

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

March 23, 2023

[REDACTED], ADMINISTRATOR
EMERITUS CORPORATION
[REDACTED]

RE: BROOKDALE GRANDON FARMS
1100 GRANDON WAY
MECHANICSBURG, PA, 17055
LICENSE/COC#: 31612

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/22/2023, 02/23/2023 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: BROOKDALE GRANDON FARMS **License #:** 31612 **License Expiration:** 01/17/2024
Address: 1100 GRANDON WAY, MECHANICSBURG, PA 17055
County: CUMBERLAND **Region:** CENTRAL

Administrator

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

Legal Entity

Name: EMERITUS CORPORATION
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 03/15/2005 **Issued By:** L&I

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 79 **Waking Staff:** 59

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Complaint **Exit Conference Date:** 02/23/2023

Inspection Dates and Department Representative

02/22/2023 - On-Site: [REDACTED]
02/23/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information			
License Capacity: 120		Residents Served: 48	
Secured Dementia Care Unit			
In Home: Yes	Area: SDCU	Capacity: 30	Residents Served: 16
Hospice			
Current Residents: 7			
Number of Residents Who:			
Receive Supplemental Security Income: 1		Are 60 Years of Age or Older: 48	
Diagnosed with Mental Illness: 0		Diagnosed with Intellectual Disability: 0	
Have Mobility Need: 31		Have Physical Disability: 0	

Inspections / Reviews

02/22/2023 Full		
Lead Inspector: [REDACTED]	Follow-Up Type: POC Submission	Follow-Up Date: 03/10/2023
03/13/2023 - POC Submission		
Submitted By: [REDACTED]	Date Submitted: 03/21/2023	
Reviewer: [REDACTED]	Follow-Up Type: POC Submission	Follow-Up Date: 03/17/2023

Inspections / Reviews *(continued)*

03/20/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/21/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 03/24/2023

03/23/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/21/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

54a - Direct Care Staff

1. Requirements

2600.

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

- 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A hired on [REDACTED], does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Direct care staff person B hired on [REDACTED] does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction

Accept [REDACTED] - 03/20/2023)

On February 28, 2023, the Business Office Manager ("BOM") worked to secure the required documents. Employee files were reviewed by the BOM for compliance on 2/22 and 2/23/23. Staff person A provided, on March 6, 2023, a copy of her current active registry status on the PA nurse registry. Staff Person B supplied her Diploma from Nepal on March 10, 2023, and a waiver application was submitted by Executive Director on March 10, 2023.

March 8, 2023- Business Office Manager was retrained by the Executive Director on the community policy regarding required pre-hire paperwork.

The Business Office Manager or designee will use the New Hire Documentation Audit form for new hires which includes the required documents for newly hired associates starting March 13, 2023.

To assist with ongoing compliance, the Executive Director ("ED") will review New Hire Checklist forms monthly for three (3) months starting March 13, 2023.

Licensee's Proposed Overall Completion Date: 03/17/2023

Implemented [REDACTED] - 03/23/2023)

63a - First Aid/CPR Training

2. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

Staff schedules were reviewed for 2/6/22,2/8/22 and 2/11/22. During these dates there were no staff working in the home that trained in first aid and certified in obstructed airway techniques and CPR.

Plan of Correction

Accept [REDACTED] - 03/20/2023)

On February 23, 2023, a course was set-up for March 15, 2023 and April 6, 2023 by the Executive Director, to update training for those staff requiring an updated CPR/First Aide Course training. An audit was completed by the Business Office Manager on February 23, 2023 of those staff CPR/First Aid records and training was scheduled if indicated.

63a First Aid/CPR Training (continued)

The Business Office Manager, Health and Wellness Director ("HWD") or designee will review employee files on hire and every 2 years for documentation of CPR trainings according to community policy starting March 13, 2023. The Health and Wellness Coordinator will cross check schedules to verify one staff member per every 50 residents is trained according to community policy starting April 9, 2023.

To assist with ongoing compliance, the Executive Director, Health and Wellness Director or designee, will review employee file audit results for initial and current trainings monthly starting April 10, 2023 for the next 2 months to verify compliance for current CPR/First Aide training documentation.

Licensee's Proposed Overall Completion Date: 04/10/2023

Implemented [redacted] - 03/23/2023)

65b - Rights/Abuse 40 Hours

3. Requirements

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.
- 4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A was hired on [redacted]. However, this staff person did not complete training in the following topics: Resident Rights and Reportable Incidents.

Staff person B was hired on [redacted]. However, this staff person did not complete training in the following topics: Resident Rights and Reportable Incidents.

Staff person C was hired on [redacted]. However, this staff person did not complete training in the following topics: Resident Rights and Reportable Incidents.

Plan of Correction

Accept [redacted] - 03/20/2023)

March 1, 2023 Business Office Manager audited the training documents for direct care staff to verify completion of orientation training.

On March 3, 2023 Direct Care Staff Person A, B, and C completed and passed the trainings on Resident Rights, and Reportable incidents.

March 6, 2023 The Executive Director retrained direct care staff and business office staff on the community policy regarding completion of the department approved training prior to providing care to residents.

To assist with ongoing compliance, the Business Office Manager or designee will review new hire files for completion of required trainings monthly, prior to caring for residents, for 2 months using the New Hire Training Audit. The ED will review this New Hire Training Audit with the BOM starting March 13, 2023.

Licensee's Proposed Overall Completion Date: 03/17/2023

65b - Rights/Abuse 40 Hours (continued)

Implemented () - 03/23/2023)

82c - Locking Poisonous Materials

4. Requirements

2600.

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

Description of Violation

On 2/23/2023, a 4 oz tube of [redacted] with a manufacture's label indicating "if swallowed contact poison control", was unlocked, unattended, and accessible to residents in the bathroom cabinet in shared room 307 located in the Secure Dementia Care Unit (SDCU).

Repeat Violation - 3/30/2022

Plan of Correction

Accept () - 03/20/2023)

On February 23, 2023, the Executive Director removed the Calazine skin cream and locked the door to the cabinet in the resident bathroom in the Secure Dementia Care Unit. A sweep was completed on February 23, 2023 of the Secure Dementia Care Unit by the Direct Care staff member for any poisonous materials. The ED audited areas were found to be in compliance on February 27, 2023.

February 22, 2023, and March 8, 2023, - The Executive Director and the Health and Wellness Coordinator retrained the direct care staff regarding the community policy on storage of poisonous materials in the Secure Dementia Care Unit.

The Medication Technician, Clare Bridge Coordinator or designee will round 5 times a week, starting March 13, 2023 for 3 months and then daily for 2 months and weekly thereafter, in the Secure Dementia Care Unit, to verify the secured storage of poisonous materials using the Claire Bridge Common and Room Audit form.

To assist with ongoing compliance, the Health and Wellness Director or designee will review the audit results weekly starting March 17, 2023.

Licensee's Proposed Overall Completion Date: 03/17/2023

Implemented () - 03/23/2023)

85a - Sanitary Conditions

5. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 2/22/2023, at approximately 9:24 am, there was a soiled adult diaper behind the toilet in the public bathroom in Secure Dementia Care Unit (SDCU) activity room.

Plan of Correction

Accept () - 03/20/2023)

On February 23, 2023, the soiled diaper was removed and disposed of by the direct care staff member. Other public area bathrooms were checked for soiled materials by the direct care staff member and audited areas were found in compliance on February 23, 2023.

March 8, 2023-Direct care staff were retrained by the Executive Director and Health and Wellness Coordinator on

85a - Sanitary Conditions (continued)

the community policy regarding maintaining the environment.

The Clare Bridge Program Coordinator, Medication Technician or designee will audit the Secure Dementia Care Unit for any issues with cleanliness five (5) times weekly for three (3) months and weekly thereafter using the Claire Bridge Common and Room Audit tool starting March 13, 2023.

To assist with ongoing compliance, the Health and Wellness Director or designee will review audit results monthly for the next three (3) months starting March 17, 2023.

Licensee's Proposed Overall Completion Date: 03/17/2023

Implemented (AC - 03/23/2023)

88a - Surfaces

6. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 2/23/2023, cabinet doors in the Secure Dementia Care Unit (SDCU) kitchenette/dining area contained sticky dried food residue.

On 2/23/2023, the bathroom in room 405 had dried fecal matter on the floor near toilet.

Plan of Correction

Accept [redacted] - 03/20/2023)

On February 23, 2023, kitchen surfaces and bathroom floor in room 405 were wiped down by the direct care staff member, removing noted food particles/ debris in the Secure Dementia Care Unit kitchenette. The dried fecal matter on the bathroom floor in room 405 was also cleaned by the direct care staff on February 23, 2023. All surfaces in the kitchenette were also inspected by direct care staff for any residue and the surfaces were wiped down on February 23, 2023.

March 8, 2023- direct care staff were retrained by the Executive Director, on the community policy on keeping the environment safe and clean.

The Clare Bridge Program Coordinator or designee will audit the Secure Dementia Care Unit for any issues with cleanliness five (5) times weekly for three (3) months using the Claire Bridge Common and Room Audi tool starting March 13, 2023.

To assist with ongoing compliance, the Executive Director or designee will review audit results monthly for the next three (3) months starting April 14, 2023.

Licensee's Proposed Overall Completion Date: 04/14/2023

Implemented [redacted] - 03/23/2023)

89b - Hot Water Temperature

7. Requirements

2600.

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

Description of Violation

On 2/23/2023 at 10:11 am, the hot water temperature in room 604 measured 125 degrees Fahrenheit.

89b - Hot Water Temperature (continued)

Repeat Violation - 3/30/2022

Plan of Correction

Accept (█) - 03/20/2023)

On February, 23, 2023, the Regional Maintenance Manager along with the Maintenance Technician adjusted the mixing valve and determined that water temperatures were in compliance on the 600 wing.

March 1, 2023- The Executive Director and Regional Maintenance Manager retrained the maintenance staff regarding the community policy on hot water temperature control in resident bathrooms.

The Maintenance Technician or designee will test water temperatures five (5) times weekly in each of the 5 wings for three (3) months using the Hot Water Audit form starting March 13, 2023. The log used for documentation of the water test will include the acceptable temperature range parameters. This audit will also be documented in the Electronic Preventive Maintenance Schedule system ("TELS").

To assist with ongoing compliance, the Executive Director or designee will review the water test results for monthly for three (3) months starting April 14, 2023.

Licensee's Proposed Overall Completion Date: 04/14/2023

Implemented (█) - 03/23/2023)

91 - Telephone Numbers

8. 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 on or by the landline telephone in common area of Secure Dementia Care Unit (SDCU) or the landline telephone in the 400 hallway.

Repeat Violation - 3/30/2022

Plan of Correction

Accept (█) - 03/20/2023)

On February 23, 2023, the Emergency phone number listings in the 400 hallway phone and the secure dementia unit common areas phones were replaced by the Maintenance Technician.

March 2, 2023- An audit was completed by the Maintenance Technician for emergency phone number listings on phones with outgoing lines.

March 2, 2023 and March 8, 2023- The Executive Director and Regional Maintenance Manager retrained the maintenance staff regarding the community policy on availability of emergency numbers posted on phones with outside lines.

The Administrative Assistant or designee will conduct an audit of phones with outside lines, to verify posting of emergency phone numbers using the Emergency Telephone Number Audit form. This will be completed weekly for two (2) months starting March 17, 2023.

To assist with ongoing compliance, the Executive Director or designee will review audit results for monthly for (2) months to verify compliance starting April 14, 2023.

Licensee's Proposed Overall Completion Date: 04/14/2023

91 Telephone Numbers (continued)

Implemented () - 03/23/2023

101o Walls, Floors, Ceilings

9. Requirements

2600.

101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

The carpet in room 405 had various liquid stains and food particles on it.

Plan of Correction

Accept () - 03/20/2023

On February 23, 2023, the Maintenance Technician vacuumed the carpet in room 405. The carpet in room 405 was shampooed by the Maintenance Technician March 3, 2023. On March 9, 2023, Resident rooms in the 400 wing were audited by the Maintenance Technician for stains and need of additional cleaning, any stains identified were addressed by the Maintenance Technician.

March 8, 2023- The Executive Director retrained the direct care staff regarding the community policy on maintaining a clean environment and reporting when carpet stains are identified. A reminder in TELS has been added to include carpet cleaning.

The Maintenance Technician or designee will establish an audit schedule in the 400 wing for any carpet stains, to occur monthly for two (2) months using the 400 Hallway Common Area /Room Audit form starting March 13, 2023. To assist with ongoing compliance, the Executive Director or designee will review the results of these audits monthly for two (2) months starting April 14, 2023.

Licensee's Proposed Overall Completion Date: 04/14/2023

Implemented () - 03/23/2023

102h Toilet Paper

10. Requirements

2600.

102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 2/22/23, at approximately 9:25 am, there was no toilet paper in the public bathroom in Secure Dementia Care Unit (SDCU) activity room.

Repeat Violation - 3/30/2022

Plan of Correction

Accept () - 03/20/2023

On February 23, 2023, a direct care staff member replaced the empty roll of toilet paper.

March 8, 2023- The Executive Director retrained the direct care staff regarding the community policy on toilet paper availability in bathrooms.

An audit schedule has been established twice weekly for the Maintenance Technician or designee to check for toilet paper/supplies for two (2) months using the Claire Bridge Common and Room Audit form starting March 13, 2023. A reminder has been set up in TELS (electronic maintenance system).

To assist with ongoing compliance, the Executive Director or designee will review audit results monthly for two (2) months starting April 14, 2023.

102h Toilet Paper (continued)

Licensee's Proposed Overall Completion Date: 04/14/2023

Implemented () - 03/23/2023)

105g - Lint Removal and Duct Cleaning

11. 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 2/22/23, at approximately 9:42 am, there was an approximate 1/2 inch accumulation of lint in the lint trap of the dryer in the 500 hallway. There were no clothes in the dryer at the time, and the dryer was cold to the touch.

Repeat Violation 3/30/2022

Plan of Correction

Accept () - 03/20/2023)

On February 23, 2023, the Maintenance Technician removed and discarded the dryer lint. The lint traps in the remaining community dryers were checked and found in compliance.

February 27th and March 8, 2023 The Executive Director and Health and Wellness Coordinator retrained the direct care staff and housekeeping staff regarding the community policy on lint removal in the dryers according to the manufacturer's directions.

A sign was placed above the dryers by the Maintenance Technician on March 10, 2023 as a reminder to check the lint trap prior to using the dryers.

The Maintenance Director or designee will inspect the community dryers five (5) times weekly for two (2) months using the Dryer Lint Trap Vent Audit form starting March 13, 2023.

To assist with ongoing compliance, the Executive Director or designee will review inspection results monthly for two (2) months starting April 14, 2023.

Licensee's Proposed Overall Completion Date: 04/14/2023

Implemented () - 03/23/2023)

109b - Rabies Vaccination

12. Requirements

2600.

109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

The home does not have a current certificate of rabies vaccination for cats belonging to Resident #1 and Resident #2.

Repeat Violation 3/30/2022

109b Rabies Vaccination (continued)

Plan of Correction

Accept () - 03/20/2023)

On February 23, 2023, the families of Resident #1 and #2 were notified by the Business Office Manager to supply the community with copies of current vaccination records for their cats or to make an appointment to get the cat vaccinated and provide that documentation to the home.

There are no other pets residing in the community at this time. Resident #2 and her cat are no longer residing in the community. Resident #1 and her family were notified in writing on March 10, 2023 to either supply the community with the vaccination information or make an appointment for the vaccine. The family for Resident #1 have made an appointment to vaccinate the cat on March 15, 2023 and supply the community with the documentation.

March 8, 2023 The Executive Director retrained the Business Office Manager regarding the community policy on maintaining records of rabies vaccination requirement for pets residing in the community. The Executive Director retrained the Sales Manager on the move in criteria for residents with pets.

The Business Manager and Resident Program Manager or designee will establish a process for auditing pet vaccination records using the Pet Audit Form semi annually as well as collecting vaccination information on any new pets brought in to reside in the community starting March 15, 2023.

To assist with ongoing compliance, the Executive Director or designee will review audit results semi annually for the next 12 months starting March 31, 2023.

Licensee's Proposed Overall Completion Date: 03/31/2023

Implemented () - 03/23/2023)

132a - Monthly Fire Drill

13. Requirements

2600.

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

Description of Violation

The home did not provide documentation that an unannounced fire drill was held during the month of November 2022.

Repeat Violation 3/30/2022

Plan of Correction

Accept () - 03/20/2023)

February 28, 2023 The Executive Director and Regional Maintenance Manager retrained maintenance staff regarding the community policy on fire drills. A fire drill was held February 28, 2023 utilizing the required form. The Fire Drill Audit form will be used to track progress.

The Regional Maintenance Manager established a routine schedule in TELS to serve as a reminder to complete fire drills according to schedule and community policy starting February 28, 2023.

To assist with ongoing compliance, the Executive Director or designee will verify compliance with the established fire drill schedule and review documentation following the drills for four (4) months starting February 28, 2023.

Licensee's Proposed Overall Completion Date: 03/17/2023

Implemented () - 03/23/2023)

132c - Fire Drill Records

14. 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

Fire Drill Documentation for fire drills held on 5/24/2022, 6/30/2022, 7/21/2022, 8/4/2022, 9/29/2022, 10/28/2022 and 12/8/2022 do not include the exit route(s) used or the number of residents evacuated.

Fire drill documentation for fire drill on 5/24/2022 did not include an evacuation time.

Repeat Violation - 3/30/2022

Plan of Correction

Accept () - 03/20/2023

February 28, 2023, the Executive Director and Regional Maintenance Manager retrained maintenance staff regarding the community policy on documentation of fire drills which included use of the state approved form.

The Maintenance Manager established a routine schedule in TELS to complete fire drills according to schedule and community policy starting February 28, 2023. To assist with ongoing compliance, the Executive Director or designee will verify compliance with the established fire drill schedule and review documentation following the drills for four (4) months starting February 28, 2023.

Licensee's Proposed Overall Completion Date: 03/17/2023

Implemented () - 03/23/2023

141b1 - Annual Medical Evaluation

15. Requirements

2600.

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

Description of Violation

Resident #3's last completed medical evaluation was completed on [REDACTED]

Resident #4's last completed medical evaluation was completed on [REDACTED]

Resident #5's last completed medical evaluation was completed on [REDACTED]

Plan of Correction

Accept () - 03/20/2023

On February 23, 2023, the Health and Wellness Coordinator notified the attending physicians of Residents 3, 4, and 5 of the need for updated Documentation of Medical Evaluations ("DME"). Resident DME's were updated and completed by the PCP on [REDACTED] for Resident 3, [REDACTED] for Resident 4 and [REDACTED] for Resident 5.

March 1, 2023- The Executive Director and District Director of Clinical Services retrained the direct care staff

141b1 - Annual Medical Evaluation (continued)

regarding the community policy on Annual Medical Evaluation completion.

The Health and Wellness Coordinator or designee will audit the DME completions monthly for two (2) months starting March 13, 2023.

To assist with ongoing compliance, the Health and Wellness Director or designee will review the results of these audits monthly for two (2) months starting April 10, 2023.

Licensee's Proposed Overall Completion Date: 04/10/2023

Implemented ([REDACTED] - 03/23/2023)

171b4 - Staff Training

16. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

- 4. At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation).

Description of Violation

Staff person D was hired on [REDACTED] Staff person D transports residents alone but does not have a direct care training certification.

Plan of Correction

Accept ([REDACTED] - 03/20/2023)

February 23, 2023, Staff Person D completed the direct care staff training and received the training certificate. A review of staff training records was completed by the Business Office Manager and at present there are no other staff driving the van.

March 8, 2023- The Executive Director retrained the direct care staff and maintenance staff on the community policy regarding staff training required for transporting residents. There are no other staff identified at this time that drive the vehicle.

The Business Office Manager or designee will include with the van driver credentials in the employee file the Direct Care Training Certificate Starting March 13, 2023.

To assist with ongoing compliance, the Executive Director will review the audit results monthly for three (3) months starting April 10, 2023.

Licensee's Proposed Overall Completion Date: 04/10/2023

Implemented ([REDACTED] - 03/23/2023)

181f - Record of Medication

17. 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 [REDACTED], resident #3's medication administration record (MAR) did not include all current medications that the resident is prescribed. The list in the resident's MAR was missing the following medications: [REDACTED]

183a - Original Containers and Injections (continued)

To assist with ongoing compliance, the Health and Wellness Director or designee will review audit/review results for the next three (3) months starting March 17, 2023.

Licensee's Proposed Overall Completion Date: 03/17/2023

Implemented () - 03/23/2023

183e - Storing Medications

19. Requirements

2600.

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

Description of Violation

On [redacted] at [redacted], resident [redacted] tablet for day 23 had a tear in the back of the packaging, exposing the medication.

Repeat Violation - 3/30/2022

Plan of Correction

Accept () - 03/20/2023

On February 23, 2023, the Medication Technician discarded the loose pill.

March 8, 2023- The Health and Wellness Coordinator retrained the direct care staff regarding the community policy on medication storage. Those who administer medications were also retrained by the Health and Wellness Coordinator to immediately report any issues identified with packaging of medications noted during administration. Other medication cards were assessed for any tears and found to be in compliance.

The Health and Wellness Coordinator or designee will audit the medication cart weekly for three (3) months starting March 17, 2023.

To assist with ongoing compliance, the Health and Wellness Director or designee, will review audit results monthly for three (3) months starting April 14, 2023.

Licensee's Proposed Overall Completion Date: 04/14/2023

Implemented () - 03/23/2023

183f - Discontinued Medications

20. Requirements

2600.

183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

Resident #3's [redacted] had an expiration date of [redacted]

Resident #3's [redacted] had an expiration date of [redacted]

183f Discontinued Medications (continued)

Resident #3's [redacted] expired in [redacted].

Plan of Correction

Accept ([redacted] - 03/20/2023)

On February 23, 2023, the Medication Technician discarded the expired medications in Resident #3's room who is approved to self medicate.

March 8, 2023 The Health and Wellness Coordinator retrained the appropriate clinical staff regarding the community policy on medication storage. The resident and family were also educated regarding keeping expired medications in the resident room.

The Health and Wellness Coordinator or designee will inspect the rooms of residents who self administer medications monthly for six (6) months during the Self Administration Medication Review process starting February 23, 2023. This inspection will also include checking for storage of expired medications.

To assist with ongoing compliance, the Health and Wellness Director or designee, will review audit results monthly for the next three (3) months starting March 17, 2023.

Licensee's Proposed Overall Completion Date: 03/17/2023

Implemented ([redacted] - 03/23/2023)

185a - Implement Storage Procedures

21. 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 #6 had a glucometer reading of [redacted] on [redacted] at [redacted]. The Resident's Medication Administration Record (MAR) has a documented reading of [redacted] for [redacted] reading.

Repeat Violation 3/30/2022

Plan of Correction

Accept ([redacted] - 03/20/2023)

March 3, 2023 The Health and Wellness Director retrained the direct care staff on the process for documentation of blood glucose results when transferring the number from the glucometer to the eMAR. A review was completed of documentation of glucometers as compared to the eMAR and found to be in compliance.

March 6, 2023 An audit was completed by the Medication Technician of glucometers for documentation compliance and no others were out of compliance.

A glucometer audit form will be implemented to review date, time, and matching documentation with the eMAR to the glucometer. This will be completed by the Health and Wellness Coordinator or designee for two (2) months starting March 13, 2023.

To assist with ongoing compliance, this form will be audited weekly by the Health and Wellness Coordinator or designee for two (2) months starting March 17, 2023.

Licensee's Proposed Overall Completion Date: 03/17/2023

Implemented ([redacted] - 03/23/2023)

187d - Follow Prescriber's Orders

22. Requirements

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

Description of Violation

Resident #4 is prescribed [REDACTED] However, this medication was not administered to resident #4 on [REDACTED] because the medication was not available in the home.

Plan of Correction

Accept [REDACTED] - 03/20/2023)

On February 23, 2023, a cart audit was completed by the Medication Technician of the 200 wing medication cart and medications were found to be available and in compliance.
March 8, 2023, the Health and Wellness Director retrained direct care staff regarding the community policy on medication administration and availability of required medications.
The Health and Wellness Coordinator or designee will run missed medication audit reports starting March 13, 2023, two (2) times weekly for two (2) months and weekly for one (1) additional month. The Health and Wellness Coordinator or designee will notify the direct care staff of any missed medications for medication not being available.
To assist with ongoing compliance, the Health and Wellness Director or designee will review audit results weekly for two (2) months starting March 13, 2023.

Licensee's Proposed Overall Completion Date: 03/17/2023

Implemented [REDACTED] 03/23/2023)

224a - Preadmission Screen Form

23. 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 #5 was admitted to the home on [REDACTED] The home could not provide a completed preadmission screening for Resident #5.

Resident #7 was admitted to the home on [REDACTED]. The home could not provide a completed preadmission screening for Resident #7.

Plan of Correction

Accept [REDACTED] - 03/20/2023)

An audit is being conducted by the Health and Wellness Coordinator and Clinical Specialist of current resident records to verify preadmission screening forms were completed according to community policy, [REDACTED].
March 3, 2023 and March 8, 2023– Clinical management staff and sales manager were retrained on the need for a complete preadmission screening form documentation by the Executive Director and District Director of Clinical Services.
Preadmissions screening forms will be reviewed for 3 months by the Health and Wellness Coordinator or designee prior to resident move-in. The reviewer will initial the screening documenting the review was completed by March 10, 2023. The Pre-admission screen has been added to the sales move-in checklist by Executive Director and Sales

224a - Preadmission Screen Form (continued)

Specialist on March 9, 2023.

To assist with ongoing compliance, the Health and Wellness Director or designee will review results of audits starting April 10, 2023.

Licensee's Proposed Overall Completion Date: 04/10/2023

Implemented () - 03/23/2023)

227d - Support Plan Medical/Dental

24. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident () current support plan dated () does not include the the resident requires a two-person assist.

Plan of Correction

Accept () - 03/20/2023)

On February 23, 2023, the roster was updated to remove the note that this resident required a 2 person transfer by the Administrative Assistant.

March 3, 2023- The Executive Director retrained the administrative and clinical staff regarding the community policy on maintaining a correct roster regarding resident evacuation status. A review was completed of the mobility status for residents by the Health and Wellness Coordinator and compliance was verified.

The Health and Wellness Coordinator or designee will review the roster for accuracy weekly. This will then be communicated with the Administrative Assistant regarding any necessary changes starting March 13, 2023.

To assist with ongoing compliance, the Health and Wellness Director or designee will review rosters audit results weekly for two (2) months starting March 17, 2023.

Licensee's Proposed Overall Completion Date: 03/17/2023

Implemented () - 03/23/2023)

227g -Support Plan Signatures

25. 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's support plan dated () is not signed or dated by the home's staff member who completed the support plan.

Resident #3's support plan dated () is not signed or dated by the home's staff member who completed the support plan.

227g Support Plan Signatures (continued)

Plan of Correction

Accept (█ - 03/20/2023)

On February 23, 2023, Resident #3's support plans were signed by resident with the Clinical Specialist.

March 8, 2023 Executive Director re educated direct care staff that support plans need to be reviewed and signed by resident or their legal representative.

Health & Wellness Coordinator or designee will audit current residents support plans to verify they are signed by residents or legal representative according to community policy starting March 16, 2023.

Health & Wellness Director, Health and Wellness Coordinator and/or designee will complete audits monthly for three (3) months of residents current support plans to verify signatures are present according to the community policy starting April 10, 2023.

Licensee's Proposed Overall Completion Date: 04/10/2023

Implemented (█ - 03/23/2023)

231c - Preadmission Screening

26. Requirements

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #6 was admitted to the Secure Dementia Care Unit on █ The home could not provide a completed preadmission screening for Resident #6.

Plan of Correction

Directed (█ - 03/20/2023)

An audit is being conducted by the Health and Wellness Coordinator and Clinical Specialist of current resident records in the Secure Dementia Care Unit to verify preadmission screening forms were completed according to community policy on March 10, 2023.

March 6 and March 7, 2023 clinical management staff were retrained on this regulation regarding the need for complete preadmission screening form documentation by the Executive Director and District Director of Clinical Services.

Ongoing Preadmissions screening forms will be reviewed for 3 months by the Health and Wellness Coordinator or designee prior to resident move in starting March 10, 2023.

To assist with ongoing compliance, the Health and Wellness Director or designee will review the results of audits monthly for three (3) months starting April 10, 2023.

[Directed]

An audit is being conducted by the Health and Wellness Coordinator and Clinical Specialist of current resident records in the Secure Dementia Care Unit to verify preadmission screening forms were completed according to

231c - Preadmission Screening (continued)

community policy on March 10, 2023. Any resident records who do not include a preadmission screening form will have documentation added to the record stating the preadmission screening form is missing from record, date violation was cited and explaining the violation. This documentation will be added to the records by the Health and Wellness Coordinator and Clinical Specialist by April 1st, 2023.

March 6 and March 7, 2023– clinical management staff were retrained on this regulation regarding the need for complete preadmission screening form documentation by the Executive Director and District Director of Clinical Services.

Ongoing – Preadmissions screening forms will be reviewed for 3 months by the Health and Wellness Coordinator or designee prior to resident move-in starting March 10, 2023.

To assist with ongoing compliance, the Health and Wellness Director or designee will review the results of audits monthly for three (3) months starting April 10, 2023.

Directed Completion Date: 04/10/2023

Implemented () - 03/23/2023

233c - Key-Locking Devices

27. 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 2/22/2023, the directions for operating the home's locking mechanism were not conspicuously posted near exit door labeled "D1" in the Secure Dementia Care Unit (SDCU).

On 2/23/2023, the exit to courtyard in SDCU activity room had a code posted near keypad locking device, however the code does not unlock the doors. The maintenance technician had to use master code to unlock.

Plan of Correction

Accept () - 03/20/2023

On February 23, 2023, the code was corrected to reflect the accurate exit code and was reposted. The directions for operating the locking mechanism was reposted near exit D1 in the secure dementia unit by the Maintenance Technician.

February 28, 2023 and March 8, 2023, the Executive Director re-educated the maintenance staff regarding signage for locking mechanisms in secure dementia unit.

Audits of the secure door locking mechanisms will be completed by the Maintenance Technician or designee five (5) days a week and weekly thereafter for two (2) months starting March 13, 2023. A notation of the audits will be made in TELS for the Maintenance Technician or designee.

To assist with ongoing compliance, the Executive Director or designee will review results of the audits to verify documents are maintained in the licensing binder starting March 17, 2023.

Licensee's Proposed Overall Completion Date: 03/17/2023

Implemented () 03/23/2023

252 Record Content

28. Requirements

2600.

252. Content of Resident Records Each resident's record must include the following information:

- 3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident #5's current picture in his/her record is dated [REDACTED].

Plan of Correction

Accept [REDACTED] 03/20/2023)

Resident #5's photo was retaken and replaced on the resident record by the Clinical Specialist on [REDACTED].

March 8, 2023- An audit was completed of resident photos by the Resident Programmer and pictures were replaced by the Resident Programmer if they were over 2 years old.

March 8, 2023 – The Executive Director retrained the programming and clinical staff on the requirement for Resident photos to be updated every year

The Resident Programmer or designee will take annual resident photos which will be placed in the medical record. In addition, the Business Office Manager will add the resident photo to the evaluation manual starting March 13, 2023. To assist with ongoing compliance, the Executive Director will review the photo process starting March 17, 2023.

Licensee's Proposed Overall Completion Date: 03/17/2023

Implemented [REDACTED] - 03/23/2023)

254a Records Discharge/Active

29. Requirements

2600.

254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On [REDACTED] at [REDACTED], the laptop computer on the medication cart located in 200 hallway was unsupervised and unsecure, showing resident #9's medication information on the screen.

Plan of Correction

Accept [REDACTED] - 03/20/2023)

Immediately on February 23, 2023, the laptop was locked to prevent any unauthorized access to confidential information by the Medication Technician.

March 6, 2023- A review was completed of Medication Technicians not leaving carts out of sight during medication administration on February 23, 2023. Other medication carts were found in compliance.

March 8, 2023 – The Health and Wellness Coordinator and Executive Director retrained the direct care staff on the community policy regarding protection of confidential information.

Health and Wellness Coordinator will review 2 medication carts three (3) times a week for maintaining confidentiality of records during medication pass starting March 17, 2023.

To assist with ongoing compliance, this form will be audited daily five (5) times weekly by the Executive Director, Health and Wellness Coordinator or designee for two (2) months then weekly thereafter for two (2) months starting March 20, 2023.

Licensee's Proposed Overall Completion Date: 03/20/2023

Implemented [REDACTED] - 03/23/2023)