

Department of Human Services  
Bureau of Human Service Licensing

November 16, 2022

[REDACTED]  
SNH PENN TENANT LLC  
[REDACTED]  
[REDACTED]

RE: GLEN MILLS SENIOR LIVING  
242 BALTIMORE PIKE  
GLEN MILLS, PA, 19342  
LICENSE/COC#: 14511

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/28/2022, 09/29/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,  
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

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

**Facility Information**

Name: *GLEN MILLS SENIOR LIVING* License #: *14511* License Expiration: *01/01/2023*  
Address: *: 242 BALTIMORE PIKE, GLEN MILLS, PA 19342*  
County: *DELAWARE* Region: *SOUTHEAST*

**Administrator**

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

**Legal Entity**

Name: *SNH PENN TENANT LLC*  
Address: [REDACTED]  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: <i>I-2</i>	Date: <i>03/19/2010</i>	Issued By: <i>Concord Township</i>
Type: <i>C-2 LP</i>	Date: <i>11/29/2000</i>	Issued By: <i>Commonwealth of PA, L&amp;I</i>
Type: <i>Other</i>	Date: <i>12/05/2000</i>	Issued By: <i>Concord Township</i>

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *53* Waking Staff: *40*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal, Incident* Exit Conference Date: *09/29/2022*

**Inspection Dates and Department Representative**

09/28/2022 - On-Site: [REDACTED]  
09/29/2022 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *100* Residents Served: *41*

**Secured Dementia Care Unit**

In Home: <i>No</i>	Area:	Capacity:	Residents Served:
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**Hospice**

Current Residents: *3*

**Number of Residents Who:**

Receive Supplemental Security Income: <i>0</i>	Are 60 Years of Age or Older: <i>41</i>
Diagnosed with Mental Illness: <i>2</i>	Diagnosed with Intellectual Disability: <i>0</i>
Have Mobility Need: <i>12</i>	Have Physical Disability: <i>0</i>

Inspections / Reviews

09/28/2022 - Full

Lead Inspector: [REDACTED]

Follow Up Type: *POC Submission*

Follow Up Date: *10/30/2022*

11/01/2022 POC Submission

Submitted By: [REDACTED]

Date Submitted: *11/16/2022*

Reviewer: [REDACTED]

Follow Up Type: *POC Submission*

Follow Up Date: *11/06/2022*

11/02/2022 POC Submission

Submitted By: [REDACTED]

Date Submitted: *11/16/2022*

Reviewer: [REDACTED]

Follow Up Type: *Document Submission*

Follow Up Date: *11/17/2022*

11/16/2022 Document Submission

Submitted By: [REDACTED]

Date Submitted: *11/16/2022*

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department’s personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted]/22, [redacted] ordered for Resident #1, were discovered missing. The home did not report this incident to the department until [redacted]/22 at [redacted] PM.

Repeat Violation: 01/20/22.

POC Submission

Accept ([redacted] - 11/01/2022)

The Executive Director provided education for the team members on DHS guidelines for reporting incidents. To maintain compliance, the Executive Director or designee will review incidents daily and determine if the DHS guidelines for reporting is applicable. 10/27/22 and on-going.

Licensee's Plan Completion Date: 10/27/2022

Implemented ([redacted] - 11/16/2022)

18 - Compliance With Laws

2. Requirements

2600.

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

Description of Violation

If a home has a boiler, it must have a valid "Certificate of Boiler or Pressure Vessel Operation" issued by the PA Department of Labor and Industry (34 Pa. Code Chapter 3, known as the Boilers and Unfired Pressure Vessels regulations, governed by Department of Labor and Industry). Upon expiration of the certificate, boilers must be inspected, and if they pass inspection, they will be issued a new certificate. On [redacted]/22, the boiler certificates provided by the home have an expiration date of [redacted]/2022.

POC Submission

Accept ([redacted] 11/01/2022)

The boiler was inspected on 8/5/22 (see attachment). New certificate received with an expiration date of 08/11/2024 (see attachment). The Executive and Maintenance Director created an outlook reminder to ensure the boiler is inspected prior to expiration date.

Licensee's Plan Completion Date: 10/27/2022

Implemented ([redacted] - 11/16/2022)

25b - Contract Signatures

3. 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.

25b - Contract Signatures (continued)

**Description of Violation**

The resident-home contract, dated [REDACTED]/22, for resident #2 was not signed by the resident.

The resident-home contract, dated [REDACTED]/22, for resident #3 was not signed by the resident.

The resident-home contract, dated [REDACTED]/21, for resident #4 was not signed by the resident, administrator, or the administrator designee.

**POC Submission**

**Accept [REDACTED] - 11/01/2022)**

An audit of resident home contracts was completed (see attachment). The Executive Director reviewed the contract with residents # 2, 3, and 4. Signed contracts are attached. The Executive Director or designee will review contract with resident on date of admission and sign and obtain appropriate signatures. To maintain compliance the Administrative Services Director will ensure all signatures were obtained prior to filing resident business file.

Licensee's Plan Completion Date: 10/27/2022

**Implemented [REDACTED] - 11/16/2022)**

41e - Signed Statement

**4. Requirements**

2600.

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

**Description of Violation**

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

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

**POC Submission**

**Accept [REDACTED] - 11/01/2022)**

The Executive Director reviewed the contracts with resident #2 and 3 (see attachment). The Executive Director or designee will review contract with resident on date of admission and sign and obtain appropriate signatures. To maintain compliance the Administrative Services Director will ensure all signatures were obtained prior to filing resident business file.

Licensee's Plan Completion Date: 10/27/2022

**Implemented [REDACTED] - 11/16/2022)**

51 - Criminal Background Check

**5. 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).

51 - Criminal Background Check (continued)

**Description of Violation**

Staff person A's date of hire is [REDACTED]/22, staff person A's criminal background check request was not completed until [REDACTED]/22.

The home has several contractors and painters in the facility working on renovations. These contractors have full access to the facility but the home has not collected their criminal background checks.

The Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) requires the home to determine if the applicant has held permanent residency in a state other than Pennsylvania within the past two years and request the appropriate criminal background checks from the Pennsylvania State Police and FBI on or before the first day of work.

**POC Submission**

**Accept (MJ - 11/01/2022)**

An audit of employee criminal background checks was completed (see attached). The Administrative Services Director or designee will complete a criminal background check upon acceptance of employment offer. To ensure compliance is maintained the Executive Director or designee will review employee criminal background checks prior to date of hire.

The Home immediately requested criminal background checks from contractor. The Construction company forwarded criminal background checks to the Executive Director.

The Maintenance Director has informed contractors that a background check must be obtained prior to providing service in The Home.

The Home as obtained criminal background checks for contractors who are working in the community and they are available for The Department's review.

The Maintenance Director or designee will ensure contractor's have a criminal background check on file in The Home. To ensure compliance is maintained, The Executive Director or designee will randomly verify that a current criminal background check is on file for a contractor who is working in The Home.

**Licensee's Plan Completion Date: 10/27/2022**

**Implemented ([REDACTED] - 11/16/2022)**

54a Direct Care Staff

**6. Requirements**

2600.

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

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

**Description of Violation**

Direct care staff person B is an LPN whose license expired on [REDACTED]/22. The home does not have other qualifications available such as; a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Repeat Violation: 01/20/22.

54a - Direct Care Staff (continued)

POC Submission

Accept (█ - 11/01/2022)

An audit was completed on LPN's to ensure that a current license is on file (see attachment). Attached is Staff person B license and confirmation from State Board of Nursing that Staff person B's license is active (see attachment). The Administrative Services Director or designee will obtain a copy of LPN license upon hire and verify with State Board of Nursing that license is active. To ensure compliance the Administrative Services and Executive Director created reminders of expiration dates via HR system.

Licensee's Plan Completion Date: 10/27/2022

Implemented (█ - 11/16/2022)

65a - FS Orientation 1st Day

7. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A's first day of work was █/22.

Staff person C's first day of work was █/21.

Staff person D's first day of work was █/22.

These staff persons did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

POC Submission

Accept (█ - 11/01/2022)

Staff person A and C orientation is attached. Staff Member D is no longer employed at The Home. An audit was completed to ensure each team member had completed orientation (see attached). The Executive Director or designee will review with each new team member prior to or during the first work day. To ensure compliance is maintained, the Administrative Services Director or designee will ensure orientation is completed prior to creating their time clock profile.

Licensee's Plan Completion Date: 10/27/2022

Implemented (█ - 11/16/2022)

65b Rights/Abuse 40 Hours

8. Requirements

65b - Rights/Abuse 40 Hours (continued)

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

**Description of Violation**

*Staff persons A, C, and D have completed their initial 40th scheduled work hour per the administrator. However, these staff persons did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), and reporting of reportable incidents and conditions.*

**POC Submission**

**Accept (█ - 11/01/2022)**

*An audit was completed to ensure orientation was completed within 40 scheduled hours (see attached). Staff person A and C were completed (see attached). Each department manager will ensure that orientation is completed within 40 scheduled hours. To maintain compliance the Executive Director or designee will follow up with new employees and review orientation prior to reaching 40 scheduled working hours. The Administrative Services Director or designee will ensure completed department orientation is in personnel file before filing.*

**Licensee's Plan Completion Date: 10/27/2022**

**Implemented (█ - 11/16/2022)**

65c - Ancillary Staff Orientation

**9. Requirements**

2600.

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

**Description of Violation**

*Ancillary staff person A, whose first day of work was █/22, did not have a general orientation to his/her specific job functions.*

**POC Submission**

**Accept (█ 11/01/2022)**

*An audit was completed to verify completion of department orientation (see attached) Staff person A's department orientation was completed (see attached). Each department manager will ensure that specific job orientation is completed within new team members. To maintain compliance the Executive Director or designee will follow up with new employees and review job specific orientation. The Administrative Services Director or designee will ensure completed job specific orientation is in personnel file before filing.*

**Licensee's Plan Completion Date: 10/27/2022**

**Implemented (█ - 11/16/2022)**

65i - Training Record

**10. Requirements**

65i - Training Record (continued)

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's staff records do not contain documentation of orientation or annual staff training.

POC Submission

Accept (█ - 11/01/2022)

An audit of training was completed (attached). Each department manager will ensure that department orientation is completed within 40 scheduled hours and annual training will be completed monthly. To maintain compliance the Executive Director or designee will follow up with new employees and review department orientation prior to reaching 40 scheduled working hours. Annual training completion will be reviewed quarterly at the Quality Management Plan meeting. Team members will be removed from schedule until they are compliant with annual training requirements. The Administrative Services Director or designee will ensure completed department orientation is in personnel file before filing.

Licensee's Plan Completion Date: 10/27/2022

Implemented (█ 11/16/2022)

85a - Sanitary Conditions

11. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 09/28/22, at approximately 10:07 AM, a brown substance was observed on the ceiling and the wall above the doorway leading to the south wing from the Salon on the third floor.

Plan of Correction

Accept (█ - 11/02/2022)

The ceiling and wall were cleaned immediately. Executive Director will re-educate team members by 11/16/22 to notify housekeeping of any areas requiring attention. Executive Director or designee will monitor compliance during rounds throughout the workday.

Licensee's Proposed Overall Completion Date: 11/16/2022

Implemented (█ 11/16/2022)

91 - Telephone Numbers

12. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in room █

Plan of Correction

Accept (█ - 11/02/2022)

Emergency phone numbers were replaced in resident apartment (see attached).

91 - Telephone Numbers (continued)

Executive Director will re-educate team members on regulation 2600.91 by 11/16/2022. If they observe an apartment without emergency telephone numbers posted, they can retrieve a replacement from the front desk and place in resident apartment. The Executive Director or designee will monitor compliance during rounds throughout the workday.

Licensee's Proposed Overall Completion Date: 11/16/2022

Implemented ( ) - 11/16/2022

103i - Outdated Food

13. Requirements

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

Description of Violation

There were unlabeled and undated canned goods in the kitchen pantry.

Plan of Correction

Accept ( ) - 11/02/2022

The dining director immediately removed can from the pantry. On 10/24/22, the dining service director re-educated the team members that items must be labeled and dated (see attached). Beginning on 10/7/22, the dining director will complete weekly audits (see attached) to ensure compliance.

Licensee's Proposed Overall Completion Date: 11/02/2022

Implemented ( ) - 11/16/2022

105g - Lint Removal and Duct Cleaning

14. 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 09/29/22, there was an accumulation of lint in the rotating drum and the lint trap of the commercial dryer in the laundry room. There were no clothes in the dryer at the time.

Repeat Violation: 08/19/21.

Plan of Correction

Accept ( ) - 11/02/2022

On 10/14/22, the Executive Director re-educated laundry employees to empty lint trap after each use (attached). The Executive Director or designee will monitor compliance during rounds throughout the workday.

Licensee's Proposed Overall Completion Date: 11/02/2022

Implemented ( ) - 11/16/2022

132a - Monthly Fire Drill

15. Requirements

2600.

132a - Monthly Fire Drill (continued)

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of February 2022.

POC Submission

Accept ( ) - 11/01/2022)

Unable to correct at this time. The Maintenance Director will ensure fire drills are performed monthly. The Executive Director or designee will verify completion monthly via fire drill log.

Licensee's Plan Completion Date: 10/27/2022

Implemented ( ) - 11/16/2022)

132b - Safety Inspection/Fire Drill

16. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection and drill observed by a fire safety expert was conducted on 04/12/2022. The previous fire safety inspection and drill observed by a fire safety expert was conducted on 10/30/2019.

POC Submission

Accept ( ) - 11/01/2022)

The Maintenance Director created an outlook reminder to schedule 2023 fire safety inspection on 1/9/23 to ensure completion by 4/12/23. The Executive Director or designee will ensure compliance via email confirmation from Fire Safety Expert.

Licensee's Plan Completion Date: 10/27/2022

Implemented ( ) - 11/16/2022)

132c Fire Drill Records

17. 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 records for the drills conducted on 12/29/21, 01/26/22, 03/31/22, 04/22/22, 05/29/22, 06/30/22, 07/08/22, and 08/21/22 do not fully document the exit route used during the drill.

POC Submission

Accept ( ) - 11/01/2022)

The Maintenance Director was educated on fully documenting each exit route used during fire drill (see attached). The Executive Director or designee will review fire drill records monthly to verify compliance.

Licensee's Plan Completion Date: 10/27/2022

Implemented ( ) - 11/16/2022)

141a - Medical Evaluation

**18. 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.

**Description of Violation**

*The medical evaluation for resident #3 was not completed within 60 days prior to admission or within 30 days after admission of the resident.*

*Repeat Violation: 08/19/21.*

**Plan of Correction**

Accept (█ - 11/02/2022)

*An audit of DME's was completed on 10/3/22 and 10/4/22 by Executive Director (attached). Resident #3 DME was completed (attached). The Resident Wellness Director or designee will ensure a DME is completed 60 days prior or 30 days after admission. The Resident Wellness Director or designee will review new resident DME upon admission. If not completed prior to admission, a physician appointment will be scheduled within 2 weeks of admission. The Executive Director or designee will spot check resident medical records monthly to ensure compliance is maintained.*

**Licensee's Proposed Overall Completion Date: 11/02/2022**

Implemented (█ 11/16/2022)

**144c1 - Smoking Area Guidelines****19. Requirements**

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

**Description of Violation**

*The home's designated smoking area has seat cushions which are not labeled as fire resistant.*

**POC Submission**

Accept (█ - 11/01/2022)

*he cushions were immediately removed and discarded. The resident who smokes was made aware that the cushions were not labeled fire resistant, and could not be used. Team members will monitor for compliance throughout workday. Non compliance will be reported to the Executive Director for follow up with resident.*

**Licensee's Plan Completion Date: 10/27/2022**

Implemented (█ - 11/16/2022)

**144d - Smoking Outside****20. Requirements**

2600.

144.d. Smoking outside of the smoking room is prohibited.

**Description of Violation**

*On 09/28/22 at approximately 10:18 AM, evidence of a resident smoking outside the designated smoking area were*

144d - Smoking Outside (continued)

found on the patio by the activities room. Staff, including the Administrator, are aware of the resident's habit of smoking in this area. The home's designated smoking area is in front of the home closer to the parking lot.

POC Submission

Accept (█ 11/01/2022)

Resident was re-educated on the appropriate smoking area. █ was also made aware that failure to adhere to the designated smoking area could result in a 30 day notice. Team members will monitor compliance during rounds throughout workday. Non-compliance will be reported to the Executive Director for follow up with resident.

Licensee's Plan Completion Date: 10/27/2022

Implemented (█ 11/16/2022)

181c - Self-administration Assessment

21. Requirements

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #3 self-administers medications to include █ and several other medications. However, during the two days of this inspection, the home could not provide documentation showing that resident #3 has been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction

Accept (█ - 11/02/2022)

Resident #3 was assessed by a physician who stated █ can self administer medications (attached). The Executive Director completed a DME audit on 10/3/22 and 10/4/22 on residents who self-administer to verify accuracy (attached). The Wellness Director or designee will ensure MD self medicating orders on DME are followed. The Executive Director or designee will check updated or annual DME's of self administering residents to ensure compliance is maintained.

Licensee's Proposed Overall Completion Date: 11/02/2022

Implemented (█ - 11/16/2022)

181f - Record of Medication

22. Requirements

2600.

181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 09/29/22, resident #3's record did not include a current list of medications. The list in the resident's record included medications the resident was no longer taking; █ Additionally, some medications the resident was taking █ were not listed.

181f - Record of Medication (continued)

POC Submission

Accept ( [redacted] - 11/01/2022)

Medication list updated by MD and reviewed with resident #3 (attached). Resident and responsible party informed to notify the wellness department of changes in medications. Resident Wellness Director or designee will review medication with resident monthly for 3 months to ensure compliance. Results of non-compliance will be reviewed with MD for recommendation.

Licensee's Plan Completion Date: 10/28/2022

Implemented ( [redacted] 11/16/2022)

183d - Prescription Current

23. 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 09/29/22, [redacted] prescribed for individual #3, was in the resident's medication box; however, this medication had an expiration date of 05/2020.

POC Submission

Accept ( [redacted] 11/01/2022)

Resident #3 informed of expiration of medication and discarded. Resident #3 educated to look at expiration dates of medications. The medication was replaced (see attached). Resident Wellness Director or designee will review medications and expiration date with resident monthly for 3 months to ensure compliance. Results of non-compliance will be reviewed with MD for recommendation.

Licensee's Plan Completion Date: 10/28/2022

Implemented [redacted] - 11/16/2022)

185a - Implement Storage Procedures

24. 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

Resident #5 is prescribed [redacted] [redacted] [redacted] [redacted] and [redacted] [redacted] [redacted] as needed. On 09/29/22 these medications were not available in the home.

Repeat Violation: 08/19/21.

Plan of Correction

Accept [redacted] - 11/02/2022)

The medication was reordered on and received on 9/29/22 (attached). The Executive Director will re-educate the wellness team by 11/16/2022 to reorder as needed medications when one week of medication is available in The Home. Starting November 2022 the Resident Wellness Director or designee will complete an as needed medication audit monthly for 3 months. Results of audit will be reviewed in the quarterly quality management plan meeting for effectiveness. If not effective, the plan of correction will be amended and a new plan of correction will be implemented to ensure the violation does not occur again.

185a - Implement Storage Procedures (continued)

Licensee's Proposed Overall Completion Date: 11/16/2022

Implemented ( ) - 11/16/2022

185b - Medication Procedures

25. Requirements

2600.

185.b. At a minimum, the procedures must include:

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.

Description of Violation

The home's procedures for the safe use of medications and medical equipment include documentation of the receipt and/or the destruction of controlled substances, a process to investigate and account for missing medications and medication errors. However, these procedures were not being followed specifically for the accounting and destruction of controlled substances.

On /2022, a report of missing was submitted to the Department. The home did not complete a full investigation into this incident and did not notify the local authorities until asked to do so during this inspection.

During this inspection, it was discovered that between have not been accounted for

POC Submission

Accept ( ) - 11/01/2022

On 8/3/22 the nursing department was re-educated on narcotic policy (see attached). Police notified on 9/29/22 and case number given to surveyor who was on-site. The Executive Director or designee will observe a narcotic count twice a week for 3 months to ensure compliance with policy. Results of observation will be reviewed in the quarterly quality management plan meeting for effectiveness. If not effective, the plan of correction will be amended and a new plan of correction will be implemented to ensure the violation does not occur again.

Licensee's Plan Completion Date: 10/28/2022

Implemented ( ) - 11/16/2022

224a - Preadmission Screen Form

26. Requirements

2600.

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

Description of Violation

Resident #3 was admitted to the home on /22; however, the resident's preadmission screening form was completed on /22.

224a - Preadmission Screen Form (continued)

Plan of Correction

Accept (MJ - 11/02/2022)

Unable to correct violation at this time. On 10/3/22 and 10/4/22, the Executive Director completed an audit of preadmission screening forms. The Resident Wellness Director or designee will complete the prescreening assessment during new resident assessment. The Executive Director or designee will review on day of move in to ensure compliance.

Licensee's Proposed Overall Completion Date: 11/02/2022

Implemented (█ - 11/16/2022)

224c - Preadmission Screening

27. Requirements

2600.

224.c. The preadmission screening shall be completed by the administrator or designee. If the resident is referred by a State-operated facility, a county mental health and intellectual disability program, a drug and alcohol program or an area agency on aging, a representative of the referral agent may complete the preadmission screening.

Description of Violation

The preadmission screening form, dated █/22, for resident #2, admitted █/22, was incomplete. The name and signature of the person completing the screening is blank.

POC Submission

Accept (█ - 11/01/2022)

Unable to correct at this time. An audit of preadmission screening forms was completed. The Resident Wellness Director or designee will complete the prescreening assessment during new resident assessment. The Executive Director or designee will review on day of move in to ensure compliance.

Licensee's Plan Completion Date: 10/28/2022

Implemented (█ - 11/16/2022)

227g -Support Plan Signatures

28. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #3 participated in the development of his/her support plan on █/22 and █/22. However, the support plan was not signed by the staff member who completed the support plan or the resident.

Resident #4 participated in the development of his/her support plan on █/22. However, the support plan was not signed by the staff member who completed the support plan.

Resident #5 participated in the development of his/her support plan on █/22. However, the support plan was not signed by the staff member who completed the support plan.

227g -Support Plan Signatures (*continued*)**Plan of Correction**

Accept ( [REDACTED] 11/02/2022)

*Unable to correct correct at this time. The Executive Director will re-educate the Wellness department by 11/16/22 to make sure support plan is signed by resident and staff member. The Resident Wellness Director or designee will ensure compliance when filing support plan in resident chart. The Executive Director or designee will spot check resident medical records monthly to ensure compliance is maintained.*

**Licensee's Proposed Overall Completion Date:** 11/16/2022

Implemented ( [REDACTED] 11/16/2022)

## 252 - Record Content

**29. 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.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

**Description of Violation**

*Resident #3's record does not include a photograph of the resident that is no more than 2 years old.*

## 252 - Record Content (continued)

**Plan of Correction****Accept ( [REDACTED] - 11/02/2022)**

*On 10/3/22 and 10/04/22, the Executive Director completed an audit of resident pictures. A new picture of resident #3 was taken and is attached. To ensure compliance residents will have a new picture taken when DME is completed. The Executive Director or designee will spot check resident medical records monthly to ensure compliance is maintained.*

**Licensee's Proposed Overall Completion Date: 11/02/2022**

**Implemented ( [REDACTED] 11/16/2022)**