Department of Human Services
Bureau of Human Service Licensing

August 4, 2021

[redacted] SENIOR OPERATIONS COUNSEL
FDG CB OPCO LLC
300 EAST MARKET ST, SUITE 100
LOUISVILLE, KY 40202

RE: ATRIA AT CRANBERRY WOODS
3020 FAIRPORT LANE
CRANBERRY TOWNSHIP, PA, 16066
LICENSE/COC#: 45268

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/15/2021, 06/16/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Larry Mazza

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *ATRIA AT CRANBERRY WOODS* **Licen e #**: *45268* **Licen e Expiration Date**: *04/13/2022*
Addre : *3020 FAIRPORT LANE, CRANBERRY TOWNSHIP, PA 16066*
County: *BUTLER* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *FDG CB OPCO LLC*
Address: *300 EAST MARKET ST, SUITE 100, LOUISVILLE, KY, 40202*
Phone: *7242418750* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *01/29/2021* **Issued By**: *Cranberry Township*

Staffing Hours

Re ident Support Staff: *0* **Total Daily Staff**: *33* **Waking Staff**: *25*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal,Complaint* **Exit Conference Date**: *06/16/2021*

Inspection Dates and Department Representative

06/15/2021 - On-Site: [redacted]
06/16/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *22*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Life Guidance* **Capacity**: *41* **Residents Served**: *9*

Hospice

Current Re ident : *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *22*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *11* **Have Physical Disability**: *0*

Inspections / Reviews

06/15/2021 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *07/11/2021*

7/19/2021 POC Submi ion

Lead Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/23/2021*

7/22/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/30/2021*

8/4/2021 - Document Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Not Required*

25b - Contract Signatures

1. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #2's resident-home contract, dated [redacted], is not signed by the resident.

Resident #3's resident-home contract, dated [redacted], is not signed by the resident.

Plan of Correction **Directed**

Contracts were not signed by Resident #2 or Resident #3 at the time of taking financial possession as we were having POA or Responsible Party sign for financial possession and resident signing during day of physical move in. To date all contracts have been signed by Residents #2 and #3. Additionally on 7/21/21 a complete audit has been done on all resident files to ensure all leasing agreements are signed by the resident and responsible party. In-service was completed on 7/21/21 with all department directors to educate on the importance of ensuring all signatures are obtained during the initial lease signing, which is the day resident agrees to take finical possession. Moving forward resident and responsible party will execute leasing agreement the same day as taking finical possession regardless of physical move in. ED, CBD or designee will perform monthly audits to ensure all contract signatures have been obtained. ED, CBD or designee will document in resident notes if physical move in differs from financial possession date.

DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall develop and implement a new admission checklist to ensure a resident-home contract is completed for each newly-admitted resident. Documentation of the checklist shall be kept in each resident's record. LM 7/22/21

Completion Date: *07/21/2021*

Document Submission **Implemented**

n-service of Contract Signatures requirement, Signed contracts of residents #2 and #3, Resident file checklist to ensure all files are complete with necessary documentation have all been attached. Additionally, we have mplemented that the CBD will adhere to the resident file checklist to ensure all addenda signatures are obtained from both resident and responsible party the day of possession.

41e - Signed Statement

1. Requirements

2600.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #2's record does not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

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

41e - Signed Statement *(continued)*

Plan of Correction **Directed**

Residents #2 and #3 have signed Resident Rights and Complaint Procedures as of 7/15/21. On 7/21/21 a complete audit was done on all resident files to ensure all leasing agreements are signed by the resident and responsible party. That includes any addenda such as Resident Rights and our Complaint Procedures. Any missing signatures have been obtained and a copy of the Resident Rights and Complaint Procedures was given upon obtaining those signatures. Additionally, an in-service was completed on 7/21/21 with all department directors to educate on the mportance of ensuring all signatures are obtained during the initial lease signing. All residents and responsible parties are given a copy of leasing agreement the day of signing the leasing agreement. Additionally we will review with residents during resident council meeting on 7/28/21, where they can find a copy posted of Resident Rights and review those rights in detail as well as our complaint procedures. ED, CBD or designee will perform monthly audits to ensure all contract signatures, including those signatures on any addenda, have been obtained.

DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall develop and implement a new admission checklist to ensure a statement is present acknowledging receipt of the resident rights and complaint procedures for each newly-admitted resident. Documentation of the checklist shall be kept in each resident's record. LM 7/22/21

Completion Date: *07/21/2021*

Document Submission **Implemented**

n-service of Contract Signatures requirement, Signed contracts of residents #2 and #3, Resident file checklist to ensure all files are complete with necessary documentation have all been attached.
Additionally, we have implemented that the CBD will adhere to the resident file checklist to ensure all addenda are explained and all signatures are obtained from both resident and responsible party the day of possession.

51 - Criminal Background Check

1. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

No Pennsylvania criminal background checks were completed for staff persons A, B, C and D. The criminal background checks present for staff persons A, B, C and D were completed through a third party.

Plan of Correction **Accept**

Atria obtains background checks through [redacted] The E-Patch print out is accessible through [redacted]. However, during the time of survey we were not in the practice of having the E-Patch version printed in files. To date we have obtained the print out of E-Patch for each individual employee and will continue to have the E-Patch accessible in each file. The Community Business Director has been retrained on the requirement to obtain the E-Patch and place n the new employee files. ED or designee will randomly check new hire files for the next 90 days to confirm the process is being followed.

Completion Date: *09/15/2021*

Document Submission **Implemented**

Background checks using E-patch verification have been attached along with in-service of CBD, to ensure the printed E-patch version of criminal background checks is used and placed in each employee file.

81b - Resident Personal Equipment

1. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

There is an uncovered quarter length bedrail present on resident #1 s bed, with 3 openings measuring approximately 24.5" across and 3.5" wide, which pose a potential entrapment hazard. Also, the bedrail is not secured to the bed and moves approximately 1" in each direction.

Plan of Correction **Accept**

Resident #1 has had bed safety rail removed as of 7/14/21. A replacement is being ordered to be secured to the bed, as well as the appropriate cover, to applied to protect against entrapment hazard. Also, on 7/14/21 an audit was performed by designee to ensure all other residents with a repositioning device have a mesh covering and have the device safely secured to the bed. On 7/20/21 and 7/22/21 Care staff were retrained on how to monitor to ensure appropriate placement of bedrail, the necessity of covering and the immediate need for reporting any defective or unsecure devices. The use of assistive devices and other apparatuses are reviewed and evaluated biweekly during the Resident Needs Review Meeting to confirm devices are still effective. ISP is updated immediately upon review. In-service sign in sheet attached.

Completion Date: *07/22/2021*

Document Submission **Implemented**

Resident # 1 has a new repositioning device that has been replaced and securely attached to the bedframe of her bed. A cover has been placed on the device to prevent entrapment. In-service documents are attached. To date there have been no additional move ins with repositioning devices/ bed rails on beds. It was confirmed during an audit on 7/14/21 that all other residents with safety devices are in compliance with regulatory guidelines and have been added to residents ISP.

85d - Trash Receptacles

1. Requirements

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 6/15/21 at approximately 9:50 am, there was a full, uncovered trash can in the the back area of the bistro kitchen.

REPEAT VIOLATION: 3/1/2021

Plan of Correction **Accept**

The trash was emptied and the trash can lid was immediately replaced during the time of inspection. The regulation and it's importance was discussed the following day of site visit with all department directors. On 7/20/21 and 7/22/21 an in service was performed with all staff during the Town Hall Meeting to review the requirement that all trash, whether outside the home or inside the home, must be kept in covered receptacles to prevent the penetration of insects and rodents. In services sign in sheets attached. The ED or designee will perform a walk through of the community on a daily basis to check that receptacles are covered and ensure ongoing compliance.

Completion Date *07/22/2021*

85d - Trash Receptacles *(continued)*

Document Submission **Implemented**

In-service trainings are attached. Directors are checking trach receptacles daily as part of "first impressions" walk through.

105g - Lint Removal and Duct Cleaning

1. Requirements

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 6/15/21 at 10:17 am, an approximate 1/8" accumulation of lint was present in the lint trap of the 1st floor laundry room dryer.

Plan of Correction **Accept**

Each dryer has been labeled with instruction to "Remove Lint After Each Use". On 7/20/21 and 7/22/21 an in-services was done with all staff to review the need to remove all lint from the lint trap and drum of clothes dryers, after each use, to reduce the risk of fire hazards. Sign in sheets for in-service are attached. ED or designee will check that lint filters are being cleaned and sign off on the Lint Log daily, to ensure ongoing compliance. In-service documentation attached.

Completion Date: *07/22/2021*

Document Submission **Implemented**

Dryers are labeled. In-service documentation attached which reviewed the need to ensure all lint is removed from dryer after each use and signed off on lint log kept in each laundry room. Department Directors to check and sign off daily that laundry area is cleaned daily, lint guards are clean and labeling on each dryer is intact.

106 - Swimming Areas

1. Requirements

2600.

106. Swimming Areas - If a home operates a swimming area, the following requirements apply:
    1. Swimming areas shall be operated in accordance with applicable laws and regulations.
    2. Written policy and procedures to protect the health, safety and well-being of the residents shall be developed and implemented.

Description of Violation

The home's written policies and procedures for the swimming area do not require an assessment prior to use of the swimming area in order to protect the health, safety and well-being of the residents. Also, the written policies and procedures do not detail the physical protections that are in place to ensure safe use and supervision of this area.

106 - Swimming Areas *(continued)*

Plan of Correction **Accept**

There was a submitted plan of corrections for the swimming pool policy for Atria communities on 6/4/21. At the time of survey the new policy had not been delivered to us yet. The updated pool policy is dated for 6/2/21 and is still awaiting Department approval. However, the policy states that the pool will only be accessible during business hours. The pool entrance will remain locked at all times to residents and guest and can only be accessed by obtaining a key fob at the front desk via the concierge or department director. Only residents assessed by their physician to use the pool safely will be granted access to the pool area. Atria at Cranberry Woods has had all physicians assess and sign off on those residents deemed safe to use the pool as of 7/16/21. The list of approved residents will be kept at the front desk for easy accessibility and updated with every new move in to ensure all residents are captured. In addition to physician approval, all residents will review and sign off on the rules for using the pool and the Release and Waiver of Liability. These will be kept in the residents file. Staff will monitor the residents using the pool every 45 minutes to ensure safety and that the pool rules are being followed. Concierge or designee at the front desk will record the time of entry to the pool when the resident signs out key fob for entry to the pool area. The approved swimmer list will be audited biweekly during the Residents Need Review meeting to ensure complete accuracy. Resident files will be audited monthly as well to verify pool rules and the Release and Waiver of Liability are current for all residents deemed safe to use the pool. I will attach the procedure for swimming pool compliance for further Department consideration.

Completion Date: *07/16/2021*

Document Submission **Implemented**

The list of approved residents will be kept at the front desk for easy accessibility and updated with every new move in to ensure all residents are captured. In addition to physician approval, all residents will review and sign off on the rules for using the pool. These will be kept in the residents file. Staff will monitor the residents using the pool every 45 minutes to ensure safety and that the pool rules are being followed. Concierge or designee at the front desk will record the time of entry to the pool when the resident signs out key fob for entry to the pool area. The approved swimmer list will be audited biweekly during the Residents Need Review meeting to ensure complete accuracy. Resident files will be audited monthly as well to verify pool rules and the Pool Authorization Letters are current for all residents deemed safe to use the pool. I have attached the signed release waivers for residents #1 and #2. Resident #3 resides on our secured dementia floor. No resident on the secured unit is unauthorized to use the pool without total supervision. All documents regarding pool policy are attached.

123b - Emergency Procedures Posted

1. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are stored in a cabinet behind and underneath the receptionist's counter, which is not a conspicuous and public place in the home.

123b - Emergency Procedures Posted *(continued)*

Plan of Correction **Accept**

The Emergency Procedure binder was immediately moved to the top and front of the concierge desk for public use and visibility the day of inspection. Concierge or designee attending the front desk will do daily checks to ensure the Emergency Procedures binder remains conspicuous and public. On 7/20/21 and 7/22/21 Concierges and all staff were in-serviced on the requirement of the Emergency Procedure binder needing to be visible and attainable for public use at all times. Additionally during in-service it was reviewed that Concierges or any covering staff will immediately report to the Executive Director if the Emergency Procedure binder should ever go missing, so that a replacement binder can be issued in order to maintain compliance. In-service sheets attached.

Completion Date: *07/22/2021*

Document Submission **Implemented**

Concierge or designee attending the front desk will do daily checks to ensure the Emergency Procedures binder remains conspicuous and public. On 7/20/21 and 7/22/21 Concierges and all staff were in-serviced on the requirement of the Emergency Procedure binder needing to be visible and attainable for public use at all times. Additionally during in-service it was reviewed that Concierges or any covering staff will immediately report to the Executive Director if the Emergency Procedure binder should ever go missing, so that a replacement binder can be issued in order to maintain compliance. In-service sheets attached.

131f - Fire Extinguisher Inspection

1. **Requirements**

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the home's Ford Starcraft conversion van has not been inspected by a fire safety expert.

Plan of Correction **Accept**

On 6/18/21 MD purchased a replacement extinguisher was placed it in the Ford Starcraft vehicle that meets regulation requirements. All extinguishers will be inspected monthly and recorded on the Preventative Maintenance calendar by Maintenance Director and/ or Maintenance Director Supervisor, to ensure regulatory compliance, that extinguishers are tagged correctly and that they are in good working order. Additionally, Atria has contracted with a Fire Safety expert to conduct an inspection of the community once a year to verify that all fire safety features and equipment are in working order.

Completion Date: *06/18/2021*

Document Submission **Implemented**

On 6/18/21 MD purchased a replacement extinguisher was placed it in the Ford Starcraft vehicle that meets regulation requirements. All extinguishers will be inspected monthly and recorded on the Preventative Maintenance calendar by Maintenance Director and/ or Maintenance Director Supervisor, to ensure regulatory compliance, that extinguishers are tagged correctly and that they are in good working order.

162c - Menus Posted

1. Requirements

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The current week's menus were not posted in a public and conspicuous place in the home.

Plan of Correction **Accept**

At the time of inspection the current week with a start date of 6/13/21 was posted. The following week was also posted. However, that menu was posted with a start date of 6/27/21. Which was a week out from the required date of 6/20/21. Menu dated 6/20/21 was immediately replaced the same day of inspection. Menus are posted with current weeks on a consistent basis. Daily checks by the department directors are performed to ensure accuracy.

Completion Date: *06/15/2021*

Document Submission **Implemented**

Menus are posted with current weeks on a consistent basis. Daily checks by the department directors are performed during "first impressions walk through" to ensure accuracy.

191 - Resident Right to Refuse

1. Requirements

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

There is no documentation that resident #2, admitted to the home on [redacted], has been educated on the resident's right to refuse or question medication if the resident believes that there may be a medication error.

There is no documentation that resident #3, admitted to the home on [redacted] has been educated on the resident's right to refuse or question medication if the resident believes that there may be a medication error.

191 - Resident Right to Refuse *(continued)*

Plan of Correction **Directed**

Resident #2 and Resident #3 have been explained and signed off on Resident Rights including, but not limited to the Right to Refuse Medication, as of 7/15/21. The home goes over each resident right, including refusing medication, during the leasing agreement. A copy of Resident Rights is provided to the resident and the responsible party, if different from the resident. On 7/21/21 a complete audit was done on all resident files to ensure all leasing agreements are signed by the resident and responsible party. That includes any addenda such as Resident Rights. Any missing signatures have been obtained and a copy of the Resident Rights was given and explained upon obtaining those signatures. Additionally we will review with residents during resident council meeting on 7/28/21, where they can find a copy posted of Resident Rights and review those rights in detail. ED, CBD or designee will perform monthly audits to ensure all contract signatures, including those signatures on any addenda, have been obtained. Additionally, RSD will review medications with the resident and responsible party during care plan meetings when signing the ISP.

DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall develop and implement a new admission checklist to ensure each newly-admitted resident is notified of their right to refuse or question medication if they believe there is a medication error. Documentation of the checklist shall be kept in each resident's record. LM 7/22/21

Completion Date: *07/21/2021*

Document Submission **Implemented**

CBD will adhere to the Resident file checklist to ensure each resident has been explained and signs off the residents right to refuse medications, in addition to all other resident rights. One of each of the Resident Rights will be reviewed at each resident council meeting.

224a - Preadmission Screen Form

1. Requirements

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #3's preadmission screening form, dated [redacted], does not include an assessment of the resident's ability to use and avoid poisonous materials and a determination if the home can meet the resident's needs. These sections of the form are blank.

224a - Preadmission Screen Form *(continued)*

Plan of Correction **Directed**

To date Resident #3's preadmission screening now states that she is unable to avoid poisonous materials. This is in accordance with her DME diagnosis. On 7/16/21 an audit was conducted on all residents to ensure prescreens are completed and residents have been assessed to safely use and avoid poisonous materials. The Resident Care Director has been retrained on 7/21/21 on the importance of prescreen being fully completed by the time of move in. Training documents are attached. ED, RSD or designee will perform monthly audits of resident charts to confirm regulatory process is being followed.

DIRECTED: Within 72 hours of receipt of the plan of correction: Resident #3's preadmission screening form shall be updated to include a determiniation if the home can meet the resident's needs. The update shall include the date and initials of the staff person amending the form. A copy of the updated preadmission screening shall be kept in the resident's record. LM 7/22/21

DIRECTED: Within 5 days of receipt of the plan of correction: A designated staff person shall develop and implement a new admission checklist to ensure a preadmission screening is completed, in its entirety, within 30 days prior to admission for all newly-admitted residents. Documentation of the checklist shall be kept in each resident's record. LM 7/22/21

Completion Date: *07/21/2021*

Document Submission **Implemented**

RSD will adhere to the Move In Checklist to ensure all resident prescreen information is completed, in it's entirety, within 30 days prior to admission for all newly admitted residents. Resident Care Director has been retrained on 7/21/21 on the importance of prescreen being fully completed by the time of move in. Training documents are attached along with Move In Checklist and Resident #3's completed preadmission screening.

227d - Support Plan Medical/Dental

1. **Requirements**

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

Resident #1's initial support plan, dated [redacted], does not address the resident's use of a quarter-length bedrail for transferring in/out of bed/chair, use of a wheelchair, rollator, and cane for ambulating and multiple diagnoses, including hypertension and hyperlipidemia, as indicated on the resident's most recent medical evaluation, dated 5/3/21.

Resident #2's initial support plan, dated [redacted], does not address the resident's use of a wheelchair for ambulating, the assistance needed for transferring in/out of bed/chair and multiple diagnoses, including hypertensive heart disease, hypothyroidism, hyperlipidemia, and major depressive disorder, as indicated on the resident's most recent medical evaluation, dated [redacted]

227d - Support Plan Medical/Dental *(continued)*

Plan of Correction **Directed**

Resident #1 and #2 have both had support plans updated with all assistive devices and diagnosis according to the most current DME as of 7/16/21. An audit was completed by ED and RSD on 7/16/21 to ensure all residents residing in personal care and memory care neighborhoods were updated with all assistive devices and diagnosis according to their most current DME. Resident Care Director retrained on 7/21/21 on the requirement to obtain all diagnosis as well as assistive devices according to current DME and those devices used PRN by resident. In-service documents attached. ED, RSD or designee will conduct monthly audits on support plans to ensure accuracy and that the regulatory process is being followed routinely.

Within 5 days of receipt of the plan of correction: A designated staff person shall develop and implement a system to ensure resident assessments and support plans are updated as care needs change. All staff persons responsible for the completion of resident assessments and support plans shall be updated on the new system. LM 7/22/21

Completion Date: *07/21/2021*

Document Submission **Implemented**

RSD will have initial ISP completed day of move in based upon residents initial assessment in accordance to the move in checklist. Both ISP's have been updated for resident #1 and #2 to include all diagnosis and assistive devices as of 7/16/21. Resident Care Director retrained on 7/21/21 on the requirement to obtain all diagnosis and assistive devices according to current DME, those devices used PRN by resident and update any changes accordingly. RSD to complete ISP day of physical move in and ensure all diagnosis and assistive devices are included based upon DME. Any resident changes are communicated by staff through the communication log and read daily by RSD or designated director. RSD or designee will update ISP accordingly based upon changes in communication log. In-service and supporting documents attached.

233b - Lock Manufacturer Statement

1. **Requirements**

2600.
233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:
1 Upon a signal from an activated fire alarm system, heat or smoke detector.
2 Power failure to the home.
3 Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

Description of Violation

The letter from the manufacturer of the home's magnetic locking system on the doors to the secured dementia care unit, dated 6/18/21, does not indicate the magnetic locking system will shut down and all doors will open easily and immediately when the following occur:

- *Power failure to the home*
- *Overriding the magnetic locking system by use of the key pad*

233b - Lock Manufacturer Statement *(continued)*

Plan of Correction **Accept**

During the day of inspection we were unable to locate the verifying lock manufacturer letter. I did locate the letter a few days after inspection and was advised, by licensing inspector, that I should submit the letter with the POC. Please see the attached manufacturer letter dated for November 11, 2020 that states we are following regulatory compliance.

Completion Date: *07/14/2021*

Document Submission **Implemented**

Lock Manufacturer letter with date of November 11, 2020 has been attached.

234b - Support Plan Needs Elements

1. **Requirements**

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

Description of Violation

Resident #3's initial support plan, dated [redacted], does not address multiple diagnoses, including Alzheimer's disease, macular degeneration and hypertension, as indicated on the resident's most recent medical examination, dated [redacted].

Plan of Correction **Directed**

Resident #3's support plan has been updated to reflect all diagnosis on the residents most recent medical examination as of 7/16/21. An audit was performed on 7/16/21 on all residents residing on memory care and personal care neighborhoods to ensure all residents support plans are reflective of diagnosis listed on the most current DME. Resident Service Director has been retrained 7/21/21 on the requirement to ensure all diagnosis listed on the DME are included on the support plan. In-service attached. ED, RSD or designee will audit all support plans monthly to confirm the process is being done and to establish a routine of compliance.

Within 5 days of receipt of the plan of correction: A designated staff person shall develop and implement a system to ensure resident assessments and support plans are updated as care needs change. All staff persons responsible for the completion of resident assessments and support plans shall be updated on the new system. LM 7/22/2

Completion Date: *07/21/2021*

Document Submission **Implemented**

RSD to complete ISP day of physical move in and ensure all diagnosis and assistive devices are included based upon DME. Any resident changes are communicated by staff through the communication log and read daily by RSD or designated director. RSD or designee will update ISP accordingly based upon changes in communication log. Resident Service Director has been retrained 7/21/21 on the requirement to ensure all diagnosis listed on the DME are included on the support plan. RSD to adhere to move in checklist to ensure all resident documents are completed n accordance to DHS regulatory guidelines. In-service and supporting documents attached.