Department of Human Services
Bureau of Human Service Licensing

June 8, 2021

[redacted]
KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC
ONE TOWN CENTER ROAD, SUITE 300
SUITE 300
BOCA RATON, FL 33486

RE: SPRING MILL SENIOR LIVING
3000 BALFOUR CIRCLE
PHOENIXVILLE, PA, 19460
LICENSE/COC#: 14632

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 03/16/2021, 03/19/2021, 03/24/2021, 03/30/2021, 04/05/2021, 04/08/2021, 04/16/2021, 04/19/2021, 04/20/2021 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,
Patricia Adams

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *SPRING MILL SENIOR LIVING* **License #:** *14632* **License Expiration Date:** *09/11/2021*
Address: *3000 BALFOUR CIRCLE, PHOENIXVILLE, PA 19460*
County: *CHESTER* **Region:** *SOUTHEAST*

Administrator

Name: [redacted] **Phone:** *6109337675* **Email:** [redacted]

Legal Entity

Name: *KAPG PHOENIXVILLE SENIOR HOUSING OPCO LLC*
Address: *ONE TOWN CENTER ROAD, SUITE 300, SUITE 300, BOCA RATON, FL, 33486*
Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date:** *09/10/2009* **Issued By:** *East Pikeland Twp*

Staffing Hours

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

Inspection

Type: *Partial* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Complaint* **Exit Conference Date:** *04/20/2021*

Inspection Dates and Department Representative

03/16/2021 - Off-Site: [redacted]
03/19/2021 - Off-Site: [redacted]
03/24/2021 - Off-Site: [redacted]
03/30/2021 - Off-Site: [redacted]
04/05/2021 - Off-Site: [redacted]
04/08/2021 - Off-Site: [redacted]
04/16/2021 - On-Site: [redacted]
04/19/2021 - Off-Site: [redacted]
04/20/2021 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *98* **Residents Served:** *54*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *1st floor* **Capacity:** *22* **Residents Served:** *9*

Resident Demographic Data as of Inspection Dates *(continued)*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *63*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *10*
Have Physical Disability: *1*

Inspections / Reviews

03/16/2021 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/04/2021*

5/14/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/19/2021*

5/21/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/31/2021*

42b - Abuse

1. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted] resident #1, [redacted], vomited a dark brown coffee ground substance in [redacted] bathroom sometime through the night. [redacted] was found unresponsive and without breathing at approximately 4:20am. Staff of the home called 911 at 4:23am. When the paramedics arrived at the home at 4:33am, CPR was not in progress, the resident's mouth was filled with a cup full of dark brown coffee ground emesis and [redacted] was without respirations on the floor of [redacted] room. The resident did not have a DNR order, therefore, CPR was initiated by the paramedic. The resident was without respirations from approximately 4:23am until paramedics started CPR at 4:34am. Resident #1 was pronounced dead at [redacted]

42b - Abuse *(continued)*

Plan of Correction **Do Not Accept**

Spring Mill Senior Living submits the Plan of Correction to comply with PA 2600 et al. and all other applicable regulations and statutes. The preparation and submission of this Plan of Correction does not constitute an admission of fault or liability on the part of Spring Mill Senior Living or an agreement by Spring Mill Senior Living as to the truth, accuracy, or validity of the facts alleged, conclusions drawn, or admission of any deficiency issued.

At 4:26am on [redacted], Staff Person A received a telephone call at home that Resident #1 was found by private duty aide without respirations or pulse, 911 had been called and was in transport, POA was notified via telephone and resident was transferred from bed to floor by two (2) Pennsylvania's Long-Term Care Task Force (LTC-TF) Regional Response Health Collaborative (RRHC) program agency nurses. CPR was initiated by an RRHC provided LPN. At 4:48am, a second call was placed to Resident #1's POA by Staff Person A, and was made aware of residents current status. CPR continued at that point. POA stated that [redacted] wanted all heroic efforts to stop. West End Ambulance staff were notified of POA's wishes. Paramedics were in contact with Phoenixville Hospital ER physician who received orders to cease CPR. The resident was pronounced by the Chester County Coroner at [redacted]

The resident did have Advanced Directives (Exhibit #1).

All staff were re-educated on 4/28/21 on the Older Adult Protective Services Act, Resident's Rights, Mandatory Reporting (Exhibit #2) by Staff Person B as an initial corrective action. Staff will have additional education provided by the PA Department of Aging "Learning Management System" as PADofA declined to come to the community. Online education will be completed by 5/28/21.

Ongoing education will continue to be provided upon hire/upon use of agency and annually for staff on Older Adult Protective Services Act, Resident Rights, as well as CPR requirements. Residents are informed regularly of their rights (upon admission as well as during resident council). Residents are and will continue to be encouraged to promptly report if someone is allegedly mistreating or neglecting them. All residents will be encouraged, and update as needed, to provide a POLST (Physician Orders for Life-Sustaining Treatment) upon admission so that advanced directives are clearly defined.

Progress of staff training on Regulation 42b will be reviewed as part of the quarterly Quality Assurance meetings as well as status-post death reviews will be conducted.

Completion Date: *05/11/2021*

42b - Abuse *(continued)*

Plan of Correction **Accept**

Spring Mill Senior Living submits the Plan of Correction to comply with PA 2600 et al. and all other applicable regulations and statutes. The preparation and submission of this Plan of Correction does not constitute an admission of fault or liability on the part of Spring Mill Senior Living or an agreement by Spring Mill Senior Living as to the truth, accuracy, or validity of the facts alleged, conclusions drawn, or admission of any deficiency issued.

At 4:26am on [redacted], Staff Person A received a telephone call at home that Resident #1 was found by private duty aide without respirations or pulse, 911 had been called and was in transport, POA was notified via telephone and resident was transferred from bed to floor by two (2) Pennsylvania's Long-Term Care Task Force (LTC-TF) Regional Response Health Collaborative (RRHC) program agency nurses. CPR was initiated by an RRHC provided LPN. At 4:48am, a second call was placed to Resident #1's POA by Staff Person A, and was made aware of residents current status. CPR continued at that point. POA stated that [redacted] wanted all heroic efforts to stop. West End Ambulance staff were notified of POA's wishes. Paramedics were in contact with Phoenixville Hospital ER physician who received orders to cease CPR. The resident was pronounced by the Chester County Coroner at [redacted]

The resident did have Advanced Directives (Exhibit #1).

All staff were re-educated on 4/28/21 on the Older Adult Protective Services Act, Resident's Rights, Mandatory Reporting, Advanced Directives, Living Wills, POLST and performance of CPR (Exhibit #2) by Staff Person B as an initial corrective action. All staff will have additional education provided by the PA Department of Aging "Learning Management System" as PADofA declined to come to the community. Online education will be completed by 5/28/21.

Ongoing education will continue to be provided upon hire/upon use of agency and annually for all staff on Older Adult Protective Services Act, Resident Rights, Advanced Directives, Living Wills, POLST and performance of CPR. Director of Health & Wellness, and designee, will attend the Chester County Department of Aging "Mandatory Abuse Reporting Train the Trainer" event on 6/8/21.

All resident charts have been audited for the presence of a POLST, DNR and Advanced Directives. All resident Facesheets have been updated to reflect DNR & POLST status. Director of Health & Wellness will create "Emergency Transfer" paperwork packets that will be flagged in each resident's chart. Director of Health & Wellness will train all direct care staff on these changes by 6/4/21.

Residents are informed regularly of their rights (upon admission as well as during resident council). Residents are and will continue to be encouraged to promptly report if someone is allegedly mistreating or neglecting them. All residents will be encouraged, and update as needed, to provide a POLST (Physician Orders for Life-Sustaining Treatment) upon admission so that advanced directives are clearly defined.

Progress of staff training on Regulation 42b will be reviewed as part of the quarterly Quality Assurance meetings as well as status-post death reviews will be conducted for six months.

Completion Date: *05/19/2021*

42k - Resident Record

1. Requirements

2600.

42.k. A resident and the resident's designated person, and other individuals upon the resident's written approval shall have the right to access, review and request corrections to the resident's record.

Description of Violation

[redacted], *staff A, reported* [redacted] *received emails on March 3 and March 24, 2021 from resident #1's family requesting resident records. The family also requested resident #1's records by emails dated February 21st an 23rd, 2021 to the Director of Nursing, staff B. The family was denied access to the records until April 9, 2021.*

Plan of Correction **Do Not Accept**

Spring Mill Senior Living submits the Plan of Correction to comply with PA 2600 et al. and all other applicable regulations and statutes. The preparation and submission of this Plan of Correction does not constitute an admission of fault or liability on the part of Spring Mill Senior Living or an agreement by Spring Mill Senior Living as to the truth, accuracy, or validity of the facts alleged, conclusions drawn, or admission of any deficiency issued.

Regulation 42.k states "A resident and the resident's designated person, and other individuals upon the resident's written approval shall have the right to access, review and request corrections to the resident's record." Spring Mill Senior Living did not receive the resident's written approval and consideration was given that the POA generally becomes inactive upon the resident's death. The requestor did not provide "Executor of Estate" paperwork and was requesting documentation that Spring Mill Senior Living does not maintain due to third party providers.

The documentation requested by the [redacted] *was provided upon clarification of request and within the scope of SMSL policy and DHS regulation. Spring Mill Senior Living policy "Record Confidentiality" (Exhibit III), indicates that records will be provided within sixty (60) days. This policy was not requested at the time of the DHS survey.*

Spring Mill Senior Living will continue to follow the policy on record review and request. Compliance will be reviewed by the Executive Director, or designee.

Completion Date: *05/11/2021*

42k - Resident Record *(continued)*

Plan of Correction **Accept**

Spring Mill Senior Living submits the Plan of Correction to comply with PA 2600 et al. and all other applicable regulations and statutes. The preparation and submission of this Plan of Correction does not constitute an admission of fault or liability on the part of Spring Mill Senior Living or an agreement by Spring Mill Senior Living as to the truth, accuracy, or validity of the facts alleged, conclusions drawn, or admission of any deficiency issued.

Regulation 42.k states "A resident and the resident's designated person, and other individuals upon the resident's written approval shall have the right to access, review and request corrections to the resident's record." Spring Mill Senior Living did not receive the resident's written approval and consideration was given that the POA generally becomes inactive upon the resident's death. The requestor did not provide "Executor of Estate" paperwork and was requesting documentation that Spring Mill Senior Living does not maintain due to third party providers.

The documentation requested by the [redacted] was provided upon clarification of request and within the scope of SMSL policy and DHS regulation. Spring Mill Senior Living policy "Record Confidentiality," indicates that records will be provided within sixty (60) days. This policy was not requested at the time of the DHS survey. The policy has been updated to comply with the regulation (Exhibit III).

Spring Mill Senior Living will follow the policy on record review and request for all future requests. Compliance will be reviewed by the Executive Director, or designee.

Completion Date: *05/19/2021*

63d - Certified CPR Staff

1. **Requirements**

2600.

63.d. A staff person who is trained in first aid or certified in obstructed airway techniques or CPR shall provide those services in accordance with his training, unless the resident has a do not resuscitate order.

Description of Violation

On [redacted], resident # 1 became unresponsive and stopped breathing. There were two agency staff present and on duty at the time and failed to render assistance to the resident in accordance with his/her training.

63d - Certified CPR Staff *(continued)*

Plan of Correction **Do Not Accept**

Spring Mill Senior Living submits the Plan of Correction to comply with PA 2600 et al. and all other applicable regulations and statutes. The preparation and submission of this Plan of Correction does not constitute an admission of fault or liability on the part of Spring Mill Senior Living or an agreement by Spring Mill Senior Living as to the truth, accuracy, or validity of the facts alleged, conclusions drawn, or admission of any deficiency issued.

At 4:26am on [redacted], Staff Person A received a telephone call at home that Resident #1 was found without respirations or pulse. EMS was called and was in transport. Resident was transferred from bed to floor by two (2) Pennsylvania's Long-Term Care Task Force (LTC-TF) Regional Response Health Collaborative (RRHC) program agency nurses. CPR was initiated by an RRHC provided LPN. At 4:48am, a call was placed to Resident #1's POA by Staff Person A, and was made aware of residents current status. CPR continued up until that point when the POA stated that [redacted] wanted all heroic efforts to stop. West End Ambulance staff were notified of POA's wishes. Paramedics were in contact with Phoenixville Hospital ER physician who received orders to cease CPR. The resident was pronounced by the Chester County Coroner at [redacted]

The resident did have Advanced Directives (Exhibit #1).

Staff were re-educated on 4/28/21 on the Older Adult Protective Services Act, Resident's Rights, Mandatory Reporting (Exhibit #2) by Staff Person B. Ongoing staff education will continue to be provided by the PA Department of Aging "Learning Management System" as they will not currently come onsite to conduct training. The education will be completed by 5/28/21.

Ongoing education will be provided for staff on Older Adult Protective Services Act, Resident Rights, as well as CPR requirements. Residents are informed regularly of their rights (upon admission as well as during resident council). Residents are and will continue to be encouraged to promptly report if someone is allegedly mistreating or neglecting them. All residents will be required to provide a POLST (Physician Orders for Life-Sustaining Treatment) upon admission and update if necessary so that advanced directives are clearly defined.

Completion Date: *05/11/2021*

63d - Certified CPR Staff *(continued)*

Plan of Correction **Accept**

Spring Mill Senior Living submits the Plan of Correction to comply with PA 2600 et al. and all other applicable regulations and statutes. The preparation and submission of this Plan of Correction does not constitute an admission of fault or liability on the part of Spring Mill Senior Living or an agreement by Spring Mill Senior Living as to the truth, accuracy, or validity of the facts alleged, conclusions drawn, or admission of any deficiency issued.

At 4:26am on [redacted], Staff Person A received a telephone call at home that Resident #1 was found by private duty aide without respirations or pulse, 911 had been called and was in transport, POA was notified via telephone and resident was transferred from bed to floor by two (2) Pennsylvania's Long-Term Care Task Force (LTC-TF) Regional Response Health Collaborative (RRHC) program agency nurses. CPR was initiated by an RRHC provided LPN. At 4:48am, a second call was placed to Resident #1's POA by Staff Person A, and was made aware of residents current status. CPR continued at that point. POA stated that [redacted] wanted all heroic efforts to stop. West End Ambulance staff were notified of POA's wishes. Paramedics were in contact with Phoenixville Hospital ER physician who received orders to cease CPR. The resident was pronounced by the Chester County Coroner at [redacted]

The resident did have Advanced Directives (Exhibit #1).

All staff were re-educated on 4/28/21 on the Older Adult Protective Services Act, Resident's Rights, Mandatory Reporting, Advanced Directives, Living Wills, POLST and performance of CPR (Exhibit #2) by Staff Person B as an initial corrective action. All staff will have additional education provided by the PA Department of Aging "Learning Management System" as PADofA declined to come to the community. Online education will be completed by 5/28/21.

Ongoing education will continue to be provided upon hire/upon use of agency and annually for all staff on Older Adult Protective Services Act, Resident Rights, Advanced Directives, Living Wills, POLST and performance of CPR. Director of Health & Wellness, and designee, will attend the Chester County Department of Aging "Mandatory Abuse Reporting Train the Trainer" event on 6/8/21.

All resident charts have been audited for the presence of a POLST, DNR and Advanced Directives. All resident Facesheets have been updated to reflect DNR & POLST status. Director of Health & Wellness will create "Emergency Transfer" paperwork packets that will be flagged in each resident's chart. Director of Health & Wellness will train all direct care staff on these changes by 6/4/21.

Residents are informed regularly of their rights (upon admission as well as during resident council). Residents are and will continue to be encouraged to promptly report if someone is allegedly mistreating or neglecting them. All residents will be encouraged, and update as needed, to provide a POLST (Physician Orders for Life-Sustaining Treatment) upon admission so that advanced directives are clearly defined.

Progress of staff training on Regulation 42b will be reviewed as part of the quarterly Quality Assurance meetings as well as status-post death reviews will be conducted for six months.

Completion Date: *05/19/2021*

88a - Surfaces

1. Requirements

88a - Surfaces *(continued)*

2600.

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

Description of Violation

At the top of the steps on the second floor landing, there was a iron support jetting out five inches from the support post causing a tripping hazard for the residents.

Plan of Correction **Accept**

Spring Mill Senior Living submits the Plan of Correction to comply with PA 2600 et al. and all other applicable regulations and statutes. The preparation and submission of this Plan of Correction does not constitute an admission of fault or liability on the part of Spring Mill Senior Living or an agreement by Spring Mill Senior Living as to the truth, accuracy, or validity of the facts alleged, conclusions drawn, or admission of any deficiency issued.

It was noted that code 2600.88a was in violation on the second floor landing by the staircase. Upon the violation infraction that occurred with code 2600.88a; there was a part of the railing that had a brace support being identified as a tripping hazard on the second floor jetting out 5 inches (est). The original construction of the building had this support in place and was in compliance with original state and county inspections before the building opened.

It is also noted that during the years of operation and multiple State inspections, this was the only the inspector that has written a deficiency on this matter.

With the support of the railing being in question, the support was repositioned to still help support the railing to eliminate any potential trip hazard. (As pictured in the Before-Railing 1 and After-Railing 2). (Exhibit IV)

Facilities Director, or designee, has inspected the area to eliminate a tripping hazard, and documentation will be maintained via TELS (Exhibit V). Executive Director will review the documentation during quarterly Quality Assurance meetings.

Completion Date: *05/11/2021*

187c - Refusal of Medication

1. **Requirements**

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.

187c - Refusal of Medication *(continued)*

Description of Violation

Resident #1 refused prescribed medication Ranitidine 150mg on 1/1/21 at 11:49; on 1/5/21 resident refused medications at 8:04pm including Reguloid Laxative Powder, Azelastin-Flutic, Iprat-albut; on 1/7/21 at 11:32am refused medications Iprat-albu, Escitalopram 5mg, Azelastin-flutic, Fungi-nail ointment, Docusate Sodium 50mg, Thermotabs, Reguloid Laxative Powder, Lisinopril 5mg, Metoprolol 25mg, Eliquis 2.5mg at 2:00pm refused Benefiber, Vitamin D3, Divalproex 125mg, Trazodone 50mg, Ferrous Sulfate 325mg and 7:39pm refused Azelastin-Flutic 137mcg, Docusate Sodium 250mg, Iprat-Albuton; on 1/8/21 at 3:44pm refused Divalproex Sod 125mg and Docusate Sodium 250mg; on 1/14/21 at 9:36am resident refused medications Azelastin-flutic, Escitalopram 5mg, Thermotabs, Lisinopril 5mg, Fungi-nail, Docusate Sodium 250mg, Metoprolol Succ 5mg, Eliquis 2.5mg; on 1/16/21 at 7:24pm resident refused medications Benefiber, Famotidine 0mg, Azelastin-flutic, Trazodone, Metoprolo, Docusate, Ipra-albut, Fungi-nail, Reguloid laxative powder; 1/17/21 at 1:35pm resident refused medications Trazodone, Divalproex, Vitamin D3, Ferrous Sulfate,; on 1/18/21 at 8:17pm resident refused medications Azelastin-flutic, Fungi-nail, Escitalopram, Eliquis, Lisinopril, Metoprolol, Docusate, Reguloid Laxative, Thermotabs, Iprat-albut; resident refused medications on 1/21/21 at 12:14pm Benefiber, Ferrous Sulfate, Vitamin D3, Trazodone, Divalproex; and on 1/22/21 at 6:51pm resident refused Eliquis, Famotidine, Azelastin-Flutic, Trazodone, Metoprolol, Docusate Sodium, Reguloid Laxative, Benefiber; on 1/26/21 at 12:48 resident refused Trazodone, Divalproex, Ferrous Sulfate, Vitamin D3, Benefiber,; on 1/28/21 at 6:55pm resident refused Azelastin-fluc, Fungi-nail, Eliquis, Famotidine, Trazodone, Reguloid Laxative, Iprat-albut, Metoprolol, Docusate Sodium, Benefiber; on 1/30/21 at 7:32pm resident refused Azelastin-flutic, Benefiber, Eliquis, Famotidine, Trazodone, Fungi-nail, Metoprolol, Docusate Sodium, Reguloid Laxative, Iprat-albut, and on 1/31/21 at 7:39pm Benefiber. There is no documentation of physicians response to the refusals.

Resident #1 refused prescribed scheduled medications on 2/5/21 at 10:57am including: Eliquis 2.5, Escitalopram 5mg, Azelastin-Flutic, Fungi-nail, Lisinopril 5mg, Metoprolol 25mg, Docusate Sodium 50mg, Thermotabs, Reguloid Laxative Powder, and Iprat-albut. There is no notation on MAR of physician's response to the refusals.

On 2/20/21 – resident #2 refused all medications including sertraline HCL 25mg, Furosemide 20mg, Senna Plus Tab, Ferrous Sulfate 325mg, Metoprolol 50mg, Amlodipine Beslylate 5 mg, Aspirin 325mg. There was no documentation the physician was advised of the refusal and their response.

187c - Refusal of Medication *(continued)*

Plan of Correction **Do Not Accept**

Spring Mill Senior Living submits the Plan of Correction to comply with PA 2600 et al. and all other applicable regulations and statutes. The preparation and submission of this Plan of Correction does not constitute an admission of fault or liability on the part of Spring Mill Senior Living or an agreement by Spring Mill Senior Living as to the truth, accuracy, or validity of the facts alleged, conclusions drawn, or admission of any deficiency issued.

It was noted that on the Medication Administration Records for Residents #1 & #2, there were dates that it was noted by the medication technician that the resident(s) had refused to take the medication.

Resident #1 was a [redacted] advanced dementia resident who had a history of combative, aggressive behaviors that at times made difficult to administer medications. Our eMAR provides space for the medication technician to note "resident refused," and "physician notified." There was no documentation reflecting the physician's response.

Resident #2 did not refuse [redacted] medications on 2/20/21 and a typographical error was made by the medication technician. The resident was, at that time, actively dying, and unable to take the medications.

All Medication Technicians and LPNs were re-inserviced on 4/28 & 4/29 on medication related regulations (2600.181-191) (exhibit VI).
Director of Health & Wellness, or designee, will audit the "medication variance" report daily and notify & follow up with any physician when a resident refuses a medication. Executive Director will review all documentation during quarterly Quality Assurance meetings.

Completion Date: *05/11/2021*

187c - Refusal of Medication *(continued)*

Plan of Correction **Accept**

Spring Mill Senior Living submits the Plan of Correction to comply with PA 2600 et al. and all other applicable regulations and statutes. The preparation and submission of this Plan of Correction does not constitute an admission of fault or liability on the part of Spring Mill Senior Living or an agreement by Spring Mill Senior Living as to the truth, accuracy, or validity of the facts alleged, conclusions drawn, or admission of any deficiency issued.

It was noted that on the Medication Administration Records for Residents #1 & #2, there were dates that it was noted by the medication technician that the resident(s) had refused to take the medication.

Resident #1 was a [redacted] advanced dementia resident who had a history of combative, aggressive behaviors that at times made difficult to administer medications. Our eMAR provides space for the medication technician to note "resident refused," and "physician notified." There was no documentation reflecting the physician's response.

Resident #2 did not refuse [redacted] medications on 2/20/21 and a typographical error was made by the medication technician. The resident was, at that time, actively dying, and unable to take the medications.

All Medication Technicians and LPNs were re-inserviced on 4/28 & 4/29 on medication related regulations (2600.181-191) (exhibit VI). This inservice included training on the newly created "Medication Refusal Form" (Exhibit VII). Once the physician has reviewed the refusal and has provided orders or recommendations, that response will be will documented in the eMAR. Director of Health & Wellness, or designee, will audit the "medication variance" report daily and notify & follow up with any physician when a resident refuses a medication. Executive Director will review all documentation during quarterly Quality Assurance meetings.

Completion Date: *05/19/2021*

190a - Completion Medication Course

1. **Requirements**

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

A private duty personal caregiver to resident #1, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:
On 1/16/21 at 7:24pm Benefiber clear powder, Famotidine 20mg, Azelastin-Flucti; Trazodone 50mg; Metoprolol 25mg; Docusate Sodium 250mg; Iprat-Albuteral; Fungi-natil Anti Fungal Ointment; Reguloid Laxative Powder.

On 2/13/21 at 4:14pm Divalproex Sod 125mg tab.

190a - Completion Medication Course *(continued)*

Plan of Correction **Accept**

Spring Mill Senior Living submits the Plan of Correction to comply with PA 2600 et al. and all other applicable regulations and statutes. The preparation and submission of this Plan of Correction does not constitute an admission of fault or liability on the part of Spring Mill Senior Living or an agreement by Spring Mill Senior Living as to the truth, accuracy, or validity of the facts alleged, conclusions drawn, or admission of any deficiency issued.

It was noted that on the Medication Administration Records for Resident #1, there were dates that it was noted by the medication technician that the private duty personal caregiver administered the medications.

All Medication Technicians and LPNs were re-inserviced on 4/28 & 4/29 on all medication related regulations (2600.181-191) (exhibit VI).
Director of Health & Wellness, or designee, will audit the "medication variance" report daily and notify & follow up with any team members who may have made this notation. Continued education will be provided to team member that all medications must be administered by a Department Approved Medication Technician. Executive Director will review the documentation during quarterly Quality Assurance meetings.

Completion Date: *05/11/2021*