Department of Human Services
Bureau of Human Service Licensing

November 21, 2022

[redacted]
HAVEN AT SPRINGWOOD OPCO LLC
2321 FREEDOM WAY
YORK, PA, 17402

RE: SEATON SPRINGWOOD
2321 FREEDOM WAY
YORK, PA, 17402
LICENSE/COC#: 33503

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: *SEATON SPRINGWOOD* **License #**: *33503* **License Expiration**: *02/12/2023*

Addre : *2321 FREEDOM WAY, YORK, PA 17402*

County: *YORK* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *HAVEN AT SPRINGWOOD OPCO LLC*

Address: *2321 FREEDOM WAY, YORK, PA, 17402*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/20/2004* **Issued By**: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *88* **Waking Staff**: *66*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *09/29/2022*

Inspection Dates and Department Representative

09/28/2022 - On-Site [redacted]

09/29/2022 - On-Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *123* **Residents Served**: *75*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Beacon* **Capacity**: *13* **Residents Served**: *8*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *75*

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

Have Mobility Need: *13* **Have Physical Disability**: *1*

Inspections / Reviews

09/28/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/14/2022*

11/01/2022 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/17/2022*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/08/2022*

11/16/2022 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/17/2022*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/23/2022*

11/21/2022 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/17/2022*

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

18 - Compliance With Laws

1. 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

On 9/28/22, neither the carbon monoxide detector in the dining room, nor the detector outside of the living room of the home were labeled with the date of installation, nor was there a log showing when or if the batteries had been changed.

Plan of Correction ***Accept (- 11/14/2022)***

- *Batteries in carbon monoxide detectors were not labeled with the date the battery was changed and it was not documented when the batteries were changed.*
- *All batteries in carbon monoxide detector batteries were changed by Director of Facilities Maintenance and the labeled with the date of 10/3/2022, the date the batteries were changed.*
- *Director of Facility Maintenance/Designee will utilize and maintain a log to ensure the batteries are replaced n the carbon monoxide detectors.*
- *nterim Executive Director educated Director of Facilities Maintenance and Maintenance Staff on regulation*
- *Director of Facility Maintenance/Designee will label the batteries with the date the batteries were changed.*
- *Executive Director will monitor for compliance at annual quality management meeting.*

Licensee's Proposed Overall Completion Date: *11/08/2022*

Implemented (11/21/2022)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

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

The resident-home contract, dated /22, for Resident # 4 was not signed by the resident.

Plan of Correction ***Directed (- 11/14/2022)***

- *Home contract for Resident#2 and Resident#4 were not signed by the residents at the time of move in.*
- *Re-education provided to Senior Lifestyle Counselor, Senior Lifestyle Coordinator and the Business Office Manager by the Interim Executive Director on 11/2/22 regarding the requirements for resident contracts.*
- *Business Office Manager will review and monitor all contracts are signed by the residents at the time of move n.*
- *Executive Director will audit move in charts quarterly to monitor for compliance.*

25b - Contract Signatures (continued)

Directed)

- The Administrator will obtain signed and dated contracts for Residents #2 and #4 by 11/30/22.

- The Business Office Manager will audit all Resident contracts by 11/30/22 to ensure all appropriate signatures and dates are present.

- Beginning 12/1/22, the Administrator will audit resident contracts quarterly to ensure the required signatures are present.

Directed Completion Date: *12/01/2022*

Implemented ([redacted] - 11/21/2022)

85e Trash Outside Home

3. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 9/29/22, the recycle dumpster bin located behind the home had one of the lids open and cardboard boxes inside.

On 9/29/22, the trash dumpster bin had both lids open with plastic bags of trash inside.

Plan of Correction ***Directed ([redacted] 11/14/2022)***

- *Dumpster lids on the trash dumpster and the recycling dumpster were open at the time of the inspection.*
- *Re-education provided to all staff by the Interim Executive Director on 11/2/22 regarding closing the dumpster ids to prevent infestation of insects and rodents.*
- *Director of Culinary/Designee and the Director of Facility Maintenance/Designee will monitor the dumpsters daily during the daily walk through to ensure that the lids are being closed.*
- *Executive Director will monitor for compliance.*

Directed)

- The dumpster lids were closed on 9/29/22 by the Director of Culinary.

- The Interim Executive Director will train all staff by 11/2/22 regarding closing the dumpster lids to prevent nfestation of insects and rodents.

- Starting 11/15/22, the Director of Culinary and the Director of Facility Maintenance will conduct daily walk throughs to ensure that the lids are being closed. Any areas of concern will be brought to the attention of the Administrator within 24 hours.

Directed Completion Date: *11/15/2022*

Implemented [redacted] 11/21/2022)

103e Left Overs

4. Requirements

2600.
103.e. Food served and returned from an individual s plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

103e - Left Overs *(continued)*

Description of Violation

On 9/28/22, there were five (5) white unlabeled and undated containers of a thick yellow substance, on the top shelf of the refrigerator in the secured care unit.

There was also an undated container of orange juice approximately one quarter full in the refrigerator in the secured care unit.

Plan of Correction ***Accept (KB - 11/14/2022)***

- *The five white unlabeled and undated containers of thick yellow substance and the undated container of partially filled orange juice were disposed of at the time of the inspection.*
- *Director of Memory Care and the staff in memory care were re-educated by the Interim Executive Director on 10/31/22, regarding dating and labeling food that is placed in the refrigerator.*
- *Director of Memory Care will monitor the refrigerator daily to ensure all food is dated and labeled.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *11/08/2022*

Implemented [redacted] - 11/21/2022)

103g - Storing Food

5. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 9/28/22, there was a disposable aluminum cake pan containing five (5) pieces of marble cake in the refrigerator of the secured care unit. There was a clear plastic lid sitting on top of the pan, but it was not sealed nor labeled.

Plan of Correction ***Accept ([redacted] 11/14/2022)***

- *The five pieces of marble cake were disposed of at the time of the inspection.*
- *Director of Memory Care and the staff in memory care were re-educated on 10/31/22 by the Interim Executive Director on labeling, covering and sealing food that is stored in the refrigerator.*
- *Director of Memory Care will monitor the refrigerator daily to ensure all food that is in the refrigerator is abeled, covered and sealed.*
- *Executive Director will monitor for compliance.*

Licensee's Proposed Overall Completion Date: *11/08/2022*

Implemented ([redacted] 11/21/2022)

103i Outdated Food

6. Requirements

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

Description of Violation

On 09/29/22 at approximately 11:30am two (2) 6.5lb cans of Sysco Large Sliced Peaches and two (2) 7lb cans of Sysco Banana Pudding were observed with large dents in the cans. These were being stored along with other cans used for

103i - Outdated Food (continued)

preparation of daily meals.

Plan of Correction ***Accept ([redacted] 11/14/2022)***

- *The two dented cans of sliced peaches and the two dented cans of banana pudding were removed from the shelf and placed in a separate area away from the other cans of food to return to Sysco.*
- *On 10/31/22, the Director of Culinary and the dining staff were re-educated by the Interim Executive Director on not using dented cans, placing the cans in a separate location away from the other cans of food, and returning the dented cans to the supplier.*
- *Director of Culinary will monitor the cans on the day they are delivered ensure dented cans are not placed in stock to be used. being used.*
- *Executive Director will monitor dry storage weekly to ensure compliance.*

Licensee's Proposed Overall Completion Date: *11/08/2022*

Implemented ([redacted] - 11/21/2022)

105g Lint Removal and Duct Cleaning

7. 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

Invoices show that the most recent cleaning of the dryer ductwork was completed on 6/12/22. However, the prior cleaning was performed on 4/23/21.

Plan of Correction ***[redacted] - 11/14/2022)***

- *On 10/31/22, Director of Facilities Maintenance was re-educated by the Interim Executive Director on the hazards of not having the dryer ductwork cleaned according to the manufacturer's instructions.*
- *Director of Facility Maintenance/Designee will utilize and maintain a dryer cleaning vent log to document when the vents are cleaned.*
- *Director of Facility Maintenance/Assistant will schedule the cleaning of the dryer ductwork to be done prior to 6/12/23.*
- *Executive Director will review during annual quality management meeting to monitor for compliance.*

Licensee's Proposed Overall Completion Date: *11/08/2022*

Implemented ([redacted] - 11/21/2022)

121a - Unobstructed Egress

8. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

The metal exterior door leading to the side of the secured care unit (SCU) to the outside concrete ramp had a significant build up of rust and debris on and around the threshold, making it very difficult to open and close, creating a blocked egress in the event of an emergency.

121a - Unobstructed Egress *(continued)*

Plan of Correction ***Directed [redacted] 11/14/2022)***

- *Exterior exit door in memory care is rusted causing difficulty to open and close.*
- *Contractor was contacted to replace the door, awaiting door arrival and date to install.*
- *Starting 11/15/22, Director of Facility Maintenance/Assistant will do a daily inside and outside walk through of the community to ensure all egress routes are unobstructed.*
- *Executive Director will review during weekly management meetings to monitor for compliance.*

Directed)
- The Administrator will hire a contractor to repair/replace the identified door, and provide an estimated time of nstall by 12/1/22.
- The Administrator will train all staff by 12/1/22 that they must notify management immediately when they notice rust, debris or other physical site issues are identified.
- The Director of Facility Maintenance will do a daily inside and outside walk through of the community to ensure all egress routes are unobstructed starting 11/15/22. Any areas identified will be repaired within 72 hours of notification.

Directed Completion Date: *11/08/2022*

Implemented [redacted] - 11/21/2022)

141a Medical Evaluation

9. 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

Resident # 5's medical evaluation was performed on [redacted]22. However the resident's date of admission was [redacted]/22.

Plan of Correction ***Accept [redacted] 11/14/2022)***

- *Resident #5's moved into the community [redacted]/22 and the medical evaluation was performed [redacted]/22. Medical evaluation was not with in the allotted time per the regulation.*
- *Sales Counselor, Sales Coordinator and the Director of Health and Wellness will be re-educated by the Interim Executive Director on 11/2/22 regarding the allotted time frame for medical evaluations to be performed for new move ins.*
- *nterim Director of Health and Wellness will audit all new move in's medical evaluations to ensure they are completed within the allotted time frame.*
- *Director of Health and Wellness/Designee will review the medical evaluation form at the time of move in to ensure it is completed within the time frame allotted.*
- *Executive Director will monitor move in paperwork to ensure compliance.*

Licensee's Proposed Overall Completion Date: *11/08/2022*

Implemented [redacted] - 11/21/2022)

141a 1-10 Medical Evaluation Information

10. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident # 6's medical evaluation dated [redacted]/22 was incomplete, as it did not include the resident's health status or cognitive function, nor the medical provider's license number.

Plan of Correction ***Directed ([redacted] 11/14/2022)***

- *Director of Health and Wellness were re educated by the Interim Executive Director on 11/2/22 regarding the information needed on the medical evaluation.*
- *Interim Director of Health and Wellness will audit all resident's medical evaluations to ensure all the required information is on the evaluation form.*
- *Director of Health and Wellness/Charge Nurse will review resident's medical evaluations when received from the physician to ensure they completed and all information is documented.*
- *Director of Health and Wellness/Charge Nurse will reach out to the resident's medical provider to have it completed if information is missing.*
- *Executive Director will review during annual quality management meeting to ensure compliance.*

(Directed)
- Resident #6's physician will be contacted by 12/1/22, and all missing information will be obtained and signed/dated appropriately.
- Director of Health and Wellness will be re-educated by the Interim Executive Director by 11/2/22 regarding the information needed on the medical evaluation.
- The Administrator will audit all resident DMEs by 12/1/22 to ensure they are accurate, complete and present in the file. Director of Health and Wellness/Charge Nurse will reach out to the resident's medical provider to have it completed if information is missing.
- The Executive Director will review during annual quality management meeting to ensure compliance.

Directed Completion Date: *12/01/2022*

Implemented [redacted] 11/21/2022)

141b1 - Annual Medical Evaluation

11. Requirements

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

Description of Violation

Resident # 1's most recent medical evaluation was completed on [redacted]/22. However, the resident's previous medical evaluation was completed on [redacted]21.

Plan of Correction ***Accept ([redacted]- 11/14/2022)***

- *Resident #1's medical evaluation was not completed within the annual time frame.*
- *Director of Health and Wellness and charge nurse were re-educated on 11/2/22 that all residents need to have a medical evaluation completed annually.*
- *Director of Health and Wellness/Charge Nurse will utilize and maintain form to keep track of due dates for resident medical evaluations.*
- *Executive Director will review during annual quality management meeting to ensure compliance.*

Licensee's Proposed Overall Completion Date: *11/08/2022*

Implemented ([redacted]- 11/21/2022)

183b - Meds and Syringes Locked

12. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

Resident # 6 is not assessed to self-administer medications. On [redacted]22, the following medications were observed in Resident # 6's room unlocked and accessible:

[redacted]

Plan of Correction ***Directed ([redacted]- 11/14/2022)***

- *Medications were removed from Resident #6 room.*
- *Resident #6 will be evaluated by medical provider to assess if able to self-administer medication.*
- *Nursing staff was re-educated by Interim Executive Director and the Interim Director of Health and Wellness on 11/2/22, to look for any medications in resident rooms, reporting to the charge nurse, and if allowed monitoring the medications are in locked containers.*
- *Director of Health and Wellness will conduct room checks to check for medications in all resident rooms and will remove and have the resident evaluated if they have medications in their room and were not evaluated to self-administer medications.*
- *Starting 11/15/22, Director of Health and Wellness will conduct room checks monthly.*
- *Executive Director will review during monthly nursing department meeting to ensure compliance.*

Directed)

183b - Meds and Syringes Locked (continued)

- The following medications were removed from Resident #6's room on [redacted] /22 by the Administrator: [redacted]

- Nursing staff will be re-educated by Interim Executive Director and the Interim Director of Health and Wellness by 11/2/22, to look for any medications in resident rooms, reporting to the charge nurse, and if allowed monitoring the medications are in locked containers.
- The Director of Health and Wellness will conduct room checks starting 11/15/22 and monthly thereafter. The Executive Director will review during monthly nursing department meeting to ensure compliance.

Directed Completion Date: *11/08/2022*

Implemented ([redacted] 11/21/2022)

183d - Prescription Current

13. 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 9/29/22, [redacted] prescribed for Resident # 6, was in the home's medication cart; however, the medication was discontinued on 9/1/22.

On [redacted] 22, three (3) bottles of [redacted], previously prescribed for Resident # 4 were found in the medication cart. This prescription had been previously discontinued.

Plan of Correction ***Accept [redacted] - 11/14/2022)***

- *Medications for Resident #4 and Resident #6 were not removed from the medication cart when they were discontinued.*
- *Discontinued medications were removed from the medication cart and destroyed by the charge nurse the day of the inspection, 9/29/22.*
- *On 11/2/22, Interim Executive Director and the Interim Director of Health and Wellness re-educated med techs on only having current prescription, OTC, sample and CAM are to be kept in the community. All discontinued medications are to be removed and disposed of.*
- *nterim Director of Health and Wellness/Charge Nurse will audit all medication carts to ensure that all medications are current.*
- *Starting 11/15/22, Director of Health and Wellness/Charge Nurse will audit medication carts monthly to ensure discontinued medications are removed and discarded.*
- *Executive Director will review during monthly nursing department meeting to ensure compliance.*

Licensee's Proposed Overall Completion Date: *11/08/2022*

Implemented ([redacted] 11/21/2022)

184a - Resident's Meds Labeled

14. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

The medication administration record (MAR) for Resident # 2's prescribed [redacted] states one tablet by mouth daily. However, the original pharmacy label on the package states to be taken twice daily.

Plan of Correction ***Accept [redacted] - 11/15/2022)***

- *Order was changed by prescriber for Resident #2's [redacted] upon admission on [redacted] 22, but the label on the bottle did not indicate the change.*
- *Order changed, see MAR" was placed on the bottle by the charge nurse to indicate the order was in the chart and to check the MAR on [redacted] /22.*
- *On 11/2/22, Interim Executive Director and the Interim Director of Health and Wellness re-educated med techs on correct labeling of the current prescription.*
- *nterim Director of Health and Wellness/Charge Nurse will audit all medication carts by 11/30/22. Starting 11/15/22, Director of Health and Wellness/Charge Nurse will audit medication carts monthly to ensure medications are labeled indicating the current prescription.*
- *Starting 12/1/22, Executive Director will review during monthly nursing department meeting to ensure compliance.*

Licensee's Proposed Overall Completion Date: *11/08/2022*

Implemented [redacted] 11/21/2022)

185a - Implement Storage Procedures

15. 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

On 9/29/22 at 11:55 am, the glucometer belonging to Resident # 6 showed 11/11/22 at 1:35 pm. The glucometer was not calibrated to the correct date and time.

Resident # 2 had the following recordings on the glucometer which were not recorded on the Medication Administration Record (MAR): [redacted] /22 [redacted] am reading of [redacted], [redacted] /22 [redacted] am reading of [redacted] and [redacted] 22 [redacted] am reading of [redacted]

The following errors were found regarding incorrect blood glucose levels documented on the MAR:
Resident # 2 On [redacted] 22, the glucometer showed [redacted] recorded on the MAR as [redacted]
Resident # 2 On [redacted] /22, the glucometer showed [redacted] recorded on the MAR as [redacted]
Resident # 3 On [redacted] /22, the glucometer showed [redacted], recorded on the MAR as [redacted]
Resident # 6 On [redacted] /22, the glucometer showed [redacted] recorded on the MAR as [redacted]

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept (KB 11/14/2022)***

- *Resident#6 glucometer was not calibrated with the correct date and time.*
- *Diabetic trained staff will be re-educated 11/10/2022 by a Certified Diabetic Educator on calibrating glucometers, using glucometers, and documenting glucometer readings.*
- *By 11/30/22, Interim Director of Health and Wellness will check all resident glucometers and calibrated if needed.*
- *Starting 11/15/22, Director of Health and Wellness/Charge Nurse will audit glucometers and glucometer readings weekly to ensure accuracy.*
- *Executive Director will review during monthly nursing department meetings.*

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

Implemented ([redacted] - 11/21/2022)

187b Date/Time of Medication Admin.

16. 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

On [redacted] 22 at [redacted] pm, Resident # 6 was in [redacted] However, the MAR shows that staff administered [redacted] and [redacted] tablets to the resident at [redacted] pm.

Plan of Correction ***Accept ([redacted] 11/15/2022)***

- *Med tech documented medication was given to Resident #6 on [redacted]/22 at [redacted]m, but Resident #6 was in the [redacted]*
- *On 11/2/22, Med techs re-educated by Interim Director of Health and Wellness on medication administration and documentation.*
- *Director of Health and Wellness/Charge Nurse will monitor EMAR documentation and medication administration by running weekly EMAR reports provided by EMAR system.*
- *Executive Director will review at monthly nursing department meeting to ensure compliance beginning 12/1/22 and thereafter.*

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

Implemented [redacted] 11/21/2022)

187d - Follow Prescriber's Orders

17. Requirements

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

Description of Violation

Resident # 2 is prescribed [redacted] checks. However, these checks were not performed for the resident on [redacted]/22, [redacted]/22 [redacted]/22 or [redacted]22, and there was no documentation of resident refusal.

Resident # 3 is prescribed daily [redacted] checks. However, this check was not performed for the resident on [redacted]/22, and there was no documentation of resident refusal.

187d - Follow Prescriber's Orders (continued)

Resident # 6 did not receive the [redacted] am doses of the following medications on [redacted] /22: [redacted]

Resident # 6 also did not receive the [redacted] pm doses of [redacted] or [redacted] on [redacted] /22.

Plan of Correction ***Accept ([redacted] - 11/15/2022)***

- *Blood glucose checks were not performed or documented for Resident #2. and Resident #3.*
- *Diabetic trained staff will be re-educated by Certified Diabetic Educator on 11/10/2022 on following prescriber orders, using glucometers, and documenting glucometer readings.*
- *Starting 11/15/22, Director of Health and Wellness/Charge Nurse will utilize and maintain glucometer audit form to audit glucometers and documentation.*
- *Director of Health and Wellness/Charge Nurse will utilize and maintain glucometer audit form to audit glucometers and glucometer readings ongoing weekly to ensure accuracy.*
- *Executive Director will review during monthly nursing department meeting to ensure compliance beginning 12/1/22 and continuing thereafter.*

- *Medications were not administered and documented for Resident #6.*
- *On 11/2/22, All med techs re-educated by Interim Director of Health and Wellness on following prescriber's orders, medication administration and documentation.*
- *Director of Health and Wellness/Charge Nurse will audit Emars weekly to ensure med techs are following prescriber's orders and documenting.*
- *Executive Director will review during monthly nursing department meeting beginning 12/1/22 to ensure compliance.*

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

Implemented [redacted] - 11/21/2022)

191 - Resident Right to Refuse

18. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident # 2, admitted [redacted] /21, and Resident # 4, admitted [redacted] 20 have not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept ([redacted] - 11/15/2022)***

- *Resident #2 and Resident #4's contract included the DHS resident right poster dated 2008, which did not nclude the resident right to refuse medication if the resident believes that there may be a medication error.*
- *Resident #2 and Resident #4 were given the updated DHS resident right poster on 9/30/22.*
- *On 11/2/22, Sales Lifestyle Counselor, Sales Lifestyle Coordinator and the Business Office Manager were re-educated on the resident's rights by the Interim Executive Director.*

191 - Resident Right to Refuse (continued)

- *By 11/30/22, The Business Office Manager will Audit all resident contracts to ensure they include the update resident rights poster.*
- *The resident contract was updated to include the updated DHS resident right poster.*
- *Executive Director will monitor resident contracts after they are signed to ensure compliance.*

Licensee's Proposed Overall Completion Date: *11/25/2022*

Implemented [redacted] - 11/21/2022)

227g -Support Plan Signatures

19. 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 # 5 participated in the development of his/her support plan on [redacted]22. However, the resident did not sign the support plan, nor is there an indication that the resident was unwilling or unable to sign..

Plan of Correction ***Directed [redacted] 11/14/2022)***

- *Resident #5 did not sign the support plan on [redacted]2022.*
- *Resident #5 will sign the support plan dated [redacted]/2022 - signed on [redacted]*
- *By 11/30/22, Interim Director of Health and Wellness/Charge Nurse will audit all resident support plans to ensure resident's support plans are signed by the resident.*
- *Director of Health and Wellness/Charge Nurse will have the resident sign the support plans after they are completed.*
- *Executive Director will review support plans during monthly nursing department meetings to ensure compliance.*

Directed Completion Date: *11/18/2022*

Implemented [redacted] 11/21/2022)

233c Key Locking Devices

20. Requirements

2600.
233.c. If key locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 9/28/22, the directions for operating the home's locking mechanism were not conspicuously posted near the exterior door to the Secure Dementia Care Unit (SDCU).

Plan of Correction ***Accept [redacted] 11/15/2022)***

- *The sign that included the code to unlock the mechanism on the exterior exit door was taken down due to the memory care unit being painted.*
- *The sign was re-hung by the Director of Memory Care on 9/29/22 in a conspicuous area by the exterior exit door.*
- *The Director of Memory Care and the staff in memory care were re-educated by the Interim Executive Director on 10/31/22 regarding the need to have the sign hanging by the exit doors at all times.*

233c - Key-Locking Devices (continued)

- *Starting 11/15/22 and continuing thereafter, The Director of Memory Care will monitor the exit doors daily to ensure that the signs are in place.*

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

Implemented ([redacted] 11/21/2022)