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

May 17, 2023

BH GLEN MILLS MANAGEMENT PA LLC

RE: MERRILL GARDENS AT GLEN MILLS
52 BALTIMORE PIKE
GLEN MILLS, PA, 19342
LICENSE/COC#: 14670

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/22/2023, 03/23/2023, 03/24/2023 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MERRILL GARDENS AT GLEN MILLS* **Licen e #**: *14670* **Licen e Expiration**: *10/16/2023*

Address: *52 BALTIMORE PIKE, GLEN MILLS, PA 19342*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *BH GLEN MILLS MANAGEMENT PA LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I 1* **Date**: *11/20/2019* **I ued By**: *Chester Heights Borough*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *87* **Waking Staff**: *65*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *03/24/2023*

Inspection Dates and Department Representative

03/22/2023 On Site

03/23/2023 On Site ray

03/24/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served**: *55*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Garden House* **Capacity**: *20* **Residents Served**: *15*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *55*

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

Have Mobility Need: *32* **Have Physical Disability**: *0*

Inspections / Reviews

03/22/2023 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/15/2023*

Inspections / Reviews *(continued)*

04/14/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/16/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/19/2023*

04/24/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/16/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/20/2023*

05/17/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/16/2023*

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

On Friday, 03/24/23, no staff present in the kitchen were ServSafe certified. 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.

Plan of Correction ***Accept (- 04/14/2023)***

he two chefs in question have been signed up for the next ServSafe class on April 30, 2023 and May 15, 2023. All other chefs were audited to assure they had the ServSafe certification. The Executive Chef will ensure that at least one employee with food safety certification will be available during hours of operation of the kitchen. This will be monitored by the General Manager. The ServSafe certification will be checked for all chefs hired in the future.

Licensee's Proposed Overall Completion Date: *05/15/2023*

Implemented (- 05/17/2023)

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 /21, for resident #1 was not signed by the resident.

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

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

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

Repeat Violation: 10/20/21.

Plan of Correction ***Accept (- 04/14/2023)***

The residents #1,2,3, and 4 have either signed the contract or provided a "Chose not to sign" document. Other resident's files were audited to assure they have been signed by the resident. The new resident file checklist will be signed by both the Business Office Director (or designee) and the General Manager (or designee) to monitor for compliance.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (05/17/2023)

25b - Contract Signatures *(continued)*

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

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

Repeat Violation: 10/20/21.

Plan of Correction ***Accept (█ - 04/14/2023)***

The residents #1,2,3, and 4 have either signed the Resident's Rights/ Complaint procedures or provided a "Chose not to sign" document. Other resident's files were audited to assure they have been signed by the resident. The new resident file checklist will be signed by both the Business Office Director (or designee) and the General Manager (or designee).) to monitor for compliance.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (█ - 05/17/2023)

42s - Privacy

4. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The home has multiple cameras covering the exterior of the home, entrances, the mail room, the game room and the bar. The home has a sign outside the main entrance stating these premises are under surveillance. Several cameras by entrances and exits (stairwell 8, parking garage, stairs to outside patio from garage) were noted to be without signs. The interior common areas: mail room, game room and the bar were also without signs. During this three-day inspection, staff were not able to verify if the cameras are recording or surveillance only or show how the home monitors the cameras.

Plan of Correction ***Accept (█ - 04/14/2023)***

"This area is under surveillance" signs were posted in the areas stated. Other areas covered by cameras were checked to assure they were under compliance. Surveillance compliance will be assessed if any new cameras are added to the system. The Maintenance Director will observe for signs to ensure they remain in place during monthly rounds for the next 3 months.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (█ - 05/17/2023)

60a - Staff/Support Plan

5. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

Staff schedules indicate the home typically schedules three staff members in the secured dementia care unit (Garden House) and three staff members on personal care (PC); each with one med tech and two caregivers. Garden House is on the first floor, along with several common areas, PC is on the second, third and fourth floors. The layout of the building suggests this is not enough staff to cover all three floors of PC adequately. Staff interviews confirm that three people on PC is not enough to safely and adequately meet the needs of the residents.

Plan of Correction ***Accept (- 04/14/2023)***

The staffing plan was immediately investigated to assure that sufficient staffing was provided to meet the needs of our residents. An additional shift has been added to the Personal Care staffing plan . The corporate staffing plan will be reviewed by the General Manager weekly for the next 3 months monitored to assure that sufficient staffing is provided.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 05/17/2023)

65d - Initial Direct Care Training

6. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
    - i. Safe management techniques.
    - ii. ADLs and IADLs
    - iii. Personal hygiene.
    - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
    - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
    - vi. Implementation of the initial assessment, annual assessment and support plan.
    - vii. Nutrition, food handling and sanitation.
    - viii. Recreation, socialization, community resources, social services and activities in the community.
    - ix. Gerontology.
    - x. Staff person supervision, if applicable.
    - xi. Care and needs of residents with special emphasis on the residents being served in the home.
    - xii. Safety management and hazard prevention.
    - xiii. Universal precautions.
    - xiv. The requirements of this chapter.
    - xv. Infection control.
    - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, hired on /22, provides unsupervised ADL services to residents. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test

65d - Initial Direct Care Training (continued)

until [redacted] 23.

Plan of Correction ***Accept ([redacted] - 04/14/2023)***

Staff Person A immediately presented us with the Department approved training certificate.
Other files were audited to assure ensure they received the training from the Department.
New hire’s files will be audited by both the BOD (or designee) and the GM (or designee) to monitor.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented ([redacted] - 05/17/2023)

65e - 12 Hours Annual Training

7. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person B received only 1 hour of annual training in training year 2022.

Direct care staff person C received only 10 hours of annual training in training year 2022.

Direct care staff person D received only 6 hours of annual training in training year 2022.

Plan of Correction ***Accept ([redacted] - 04/14/2023)***

Staff Persons B, C, and D were immediately given the training to be completed by 4/24/23.
Other staff members training schedules were audited to assure compliance.
Staff training schedule will be reviewed monthly for compliance by the Business Office Director utilizing the newly created “Staff training” Binder.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented ([redacted] - 05/17/2023)

65f - Training Topics

8. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.

65f - Training Topics *(continued)*

7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person B did not receive training in medication self-administration training, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques , care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2022.

Direct care staff person C did not receive training in medication self-administration training, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques , care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2022.

Direct care staff person D did not receive training in medication self-administration training, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques , care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2022.

Plan of Correction ***Accept (- 04/14/2023)***

Staff members B, C, and D were immediately instructed to complete the assigned trainings . Other staff member's training plans were audited for completion. Future trainings will be audited monitored by the Business Office Director monthly using the newly developed "Training" binder.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 05/17/2023)

65g - Annual Training Content

9. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person B did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite

65g - Annual Training Content (continued)

staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, new population groups that are being served at the home that were not previously served, if applicable during training year 2022.

Staff person C did not receive training in emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, new population groups that are being served at the home that were not previously served, if applicable during training year 2022.

Staff person D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, new population groups that are being served at the home that were not previously served, if applicable during training year 2022.

Plan of Correction ***Accept (- 04/14/2023)***

Staff members B, C, and D were immediately instructed to complete the assigned trainings. Other staff member's training plans were audited for completion. Future trainings will be monitored monthly by the Business Office Director using the newly developed "Training" binder.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 05/17/2023)

82c - Locking Poisonous Materials

10. 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

Multiple toiletries including a tube of Crest Cavity Protection Toothpaste, with a manufacture's label indicating "If more than used for brushing is accidently swallowed, get medical help or contact a Poison Control Center right away", was unlocked, unattended, and accessible to residents in room . Not all the residents of the home, including residents of "Garden House", have been assessed capable of recognizing and using poisons safely.

Multiple toiletries including a container of , with a manufacture's label indicating "If swallowed, get medical help or contact a Poison Control Center right away", were kept in a toolbox under the bathroom sink, unlocked, unattended, and accessible to residents in room Not all the residents of the home, including residents of "Garden House", have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 04/14/2023)***

The inappropriate materials for residents in Memory Care were immediately removed from their access. All residents materials were placed in a "Tackle Box" with a combination lock to keep them secure. All resident's apartments will be checked during the "Safety walk" performed weekly by the Resident Care Director and/or General Manager or their designees.

82c - Locking Poisonous Materials *(continued)*

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

Implemented (- 05/17/2023)

85a Sanitary Conditions

11. Requirements

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

Description of Violation

On 03/24/23, at 11:13 am, the mattress in room was soiled and unsanitary. Additionally, the room smelled of feces and urine.

On 03/24/23, at 12:59 pm, the carpet in room was stained with urine. Additionally, the room smelled of urine.

Plan of Correction ***Accept (- 04/14/2023)***

The mattress was removed and discarded as well as the carpet cleaned in Apt immediately on the same day they were discovered. Other apartments were checked for sanitation concerns. The Housekeeping staff members have been instructed to bring any potential concerns to the attention of the General Manager.

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

Implemented (- 05/17/2023)

95 Furniture and Equipment

12. Requirements

2600.
95. Furniture and Equipment Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

Resident #3 uses a handrail on bed for positioning, movement and transferring. The handrail has a large opening which presents as a hazard to the resident.

Plan of Correction ***Accept (- 04/14/2023)***

The handrail in the apartment of resident #3 was immediately covered with a cloth covering to prevent hazards. Other handrails have been evaluated for safety. Future hand rail usage will be evaluated for hazards by the Health Services Director or designee.

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

Implemented (- 05/17/2023)

124 Notice to Fire Department

13. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the

124 - Notice to Fire Department (continued)

home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction ***Accept (- 04/14/2023)***

A letter from the local fire department was requested on 4/11/23. The emergency binder was audited for other possible omissions. The Emergency binder will be audited reviewed during the upcoming Quality Assurance meetings n the future.

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

Implemented (- 05/17/2023)

141b1 - Annual Medical Evaluation

14. 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 /22. The resident's previous medical evaluation was completed on /21.

Repeat Violation: 06/27/22.

Plan of Correction ***Accept (- 04/14/2023)***

HSD and RCD will complete a full house audit on residents' medical evaluation (DME) to be completed by 5/19/23. All new admission DME will be reviewed for full completion prior to admission by HSD or RCD. HSD and GM will review all new admission charts for DME compliance post admission before signing off chart as completed. Annual DME renewal will be tracked in Yardi EHR to ensure compliance. RCD/HCD or designee will run Yardi report monthly to check for renewal dates.
Results of the audit will be reviewed monthly by the General Manager via QA

Licensee's Proposed Overall Completion Date: *05/19/2023*

Implemented (- 05/17/2023)

171b4 - Staff Training

15. 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 E regularly transports residents to medical appointments. However, staff person E has not completed the initial new hire direct care staff person training. No other staff accompanies staff person E on these appointments.

Plan of Correction ***Accept (- 04/24/2023)***

The Driver has been assigned to complete the new hire direct care training and completed this training on April 18, 2023. There are no other drivers that would need to complete this training. Future drivers will be assigned this

171b4 - Staff Training (continued)

same training schedule.

Licensee's Proposed Overall Completion Date: *04/19/2023*

Implemented (- 05/17/2023)

185b - Medication Procedures

16. Requirements

2600.
185.b. At a minimum, the procedures must include:

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

Description of Violation

On 03/24/23, during a medication audit, a discrepancy was observed with resident #3's - Take one-half tablet (25MG) by mouth once daily. The narcotic count sheet lists 21 doses remaining; however, only 20 doses remained in the prescription card. Staff stated this would be reported to the Department as a med error and the home will start an investigation.

Plan of Correction ***Accept (- 04/14/2023)***

RCD/HSD or designee will complete a full audit of all narcotic medications in house once weekly for the next three months to ensure all medications running low are reordered in a timely manner. RCD/HSD will re-educate med staff on the medication administration process and the 6 rights involved along with the proper process and procedure for giving and counting narcotic medications by 4/28/23.
Results of the audit will be reviewed monthly by the General Manager.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 05/17/2023)

187d - Follow Prescriber's Orders

17. Requirements

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

Description of Violation

Resident #4 is prescribed - take two tablets (650 MG) every 6 hours for pain. However, this medication was not administered to resident #4 between /23 to /23 because, according to a resident interview conducted on 03/24/23, the medication was not available in the home for the previous five days.

Repeat Violation: 06/27/22, 10/20/21

Plan of Correction ***Accept (- 04/24/2023)***

HSD and RSD will complete a full house audit on residents prescribed orders to be completed by 4/24/2023. RCD HSD or designee in-service staff on the importance of timely medication verification and reordering by 4/24/23.

187d - Follow Prescriber's Orders (continued)

Then monthly for the next 3 months. for sustained compliance with regulation 2600.187.d
Results of the audit will be reviewed monthly by the General Manager via QA

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 05/17/2023)

190a - Completion Medication Course

18. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person's C and D most recent annual practicum was completed on 22. However, these annual practicums were not completed in accordance with the Department's medication administration annual requirements.

Repeat Violation: 06/27/22.

Plan of Correction ***Accept (- 04/24/2023)***

HSD and RCD will complete a full house audit on care staff medication administration training to be completed by 4/24/2023. Then monthly audits for the next 3 months for sustained compliance with regulation 2600.190a
Results of the audit will be reviewed monthly by the General Manager via QA

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 05/17/2023)

191 - Resident Right to Refuse

19. 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 written documentation.

Repeat Violation: 10/20/21.

Plan of Correction ***Accept (- 04/14/2023)***

The residents listed were presented with a document displaying the right to refuse medications. Other resident files were audited to assure that this document was present. Future residents will have the "right to refuse" listed on their resident rights included as part of the admission packet.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 05/17/2023)

233a - Lock Approval

20. Requirements

2600.
233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The home does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the magnetic locks, used on the exit doors from the SDCU.

Plan of Correction ***Accept (- 04/14/2023)***

A letter from the local building authority was requested on 4/11/23. The emergency binder was audited for other possible omissions. The Emergency binder will be audited during the upcoming Quality Assurance meetings in the future

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 05/17/2023)

236 - Staff Training

21. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person B, who works in the Secure Dementia Care Unit (SDCU) had 0 hours of training in dementia care during the 2022 training year.

Direct care staff persons C and D, who work in the Secure Dementia Care Unit (SDCU) had only 5 hours of training in dementia care during the 2022 training year.

Plan of Correction ***Accept (- 04/14/2023)***

Although there were no training certificates in Staff member B's file, did attend the two hour training presented by the Merrill Garden's representative, the two hour Dementia Training by Fox Rehab , and another training done by the Glen Mills' staff. These certificates have been placed in file. Other staff member's files have been audited to assure they have the proper documentation. The Dementia training will be audited monitored by the Business Office Director using the newly developed "Training" Binder.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 05/17/2023)