Department of Human Services
Bureau of Human Service Licensing

August 30, 2022

[redacted], ADMINISTRATOR
[redacted]

RE: MARIS GROVE
500 MARIS GROVE WAY
1ST AND 3RD FLOORS
GLEN MILLS, PA, 19342
LICENSE/COC#: 13466

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/18/2022 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

Facility Information

Name: *MARIS GROVE* **License #**: *13466* **License Expiration**: *03/11/2023*

Address: *500 MARIS GROVE WAY, 1ST AND 3RD FLOORS, GLEN MILLS, PA 19342*

County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *MARIS GROVE INC*

[redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *02/03/2022* **Issued By**: *Concord Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *66* **Waking Staff**: *50*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/18/2022*

Inspection Dates and Department Representative

07/18/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served**: *33*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire home* **Capacity**: *66* **Residents Served**: *33*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *33*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *33* **Have Physical Disability**: *0*

Inspections / Reviews

07/18/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/06/2022*

Inspections / Reviews *(continued)*

08/15/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/29/2022*

08/30/2022 - Document Submission

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

82c - Locking Poisonous Materials

1. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 7/18/22 at 1:00pm, there was [redacted] on the sink counter in resident room [redacted] of the secure dementia care unit (SDCU) with a manufacture's label indicating contact poison control if swallowed.

On 7/18/22 at 1:20pm, there was Remedy antifungal ointment and Remedy antifungal powder on the unlocked mirror cabinet in resident room [redacted] of the SDCU with a manufacture's label indicating contact poison control if swallowed.

On 7/18/22 at 1:35pm, there was [redacted] on the bathroom counter in resident room [redacted] of the SDCU with a manufacture's label indicating contact poison control if swallowed.

Plan of Correction ***Accept***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The deficient practice was corrected at the time of the survey and the poisonous materials for the residents in rooms [redacted] and [redacted] were secured.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

A 100% audit of all Memory Care rooms was completed by the 3-11 nurse and nurse supervisor. All poisonous materials were secured and caregivers were educated on the spot of any identified deficient practices.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

All poisonous materials will be secured within the MC neighborhood. All staff will be re-educated on the poisonous material regulation and their responsibility to secure all items that if ingested are poisonous. The Memory Care families will be notified of this regulation and the Personal Care Home's duty to remain compliant. The Personal Care Administrator or Designee will audit compliance for poisonous material storage by conducting weekly audits of occupied Memory Care rooms for 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *09/16/2022*

82c - Locking Poisonous Materials *(continued)*

Document Submission ***Implemented***

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What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The deficient practice was corrected at the time of the survey and the poisonous materials for the residents in rooms [redacted] and [redacted] were secured.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

A 100% audit of all Memory Care rooms was completed by the 3-11 nurse and nurse supervisor. All poisonous materials were secured and caregivers were educated on the spot of any identified deficient practices.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

All poisonous materials will be secured within the MC neighborhood. All staff will be re-educated on the poisonous material regulation and their responsibility to secure all items that if ingested are poisonous. The Memory Care families will be notified of this regulation and the Personal Care Home's duty to remain compliant. The Personal Care Administrator or Designee will audit compliance for poisonous material storage by conducting weekly audits of occupied Memory Care rooms for 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

103f - Refrigerator/Freezer Temps

1. Requirements

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

Description of Violation

On 7/18/22 at 2:00pm the temperature in the walk in freezer was 8 degrees Fahrenheit.

Plan of Correction ***Accept***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

103f - Refrigerator/Freezer Temps (continued)

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The freezer was checked again and was in compliance with the temperature requirement within 30 minutes. Food items were not served from this freezer until the freezer came to temperature.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

The freezer noted to be out of compliance had received a delivery that morning that affected the registered temperature. The freezer was checked again and was in compliance with the temperature requirement by 3:58 PM on the day of survey. Food items were not served from this freezer until the freezer came to temperature.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

All refrigeration/freezer units that store food will have internal thermometers which are checked and logged in the morning, midday and evening by designated Dining staff. Refrigerators and Freezers will be maintained within appropriate temperatures. If temperatures are out of the required zone, there will be corrective action noted on the unit's posted log. All Dining staff will be in-serviced by the Dinning General Manager or Designee on the proper procedure for recording equipment temperatures with emphasis on the process of noting corrective action if temperatures are outside the standard. The Dining General Manager, Assistant General Manager, Chef or Designee will complete daily audits to monitor for compliance for 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *09/16/2022*

Document Submission ***Implemented***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The freezer was checked again and was in compliance with the temperature requirement within 30 minutes. Food items were not served from this freezer until the freezer came to temperature.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

The freezer noted to be out of compliance had received a delivery that morning that affected the registered

103f - Refrigerator/Freezer Temps (continued)

temperature. The freezer was checked again and was in compliance with the temperature requirement by 3:58 PM on the day of survey. Food items were not served from this freezer until the freezer came to temperature.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

All refrigeration/freezer units that store food will have internal thermometers which are checked and logged in the morning, midday and evening by designated Dining staff. Refrigerators and Freezers will be maintained within appropriate temperatures. If temperatures are out of the required zone, there will be corrective action noted on the unit's posted log. All Dining staff will be in-serviced by the Dinning General Manager or Designee on the proper procedure for recording equipment temperatures with emphasis on the process of noting corrective action if temperatures are outside the standard. The Dining General Manager, Assistant General Manager, Chef or Designee will complete daily audits to monitor for compliance for 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

103i - Outdated Food

1. Requirements

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

Description of Violation

On 7/18/22 at 1:50pm, there was a half gallon of milk with use by date of 7/17/22 in 3rd floor fridge.

Plan of Correction ***Accept***

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What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

No residents were identified as having been served spoiled or outdated food. An inspection of remaining refrigerated items was completed at the time of the survey to correct the deficient practice. No other expired food items were identified.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken

No residents were identified as having been served spoiled or outdated food. An inspection of remaining refrigerated items was completed at the time of the survey to correct the deficient practice. No other expired food items were identified.

103i - Outdated Food (continued)

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

All Dining staff will be in-serviced by the Dinning General Manager or Designee on proper food storage guidelines relating to expiration dates of product. Designated Dining staff members will ensure that expiration dates are monitored and items are stored according to guidelines. [redacted] *Refrigeration and Freezer Storage Chart is to be used as a reference point to staff. Dining General Manager, Assistant General Manager, Chef or Designee will complete daily audits to monitor for compliance for 4 weeks.*

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *09/16/2022*

Document Submission ***Implemented***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

No residents were identified as having been served spoiled or outdated food. An inspection of remaining refrigerated items was completed at the time of the survey to correct the deficient practice. No other expired food items were identified.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken

No residents were identified as having been served spoiled or outdated food. An inspection of remaining refrigerated items was completed at the time of the survey to correct the deficient practice. No other expired food items were identified.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

All Dining staff will be in-serviced by the Dinning General Manager or Designee on proper food storage guidelines relating to expiration dates of product. Designated Dining staff members will ensure that expiration dates are monitored and items are stored according to guidelines. [redacted] *Refrigeration and Freezer Storage Chart is to be used as a reference point to staff. Dining General Manager, Assistant General Manager, Chef or Designee will complete daily audits to monitor for compliance for 4 weeks.*

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality

103i - Outdated Food (continued)

assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

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 7/18/22 at 12:50pm, there was an approximate 1/4 inch accumulation of lint in the lint trap of the dryer. There were no clothes in the dryer at the time.

Plan of Correction ***Accept***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The deficient practice was corrected at the time of the survey and the lint traps were cleaned for both drying units on the Memory Care Neighborhood.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

The deficient practice was corrected at the time of the survey and the lint traps were cleaned for both drying units on the Memory Care Neighborhood.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

All staff were re-educated on the need to remove lint from drying vents after each use to prevent lint buildup and the risk of a fire event. Lint traps in dryers will remain free from lint after use. The Personal Care Administrator or Designee will incorporate a Q shift check of lint traps into walking rounds daily. An audit for lint removal compliance will be completed 3 times a week for 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *09/16/2022*

105g - Lint Removal and Duct Cleaning *(continued)*

Document Submission ***Implemented***

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What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The deficient practice was corrected at the time of the survey and the lint traps were cleaned for both drying units on the Memory Care Neighborhood.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

The deficient practice was corrected at the time of the survey and the lint traps were cleaned for both drying units on the Memory Care Neighborhood.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

All staff were re-educated on the need to remove lint from drying vents after each use to prevent lint buildup and the risk of a fire event. Lint traps in dryers will remain free from lint after use. The Personal Care Administrator or Designee will incorporate a Q shift check of lint traps into walking rounds daily. An audit for lint removal compliance will be completed 3 times a week for 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

132c - Fire Drill Records

1. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drills conducted on 1/22/22, 3/16/22, 4/28/22, 5/23/22, 6/11/22 do not include the evacuation routes used.

Plan of Correction ***Accept***

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132c - Fire Drill Records (continued)

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The [redacted] *Company was contacted and requested an updated Fire Drill record to include the areas of evacuation and exit routes used.*

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

The [redacted] *Company was contacted and requested an updated Fire Drill record to include the areas of evacuation and exit routes used.*

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

The Personal Care Home will request that the [redacted] *Company will provide the documentation specific to the 2600 regulations related to documentation of the areas of evacuation and exit route used. Fire Drill documentation will include all information as specified in the 2600 Regulation. The Personal Care Administrator or Designee will review the next Fire Drill documentation for compliance.*

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *09/16/2022*

Document Submission ***Implemented***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The Fire Consultant Company was contacted and requested an updated Fire Drill record to include the areas of evacuation and exit routes used.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

The Fire Consultant Company was contacted and requested an updated Fire Drill record to include the areas of evacuation and exit routes used.

What measures will be put into place or what system changes will you make to ensure that the deficient practice

132c - Fire Drill Records (continued)

does not recur?

The Personal Care Home will request that the Fire Consultant Company will provide the documentation specific to the 2600 regulations related to documentation of the areas of evacuation and exit route used. Fire Drill documentation will include all information as specified in the 2600 Regulation. The Personal Care Administrator or Designee will review the next Fire Drill documentation for compliance.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

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.

WITHDRAWN [redacted] 8-24-22

Description of Violation

During the fire drill on 2/18/22 at 10:11am, residen[redacted] t evacuate to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction ***Accept***

The Personal Care Home Administrator spoke with [redacted], Licensing Supervisor at the Department of Human Services on 8/9/22 and discussed the February Fire Drill deficiency. After discussion and review of the documentation the Personal Care Home had, [redacted] agreed upon removal of the cited deficiency 2600.132.h.

Completion Date: *08/09/2022*

Document Submission ***Implemented***

The Personal Care Home Administrator spoke with [redacted], Licensing Supervisor at the Department of Human Services on 8/9/22 and discussed the February Fire Drill deficiency. After discussion and review of the documentation the Personal Care Home had, [redacted] agreed upon removal of the cited deficiency 2600.132.h.

141b1 - Annual Medical Evaluation

1. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's most recent medical evaluation was completed [redacted].

Resident #3's most recent medical evaluation was completed [redacted]. The resident's previous medical evaluation was completed on [redacted].

Plan of Correction ***Accept***

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141b1 - Annual Medical Evaluation (continued)

matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Upon discovery of the deficient practice for resident #2 the Provider was contacted to complete the DME. Resident #3 was cited as having a missing 2020 and 2021 DME. The Personal Care Home ask this citation be reviewed as Resident #3's chart did have a 2020 DME that was completed in [redacted] r of 2019 and [redacted] original DME date was [redacted]. The [redacted] 2019 DME and visit were considered [redacted] annual medical evaluation. The resident was seen by a provider on [redacted] 2021 but a DME form was present in the resident's chart or able to be located resulting in the deficient practice.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

Upon discovery of the deficient practice a 100 % audit was completed of all resident charts to check for an up to date DME. Immediate completion of any deficient assessments was done.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

A new tracking tool was created to ensure timely completion of all future DME's. Clinical leadership was educated on the 2600 regulations on timely completion of DME's. All DME's will be completed according to regulation. The Personal Care Administrator or Designee will audit compliance for DME compliance weekly for all new and annual DME due within the next 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *09/16/2022*

Document Submission ***Implemented***

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What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Upon discovery of the deficient practice for resident #2 the Provider was contacted to complete the DME. Resident #3 was cited as having a missing 2020 and 2021 DME. The Personal Care Home ask this citation be reviewed as Resident #3's chart did have a 2020 DME that was completed in [redacted] of 2019 and [redacted] original DME date was [redacted]. The [redacted] 2019 DME and visit were considered [redacted] annual medical evaluation. The resident was seen by a provider on [redacted], 2021 but a DME form was present in the resident's chart or able to be

141b1 - Annual Medical Evaluation (continued)

located resulting in the deficient practice.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

Upon discovery of the deficient practice a 100 % audit was completed of all resident charts to check for an up to date DME. Immediate completion of any deficient assessments was done.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

A new tracking tool was created to ensure timely completion of all future DME's. Clinical leadership was educated on the 2600 regulations on timely completion of DME's. All DME's will be completed according to regulation. The Personal Care Administrator or Designee will audit compliance for DME compliance weekly for all new and annual DME due within the next 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

183e - Storing Medications

1. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #1's [redacted] *was not dated for opening.. According to the manufacturer's instructions it must be used within 28 days after initial use.*

Plan of Correction ***Accept***

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What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The identified insulin pen in resident # 1's medication cabinet that did not have the date of open and date of expiration was discarded and a new pen was opened and labeled per the manufacturer's instruction.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

183e - Storing Medications (continued)

An audit of residents using insulin pens was completed and no other residents were identified as effected by the deficient practice.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

All Nursing and Certified Medication Administration Assistants were re-educated on the instructions related to labeling and storage of insulin pens per the Manufacturer's instructions. All insulin pens will be labeled and dated per regulations. The Wellness Manager or Designee will audit of dating and disposal of insulin pens weekly for the next 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *09/16/2022*

Document Submission ***Implemented***

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What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The identified insulin pen in resident # 1's medication cabinet that did not have the date of open and date of expiration was discarded and a new pen was opened and labeled per the manufacturer's instruction.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

An audit of residents using insulin pens was completed and no other residents were identified as effected by the deficient practice.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

All Nursing and Certified Medication Administration Assistants were re-educated on the instructions related to labeling and storage of insulin pens per the Manufacturer's instructions. All insulin pens will be labeled and dated per regulations. The Wellness Manager or Designee will audit of dating and disposal of insulin pens weekly for the next 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

183e - Storing Medications (continued)

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

184a - Labeling OTC/CAM

1. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #4 is prescribed [redacted] *. However the Medication administration record reads* [redacted].

Resident #4 is prescribed [redacted] *tablet every one day and is given at 9am. However, the medication label reads take 1 tab by mouth every evening.*

Plan of Correction ***Accept***

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What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The Provider was immediately notified of the discrepancy in the Resident #4's Omega 3 and Donepezil medications. Clarification orders were received and the EMAR was updated to reflect current orders. New orders were communicated to the pharmacy.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

The Wellness Manager or designee completed the July review of Physician Orders sheets and the medication cabinet contents for all Memory Care residents.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

The Wellness Manager and designee re-educated the Memory Care Nursing team on the redlining process, which is an ongoing audit of Provider orders to ensure accurate, timely and complete transcription of orders. All Physician orders will be transcribed accurately. The Director of Nursing or designee will audit compliance weekly for the next 4 weeks.

184a - Labeling OTC/CAM (continued)

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.
Completion Date: *09/16/2022*

Document Submission ***Implemented***

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What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The Provider was immediately notified of the discrepancy in the Resident #4's Omega 3 and Donepezil medications. Clarification orders were received and the EMAR was updated to reflect current orders. New orders were communicated to the pharmacy.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

The Wellness Manager or designee completed the July review of Physician Orders sheets and the medication cabinet contents for all Memory Care residents.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

The Wellness Manager and designee re-educated the Memory Care Nursing team on the redlining process, which is an ongoing audit of Provider orders to ensure accurate, timely and complete transcription of orders. All Physician orders will be transcribed accurately. The Director of Nursing or designee will audit compliance weekly for the next 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

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 #4 is [redacted] This medication was administered on [redacted] at [redacted] and [redacted] at [redacted] however it was not documented on the electronic MAR. Additionally, this medication was administered on [redacted], was crossed out on the controlled substance log but was

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

documented on the electronic medication administration record.

Repeat: 6/17/21

Plan of Correction ***Accept***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident #4 did receive [redacted] PRN [redacted] as ordered by the prescriber and was documented on the controlled medications utilization record however, it was not documented in the Electronic Medication Administration resulting in the deficient practice.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

A 100 % audit will be completed of residents receiving controlled medications from the date of survey to present.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

The Memory Care Manager and designee will re-educate the Memory Care Nurses and Certified Medication Administration Assistants. The staff member responsible for the deficient practice will receive performance counseling in accordance with the Erickson Policy on Narcotic Administration Documentation. Staff will document medication administration according to facility policy. The Wellness Manager or designee will conducted weekly audits on 10% of residents currently receiving controlled medications for next 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *09/16/2022*

Document Submission ***Implemented***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident #4 did receive [redacted] PRN [redacted] as ordered by the prescriber and was documented on the controlled

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

medications utilization record however, it was not documented in the Electronic Medication Administration resulting in the deficient practice.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

A 100 % audit will be completed of residents receiving controlled medications from the date of survey to present.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

The Memory Care Manager and designee will re-educate the Memory Care Nurses and Certified Medication Administration Assistants. The staff member responsible for the deficient practice will receive performance counseling in accordance with the Erickson Policy on Narcotic Administration Documentation. Staff will document medication administration according to facility policy. The Wellness Manager or designee will conducted weekly audits on 10% of residents currently receiving controlled medications for next 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

227h - Support Plan Refuse Sign

1. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #1's support plan dated [redacted] does not indicate if the resident participated and if the resident was unable or refused to sign the support plan.

Plan of Correction ***Accept***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The deficient practice was corrected upon discovery during the Personal Care Home's survey.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

227h - Support Plan Refuse Sign (continued)

A 100% audit will be completed of all Memory Care RASPS to ensure the support plan indicates a resident's ability to sign their Support Plan.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

The Assistant Administrator will reeducate the Memory Care Manager and designees on the need to notate the resident's inability or refusal to sign their support plan. RASP's will be completed according to regulations. The Memory Care or Designee will audit the signature section of the RASP's weekly for all new admissions and annual RASPS completed within the next 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *09/16/2022*

Document Submission ***Implemented***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The deficient practice was corrected upon discovery during the Personal Care Home's survey.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

A 100% audit will be completed of all Memory Care RASPS to ensure the support plan indicates a resident's ability to sign their Support Plan.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

The Assistant Administrator will reeducate the Memory Care Manager and designees on the need to notate the resident's inability or refusal to sign their support plan. RASP's will be completed according to regulations. The Memory Care or Designee will audit the signature section of the RASP's weekly for all new admissions and annual RASPS completed within the next 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

227h - Support Plan Refuse Sign (continued)

252 - Record Content

1. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.

Description of Violation

Resident #2's record does not include eye color.

Plan of Correction ***Accept***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The deficient practice identified for resident #2 was corrected upon discovery during the Personal Care Home's survey.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

A 100% audit was completed of all Memory Care charts to ensure the content of the record was complete.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

The Personal Care Home will utilize a new admission checklist to ensure that new admissions have the complete content of the resident record as required by the 2600 regulations. All records will contain complete demographic information. The Memory Care Manager or Designee will audit the completeness of records for new admissions weekly for the next 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *09/16/2022*

Document Submission ***Implemented***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the

252 - Record Content (continued)

facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The deficient practice identified for resident #2 was corrected upon discovery during the Personal Care Home's survey.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

A 100% audit was completed of all Memory Care charts to ensure the content of the record was complete.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

The Personal Care Home will utilize a new admission checklist to ensure that new admissions have the complete content of the resident record as required by the 2600 regulations. All records will contain complete demographic information. The Memory Care Manager or Designee will audit the completeness of records for new admissions weekly for the next 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

185a - Implement Storage Procedures

1. Requirements

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

Description of Violation

The Glucometer reading for resident #1 on 7/14/22 at 11:01am was [redacted] but was documented in the Medication Administration Record as [redacted]

On 7/18/22 at 1:20pm the glucometer for resident #1 was calibrated to 2:11pm 7/18/22.

Repeat: 4/23/21, 8/6/21

Plan of Correction ***Accept***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

185a - Implement Storage Procedures (continued)

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The glucometer calibration for resident #1 was corrected upon discovery immediately following the Personal Care Home's survey.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

There are currently no other residents with glucose monitoring within the Personal Care Home.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

The Wellness Manager or designee will educate Memory Care staff on proper calibration and documentation of glucose monitoring. All glucometers will remain calibrated. Memory Care Nurses to include glucometer checks as part of weekly medication cabinet audits for the next 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *09/16/2022*

Document Submission ***Implemented***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The glucometer calibration for resident #1 was corrected upon discovery immediately following the Personal Care Home's survey.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

There are currently no other residents with glucose monitoring within the Personal Care Home.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

The Wellness Manager or designee will educate Memory Care staff on proper calibration and documentation of

185a - Implement Storage Procedures (continued)

glucose monitoring. All glucometers will remain calibrated. Memory Care Nurses to include glucometer checks as part of weekly medication cabinet audits for the next 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #1 is prescribed [redacted]. However, resident #1 was only administered once on [redacted]

Repeat: 6/17/21, 7/12/21, 8/6/21

Plan of Correction ***Accept***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The Certified Medication Administration Assistant involved in the deficient practice received performance counseling on proper Narcotic Medication Administration and documentation. The resident was assessed by the Mental Health Provider and no adverse effects noted from the missed medications.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? A 100 % audit will be completed of residents receiving controlled medications from the date of survey to present.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

The Memory Care Manager and designee will re-educate the Memory Care Nurses and Certified Medication Administration Assistants on Narcotic administration documentation per policy. Medications will be administered per physician orders. The staff member responsible for the deficient practice will receive performance counseling in accordance with the Erickson Policies on Narcotic administration documentation. The Wellness Manager or designee will conducted weekly audits on 10% of residents currently receiving controlled medications for next 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

187d - Follow Prescriber's Orders (continued)

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.

Completion Date: *09/16/2022*

Document Submission ***Implemented***

Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with federal and/or state law.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The Certified Medication Administration Assistant involved in the deficient practice received performance counseling on proper Narcotic Medication Administration and documentation. The resident was assessed by the Mental Health Provider and no adverse effects noted from the missed medications.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? A 100 % audit will be completed of residents receiving controlled medications from the date of survey to present.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

The Memory Care Manager and designee will re-educate the Memory Care Nurses and Certified Medication Administration Assistants on Narcotic administration documentation per policy. Medications will be administered per physician orders. The staff member responsible for the deficient practice will receive performance counseling in accordance with the Erickson Policies on Narcotic administration documentation. The Wellness Manager or designee will conducted weekly audits on 10% of residents currently receiving controlled medications for next 4 weeks.

How the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored monthly through our facility Quality Assurance/Performance Improvement program.