

Department of Human Services
Bureau of Human Service Licensing

May 16, 2022

[REDACTED]
MS LOWER MAKEFIELD SH LLC
7902 WESTPARK DRIVE
ATTN LICENSING
MCLEAN, VA, 22102

RE: SUNRISE SENIOR LIVING OF LOWER
MAKEFIELD
631 STONY HILL ROAD
YARDLEY, PA, 19067
LICENSE/COCC#: 13809

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/10/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[REDACTED]

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: *SUNRISE SENIOR LIVING OF LOWER MAKEFIELD* License #: *13809* License Expiration: *08/13/2022*
Address: *631 STONY HILL ROAD, YARDLEY, PA 19067*
County: *BUCKS* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *MS LOWER MAKEFIELD SH LLC*
Address: *7902 WESTPARK DRIVE, ATTN LICENSING, MCLEAN, VA, 22102*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *1-2* Date: *07/16/2008* Issued By: *Lower Makefield Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *84* Waking Staff: *63*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Incident* Exit Conference Date: *03/10/2022*

Inspection Dates and Department Representative

03/10/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *95* Residents Served: *55*

Secured Dementia Care Unit

In Home: *Yes* Area: *29* Capacity: *Reminiscence* Residents Served: *14*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *54*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *29* Have Physical Disability: *0*

Inspections / Reviews

03/10/2022 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/01/2022*

04/01/2022 - POC Submission

Inspections / Reviews *(continued)*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *04/29/2022*

05/16/2022 - Document Submission

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

85a - Sanitary Conditions

1. Requirements

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

Description of Violation

On 03/10/22, at 2pm, the main laundry room on the first floor was cluttered with plastic bins, unfolded linens, and the washer machine has not been clean.

Plan of Correction

Accept

The Maintenance Coordinator (MC) decluttered the main laundry room of the plastic bins, organized unfolded linens and cleaned the washing machine.
(March 10, 2022)

All housekeeping team members have been re-trained, and education was provided on the importance of keeping the laundry room clean and free of clutter which includes plastic bins on the floor and unfolded linens on selves.
(March 11, 2022)

The ED has scheduled Team Member Townhall meeting to review the need for areas of the community including the laundry room to be free of clutter and clean.
(April 21, 2022)

The MC completes random checks weekly to verify the laundry room is sanitary and clutter is removed.
(March 10, 2022 & ongoing)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.
(April 27, 2022, May 27, 2022 & June 27, 2022)

Completion Date: 04/27/2022

Document Submission

Implemented

Town Hall Meeting Minutes and signatures

95 - Furniture and Equipment

1. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The dryer on the second-floor laundry room is out of order. The home has no work order on file or time frame when the dryer is expected to be repaired.

On 03/01/22, at 4:03, the duct work insulation sleeve connected to the dryer was not properly secured on the vent pipe, causing the room to steam and activate the fire alarm system. The home does not have documentation of monthly inspection of duct work connectivity.

Plan of Correction

Accept

The dryer on the second-floor laundry room has been repaired and operating at normal capacity.

95 - Furniture and Equipment (continued)

(March 10, 2022)

The MC repaired the dryer by properly securing the duct work insulation sleeve on the vent pipe.
(March 10, 2022)

The insulation sleeves on all dryers were checked immediately to ensure they were secured properly.
(March 10, 2022)

The MC completes monthly documentation checks on the dryers using a checklist to verify the duct work insulation sleeves are secured properly.
(March 17, 2022)

If any dryers are not working properly reported by the MC or a Team Member, a work order will be entered immediately through our work order system (TELS) for timely follow up. If the MC is unable to repair the dryers in-house, this will be documented in TELS, and an outside vendor will be called right away for service. The dryer will be out of order and inoperable until repaired.
(March 10, 2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.
(April 27, 2022, May 27, 2022 & June 27, 2022)

Completion Date: 04/27/2022

Document Submission

Implemented

education on dryers

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 03/10/2022, there was an approximate 10 inches accumulation of lint in the lint trap of the main dryer on the first floor. There were no clothes in the dryer at the time.

The manufacturer's instructions for cleaning the ducts of the home's dryer indicates cleaning every three months. However, the home cleans the ducts every 6 months.

Plan of Correction

Accept

The MC immediately removed lint from the link trap of the main dryer on the first floor.
(March 10, 2022)

The MC inspected all dryers to verify that lint traps and drums were free from lint.
(March 10, 2022)

105g - Lint Removal and Duct Cleaning (continued)

All housekeeping team members have been re-trained, and education was provided on the importance of cleaning out the lint from the dryer lint traps after each use.
(March 21, 2022)

Dryers are inspected daily by the housekeeping team to verify lint traps and drum are being properly cleaned from any accumulation of lint.
(March 10, 2022 and ongoing)

The MC completes random checks on each dryer on a weekly basis to verify compliance with removing lint and duct cleaning will continue a quarterly basis.
(March 10, 2022 and ongoing)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.
(April 27, 2022, May 27, 2022 & June 27, 2022)

Completion Date: 04/27/2022

Document Submission

Implemented

Townhall Meeting mins and signatures

125a - Combustible Storage

1. Requirements

2600.

125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

Twelve cardboard boxes were stored near the boiler.

Paper manufacturers' instructions were taped onto the boilers.

Plan of Correction

Accept

The MC immediately removed paper manufacturer instruction from the boiler and put in a secured area.
(March 10, 2022)

By end of day the MC removed the cardboard boxes that were stored near the boiler.
(March 10, 2022)

The MC and the ED check weekly to verify there are no combustible or flammable materials are stored in the boiler room.
(March 10, 2022 and ongoing)

The ED has scheduled Team Member Townhall meeting to review the importance of verifying that combustible or flammable materials are not stored near heat sources or hot water heaters.
(April 21, 2022)

Additional storage has been identified by the ED and MC in the outside sheds on the property and a storage shed

125a - Combustible Storage (continued)

offsite to store any boxes containing overstock supplies.
(March 28, 2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.
(April 27, 2022, May 27, 2022 & June 27, 2022)

Completion Date: 04/27/2022

Document Submission

Implemented

Townhall meeting mins and signatures

132d - Evacuation

1. Requirements

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

During the fire alarm on [REDACTED], resident #1 did not evacuate to a public thoroughfare or a fire safe area. Resident#1 was sitting at the bistro area on the first floor of the building which is not a fire safe area and was instructed by staff to remain because the fire alarm sound was for the second floor.

Plan of Correction

Accept

Respectfully request this violation be withdrawn due to the fact our resident was in a fire safe area based on the fire produced by the fire safety expert.

The MC and ED provided an in-service to team members on fire safe areas within the community
(March 21, 2022)

Resident #1 was spoken to regarding the fire safe areas in the community and need to evacuate to a fire safe area when the fire alarm is activated.
(March 11, 2022)

The ED will discuss and review at Resident Council Meeting the fire safe areas in the community. Any residents that did not attend Resident Council per the sign in sheet, will be contacted on a one-off basis by the ED to review evacuation plan to residents.
(April 28, 2022)

Residents and Team Members are expected to follow evacuation protocols during a fire and fire drill in compliance with their residency agreement and community guidelines. Once the fire alarm sounds, an announcement is made over the radios/overhead speaker with the location of the fire per the fire panel. All residents should be evacuated to a fire safe area with the assistance by the Team Members and remain in place until the fire official gives an 'all clear'. A head count is given to the ED and MC to ensure all residents and Team Members are safe. Non-compliance with these protocols may result in further disciplinary action or discharge from the community. This will be monitored and documented during

132d - Evacuation (continued)

*monthly fire drills with the fire officials to support further compliance.
(March 11, 2022 and ongoing)*

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.

(April 27, 2022, May 27, 2022 & June 27, 2022)

Completion Date: 04/28/2022

Document Submission

Implemented

Resident council meeting minutes

Department of Human Services
Bureau of Human Service Licensing

September 7, 2022

[REDACTED]
MS LOWER MAKEFIELD SH LLC
7902 WESTPARK DRIVE
ATTN LICENSING
MCLEAN, VA, 22102

RE: SUNRISE SENIOR LIVING OF LOWER
MAKEFIELD
631 STONY HILL ROAD
YARDLEY, PA, 19067
LICENSE/COCC#: 13809

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/13/2022, 06/14/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[REDACTED]

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: *SUNRISE SENIOR LIVING OF LOWER MAKEFIELD* License #: *13809* License Expiration: *08/13/2022*
Address: *631 STONY HILL ROAD, YARDLEY, PA 19067*
County: *BUCKS* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *MS LOWER MAKEFIELD SH LLC*
Address: *7902 WESTPARK DRIVE, ATTN LICENSING, MCLEAN, VA, 22102*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *1-2* Date: *07/16/2008* Issued By: *Lower Makefield TWP*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *106* Waking Staff: *80*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Monitoring* Exit Conference Date: *06/14/2022*

Inspection Dates and Department Representative

06/13/2022 - On-Site: [REDACTED]
06/14/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *95* Residents Served: *68*

Secured Dementia Care Unit

In Home: *Yes* Area: *Reminiscence* Capacity: *30* Residents Served: *19*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *68*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *38* Have Physical Disability: *0*

Inspections / Reviews

06/13/2022 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *07/07/2022*

Inspections / Reviews (*continued*)

07/13/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *08/26/2022*

09/07/2022 - Document Submission

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

The resident-home contract, dated [REDACTED] for resident #1 was not signed by the resident. The resident-home contract, dated [REDACTED] for resident #2 was not signed by the resident.

Plan of Correction

Accept

The Executive Director (ED) immediately had resident #1 and resident #2 sign their resident-home contract dated from [REDACTED] (06/31/2022)

The ED completed an audit of new residents from [REDACTED] and verified the resident-home contracts were signed by the resident. No additional concerns identified. (06/15/2022)

When there is a new resident, the ED will review and sign the resident-home contract with the resident and the payer (if different from the resident) and cosigned by the residents designated responsible person if any, if the resident agrees. ED will secure all resident files in the ED office (06/15/2022)

The ED will complete a monthly audit of all new residents and verifies that all signatures on the resident-home contract have been obtained (07/15/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again. (07/27/2022 and for up to 3 months)

Completion Date: 09/30/2022

Document Submission

Implemented

The Executive Director (ED) immediately had resident #1 and resident #2 sign their resident-home contract dated from [REDACTED]. (06/31/2022)

The ED completed an audit of new residents from [REDACTED] and verified the resident-home contracts were signed by the resident. No additional concerns identified. (06/15/2022)

When there is a new resident, the ED will review and sign the resident-home contract with the resident and the payer (if different from the resident) and cosigned by the residents designated responsible person if any, if the resident agrees. ED will secure all resident files in the ED office (06/15/2022)

25b - Contract Signatures (continued)

The ED will complete a monthly audit of all new residents and verifies that all signatures on the resident-home contract have been obtained (07/15/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again. (07/27/2022 and for up to 3 months)

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

Staff A does not reside in PA. The home did not run the FBI check for Staff A, hired on [REDACTED]

Plan of Correction

Accept

The ED and the Business Office Coordinator (BOC) completed an audit of new hires since [REDACTED] and verified the staff persons FBI checks were run and included in their files. No additional concerns identified. (06/13/2022)

When there is a new hire in the pre-hiring process who has not resided in PA in the last 2 years, they will be required to complete a criminal history check and FBI (finger printing) check prior to hire. Once complete, the documentation of the Criminal history check & FBI check will be filed in the staff persons personnel record by the BOC. (06/21/2022)

The BOC completes a monthly audit of all new hires and will verify all criminal history checks are complete. (07/15/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again. (07/27/2022 and for up to 3 months)

Completion Date: 09/30/2022

Document Submission

Implemented

The ED and the Business Office Coordinator (BOC) completed an audit of new hires since [REDACTED] and verified the staff persons FBI checks were run and included in their files. No additional concerns identified. (06/13/2022)

When there is a new hire in the pre-hiring process who has not resided in PA in the last 2 years, they will be required to complete a criminal history check and FBI (finger printing) check prior to hire. Once complete, the documentation of the Criminal history check & FBI check will be filed in the staff persons personnel record by the BOC. (06/21/2022)

51 - Criminal Background Check (continued)

*The BOC completes a monthly audit of all new hires and will verify all criminal history checks are complete.
(07/15/2022)*

*This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.
(07/27/2022 and for up to 3 months)*

103e - Left Overs**1. Requirements**

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There were three individual fruit cups unlabeled, undated in the refrigerator in the home's memory unit kitchen.

Plan of Correction**Accept**

*The ED immediately removed & disposed of the three cups individual fruit cups that were unlabeled and not dated in the Reminiscence (memory care) refrigerator.
(06/13/2022)*

*The ED completed an audit of the Reminiscence refrigerator to verify there were no food items not labeled or dated. No additional concerns were identified.
(06/13/2022)*

*The ED, Dining Service Coordinator (DCS) & Reminiscence Coordinator (RC) provided an in-service to the culinary staff & memory care Staff who serve food to residents that food served and returned from a resident's plate may not be served again or used for other dishes and if keeping leftovers is needed, the leftover food should be properly labeled and dated.
(06/21/2022)*

*The ED or designee conduct weekly checks of the refrigerators to verify that any leftover food is properly labeled and dated.
(06/22/2022)*

*The ED scheduled Team Member Townhall meeting to review the importance of labeling and dating leftover resident food.
(06/30/2022)*

*This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.
(07/27/2022 and for up to 3 months)*

Completion Date: 09/30/2022

103e - Left Overs (continued)**Document Submission****Implemented**

The ED immediately removed & disposed of the three cups individual fruit cups that were unlabeled and not dated in the Reminiscence (memory care) refrigerator.

(06/13/2022)

The ED completed an audit of the Reminiscence refrigerator to verify there were no food items not labeled or dated. No additional concerns were identified.

(06/13/2022)

The ED, Dining Service Coordinator (DCS) & Reminiscence Coordinator (RC) provided an in-service to the culinary staff & memory care Staff who serve food to residents that food served and returned from a resident's plate may not be served again or used for other dishes and if keeping leftovers is needed, the leftover food should be properly labeled and dated.

(06/21/2022)

The ED or designee conduct weekly checks of the refrigerators to verify that any leftover food is properly labeled and dated.

(06/22/2022)

The ED scheduled Team Member Townhall meeting to review the importance of labeling and dating leftover resident food.

(06/30/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur again.

(07/27/2022 and for up to 3 months)

103g - Storing Food**1. Requirements**

2600.

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

Description of Violation

There was an opened bag of cookie dough that was not tightly sealed in the freezer part of the refrigerator in the home's memory unit kitchen.

Plan of Correction**Accept**

The (ED) immediately sealed the bag of cookie dough that was observed not tightly sealed in the freezer part in the refrigerator of the memory care kitchen.

(06/13/2022)

The ED, Dining Service Coordinator (DCS) & Reminiscence Coordinator (RC) provided an in-service on sanitation, proper food storage, importance of sealing opened containers/food and items that are prohibited in the kitchen to the culinary staff & Memory Care Staff.

(06/21/2022)

103g - Storing Food (continued)

The ED or designee conduct weekly checks of the kitchen to verify that food is covered and protected by contamination while being stored, prepared transported or served
(06/22/2022)

The ED scheduled Team Member Townhall meeting to review the importance of storing food in a closed or sealed container.
(06/30/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.
(07/27/2022 and for up to 3 months)

Completion Date: 09/30/2022

Document Submission**Implemented**

The (ED) immediately sealed the bag of cookie dough that was observed not tightly sealed in the freezer part in the refrigerator of the memory care kitchen.
(06/13/2022)

The ED, Dining Service Coordinator (DCS) & Reminiscence Coordinator (RC) provided an in-service on sanitation, proper food storage, importance of sealing opened containers/food and items that are prohibited in the kitchen to the culinary staff & Memory Care Staff.
(06/21/2022)

The ED or designee conduct weekly checks of the kitchen to verify that food is covered and protected by contamination while being stored, prepared transported or served
(06/22/2022)

The ED scheduled Team Member Townhall meeting to review the importance of storing food in a closed or sealed container.
(06/30/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.
(07/27/2022 and for up to 3 months)

132h - Designated Meeting Place**1. Requirements**

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

Resident #2 stated that he/she had not evacuated to a designated meeting place away from the building or within the

132h - Designated Meeting Place (continued)

fire-safe area during the monthly fire drills. Staff B confirmed the resident's statement.

Plan of Correction

Accept

Resident #1 was spoken to regarding the fire safe areas in the community and need to evacuate during every drill. (06/14/2022)

Staff B was given an in-service on properly evacuating all residents to a fire safe area during drills (06/14/2022)

The Maintenance Coordinator (MC) conducted a fire drill and successfully evacuated all residents, including Resident #1 to a fire safe area (06/29/2022)

The ED scheduled Team Member Townhall meeting to review the importance of evacuating all residents during a fire drill to a fire safe area. (06/30/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.

(07/27/2022 and for up to 3 months)

Completion Date: 09/30/2022

Document Submission

Implemented

Resident #1 was spoken to regarding the fire safe areas in the community and need to evacuate during every drill. (06/14/2022)

Staff B was given an in-service on properly evacuating all residents to a fire safe area during drills (06/14/2022)

The Maintenance Coordinator (MC) conducted a fire drill and successfully evacuated all residents, including Resident #1 to a fire safe area (06/29/2022)

The ED scheduled Team Member Townhall meeting to review the importance of evacuating all residents during a fire drill to a fire safe area. (06/30/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.

(07/27/2022 and for up to 3 months)

141a 1-10 Medical Evaluation Information

1. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #2's medical evaluation dated [REDACTED] does not include (8) body positioning/movement. Resident #3's medical evaluation dated [REDACTED] does not include (8) body positioning/movement.

Plan of Correction**Accept**

The Resident Care Director (RCD) reviewed the Documentation of Medical Evaluation (DME) form with Resident #2 & Resident #3 physician and corrected question #8 referencing body positioning/movement. The ED reviewed the completed DME to verify questions 1 through 10 were completed.
(06/14/2022)

The RCD completed an audit of all resident charts and verified that questions 1-10 on the medical evaluation was completed. No additional concerns identified.
(06/15/2022)

The RCD scheduled an in-service with the Wellness Team on the importance of the medical evaluation form being completed for new admissions.
(07/13/2022)

When there is a new resident, the RCD or ED will review The medical evaluation form to verify questions 1-10 are filled out appropriately.
(6/20/2022 for 3 months)

The RCD will complete a monthly audit of new residents to verify the medical evaluation is filled out in its entirety.
(07/15/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.
(07/27/2022 and for up to 3 months)

Completion Date: 09/30/2022

Document Submission**Implemented**

The Resident Care Director (RCD) reviewed the Documentation of Medical Evaluation (DME) form with Resident #2

141a 1-10 Medical Evaluation Information (continued)

& Resident #3 physician and corrected question #8 referencing body positioning/movement. The ED reviewed the completed DME to verify questions 1 through 10 were completed.
(06/14/2022)

The RCD completed an audit of all resident charts and verified that questions 1-10 on the medical evaluation was completed. No additional concerns identified.
(06/15/2022)

The RCD scheduled an in-service with the Wellness Team on the importance of the medical evaluation form being completed for new admissions.
(07/13/2022)

When there is a new resident, the RCD or ED will review The medical evaluation form to verify questions 1-10 are filled out appropriately.
(6/20/2022 for 3 months)

The RCD will complete a monthly audit of new residents to verify the medical evaluation is filled out in its entirety.
(07/15/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.
(07/27/2022 and for up to 3 months)

182c - Medication Administration**1. Requirements**

2600.

182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

Resident #3 is prescribed [REDACTED]. On [REDACTED], the resident was given [REDACTED] by two different staff. The staff who gave the [REDACTED] did not enter the initials at the time of [REDACTED], leading to a med error. On [REDACTED], resident #4 was given resident #5's [REDACTED]. The staff member who administered these medications failed to identify the correct resident.

Plan of Correction**Accept**

The RCD immediately notified Resident #3, #4 & #5 physician of the medication error. No further orders or instructions were given by physician and residents are stable. As submitted to DHS in accordance with reporting regulations
(03/23/2022 & 03/30/2022)

182c - Medication Administration (continued)

RCD immediately took staff member in both incidents off the medication cart to conduct further training on medication administration, documentation and insulin administration
(03/23/2022 & 03/30/2022)

RCD will conduct quarterly random medication observations to verify compliance with the medication administration policy
(07/07/2022)

RCD trained medication care managers and reviewed adherence to the medication administration policy, including identifying the correct resident & proper documentation
(07/13/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.
(07/27/2022 and for up to 3 months)

Completion Date: 09/30/2022

Document Submission**Implemented**

The RCD immediately notified Resident #3, #4 & #5 physician of the medication error. No further orders or instructions were given by physician and residents are stable. As submitted to DHS in accordance with reporting regulations
(03/23/2022 & 03/30/2022)

RCD immediately took staff member in both incidents off the medication cart to conduct further training on medication administration, documentation and insulin administration
(03/23/2022 & 03/30/2022)

RCD will conduct quarterly random medication observations to verify compliance with the medication administration policy
(07/07/2022)

RCD trained medication care managers and reviewed adherence to the medication administration policy, including identifying the correct resident & proper documentation
(07/13/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.
(07/27/2022 and for up to 3 months)

183d - Prescription Current

1. Requirements

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

On [REDACTED] prescribed for resident #6 was in the home's medication cart; however, the medication expired on [REDACTED]

Plan of Correction

Accept

RCD immediately removed Resident #6's expired [REDACTED] from medication cart
(06/14/2022)

RCD completed a cart audit to all medication carts to verify there are no expired medications. No additional concerns identified.
(06/15/2022)

RCD reviewed adherence to the medication administration policy, including the importance that medications are current and not expired, with medication care managers and wellness team
(07/13/2022)

RCD or designee will conduct a monthly MAR to cart audits to verify all medications in the medication cart are not expired.
(07/15/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.
(07/27/2022 and for up to 3 months)

Completion Date: 09/30/2022

Document Submission

Implemented

RCD immediately removed Resident #6's expired [REDACTED] from medication cart
(06/14/2022)

RCD completed a cart audit to all medication carts to verify there are no expired medications. No additional concerns identified.
(06/15/2022)

RCD reviewed adherence to the medication administration policy, including the importance that medications are current and not expired, with medication care managers and wellness team
(07/13/2022)

RCD or designee will conduct a monthly MAR to cart audits to verify all medications in the medication cart are not expired.
(07/15/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the

183d - Prescription Current (continued)

Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again. (07/27/2022 and for up to 3 months)

186b - Medication Used by Resident

1. Requirements

2600.

186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

On [redacted], resident #4 was administered [redacted] [redacted] prescribed for and belonging to resident #5.

Plan of Correction

Accept

The RCD immediately notified Resident #4 and Resident #5's physician of the medication given to Resident #5 in error. No further orders or instructions were given by physician and residents are stable. As submitted to DHS in accordance with reporting regulations (03/30/2022)

RCD reviewed adherence to the medication administration policy, including administering meds to the correct resident, the 3 checks and 5 right of medication administration with the medication care manager (03/30/2022)

RCD will conduct quarterly random medication observations to verify compliance with the medication administration policy (07/13/2022)

RCD will train medication care managers and will review adherence to the medication administration policy, including identifying the correct resident & proper documentation (07/13/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.

(07/27/2022 and for up to 3 months)

Completion Date: 09/30/2022

Document Submission

Implemented

The RCD immediately notified Resident #4 and Resident #5's physician of the medication given to Resident #5 in error. No further orders or instructions were given by physician and residents are stable. As submitted to DHS in accordance with reporting regulations (03/30/2022)

RCD reviewed adherence to the medication administration policy, including administering meds to the correct resident, the 3 checks and 5 right of medication administration with the medication care manager (03/30/2022)

186b - Medication Used by Resident (continued)

RCD will conduct quarterly random medication observations to verify compliance with the medication administration policy
(07/13/2022)

RCD will train medication care managers and will review adherence to the medication administration policy, including identifying the correct resident & proper documentation
(07/13/2022)

**This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.
(07/27/2022 and for up to 3 months)**

187b - Date/Time of Medication Admin.

1. Requirements

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 #3 is prescribed [redacted] 03/23/2022, the resident was given [redacted] in [redacted] but the staff member did not enter the initials, leading to a med error of the resident getting the same dose again at [redacted]

Resident #7 is prescribed [redacted] resident's [redacted] medication administration record (MAR) does not include the initials of the staff person who administered it on [redacted]

Plan of Correction

Accept

The RCD immediately notified Resident #3 physician of the medication error. No further orders or instructions were given by physician and resident is stable. As submitted to DHS in accordance with reporting regulations
(03/23/2022)

RCD immediately took staff member off the medication cart to conduct further training, including the 3 checks and 5 rights of medication administration
(03/23/2022)

RCD reviewed adherence to the medication administration policy, including date/time of medication administration & proper documentation with medication care manager
(03/30/2022 and ongoing)

RCD or designee will conduct weekly MAR audits to verify all medications were administered and documented.
(07/07/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new

187b - Date/Time of Medication Admin. (continued)

POC and training will be implemented and monitored to ensure the violation does not occur again. (07/27/2022 and for up to 3 months)

Completion Date: 09/30/2022

Document Submission

Implemented

The RCD immediately notified Resident #3 physician of the medication error. No further orders or instructions were given by physician and resident is stable. As submitted to DHS in accordance with reporting regulations (03/23/2022)

RCD immediately took staff member off the medication cart to conduct further training, including the 3 checks and 5 rights of medication administration (03/23/2022)

RCD reviewed adherence to the medication administration policy, including date/time of medication administration & proper documentation with medication care manager (03/30/2022 and ongoing)

RCD or designee will conduct weekly MAR audits to verify all medications were administered and documented. (07/07/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again. (07/27/2022 and for up to 3 months)

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #3 is prescribed [redacted]. However, the resident was administered this med twice on [redacted]

Resident #4 was given resident #5's [redacted] mg in addition to the resident's own morning medications [redacted] on [redacted]

Plan of Correction

Accept

The RCD immediately notified Resident #3 physician of the medication error. No further orders or instructions were given by physician and resident is stable. As submitted to DHS in accordance with reporting regulations (03/23/2022)

RCD immediately took staff member off the medication cart to conduct further training, including the 3 checks and 5 rights of medication administration (03/23/2022)

187d - Follow Prescriber's Orders (continued)

RCD reviewed adherence to the medication administration policy, including following the directions of all prescribers, including the 3 checks and 5 rights of medication administration with the medication care manager (03/23/2022 and ongoing)

RCD will conduct a monthly MAR to cart audits to verify all medications are available in carts for both scheduled and PRN medications directed by the prescriber (07/07/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again. (07/27/2022 and for up to 3 months)

Completion Date: 09/30/2022

Document Submission

Implemented

The RCD immediately notified Resident #3 physician of the medication error. No further orders or instructions were given by physician and resident is stable. As submitted to DHS in accordance with reporting regulations (03/23/2022)

RCD immediately took staff member off the medication cart to conduct further training, including the 3 checks and 5 rights of medication administration (03/23/2022)

RCD reviewed adherence to the medication administration policy, including following the directions of all prescribers, including the 3 checks and 5 rights of medication administration with the medication care manager (03/23/2022 and ongoing)

RCD will conduct a monthly MAR to cart audits to verify all medications are available in carts for both scheduled and PRN medications directed by the prescriber (07/07/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again. (07/27/2022 and for up to 3 months)

202 - Prohibitions

1. Requirements

2600.

202. The following procedures are prohibited:

- 4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

Description of Violation

Resident #8 is prescribed [REDACTED] According to the [REDACTED]

202 - Prohibitions (continued)

MAR, the resident was administered this med to control behaviors on [REDACTED]

Plan of Correction**Accept**

The RCD reviewed Resident #8 diagnosis associated with [REDACTED] with physician. The diagnosis was corrected immediately

(06/14/2022)

RCD or designee will conduct a monthly MAR to cart audits to verify all medications have the proper diagnosis for both scheduled and PRN medications directed by the prescriber

(07/07/2022)

RCD reviewed orders to verify that medications are not ordered to control agitation and completed a cart audit to all medication carts to verify resident diagnoses are accurate, No additional concerns identified.

(07/13/2022 and ongoing)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.

(07/27/2022 and for up to 3 months)

Completion Date: 09/30/2022

Document Submission**Implemented**

The RCD reviewed Resident #8 diagnosis associated with [REDACTED] with physician. The diagnosis was corrected immediately

(06/14/2022)

RCD or designee will conduct a monthly MAR to cart audits to verify all medications have the proper diagnosis for both scheduled and PRN medications directed by the prescriber

(07/07/2022)

RCD reviewed orders to verify that medications are not ordered to control agitation and completed a cart audit to all medication carts to verify resident diagnoses are accurate, No additional concerns identified.

(07/13/2022 and ongoing)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.

(07/27/2022 and for up to 3 months)

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.

224a - Preadmission Screen Form (continued)

Description of Violation

Resident #3's preadmission screening form, [REDACTED] does not include the resident's ability to safely use poisonous materials and/or a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction**Accept**

The Resident Care Director (RCD) reviewed the prescreen form dated [REDACTED] with Resident #3 physician and corrected the question regarding the residents ability to safely use poisonous materials and/or determination that the needs of the resident can be by the services provided.

(06/14/2022)

The RCD completed an audit of resident charts from and verified that the prescreening forms were filled out in its entirety. No additional concerns identified.

(06/15/2022)

When there is a new resident, the RCD or ED will review the prescreening form are filled out appropriately.

(06/20/2022)

The RCD scheduled an in-service with the Wellness Team on the importance of the prescreening form being completed for new admissions within 30 days prior to admission.

(07/13/2022)

The RCD will complete a monthly audit of new residents to verify the medical evaluation is filled out in its entirety.

(07/15/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.

(07/27/2022 and for up to 3 months)

Completion Date: 09/30/2022

Document Submission**Implemented**

The Resident Care Director (RCD) reviewed the prescreen form dated [REDACTED] with Resident #3 physician and corrected the question regarding the residents ability to safely use poisonous materials and/or determination that the needs of the resident can be by the services provided.

(06/14/2022)

The RCD completed an audit of resident charts from and verified that the prescreening forms were filled out in its entirety. No additional concerns identified.

(06/15/2022)

When there is a new resident, the RCD or ED will review the prescreening form are filled out appropriately.

(06/20/2022)

The RCD scheduled an in-service with the Wellness Team on the importance of the prescreening form being completed for new admissions within 30 days prior to admission.

224a - Preadmission Screen Form (continued)

(07/13/2022)

The RCD will complete a monthly audit of new residents to verify the medical evaluation is filled out in its entirety.

(07/15/2022)

This Plan of Correction will be discussed and evaluated (for up to 3 months) by the ED and Coordinators at the Quality Management (QAPI) meeting to ensure it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to ensure the violation does not occur again.

(07/27/2022 and for up to 3 months)