



**Sent via e-mail kca@sageseniors.com
Sent via e-mail Daylesford.ed@sagelife.com
July 24, 2020**

Ms. Kelly Cook Andress
President
Berwyn Real Estate, LP
1489 Baltimore Pike, Suite 245
Springfield, Pennsylvania 19064

RE: Daylesford Crossing
1450 East Lancaster Avenue
Paoli, Pennsylvania 19301
License #: 141540

Dear Ms. Andress:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on February 26 and 27, 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: *DAYLESFORD CROSSING*
Address: *1450 EAST LANCASTER AVENUE,, PAOLI, PA 19301*
County: *CHESTER* Region: *SOUTHEAST*

License Number: *14154*

Administrator

Name: *Lydia Gemmer* Phone: *6106404000* Email: *daylesford.ed@sagelife.com*

Legal Entity

Name: *BERWYN REAL ESTATE LP*
Address: *1489 BALTIMORE PIKE, SUITE 245,, SPRINGFIELD, PA, 19064*

Certificate(s) of Occupancy

Type: *C-1* Date: *08/05/2015* Issued By: *Treydffrin Twp*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *108* Waking Staff: *81*

Inspection

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

Inspection Dates and Department Representative

02/26/2020 - On-Site: Charlotte Wiley, Sandra Wooters
02/27/2020 - On-Site: Charlotte Wiley, Sandra Wooters

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* Residents Served: *76*

Secured Dementia Care Unit

In Home: *Yes* Area: *Connections* Capacity: *24* Residents Served: *17*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *76*
Diagnosed with Mental Illness: *3* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *32* Have Physical Disability: *0*

16b - Incident Policies

Regulations

2600.

16.b. The home shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

Description of Violation

The home's written policy on reportable incidents does not address the procedures of investigation and prevention of reportable incidents.

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.)

At the time of the survey, only one incident reporting policy was inadvertently included in our survey binder and available to the surveyors (Incident Reporting to State Licensing Agency-PA).

There are 3 SageLife Policies that make up our comprehensive incident/accident reporting program. These address the areas of prevention, reporting, notification, investigation and management of reportable incidents and conditions. All three policies are now located in our state survey binder as of May 12, 2020 and are attached as **Exhibit A**.

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir 5/14/2020
Printed Name and Title Date

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

The above plan of correction is approved as of 7/20/20
(Date)

Plan of correction implementation status as of 7/20/20
(Date)

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

Implemented
 Not Implemented

18 - Compliance With Laws

Regulations

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Personal care and assisted living homes must post the required influenza information in a public place in the home year-round as required by the Influenza Awareness Act (HB 1785). The home did not have an influenza poster anywhere.

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.)

Daylesford Crossing would like this regulation to be reviewed for consideration for withdrawal.

Daylesford Crossing had a CDC influenza flyer posted in the Community on the first day of the inspection. The DON was not aware that the regulation required the DHS influenza poster to be posted in the community.

Immediately upon notice that the DHS influenza poster needed to be posted the Director of Nursing posted it on all four floors.

The DHS Poster was posted prior to the inspectors leaving the building on 2/27/20.

Daylesford Crossing has given the poster a spot on the community bulletin boards on each floor.

The poster will be replaced by the Director of Nursing in the event that the poster is damaged or goes missing.

Supporting Documentation:

- Copy of the CDC flyer that was posted in the Community- **Exhibit B**

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Executive
Printed Name and Title

5/14/2020
Date

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(Date)

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(Date)

The above plan of correction was approved by *MG*
(Initials)

- Implemented
 Not Implemented

29a SOPb7 - Hospice Care: Sufficient Staff for Safe Evacuation

Regulations

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:

- 7. The home is to maintain sufficient staffing at all times to provide for the safe evacuation of all residents, including the resident who is actively dying while receiving hospice care and services, in accordance with the fire drill practice requirements specified in paragraph (5) and § 2600.132(a)-U). A resident who meets the conditions of paragraphs (1)-(3) is a resident with mobility needs in accordance with § 2600.4 (relating to definitions).

Description of Violation

The home did not evacuate residents receiving hospice care, who were not actively dying, during fire drills conducted on, 2/20/20 at 2:30 pm (6 residents); 1/31/2020 at 2:00 pm (6 residents); 12/31/19 at 11:00 am (7 residents); 11/1 /19 at 12:30 am (8 residents); 8/30/19 at 6:25 am (12 residents) and 7/15/19 at 2:00 pm (14 residents).

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.)

Daylesford Crossing allowed Residents receiving hospice services to remain in the home during fire drills even when not actively dying.

The Director of Nursing (DON) did have physician approvals for all of the hospice residents but was unaware of the policy that the resident must be actively dying.

Both the Building Engineer and the DON were educated about the regulation and all future fire drills will include all residents with the exception of those that are actively dying, **Exhibit D**

The Executive Director will review each monthly fire drill to ensure compliance.

Supporting Documentation:

- Fire Drill data from next fire drill (March 4, 2020)- **Exhibit E**

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir
Printed Name and Title

5/14/2020
Date

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Implemented

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(Initials)

41e - Signed Statement

Regulations

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 #1'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 (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 Contract of a Resident in Memory Care was signed by the Spouse and not by the Resident as required by Regulations. The resident rights and complaint procedure is located in a section of the contract which has a separate signature. The Director of Community Relations did not have compliance reviews in place to spot the missing signature.

The Director of Community Relations (DCR) immediately had the resident sign the resident rights and complaint procedures.

The DCR audited all Resident Contract Files for missing signatures on 3/19/20.

The DCR revised her Audit Tool for Resident Agreements to include the review of resident signatures in the appropriate spots.

The Executive Director (ED) will review each new contract prior to filing in the resident file cabinet. In addition, the ED will spot check 5-10 resident files for accurate completion at the monthly QA Meeting.

Supporting Documentation:

- Copy of the new Audit Tool for Resident Agreement- **Exhibit C**

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir 5/14/2020
Printed Name and Title Date

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(Date)

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(Initials)

- Implemented
- Not Implemented

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

The home has cameras recording activities of four areas on the outside of the home. There are no signs to indicate cameras are in use and recording.

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.)

Daylesford Crossing has exterior cameras that record the perimeter of the building and a portion of the parking lot. There is not any interior or corridor video monitoring or recording. The RCG specifically says that the video monitoring and recording of the home's exterior is permitted, therefore it was assumed that this was not a violation of the resident rights.

Upon notification of the violation, the building engineer immediately ordered four permanent signs and placed temporary signs around the outside of the building notifying residents and staff of the cameras. The permanent signs were received on 3/20/20 and placed at designated spots around the building.

Supporting Documentation:

- Photo of one of the permanent signs posted- **Exhibit F**

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir
Printed Name and Title

5/14/2020
Date

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(Date)

Implemented

Not Implemented

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(Initials)

54a - Direct Care Staff

Regulations

2600.

54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person A, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

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.)

Direct staff person A did not have her Diploma/GED copy in her employee file.

The Resident Services Coordinator (RSC) is responsible to collect the documentation upon hire and she immediately searched for the document. She contacted the staff person to bring in a duplicate and the staff person brought in a copy of the diploma that afternoon. The Document was available for review by the inspector before she left on 2/27/20.

The Business Office Manager has added the diploma documentation to his checklist for all files he receives from the RSC for direct care staff.

An audit of all Direct care staff files to confirm Diploma and/or GED inclusion was completed on 5/6/20 by the Business Office Manager.

To ensure compliance in the future, the Business office manager will spot check 5 – 10 employee files each month as part of the QA meeting.

Supporting Documentation:

- Business Office Employee File Checklist- **Exhibit G**
- Copy of Staff person A Diploma- **Exhibit H**

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir 5/14/2020
Printed Name and Title Date

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The above plan of correction is approved as of 7/20/20 (Date) Plan of correction implementation status as of 7/20/20 (Date)

- Implemented
- Not Implemented

The above plan of correction was approved by *MG* (Initials)

65c - Ancillary Staff Orientation

Regulations

2600.

65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Ancillary staff person B, whose first day of work was 2/24/2017, did not have a general orientation to his/her specific job functions.

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.)

Daylesford Crossing would like this regulation to be reviewed for consideration for withdrawal.

Staff person B did not have a record of general orientation for her housekeeping position when she was hired 3 years ago. There is record of the staff person's DHS required First 8 hour training and the first 40 hour training. The staff person was trained to her housekeeping position but, unfortunately Daylesford Crossing did not have the ability to prove the training hours as the ADP payroll service which recorded training hours of training 3 years ago is no longer used by the community.

For the past two years, Daylesford Crossing has used a peer mentor program as well as a 3-5 day job specific training for every position in the Community.

Because the inspector mentioned that the job description needed to be signed, the Business Office Manager audited all employee files to ensure that all employee job description forms were signed.

The protocol for adhering to DHS required trainings, job position trainings and signing of job descriptions has been successfully in place for the past two years and Daylesford Crossing will continue this practice into the future to ensure that all employees are adequately prepared to serve the Personal care population.

Supportive Documentation:

- Copy of Staff person B's first 8 and first 40 hour training record.- Exhibit I

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir 5/14/2020
Printed Name and Title Date

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(Date)

Implemented

Not Implemented

The above plan of correction was approved by *MG*
(Initials)

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 carpet is frayed approximately 11 inches by 1/4 inch in the SDCU near the elevator.

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.)

Daylesford Crossing would like this regulation to be reviewed for consideration for withdrawal.

This violation was brought to the attention of the community after the exit interview. The 4.5 year old carpet in SDCU was later found to have a worn spot at the transition between carpets just outside the office area. It does not represent a trip hazard nor does it indicate that the building is in disrepair. The Building Engineer immediately trimmed what he could around the area of the carpet and has been checking it daily as part of his routine.

The Building Engineer has procedures in place to identify hazards within the community.

WITHDRAWN

7/20/20 *MJ*

Supportive Documentation:

- Picture of Carpet on 2/27/20 – Exhibit J
- Picture of Carpet on 5/8/20- Exhibit J

Legal Entity Representative

Lydia Gernone
Signature

Lydia Gernone Executive
Printed Name and Title

5/14/2020
Date

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The above plan of correction is approved as of _____ (Date)

Plan of correction implementation status as of _____ (Date)

- Implemented
- Not Implemented

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

101j1 - Mattress Fire Retardant

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

- 1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 2, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

The mattress in room 2 is indented (sunken in the middle) and not a supportive mattress.

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.)

Daylesford Crossing would like this regulation to be reviewed for consideration for withdrawal.

The violation states that the mattress in SDCU room 2 is sunken in the middle and not supportive. Daylesford Crossing provided a mattress to all Community residents. The resident in Room 2 was provided a bed upon move in by Daylesford Crossing. **WITHDRAWN**

Shortly after move in, the family of the resident in room 2 decided that they wanted to bring a different bed for mom and did so. The resident nor her Family had never complained about the bed, nor did she exhibit any behaviors that indicated she was uncomfortable while sleeping. 7/20/20 *MG*

The beds in SDCU were immediately checked by the program director to ensure that all beds did not show any signs of indentation and the bed in Room 2 was removed and replaced with a hospital bed per family request.

Daylesford Crossing will continue to allow residents to provide their own furniture. We will check the furniture for obvious signs of wear and tear upon move in.

The Director of Community Relations will encourage the families to refrain from bringing furniture with obvious signs of wear and tear to the community.

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir 5/14/2020
Printed Name and Title Date

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(Date)

Plan of correction implementation status as of _____
(Date)

- Implemented
- Not Implemented

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

103i - Outdated Food

Regulations

2600.

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

Description of Violation

On 2/27/2020, there was a dented can of sweet potatoes on the shelf in the main 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.)

A dented can was found in the kitchen of the community kitchen.

A designated area for dented cans existed in the storage area but the dented can was not in the designated area.

All kitchen staff was immediately educated on the process of identifying and storing dented cans in the kitchen- **Exhibit K**

The Dining Director will spot check the cans to ensure that any cans that are delivered with dents are stored in the designated

area until returned to the food supply company or destroyed.

Compliance to this regulation has been met.

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir 5/14/2020
Printed Name and Title Date

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(Date)

Plan of correction implementation status as of 7/20/20
(Date)

Implemented

Not Implemented

The above plan of correction was approved by *MG*
(Initials)

123a - Exit Doors

Regulations

2600.

123.a. Exit doors must be equipped so that they can be easily opened by residents from the inside without the use of a key or other manual device that can be removed, misplaced or lost.

Description of Violation

On 2/26/19, the 1st floor emergency exit is locked with an electronic key and delayed egress. There is no instructions on how to exit using the electronic key pad and delayed egress.

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 fire exit door did not have a sign indicating that it was a delayed egress. The door automatically opens with the activation of the emergency alarms, or when putting in the key code, but it does not have a sign indicating that it was a delayed door.

A sign was created with the proper instruction and placed at the door immediately on the first day (2/26/20) of the inspection and was shown to the inspector.

The signs will remain on the door to alert all staff and residents can exit the building safely.

Supportive Documentation:

- Picture of door area with sign.- **Exhibit L**

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir 5/14/2020
Printed Name and Title Date

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(Date)

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(Date)

- Implemented
- Not Implemented

The above plan of correction was approved by *MG*
(Initials)

132d - Evacuation

Regulations

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The fire drill held on 5/31/2019, evacuation time was 7 minutes and 2 seconds. The fire safety expert letter dated 3/21/2019, indicates an extended evacuation time of 6 minutes and 26 seconds.

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 fire drill dated 5/31/19 took 34 seconds longer than the 6 minute 26 second time allowed by the Community's fire expert.

The Building Engineer recorded the actual time of the fire drill on that day. The Building Engineer is aware of the time limit provided by the fire safety expert.

The Building Engineer has improved the fire safety training since his employ just a few days before that fire drill.

The Building Engineer and the entire community continue to successfully complete timely fire drills over the past year as was evident on the Fire Drill record.

Supportive Documentation:

Retraining re regulation **Exhibit M**

Fire Drills, past year **Exhibit N**

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir 5/14/2020
Printed Name and Title Date

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7/20/20
(Date)

Plan of correction implementation status as of

7/20/20
(Date)

Implemented

Not Implemented

The above plan of correction was approved by

MG
(Initials)

132e - Fire Drill Sleeping Hours

Regulations

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The conducted sleeping hour fire drills on 1/3/19 at 5:55 am, 8/30/19 at 6:25 am and 11/1/19 at 12:30 am. There was more than a six month period between 1/3/2019 and 8/30/2019 fire drills held during sleeping hours.

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 Community conducted 3 sleeping hour fire drills in 2019 but did leave a period where two of the drills were 7 months apart and therefore in violation of this regulation. The newly hired Building Engineer was aware of the regulation but did not realize that the 6 months time limit had passed.

The Building Engineer along with the Administrator came up with a fire drill schedule that allows for 3 sleeping hour drills per year which will exceed the regulation requirement.

The fire drill schedule was put into place on January 2020.

Supportive Documentation:

- 2020 Fire Drill Schedule- **Exhibit O**

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir 5/14/2020
Printed Name and Title Date

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(Date)

Implemented

Not Implemented

The above plan of correction was approved by *MG*
(Initials)

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

The home did not evacuate residents receiving hospice care hospice, who were not actively dying, during the following fire drills: 2/20/20 at 2:30 pm (6 residents); 1/31/2020 at 2:00 pm (6 residents); 12/31/19 at 11 am (7 residents); 11/1/19 at 12:30 am (8 residents); 8/30/19 at 6:25 am (12 residents) and 7/15/19 at 2 pm (14 residents).

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.)

Daylesford Crossing would like this regulation to be reviewed for consideration for withdrawal as we feel it is has already been sited on page 5 (Reg 29a.b)

Daylesford Crossing allowed Residents receiving hospice services to remain in the home during fire drills even when not actively dying.

The Director of Nursing (DON) did have physician approvals for all of the hospice residents but was unaware of the policy that the resident must be actively dying. Both the Building Engineer and the DON were educated about the regulation and all future fire drills will include all residents with the exception of those that are actively dying.

Supporting Documentation:

- Fire Drill data from next fire drill- **Exhibit E**

Legal Entity Representative

Lydia Benner
Signature

Lydia Benner Executive 5/14/2020
Printed Name and Title Date

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(Date)

Implemented

Not Implemented

The above plan of correction was approved by *MB*
(Initials)

183d - Prescription Current

Regulations

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

In room 311 there was prescribed medications Iprat-Albi inhaler solution found unlocked on the bedside table prescribed to an individual who is not a resident of room 311 or 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.)

A family member left their inhaler in the resident's apartment. The medication was immediately removed from the resident's room on 2/27/20 upon discovery.

The family was notified that they are not to leave any personal medication in the resident's room. Any medications for the resident must be brought up to the nurse's station.

Pharmaceutical protocols were added to the community's house rules to make residents and families aware of the importance of how medications are to be brought to the community.

Nurses and med techs will be educated on protocols relating to medications coming from the resident homes by 5/31/20.

Supportive Documentation:

- Daylesford Crossing Home Rules- **Exhibit P**

Legal Entity Representative

Lydia Gemme
Signature

Lydia Gemme Exec Dir
Printed Name and Title

5/14/2020
Date

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(Date)

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(Initials)

- Implemented
 Not Implemented

187a - Medication Record

Regulations

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #2 is prescribed Bumex 1 mg, Mucinex 600 mg, Cureg 3.125 mg, Lasix 40 mg, Albuterol Sol, Temazepam cap 15 mg, Nystatin 1, Neosporin ointment 100 units, and Hydrocortisone. However, resident's January 2020 medication administration record does not indicate a diagnosis.

Resident #2 is prescribed Ipratropium/Albuterol Sol, AYR Saline Nasal Gel, and Restoril 15 mg. However, resident's February 2020 medication administration record does not indicate a diagnosis.

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 Resident's diagnosis' were missing from the MAR. This occurred due to the nurse re-writing the MARs and omitting the diagnoses.


The Diagnosis were immediately added to the MARs on 2/27/20.

The nurses will be educated on the protocols for documentation of diagnosis for each medication **by 5/31/20**.

An MAR program, Point Click Care has been instituted in the community and requires a diagnosis for each medication as it is input into the order. This feature would make it impossible to have an MAR for a resident without a diagnosis.

Point Click Care was fully implemented by 3/15/20.

Legal Entity Representative


Signature


Printed Name and Title

5/14/2020
Date

187a - Medication Record *(continued)*

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The above plan of correction is approved as of 7/20/20 Plan of correction implementation status as of 7/20/20
(Date) (Date)

Implemented

Not Implemented

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

187b - Date/Time of Medication Admin.

Regulations

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1 is prescribed Senna tab 8.6 mg at 9 pm and Trazadone 50 mg at 10 pm. Resident #1's December 2019 medication administration record does not include the initials of the staff person who administered these medications on 12/30/ 2019.

Resident #1 is prescribed Senna tab 8.6 mg. Resident #1's January 2020 medication administration record does not include the initials of the staff person who administered this medication on 1/31/2020 at 9 pm.

Resident #1 is prescribed Klonopin 0.5 mg. Resident #1's January medication administration record does not include the initials of the staff person who administered this medication on 1/31/20 at 8 am .

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 MAR does not have initials of the staff person who administered meds to Resident #1 on 1/30/20.

This violation occurred because the med tech did not follow protocol.

All resident MARS were reviewed by 3/1/20 for any other omissions.

Nurses and med techs will be educated regarding medication administration documentation by 5/31/20.

Point Click care was fully implemented in the community on 3/15/20. During the Med tech's shift, the program will alert the med tech of any medications that are due and will indicate if they are missed. This process eliminates all chances that the med administration will not be recorded as it will not allow the tech to complete her shift without proper documentation.

The DON will monitor the Point Click Care program daily to ensure that all medications are administered and recorded.

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir 5/14/2020
Printed Name and Title Date

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The above plan of correction is approved as of 7/20/20 (Date)

Plan of correction implementation status as of 7/20/20 (Date)

Implemented

Not Implemented

The above plan of correction was approved by *MG* (Initials)

187c - Refusal of Medication

Regulations

2600.

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

Description of Violation

Resident #2 is prescribed Ensure supplement daily. The resident was not given the supplement from February 1st to 27th. There is no indication the physician was contacted regarding the refusal by the resident.

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 physician was not notified of the resident's refusal to take Ensure. This occurred due to a lack of knowledge of the protocol. Physician was immediately notified of the resident's refusal of the Ensure and a review of the protocol was completed with the nurse that did not notify. **Exhibit Q** Education to nurses and med techs on the protocol of notification of MD for refusals of all medications and supplements will be completed by 5/31/20. Point Click Care MAR program was implemented in the community on 3/15/20. This program will remind the medication administer to notify the prescriber if the resident refuses any medications. Random audits will be completed by the Director of Nursing and report given at the Quality assurance meeting.

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer, Executive Director 5/14/2020
Printed Name and Title Date

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The above plan of correction is approved as of 7/20/20 Plan of correction implementation status as of 7/20/20
(Date) (Date)

The above plan of correction was approved by *MG* Implemented
(Initials) Not Implemented

187d - Follow Prescriber's Orders

Regulations

2600.

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

Description of Violation

Regulations

2600.

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

Description of Violation

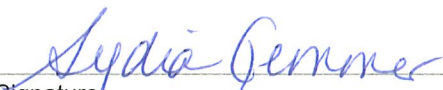
Resident #3 is prescribed Salonpas w/Lidocaine 4%. However, this medication was not administered to resident #3 on 1/14/2020, 1/26/20, 1/27/20, 1/ 28/20, 1/29/20 and 1/30/20 because the medication was not available in the home.

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.)

Salonpas medication was not administered to resident #3 as was prescribed by the physician. The physician was notified of the missing doses- **Exhibit R**
All resident MARS were audited by 3/1/2020 to ensure no other omissions were present. Education to nurses and med techs on the protocol of omission of a medication will be completed **by 5/31/20**. Point Click Care program was implemented on 3/15/20. With this program, any medication omission will immediately be brought to the attention of the med tech and the nurse on duty.

Legal Entity Representative


Signature

 Lydia Gemmer-Exec Dir 5/14/2020
Printed Name and Title Date

187d - Follow Prescriber's Orders *(continued)*

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(Date) (Date)

Implemented

Not Implemented

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

188b - Medication Error Reporting

Regulations

2600.

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

Description of Violation

Resident #3 is prescribed Salonpas w/lidocaine 4%. However, resident 3 was not administered SalonPas w/lidocaine 4% on 1/14/2020, 1/26/20, 1/27/20, 1/28/20 1/29/2020, 1/30/2020 at 9 am. Documentation to indicate the physician was contacted was not recorded for failure to administer the SalonPas Patch .

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 physician was not notified when the med tech failed to administer the Salonpas patch to resident 3. This occurred due to the nurse not following or knowing the written protocol. The physician and the resident's designated person were notified of the omission. A progress note was placed in the chart. **Exhibit R**

All residents MARS were audited to ensure no other omissions were present. Education to nurses and med techs on the protocol of omission of a medication will be completed **by 5/31/20**. Point Click Care program was implemented on 3/15/20. With this program, any medication omission will immediately be brought to the attention of the med tech and the nurse on duty. Using this information, the nurse will follow protocol and notify the designated person and the prescriber.

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir 5/14/2020
Printed Name and Title Date

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The above plan of correction is approved as of 7/20/20 (Date) Plan of correction implementation status as of 7/20/20 (Date)

- Implemented
- Not Implemented

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

188c - Medication Error Documentation

Regulations

2600.

188.c. Documentation of medication errors and the prescriber's response shall be kept in the resident's record.

Description of Violation

Resident #3 is prescribed Salonpas w/lidocaine 4%. However, resident #3 was not administered SalonPas w/lidocaine 4% on 1/14/2020, 1/26/20, 1/27/20, 1/28/20 1/29/2020, 1/30/2020 at 9 am. Documentation to indicate the physician was contacted was not recorded for failure to administer the SalonPas Patc h.

Plan of Correction (POC)

(Att ach 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 viol at io n from occurring aga in. If steps cannot be completed immed iate ly, include dates by which the steps will be comp lete d.)

Daylesford Crossing would like this regulation to be reviewed for consideration for withdrawal. As sited in the previous page and regulation, the physician was not contacted so therefore "the documentation to indicate the physician was contacted" could not possibly be recorded

The physician was not notified when the med tech failed to administer the Salonpas patch to resident #3, so therefore the documentation indicating that the physician was contacted could not be recorded.

This occurred due to the nurse not following or knowing the written protocol.

The physician and the resident's designated person were notified of the omission. After they were notified, a progress note was placed in the chart. Exhibit R The documentation to indicate the physician was contacted was recorded at this time.

All residents MARS were audited to ensure no other omissions were present.

Education to nurses and med techs on the protocol of omission of a medication will be completed by 5/31/20.

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir 5/14/2020
Printed Name and Title Date

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The above plan of correction is approved as of 7/20/20 (Date) Plan of correction implementation status as of 7/20/20 (Date)

- Implemented
- Not Implemented

The above plan of correction was approved by *MG* (Initials)

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 #1, admitted 6/17/2019, 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.)

Daylesford Crossing respectfully requests a review of this violation to withdraw because of duplicate violation to 41e (pg 6)

The Contract of a Resident in Memory Care was signed by the spouse and not by the resident as required by regulations. At Daylesford Crossing, the resident rights includes the reference to the resident having the ability to refuse medication.

The Director of Community Relations (DCR) immediately had the resident sign the resident rights which included the right to refuse medication.

The DCR audited all Resident Contract files for missing signatures on 3/19/20.

The DCR revised her Audit Tool for Resident Agreements to include the review of resident signatures in the appropriate spots.

The Executive Director (ED) will review each new contract prior to filing in the resident file cabinet.

The ED will spot check 5 – 10 resident files for accurate completion at the monthly QA Meeting.

Supporting Documentation:

- Copy of the new Audit Tool for Resident Agreement- **Exhibit C**

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir 5/11/2020
Printed Name and Title Date

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The above plan of correction is approved as of 7/20/20
(Date)

Plan of correction implementation status as of 7/20/20
(Date)

- Implemented
- Not Implemented

The above plan of correction was approved by *MG*
(Initials)

233c - Key-Locking Devices

Regulations

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the exit door in the stairwell of the Secure Dementia Care Unit (SDCU).

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 locking device at the rear door of SDCU that leads into the stairwell did not have the required code posted near the door.

The code was immediately placed by the door to ensure that the staff could open the door in an emergency other than fire. The door does automatically unlock when the fire alarm is activated.

The SDCU director will monitor this door to assure that the sign with the code is always present.

Supporting Documentation:

- Photo of the sign with the code in SDCU- **Exhibit S**

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer, Executive 5/14/2020
Printed Name and Title Date

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(Date)

Plan of correction implementation status as of 7/20/20
(Date)

The above plan of correction was approved by *MG*
(Initials)

- Implemented
- Not Implemented

234a - Admission Support Plan

Regulations

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on 9/5/2018. However, the resident's initial support plan was completed on 9/10/2018.

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 initial support plan for Resident 4 in SDCU was completed within 5 days of admission instead of the required 3 days.

The DON immediately educated the memory care director on the importance of completing the initial support plan within the 72 hour required time frame to ensure that the resident's support needs are being met. - **Exhibit T**

An audit was performed by the memory care director by 3/15/20 to assure that all support plans were complete.

DON will review all SDCU resident initial support plans within 72 hours to assure they are complete.

In addition, the Point Click Care program will highlight all care plans that are not completed by the due dates. This would include all admissions going into SDCU.

Legal Entity Representative

Lydia Gemmer
Signature

Lydia Gemmer Exec Dir 5/14/2020
Printed Name and Title Date

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The above plan of correction is approved as of 7/20/20
(Date)

Plan of correction implementation status as of 7/20/20
(Date)

Implemented

Not Implemented

The above plan of correction was approved by *MG*
(Initials)