

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

March 8, 2023

[REDACTED]
NORTH WALES 1089 MC BG OPCO LLC
[REDACTED]
[REDACTED]

RE: PARK CREEK PLACE - MEMORY
CARE
1089 HORSHAM ROAD
NORTH WALES, PA, 19454
LICENSE/COC#: 14256

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/25/2023, 01/26/2023 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

Facility Information

Name: *PARK CREEK PLACE MEMORY CARE* License #: *14256* License Expiration: *10/02/2023*
 Address: *1089 HORSHAM ROAD, NORTH WALES, PA 19454*
 County: *MONTGOMERY* Region: *SOUTHEAST*

Administrator

Name: [Redacted] Phone: [Redacted] Email: [Redacted]

Legal Entity

Name: *NORTH WALES 1089 MC BG OPCO LLC*
 Address: [Redacted]
 Phone: [Redacted] Email: [Redacted]

Certificate(s) of Occupancy

Type: *C 2 LP* Date: *07/19/1996* Issued By: *Commonwealth of PA, L&I*
 Type: *I 2* Date: *01/26/2017* Issued By: *Montgomery Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *72* Waking Staff: *54*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *01/26/2023*

Inspection Dates and Department Representative

01/25/2023 On Site [Redacted]
 01/26/2023 On Site [Redacted]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *48* Residents Served: *36*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Entire Home* Capacity: *48* Residents Served: *36*

Hospice
 Current Residents: *8*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *36*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *36* Have Physical Disability: *0*

Inspections / Reviews

01/25/2023 - Full
 Lead Inspector: [Redacted] Follow-Up Type: *POC Submission* Follow-Up Date: *02/12/2023*

Inspections / Reviews *(continued)*

02/13/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/07/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 02/17/2023

03/08/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/07/2023

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

Per the Care Facility Carbon Monoxide Alarms Standards Act of Jun. 23, 2016; Carbon Monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance. There was no Carbon Monoxide detector for the three gas fired water heaters.

Personal care homes are considered "public places" under the Clean Indoor Air Act (35 P.S. § 637.1 – 637.11) and thus are subject to these regulations. According to the act, personal care homes must post a sign at each entrance that states "Smoking Permitted in Designated Areas Only" or "No Smoking." The international "No Smoking" symbol is also permitted. It is recommended that "Smoking Permitted" signs be posted at outdoor designated smoking areas. If the building is a multi-purpose building (such as a building that has independent living and/or skilled nursing as well as personal care services), signs shall be posted at every entrance to the personal care home part of the building. Smoking is not permitted in independent apartments that are intermingled with personal care home apartments, as the building is being used to provide food or health care related services and is subject to the smoking ban. Corporate policy states staff "are not allowed to smoke on company property at any time". According to the Administrator the home is a non-smoking campus. There are no signs posted by the employee entrance and evidence of smoking (ie: cigarette butts) are littered on the grounds by and around this entrance.

The PA Department of Agriculture Food Employee Certification Act, 3 Pa C.S.A. 6501 – 6510, effective January 22, 2011, requires one employee per licensed food facility to obtain a nationally recognized food manager certification. National exam programs are those that have been approved by ANSI using the Conference of Food Protection certified food protection manager standards. The Food Employee Certification Act requires one supervisory employee per food facility to obtain a food safety certification by taking an ANSI-CFP nationally recognized food safety class. The certified employee must be available during all hours of operation. The certified employee is the Person-in-Charge (PIC) when in the facility. On Thursday, 01/26/23 there were no staff present in the kitchen who were ServSafe certified.

Plan of Correction

Accept (MJ - 02/13/2023)

On 2/7/2023 the Regional Director of Facilities Management (RDFM) installed carbon monoxide alarms in the proximity of the home's three gas-fired water heaters.

On 1/30/2023 the Executive Director (ED) audited the community for additional fossil fuel-burning appliances and the presence of carbon monoxide alarms. Additional appliances identified had carbon monoxide alarms affixed within the regulated distance. (Exhibit A1 – Audit tool)

On 1/30/2023 the RDFM) educated the ED on the requirements set within regulation 2600.18 and the Care Facility Carbon Monoxide Alarms Standard Act of June 23, 2016. (Exhibit A2 – In-service)

Beginning 1/30/2023 the ED or designee will audit community's fossil fuel-burning appliance to ensure the presence of carbon monoxide alarms as required weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1. (Exhibit A2a – Audit tool)

On 1/30/2023 the ED disposed of the cigarette butts located outside of the facility's entrance.

On (1/30/23) the ED audited the community grounds for cigarette butts improperly disposed of. Cigarette butts identified were then disposed of. (Exhibit A3 – Audit tool)

On 1/25/2023 the ED posted "No-smoking" signs at each entrance of the home. (Exhibit-A4a,b,c-Photos)

On 1/20/2023 the ED educated current employees on the requirements set within regulation 2600.18 and Enlivant

18 - Compliance With Laws (continued)

Employee Handbook, page 13, the section titled "No Smoking Policy". (Exhibit A5- In-Service) Beginning 1/30/2023 the ED or designee will evaluate the facility's entrance 3 times per week x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 for evidence of cigarette smoking, including the evidence of cigarette butts. (Exhibit A6 – Audit tool)

On 1/30/2023 the Regional Executive Director (RED) educated the ED on the requirements set within regulations 2600.18 and the PA Department of Agriculture Food Employee Certification Act. (Exhibit A7 – In-service)

On 1/27/23, the ED validated that the Chefs ServSafe certification is active. (Exhibit A8).

On 2/2/2023, the Assistant Chef attained ServSafe Food Handler certification. (Exhibit A9 – ServSave Certificate)

Beginning 1/30/2023 the ED or designee will audit schedule to ensure one employee certified in food safety is available during all hours of the kitchens operation 3 times per week x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1.(Exhibit A10 – Audit tool)

Results of these audits will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion date 2/7/2023.

Licensee's Proposed Overall Completion Date: 02/12/2023

Implemented [redacted] - 03/08/2023)

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 [redacted]/22, for resident #1 was not signed by the resident.

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

The resident-home contract, dated [redacted]20, 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.

Plan of Correction

Accept ([redacted] 02/13/2023)

Residents #1, #2, #3, and #4 have signed their respective resident-home contracts as of [redacted] 2023. (Attachment B1a,b,c,d- Signed contracts)

On 1/30/2023, the RED educated the ED and Community Relations Manager (CRM) on the requirements set within regulation 2600.25b (Exhibit B2 – In-service)

On 1/30/2023, the ED completed an internal audit of current resident-home contracts to ensure that they were signed by the resident and/or cosigned by the resident's designated person. Contracts identified as having omitted signatures were presented accordingly for signing. (Exhibit B3- Audit tool)

The ED and/or designee will audit new resident contracts weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 to validate resident-home contracts were signed by the resident if able. (Exhibit B4- Audit tool)

Results of the audits will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion date 2/7/2023.

25b - Contract Signatures (continued)

Licensee's Proposed Overall Completion Date: 02/12/2023

Implemented [REDACTED] - 03/08/2023)

41e Signed Statement

3. 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 #'s 1, 2, 3, and 4's records did not contain a statement signed by the residents acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction

Accept [REDACTED] - 02/13/2023)

Residents #1, #2, #3, and #4 have acknowledged receipt on or by [REDACTED]/2023 by signing a copy of the home's residency agreement, including Appendix E, which lists "Resident Rights". (Exhibit B1a,b,c,d- Signed contracts)

On 1/30/2023 the RED educated the ED and CRM on the requirements set within regulation 2600.41e (Exhibit C2 – n-service)

On 1/30/2023, the ED completed an internal audit of current resident records to ensure they contained a signed copy of the homes residency agreement, which contains the "Resident Rights" and "Complaint Procedures". Copies identified as having omitted signatures were presented accordingly for signing and placed within the resident's administrative record. (Exhibit B3- Audit tool)

The ED and/or designee will audit new resident records weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 to validate that the resident was presented with and signed the home's residency agreement, which contains the "Residents Rights" and "Complaint Procedures". (Exhibit B4- Audit tool)

Results of the audits will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion date 2/7/2023.

Licensee's Proposed Overall Completion Date: 02/12/2023

Implemented [REDACTED] 03/08/2023)

42 Safeguard

4. Requirements

2600.

42. . A resident has the right to a system to safeguard a resident s money and property.

Description of Violation

The contract language in the home's residency agreement, as represented by resident #'s 1, 2, 3, and 4 contracts, do not provide a system for safeguarding of the residents' property.

Plan of Correction

Accept (MJ - 02/13/2023)

By 2/17/2023, the homes Resident Handbook, section titled, "Keys and Locks" will be updated to state, "A lockable storage cabinet is available in your apartment for the storage of medications and personal items". (Exhibit D1)

By 2/17/2023, Resident's #1, 2, 3, and 4 will be presented and signed, acknowledging receipt of the revised Resident Handbook by the ED. (Exhibit D2)

42x - Safeguard (continued)

By 2/17/2023, the ED will present the homes current residents and their responsible parties with the revised Resident Handbook.

The ED will validate sustained compliance by auditing that new residents were presented and acknowledged receipt of the revised Resident Handbook, weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 1. (Exhibit D3– Audit tool) Results of the audits will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion date 2/24/2023.

Licensee's Proposed Overall Completion Date: 02/12/2023

Implemented [redacted] - 03/08/2023)

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).

Description of Violation

Staff member A's date of hire is [redacted] 22, staff member A's criminal background check request was completed on [redacted]/22. However, staff member A did not reside in Pennsylvania for two years prior to employment at the home. 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.

Plan of Correction

Accept [redacted] 02/13/2023)

On 1/30/2023, Staff person A submitted an application for a FBI background check to the Department of Aging and provided ED with supporting documentation.

On 1/30/2023, the ED audited Staff person A's employee file to ensure all orientation and training with the home's policies and procedures were completed.

On 1/27/2023, the ED obtained a written statement from Staff person A verifying that they are not disqualified from employment under the act. (Exhibit E1 - statement)

On 1/27/2023, the ED arranged plan of supervision of Staff person A, that is to be conducted by CSM or designee as per the Regulatory Compliance Guide (RCG) and advising Licensing Surveyor's recommendation. (Exhibit E2 – Supervision Check-in Audit Tool)

On 2/2/2023, the RED in-serviced the ED and Administrative Specialist on the requirements stated within 2600.51. Exhibit E4 - In-service)

On 1/30/2023, the ED audited personnel files of current direct care staff to validate each employee has a criminal background check completed in accordance with the Older Adult Protective Services Act. One additional current employees were identified with an omitted FBI background check was identified. The employee was placed on a plan of supervision, in accordance with the RCG and Licensing Surveyor's recommendation. (Exhibit E5 - Audit tool)

Beginning 1/30/2023, for the duration of 90 days, the ED and/or designee will audit newly hired employee personnel files on an employee's first day of employment to validate that each employee has a criminal background check completed in accordance with the Older Adult Protective Services Act to validate sustained compliance. (Exhibit E6- Audit Tool)

51 - Criminal Background Check (continued)

Results of the audits will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Completion Date: 2/2/2023.

Licensee's Proposed Overall Completion Date: 02/12/2023

Implemented () - 03/08/2023)

85a - Sanitary Conditions

6. Requirements

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

Description of Violation

On 01/26/22, at 2:25 pm, an unlabeled, unmarked washrag was found in the shared bathroom of room ()

Plan of Correction

Accept () - 02/13/2023)

On 1/26/2023 the Memory Care Manager (MCM) removed the washrag from the shared bathroom of room C2. On 1/30/2023, the MCM educated the homes currently employed direct-care staff to the requirements set within regulations 2600.85a. (Exhibit F1-In-service) On 1/31/2023 the MCM audited the home's shared bathrooms for additional unsanitary conditions, not limited to unlabeled washrags. No additional instances of unsanitary conditions were identified. (Exhibit F2-Audit tool) Beginning 2/6/2023 the MCM or designee will audit five shared bathrooms weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 for unsanitary conditions to validate sustained compliance. (Exhibit F3-Audit tool) Results of the audits will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Completion Date: 2/6/2023.

Licensee's Proposed Overall Completion Date: 02/12/2023

Implemented () - 03/08/2023)

85e - Trash Outside Home

7. 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

The home has two dumpsters outside the home. On 01/26/23, at approximately 2:10 pm, the side panels on both dumpsters were open. Staff were not actively using the dumpsters at this time.

Plan of Correction

Accept () - 02/13/2023)

On 1/26/2023, the ED closed the side panels on both dumpsters. On 1/27/2023, the ED educated the home's current staff on the requirements set within regulation 2600.85e. (Exhibit G1- In-service) Beginning 1/30/2023, The ED or designee will evaluate the dumpster and its perimeter twice weekly x 4 weeks, then bi-weekly x 4 weeks, and then monthly x 1 to ensure that the dumpster side panels are closed when staff are not actively using the dumpster. (Exhibit G2- Audit Tool)

85e - Trash Outside Home (continued)

Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on the month of compliance.

Completion date 1/30/2023.

Licensee's Proposed Overall Completion Date: 02/12/2023

Implemented [redacted] 03/08/2023)

89b - Hot Water Temperature

8. Requirements

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 01/26/23, at 2:25 pm, the hot water temperature at the bathroom sink in room [redacted] measured 128.4 degrees Fahrenheit and at 3:22 PM it was 124.3 degrees Fahrenheit.

Plan of Correction

Accept [redacted] - 02/13/2023)

On 1/26/2023 the ED lowered the temperature of the hot water heater from 130 to 120 degrees Fahrenheit.?

On 1/27/2023, the ED re-evaluated the hot water temperature in room C2 and determined water temperatures did not exceed 120 degrees Fahrenheit.

On 1/31/2023, the ED audited the supplied water temperature of the home's rooms and validated that temperatures were within the regulated range (Exhibit H1 – audit tool)?

On 1/30/2023 the Regional Director of Facilities Management (RDFM) educated the Executive Director (ED) on the requirements set within 2600.89b (Exhibit H2 – In-service)?

Beginning, 2/6/2023 the ED or designee will evaluate the hot water temperature in 5 resident rooms weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit H3 – Audit tool)?

Results of the audits will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.?

Completion date 2/6/2023.?

Licensee's Proposed Overall Completion Date: 02/12/2023

Implemented [redacted] - 03/08/2023)

101j7 - Lighting/Operable Lamp

9. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

The bedside lamp in room [redacted] had a broken on/off switch and could not be used from the bedside.

Plan of Correction

Accept [redacted] 02/13/2023)

On 1/26/2023 the ED removed the lamp with the broken on/off switch in room [redacted] and replaced it with a functioning lamp.

On 2/1/2023 the ED audited resident rooms for a functioning bedside lamp. In instances identified where a bedside lamp was not present or appropriately functioning, the ED provided a functioning lamp. (Exhibit I1 – Audit tool)

On 2/1/2023 the ED educated current direct care staff on the requirements set within regulation 2600.101j7.

101j7 - Lighting/Operable Lamp (continued)

Exhibit I2 – In service)

Beginning 2/6/2023 the ED will audit five resident rooms weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit I3 – Audit tool)

Results of the audits will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion date 2/6/2023.

Licensee's Proposed Overall Completion Date: 02/12/2023

Implemented [redacted] 03/08/2023)

132g Fire Drills Days/Times

10. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The fire drills completed on 12/30/21, 01/27/22, and 02/17/22 were all completed on a Thursday.

Plan of Correction

Accepted [redacted] - 02/13/2023)

By 2/1/2023 the ED will conduct an unannounced fire drill on days other than Thursdays, on each shift to ensure fire drills are conducted on different days of the week, at different times of the day and night. (Exhibit J1 – Audit tool)

On 1/30/2023 the RED educated the ED on the requirements set within regulations 2600.132g. (Exhibit J2 – In-service)

Beginning 2/1/2023 the ED will audit the homes fire drill log monthly x 3 months to validate sustained compliance. Exhibit J3 – Audit tool)

Results of the audits will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion date 2/1/2023.

Licensee's Proposed Overall Completion Date: 02/12/2023

Implemented [redacted] - 03/08/2023)

185a Implement Storage Procedures

11. 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 #1 is prescribed [redacted] as needed. On [redacted]/23, this medication was not available in the home.

Plan of Correction

Accepted [redacted] 02/13/2023)

On 1/27/2023 the pharmacy delivered Resident #1's prescribed [redacted]

On 1/27/2023 the CSM audited the home's medication carts to ensure that current resident-prescribed medications were on-hand. No additional medications were noted as unavailable. (Exhibit K1 – Audit tool)

On 1/30/2023 the ED educated the CSM on the requirements set within regulation 2600.18a. (Exhibit K2.1 – In

185a - Implement Storage Procedures (continued)

service).

By 2/12/2023, the CSM will educate the Medication Technicians on the requirements set within regulation 2600.18a Exhibit K2.2)

Beginning 2/6/2023 the CSM will audit prescribed medications belonging to 3 residents weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit K3- Audit tool)

Results of the audits will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion date 2/6/2023.

Licensee's Proposed Overall Completion Date: 02/12/2023

Implemented () - 03/08/2023)

191 - Resident Right to Refuse

12. 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

Residents 1, 2, 3 and 4 have not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error. The home could not provide signed documentation.

Plan of Correction

Accept () - 02/13/2023)

Residents #1, #2, #3, and #4 have acknowledged having been educated on resident rights, including the right to refuse medications, as evidenced by signing a copy of the home's Residency Agreement, including Appendix A, "Resident Concern Procedures", and Appendix E, "Resident Rights" presented by the ED. (Attachment B1a,b,c,d - Signed contracts)

On 1/30/2023, the RED educated the ED and CRM on the requirements set within regulation 2600.191 (Exhibit L1 - n-service)

On 2/3/2023, the ED completed an internal audit of current resident records to ensure they contained a signed copy of the home's Residency Agreement, including Appendix A, "Resident Concern Procedures" and Appendix E "Resident Rights". Copies identified as having omitted signatures were presented accordingly for signing. (Exhibit B3- Audit tool)

The ED and/or designee will audit new resident records weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 to validate that the resident was presented with and signed the home's Residency Agreement, including Appendix A and Appendix E. (Exhibit B4- Audit tool)

Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion date 2/7/2023.

Licensee's Proposed Overall Completion Date: 02/12/2023

Implemented () - 03/08/2023)

231e - No Objection Statement

13. Requirements

2600.

231e - No Objection Statement (continued)

231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]/22. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction

Accept [REDACTED] - 02/13/2023)

On [REDACTED] 2023 Resident #1 and their designated person signed the Secured Dementia Care Facility (SDCU) "No Objection statement". (Exhibit M1-Signed statement)

On 1/30/2023, the RED educated the ED on the requirements within regulation 2600.231. (Exhibit M2 – In service)

On 2/3/2023, the ED completed an internal audit of current residents SDCU "No Objection Statements" to ensure that they were signed by the resident. Statements identified as having omitted signatures were presented accordingly for signing. (Exhibit M3- Audit tool)

The ED and/or designee will validate sustained compliance by auditing new resident SDCU No Objection Statements weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 to validate resident-home contracts were signed by the resident if able. (Exhibit M4- Audit tool)

Results of the audits will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Completion date 2/9/2023.

Licensee's Proposed Overall Completion Date: 02/12/2023

Implemented [REDACTED] - 03/08/2023)

233b Lock Manufacturer Statement

14. Requirements

2600.

233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:

- 1. Upon a signal from an activated fire alarm system, heat or smoke detector.
- 2. Power failure to the home.
- 3. Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

Description of Violation

The home could not provide a statement from the manufacturer of the magnetic locks verifying that the locks will release when the fire alarm system is activated, the home's power fails, and when the lock releasing device is operated.

Plan of Correction

Accept [REDACTED] 02/13/2023)

On 1/25/2023, the ED initiated a service request from Johnson Controls, Inc, the service provider for the homes fire suppression and magnetic locks.

On 2/3/2023, representative from Johnson Controls, Inc visited the home for inspection and verification of functionality of the home's locking system within regulation 2600.233b and provided statement. (Exhibit N1 – statement).

Completion date 2/9/2023.

Licensee's Proposed Overall Completion Date: 02/12/2023

Implemented [REDACTED] 03/08/2023)