness at the quarterly Quality Management Meeting.

Legal Entity Representative

Heather Mulle — Signature

Heather Mille, Executive Director — Printed Name and Title

4/2/2020 — Date

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☐ Not Implemented

65b - Rights/Abuse 40 Hours

Regulations

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A completed his/her 40th scheduled work hour on 5/22/19. However, this staff person did not complete training in the following topics: emergency medical plan.

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.)

Staff person A is no longer employed at Glen Mills Senior Living.

The Executive Director or Designee will re-train all staff on the Emergency Medical Plan by 4/15/20 in the event another employee was missed.

The Emergency Medical Plan is part of General Orientation of all new staff persons and is conducted within the first 40 scheduled work hours from each new staff person's start date.

Audits to ensure compliance to this regulation will be performed and documented weekly x 4 weeks by the Executive Director or Designee. If at the end of 4 weeks there is further evidence of non-compliance, a plan for further monitoring will be established.

Legal Entity Representative

Signature | Heather Miller, Executive Director | 4/2/2020

Printed Name and Title | Date

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☐ Not Implemented

66b - Training Plan Content

Regulations

2600.

66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

Description of Violation

The home's training plan would benefit from diabetic training to improve the knowledge of the nursing professionals.

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.)

The DRC, Executive Director or Designee will in-service all staff by April 30th, 2020 on diabetes, to help identify signs of Hypo and Hyper glycaemia in our residents, therefore, improving their knowledge and skills to carry out their job duties.

Annual staff training plans now include diabetic training for all staff and has been added to General Orientation for new hires.

Legal Entity Representative

Heather Mills — Heather Mills Executive Director — 4/2/2020

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85a - Sanitary Conditions

Regulations

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

The door of room 331 was soiled and stained.

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.)

The door was observed with black marks from the wheelchair used by the resident living In room 331.

The door to room 331 was cleaned and painted on January 16th, 2020.
During daily rounds of the Community by the Maintenance Director or Designee, doors will be audited for cleanliness and conditions that are unsanitary. Doors in need of cleaning will be cleaned same day by Housekeeping. Doors in need of paint will be painted by Maintenance within 3 days of the audit.

An audit sheet will be used to track doors to be cleaned and or/painted. The form will be filled out by the Maintenance Director and/or Designee, and signed by the Housekeeping Supervisor and/or Maintenance as they complete cleaning and/or painting.

The form will be returned to the Executive Director and reviewed weekly x 4 weeks to ensure completion of the work and to ensure compliance to this regulation. If at the end of 4 weeks there is further evidence of non-compliance, a plan for further monitoring will be established.

This process will be reviewed for effectiveness at the quarterly Quality Management meeting.

Legal Entity Representative

Heather Miller | Heather Miller Executive Director | 4/2/2020
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☐ Not Implemented

85e - Trash Outside Home

Regulations

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 1/14/20, at 10:30 am, the trash receptacle located outside near the boiler room and employee entrance was overrun with trash. The lid was not able to close. Trash was also in bags on the ground next to the trash receptacle.

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.)

Trash removal was increased from twice a week pickup to three times a week pick up the week of 1/20/2020.

Department Managers will in-service staff by 4/15/20 on the importance of a clean area around the trash receptacle by keeping trash in the dumpster, thereby preventing the penetration of insects and rodents.

Legal Entity Representative

Heather Mills — Signature

Heather Mills- Executive Director — Printed Name and Title

4/2/2020 — Date

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☐ Not Implemented

88a - Surfaces

Regulations

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The wallpaper on the 1st floor near room 121 and on the 3rd floor outside of room 325 are peeling and in disrepair.

The door to the fire extinguisher located in the kitchen has a hole.

There is a hole in the ceiling on the 3rd floor near rooms 306 and 307.

Garden stakes, tomato plant support poles and metal galvanized steel wired round tomato cage present a tripping hazard in the patio area.

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.)

The wallpaper that was peeling was resealed 1/14/20.
The door to the fire extinguisher located in the kitchen with a hole was replaced on 1/15/20.
Garden stakes, tomato plant support poles and metal galvanized steel wired round tomato cage in the patio area that presented a tripping hazard were removed on 1/14/20.

The Maintenance Director or Designee will make rounds of the inside and outside of the Community no less than 3 times weekly to evaluate the grounds for any floors, walls, ceilings, windows doors and other surfaces that may not be clean, in good repair and free of hazards.
The Maintenance Director or Designee will document any repairs or cleaning necessary and will review them with the Executive Director or Designee no less than weekly to develop a plan for cleaning, repair or replacement.

Repairs and cleaning necessary as a result of the rounds will be reviewed at the quarterly Quality Management Meeting to ensure effectiveness of the procedure.

Legal Entity Representative

Heather Mills — Heather Miller, Executive Director 4/2/2020

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☐ Not Implemented

95 - Furniture and Equipment

Regulations

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

A unused ice cream freezer had scoops of wasted ice cream on the interior base of the freezer.

The door handle to the dryer located on the third floor was broken and not in good repair.

The dining room chairs are heavily soiled and not in good repair.

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.)

The Food Service Director or Designee will re-educate dietary staff by 4/15/20 as to Furniture and equipment that needs to be kept in good repair, clean and free of hazards in the Dining Service Department.

The broken door handle to the dryer located on the third floor has been replaced. The Maintenance Director or Designee will be responsible for checking all laundry equipment each morning to ensure it is in good working condition. An audit form will be used to track these daily checks and any equipment not in good repair, not clean or free from hazards will be addressed with a plan of action documented on the audit form. Audits will be reviewed by the Executive Director or Designee weekly.

The ice cream freezer will be checked daily by the cook on duty for any ice cream on the interior base of the freezer. A checklist is used to for documenting this. The document is turned in to the Food Service Director the following morning for review and to ensure we are in compliance with this regulation.

Maintenance and/or the Food Service Director or Designee will check all dining room chairs by 4/15/2020 for any that might need repair. Thereafter, dining room chairs that are soiled will be washed every evening and any chairs not in good repair will be pulled from the dining room by the dining staff on duty. Maintenance will evaluate whether chairs can be repaired or if they are beyond repair, they will

Continued on next page

Legal Entity Representative

Signature

Heather Miller, Executive Director 4/2/2020

Printed Name and Title Date

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☐ Not Implemented

96.

be disposed of appropriately. A checklist will be used by the Evening Cook on duty to document the number of soiled chairs cleaned and it will be reviewed by the Food Service Director no less than 3 times weekly x 4 weeks for compliance to this regulation. The Food Service Director or Designee will do a walkthrough of the dining room no less than 3 times weekly x 4 weeks to ensure there are no chairs in need of cleaning and good repair in addition to the nightly process completed by the dining staff. If at the end of 4 weeks there is further evidence of non-compliance, a plan for further monitoring will be established.

The above processes will be reviewed for effectiveness at the quarterly Quality Management meeting.

Heather Miller Heather Miller Executive Director 4/2/2020

103f - Refrigerator/Freezer Temps

Regulations

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There was no thermometer in the ice cream freezer located in the kitchen.

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.)

The thermometer was placed in the ice cream freezer 1/14/20.

All Dietary Staff Members will be in-serviced by 4/15/20 as to proper thermometer use in the ice cream freezer.

The Cook will initial next to each reading on the ice cream freezer thermometer log after verification that the thermometer is in the freezer, daily x 4 weeks. Thereafter, the cook will continue this process weekly x 3 weeks. If at the end of 4 weeks there is further evidence of non-compliance, a plan for further monitoring will be established.

This process will be reviewed for effectiveness at the Quarterly Management Meeting.

Legal Entity Representative

Signature | Heather Miller Executive Director | 4/2/2020
Printed Name and Title | Date

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103g - Storing Food

Regulations

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

A 1/2 bag of frozen peas and a bag of corn on the cob were observed in the small freezer in the kitchen opened and unsealed.

There were 5 drums of ice cream located in the ice cream freezer without lids.

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.)

The Food Service Director or Designee will re-educate dietary staff by 4/15/20 as to proper food storage requirements.

The bags of peas and corn were closed and sealed at the time of survey. Ice cream lids were placed over top of the 5 exposed tubs of ice cream at that time also.

A checklist will be filled out by the morning and evening cooks after ensuring all dry food, frozen food and refrigerated food are label correctly, stored correctly and dated correctly. The checklist will be reviewed by the Food Service Director or Designee no less than 3 times weekly x 4 weeks to ensure completion. The Food Service Director or Designee will perform a visual audit of the freezers and coolers during the checklist review to ensure the tasks were completed.

If at the end of 4 weeks there is further evidence of non-compliance, a plan for further monitoring will be established. This process will be reviewed for effectiveness at the Quarterly Management Meeting.

Legal Entity Representative

Signature | Printed Name and Title | Date

Heather Miller Executive Director 4/2/2020

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103i - Outdated Food

Regulations

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was a box of Cheerios in the kitchen with an expiration date of 12-30-19.

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.)

The Food Service Director or Designee will re-educate dietary staff on outdated or spoiled food and the use of dented cans by 4/15/20.

A checklist will be filled out by the morning and evening cooks after ensuring that no dry food is outdated, spoiled or in dented cans. The checklist will be reviewed by the Food Service Director or Designee no less than 3 times weekly x 4 weeks to ensure completion. The Food Service Director or Designee will perform a visual audit of the dry food storage during the checklist review to ensure the tasks were completed.

If at the end of 4 weeks there is further evidence of non-compliance, a plan for further monitoring will be established.

This process will be reviewed for effectiveness at the Quarterly Management Meeting.

Legal Entity Representative

Signature | Heather McNeil Executive Director | 4/20/2020
Printed Name and Title | Date

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105g - Lint Removal and Duct Cleaning

Regulations

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 1-13-20, there was an approximate 1/4 inch accumulation of lint in the lint trap of the dryer in the laundry room on the 3rd floor. There were no clothes in the dryer at the time.

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.)

Staff will remove lint from the lint trap and drum of clothes dryers after each use.

The Nurse on duty for each shift will be responsible for checking lint traps no less than 3 times weekly x 4 weeks to ensure staff is following procedure and that there is no lint in the dryers. If at the end of 4 weeks there is further evidence of non-compliance, a plan for further monitoring will be established.

Any instances of lint in the dryer will be reported by each shift Nurse to the Director of Resident Care (DRC) for follow up.

This process will be reviewed for effectiveness at the Quarterly Management Meeting.

Legal Entity Representative

Heather Miller — Heather Miller, Executive Director — 4/2/2020

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107c - Food/Water 3 Day Supply

Regulations

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 1-13-2020, the home served 52 residents, requiring 156 gallons of emergency drinking water. However, the home had only 107.5 gallons. The home does not have a contract with a local bottled water supplier that includes delivery of emergency water.

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.)

The emergency water supply was corrected on 1/14/20 to the correct number of 156 gallons.

The Community does have a contract with a local bottled water supplier for delivery of emergency water (DS Services). An additional copy of it is included with this POC.

The Food Service Director will audit the emergency water supply weekly prior to placing the weekly food order so that any water that is needed can be included with the food order. The results of the weekly audit will be reviewed at the weekly At Risk meeting as part of the regular agenda to ensure any emergency water needs have been addressed.

This process will be reviewed for effectiveness at the Quarterly Management Meeting.

Legal Entity Representative

Heather Miller — Heather Miller, Executive Director — 4/2/2020

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☐ Not Implemented

132h - Designated Meeting Place

Regulations

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drills on 8-22-19, at 6:31 am, [redacted], residents did not evacuate to a designated meeting place away from the building or within the fire-safe area. The residents were evacuated to the hallways until further instructions.

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.)

Fire Drills are performed by an outside service through Fire and Life Safety Solutions.

Fire drills for the above two dates were reviewed by the Executive Director with [redacted] of DHS on Friday 3/27/20 and [redacted] of Fire and Life Safety Solutions . Both evacuations were appropriate based upon the location of the fire in the Community.

The Executive Director reviews all Fire Drill reports the day following a fire drill to ensure compliance with all regulations related to Fire Drills.

If a fire drill is not performed in accordance with regulations, the fire drill for that month is repeated.

Legal Entity Representative

Heather Miller Executive Director 4/2/2020

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141a 1-10 Medical Evaluation Information

Regulations

2600.

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

The medical evaluation for residents #1 and #2 did not include medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications, body positioning and movement stimulation for residents, if appropriate.

The medical evaluation for resident #3 did not include the health status.

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.)

The medical evaluations for residents #1 and #3 have been updated. Resident #2 no longer lives at the Community.

The DRC or Designee will audit all current resident medical evaluations by 5/30/2020 to ensure they are updated and revised according to the specifications of this regulation.

Following completion of this audit, all newly acquired Medical Evaluations will be reviewed by the DRC or Designee.

This process will be reviewed for effectiveness at the Quarterly Management Meeting.

Legal Entity Representative

Heather Miller — Heather Miller Executive Director — 4/2/2020

Signature | Printed Name and Title | Date

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171c - Home's Vehicle Documents

Regulations

2600.

171.c. The home shall maintain current copies of the following documentation for each of the home's vehicles used to transport residents:

1. Vehicle registration.
2. Valid driver's license for vehicle operator.
3. Vehicle insurance.
4. Current inspection.
5. Commercial driver's license for vehicle operator if applicable.

Description of Violation

The home does not have a copy of vehicle insurance and vehicle registration for its van used to transport residents. The vehicle registration expired on 6-30-19.

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.)

The vehicle used to transport residents is rented through The Hertz Corporation.

We have obtained a current copy of the insurance and registration for this vehicle (attached).

Both insurance and registration will be checked monthly, as part of the monthly safety check done on the van by the Lifestyle 360 department.

Review of the monthly safety check will be discussed at the Quarterly Management Meeting.

Legal Entity Representative

Signature | Heather Miller, Executive Director | 4/2/2020
Printed Name and Title | Date

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

Plan of correction implementation status as of 5/26/20 (Date)

☒ Implemented
☐ Not Implemented

181a - Self-adminstration Assist

Regulations

2600.

181.a. A home shall provide residents with assistance, as needed, with medication prescribed for the resident's self-administration. This assistance includes helping the resident to remember the schedule for taking the medication, storing the medication in a secure place and offering the resident the medication at the prescribed times.

Description of Violation

Resident #4, requires assistance with storing medications and scheduled reminders to self-administer medications. The home has failed to provide this assistance, resulting in expired medications, medication treatments not being applied, and the physicians orders not be followed.

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.)

The DRC or Designee will re-educate Nursing staff as to proper protocols related to residents who Self-administer medications by 4/30/20.

Resident #4 audit was completed to remove expired medications on 1/14/20.

A self-medication evaluation for this resident was completed on 3/2/2020 to determine resident #4's ability to self- medicate.

An audit will be completed by DRC or Designee no less than monthly x 3 months for residents that self-administer to remove expired medications and ensure orders are being followed. If no errors are found after 3 months, the audit will be completed quarterly.

Legal Entity Representative

Heather Miller — Heather Miller, Executive Director — 4/2/2020

Signature | Printed Name and Title | Date

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Plan of correction implementation status as of 5/26/20 (Date)

☒ Implemented

☐ Not Implemented

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

183f - Discontinued Medications

Regulations

2600.

183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

The following medications for resident #4 were expired as follows: PreServision Areds 2/21/18, Simethicone 4/20/19, Cipro Orth Sol .3% 1/7/20 and Erythromycin Opthalmic 1/11/20. These medications were still in 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.)

The above medications for resident #4 were removed from the resident's medication box on 1/14/20.

A self-medication evaluation for this resident was completed on 3/2/20 to reconcile medication.

An audit will be completed by DRC or Designee no less than monthly x 3 months for residents that self-administer to remove expired medications and ensure orders are being followed. If no errors are found after 3 months, the audit will be completed quarterly.

This process will be reviewed for effectiveness at the Quarterly Management Meeting.

Legal Entity Representative

Signature

Heather Mills-Executive Director 4/2/2020

Printed Name and Title Date

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Plan of correction implementation status as of 5/26/20 (Date)

☒ Implemented

☐ Not Implemented

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

184b - Resident's Meds Labeled

Regulations

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 1-14-20, a bottle of Clear Eye Solution, belonging to resident #4 was in the residents room and not labeled with the resident's name.

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 self-medication evaluation for this resident was completed on 3/2/20 to reconcile medication, at which time the Clear Eye Solution was checked for correct labeling with the resident's name.

An audit will be completed by DRC or Designee no less than monthly x 3 months for residents that self-administer to ensure resident's name is labeled on all medication. If no errors are found after 3 months, the audit will be completed quarterly.

This process will be reviewed for effectiveness at the Quarterly Management Meeting

Legal Entity Representative

Signature

Heather Miller, Executive Director 4/2/2020
Printed Name and Title Date

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☒ Implemented
☐ Not Implemented

185a - Implement Storage Procedures

Regulations

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #4, is prescribed 2 mg of Loperamide as needed. On 1-14-20, at 3:15 pm, the medication was not available in the home.

Resident #1 has an order to have blood sugar levels documented, the home failed to document this information as prescribed by the physician.

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.)

Resident #4:

Resident #4 self- medicates.

Resident #4 audit was completed on 1/14/20 to remove expired medications.

A self-medication evaluation for this resident was completed on 3/2/20 to reconcile medication.

An audit will be completed by DRC or Designee no less than monthly x 3 months for residents that self-administer to ensure all medication is present as per doctor's orders. If no errors are found after 3 months, the audit will be completed quarterly.

Resident #1:

All staff that perform blood glucose testing will be re-educated by the DRC or Designee regarding proper documentation of blood glucose readings by 4/15/2020,

Audits will be conducted by DRC or Designee weekly x 4 weeks, then monthly if compliant.

Audit results will be reviewed at the quarterly Quality Management Meeting.

Signature | Heather Miller Executive Director 4/2/2020
Printed Name and Title/ Date

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Plan of correction implementation status as of 5/26/20 (Date)

☒ Implemented
☐ Not Implemented

187d - Follow Prescriber's Orders

Regulations

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

Description of Violation

Resident #4, is prescribed Aspercreme Pad Lido 4%. However, this medication was not administered to resident within the last 30 days because the medication was not available in 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.)

Resident #4 self- medicates.

An audit will be completed by DRC or Designee no less than monthly x 3 months for residents that self-administer to ensure all medication is present as per doctor's orders. If no errors are found after 3 months, the audit will be completed quarterly.

This process will be reviewed for effectiveness at the quarterly Quality Management Meeting

Legal Entity Representative

Heather Miller — Signature

Heather Miller, Executive Director — Printed Name and Title

4/2/2020 — Date

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Plan of correction implementation status as of 5/26/20 (Date)

☒ Implemented
☐ Not Implemented

191 - Resident Right to Refuse

Regulations

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #7, admitted 12-20-19, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

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.)

Resident #7 was re-educated 3/31/2020 by the Executive Director on his right to refuse medications

All residents will be re-educated by the Executive Director or Designee on their right to refuse medication by April 30th, 2020.

Legal Entity Representative

Signature

Heather Miller, Executive Director 4/2/2020

Printed Name and Title Date

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☒ Implemented

☐ Not Implemented

227d - Support Plan Medical/Dental

Regulations

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident #1, dated 12/11/19, indicates the resident has a need for hearing aids. The resident's support plan, dated 12/11/19 does not document how this need will be met.

The assessment for resident #8, dated 9/11/19, indicates the resident has a need for bed rails. The resident's support plan, dated 9/19/19 does not document how this need will be met.

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.)

Resident #1's RASP was updated by the DRC regarding her hearing needs.

Resident #8:
Per evaluation by PT, the bed rails for resident #8 are no longer needed. The RASP was updated by the DRC to reflect the change.

Resident's service needs will be reviewed at the weekly At Risk meeting and RASPS updated, if applicable.

Legal Entity Representative

Signature | Printed Name and Title | Date

Martha Miller, Executive Director 5/27/2020

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☒ Implemented
☐ Not Implemented

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251b - Record Entries Legible

Regulations

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on resident's #1 , Resident Assessment Support plan. The documented was dated 12-11-19.

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.)

The DRC or Designee will educate nursing staff by April 15th, 2020 as to proper documentation and how to correct errors when documenting.

New hires in Nursing will receive training on documentation and correcting errors as part of their initial orientation to the job.

Legal Entity Representative

Heather Miller — Signature

Heather Miller Executive Director — Printed Name and Title

4/21/2020 — Date

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Plan of correction implementation status as of 5/26/20 (Date)

☒ Implemented
☐ Not Implemented