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

June 13, 2023

[redacted]
HERITAGE SPRINGS MEMORY CARE INC
327 FARLEY CIRCLE
LEWISBURG, PA, 17837

RE: HERITAGE SPRINGS MEMORY CARE
327 FARLEY CIRCLE
LEWISBURG, PA, 17837
LICENSE/COC#: 22598

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 04/12/2023, 04/13/2023 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

We have directed corrective actions for your facility to implement to correct noncompliant items.

Please submit documentation verifying compliance in SansWrite as corrective actions are implemented. The Department will review this documentation to determine compliance. Please note that in order for the Department to verify your compliance, you are required to upload documentation into SansWrite AFTER the Plan of Correction has been accepted by the Department, and not with the initial submission of your Plan of Correction.

Submit documentation electronically by **07/03/2023**.

If you need assistance regarding submission of evidence to demonstrate compliance, please contact me at [redacted]

Sincerely,

[redacted]
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *HERITAGE SPRINGS MEMORY CARE* **License #**: *22598* **License Expiration**: *03/22/2024*

Address: *327 FARLEY CIRCLE, LEWISBURG, PA 17837*

County: *UNION* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *HERITAGE SPRINGS MEMORY CARE INC*

Address: *327 FARLEY CIRCLE, LEWISBURG, PA, 17837*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *01/03/2017* **Issued By**: *Central Keystone*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *60* **Waking Staff**: *45*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *04/13/2023*

Inspection Dates and Department Representative

04/12/2023 - On-Site: [redacted]

04/13/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *30*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire building* **Capacity**: *64* **Residents Served**: *30*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *30*

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

Have Mobility Need: *30* **Have Physical Disability**: *0*

Inspections / Reviews

04/12/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/14/2023*

05/19/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/08/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/24/2023*

Inspections / Reviews *(continued)*

06/02/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/08/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/07/2023*

06/13/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/08/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/03/2023*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted]/22, Resident #1, had an unwitnessed fall with injury that was not reported to the Department until [redacted]/22 and Resident #2 had an unwitnessed fall with injury on [redacted]/22 that was not reported to the Department until [redacted]/22.

Plan of Correction ***Accept [redacted] - 05/18/2023)***

Nurses were reeducated on the importance of completing an incident report immediately. This education was completed the day of the annual inspection. Past practice was to wait until the emergency room and/or hospitalist would contact HS staff with update. Both of these instances HS nurses tried to gain information from hospital but the hospital staff would not release. We will now be submitting preliminary reports to BHS followed by an updated report when information is obtained. Education will also occur with families with regard to keeping HS updated or provide HS nursing and administration with the password to be able to obtain updated. Resident Care Director will be responsible for oversight. Executive Director will review daily reports to ensure reportable incidents are completed and submitted in a timely manner.

Licensee's Proposed Overall Completion Date: *05/30/2023*

Update: *05/18/2023*

Please send proof of staff training.

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

Resident #3 was admitted on [redacted]/23. As of [redacted]/23, Resident #3 or responsible party did not sign the contract.

Resident # 4 was admitted on [redacted]/22. The contract in the record for resident #4 was not signed by the resident.

Plan of Correction ***Do Not Accept [redacted] - 05/18/2023)***

The contract for Resident #3 was emailed to [redacted] who were both Power of Attorneys. The [redacted] signed all documents with the exception of the contract because the [redacted] handles the finances. Contract was reviewed with both parties by Executive Director and the [redacted] was still undecided on financial plan but gave verbal approval on admission date. Contract was returned via email with signature and date of admission of [redacted]/22. Effective immediately, all new admissions will not be permitted to be admitted until all documents are signed. Resident #4 was not able to sign [redacted] name to the agreement. As recommended during survey, all attempts will be made to have resident sign the contracts the day of admission or mark it with an 'x' and witnessed by Executive Director.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Update: *05/18/2023*

Please include in plan of correction:

25b - Contract Signatures (continued)

Who is responsible for fixing the problem (title) and what did they do to fix it?
What action that person will take, and when that action will happen - (must have date).
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] - 06/02/2023)***

The contract for Resident #3 was emailed to [redacted] who were both Power of Attorneys. The [redacted] signed all documents with the exception of the contract because the [redacted] handles the finances. Contract was reviewed with both parties by Executive Director and the [redacted] was still undecided on financial plan but gave verbal approval on admission date. Contract was returned via email with signature and date of admission of [redacted]/22. Effective immediately, all new admissions will not be permitted to be admitted until all documents are signed. Resident #4 was not able to sign [redacted] name to the agreement. As recommended during survey, all attempts will be made to have resident sign the contracts the day of admission or mark it with an 'x' and witnessed by Executive Director.

Executive Director will be responsible for reviewing all preadmission forms for proper signatures before admission date is scheduled.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Update: *06/02/2023*

Please send signed contracts for resident #3 and #4.

29a SOPb1- Hospice Care: Doctor Certification

3. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

Description of Violation

Resident #6, who was not evacuated during the fire drill conducted on [redacted]/22, does not have a written certification from a physician that the resident is actively dying and may be injured or suffer a hastened death as the result of participating in a fire drill.

Plan of Correction ***Do Not Accept ([redacted] - 05/18/2023)***

Any resident who is admitted to hospice will have an order from their primary care physician if they feel that moving them during a fire drill or emergency would be detrimental to their condition. Resident Care Director will be responsible for working with the Hospice agency. Executive Director will review all hospice resident files to ensure compliance.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Update: *05/18/2023*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix it?
What is the status of Resident #6?
What action that person will take, and when that action will happen - (must have date).
Who (title) will monitor ongoing compliance?

29a SOPb1- Hospice Care: Doctor Certification (continued)

All POC's at a minimum must include the above information.

Plan of Correction ***Accept ([redacted] - 06/02/2023)***

Resident #6 has since expired and is no longer in the facility.
Any resident who is admitted to hospice will have an order from their primary care physician if they feel that moving them during a fire drill or emergency would be detrimental to their condition. Resident Care Director will be responsible for working with the Hospice agency to obtain an order that the resident is too frail to be evacuated. Executive Director will review all hospice resident files to ensure compliance.

Licensee's Proposed Overall Completion Date: *06/01/2023*

41e - Signed Statement

4. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

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

Plan of Correction ***Do Not Accept ([redacted] - 05/18/2023)***

Resident #3's Resident Rights were part of the Resident Agreement which was signed and dated [redacted]/23 but not received until [redacted]/23. All new admissions will be on hold until all proper paperwork is in place. This is the responsibility of the Executive Director.

Licensee's Proposed Overall Completion Date: *05/11/2023*

Update: *05/18/2023*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix it?
What action that person will take, and when that action will happen - (must have date).
Were all current resident records audited for compliance?
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] - 06/02/2023)***

Resident #3's Resident Rights were part of the Resident Agreement which was signed and dated [redacted]/23 but not received until [redacted]/23. All new admissions will be on hold until all proper paperwork is in place. This is the responsibility of the Executive Director. Executive Director reviewed all resident files to ensure documents are signed on 5/16/23. Periodic audits will occur on a quarterly basis to ensure compliance.

Licensee's Proposed Overall Completion Date: *06/01/2023*

60a - Staff/Support Plan

5. Requirements

2600.

60a - Staff/Support Plan *(continued)*

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

The home currently serves 30 residents; 3 residents use wheelchairs and 8 use walkers. 3 residents required assistance of 1 to transfer and evacuate during an emergency.
Schedules were reviewed. On 4/2/23 - 2 staff persons were scheduled from 11:15 pm to 3:00am, 4/4/23 through 4/6/23, 2 staff persons were scheduled from 11:15 pm to 6:45am. The last overnight fire drill occurred on 2/18/23 at 2:15am with 29 residents in the home. The evacuation time was 7 minutes and 8 seconds with 4 staff members present. In the event of an emergency the home does not have enough staff to meet the needs of the residents.

Plan of Correction ***Do Not Accept [redacted] - 05/19/2023)***

During our annual inspection, Executive Director challenged this violation and asked for permission to show payroll logs to prove we had 3 staff members on at all times. Once the inspector reviewed the logs [redacted] agreed that this violation would be removed. Not sure why this is still showing as a violation.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Update: *05/19/2023*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix it?
What action that person will take, and when that action will happen - (must have date).
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept ([redacted] - 06/02/2023)***

During our annual inspection, Executive Director challenged this violation and asked for permission to show payroll logs to prove we had 3 staff members on at all times. Once the inspector reviewed the logs [redacted] agreed that this violation would be removed. Not sure why this is still showing as a violation. Executive Director creates schedule to reflect staffing needs. Resident Care Director, along with Executive Director finds proper coverage or fills voids is needed to ensure staffing levels are appropriate to meet the needs of our residents.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Update: *06/02/2023*

Please send staff schedule from May 1, 2023, to current.

65e - 12 Hours Annual Training

6. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Staff A, hired on [redacted]/17, completed 6.5 hours of training in 2022, Staff B, hired on [redacted]/20 completed 4 hours of training in 2022, and staff D hired on [redacted]/20, completed 7 hours of training in 2022.

Plan of Correction ***Do Not Accept ([redacted] - 05/18/2023)***

Heritage Springs uses the CARES program for 10 hours of Dementia training. This was done every two years because the certificate was valid for two years. The inspector pointed out that this has to be done yearly or 10 additional

65e - 12 Hours Annual Training (continued)

hours from another source needs to be done each year. Executive Director, Resident Care Director and Administrative Assistant will make sure each staff member completes the CARES training yearly to remain in compliance.

Licensee's Proposed Overall Completion Date: *09/01/2023*

Update: *05/18/2023*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix it?
What action that person will take, and when that action will happen - (must have date).

Was the training completed for the below staff persons?
Staff A, hired on [redacted]/17, completed 6.5 hours of training in 2022, Staff B, hired on [redacted]/20 completed 4 hours of training in 2022, and staff D hired on [redacted]/20, completed 7 hours of training in 2022.

Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] - 06/02/2023)***

Training for Staff A, B and D were completed by the end of May 2023. Administrative Assistant will review training records monthly to ensure all staff have completed trainings in a time manner. Executive Director will perform quarterly audits to maintain compliance. Heritage Springs uses the CARES program for 10 hours of Dementia training. This was done every two years because the certificate was valid for two years. The inspector pointed out that this has to be done yearly or 10 additional hours from another source needs to be done each year. Executive Director, Resident Care Director and Administrative Assistant will make sure each staff member completes the CARES training yearly to remain in compliance.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Update: *06/02/2023*

Please send proof of staff person's A, B and D's 12 hours of training for 2022.

65f - Training Topics

7. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

For training year 2022:
Staff A did not receive training in infection control and safe management techniques.
Staff B did not receive training in instruction on meeting the needs (DME and RASP), care for residents with dementia & cognitive impairment, and safe management techniques.
Staff C did not receive training in safe management techniques. Staff D did not receive training in personal care service needs of the resident and safe management techniques.

Plan of Correction ***Do Not Accept [redacted] 05/18/2023)***

Training is held during staff meeting once a month. Staff who do not attend staff meeting will be required to

65f - Training Topics (continued)

review the information and sign a signature sheet to verify that they did indeed review the information. Resident Care Director and Executive Director will be responsible to make sure all staff complete the required training each month.

Licensee's Proposed Overall Completion Date: *10/01/2023*

Update: *05/18/2023*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix it?
What action that person will take, and when that action will happen - (must have date).

Was this training completed?
For training year 2022:
Staff A did not receive training in infection control and safe management techniques.
Staff B did not receive training in instruction on meeting the needs (DME and RASP), care for residents with dementia & cognitive impairment, and safe management techniques.
Staff C did not receive training in safe management techniques. Staff D did not receive training in personal care service needs of the resident and safe management techniques.

Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept ([redacted] - 06/02/2023)***

Staff A B and C were required to repeat CARES training for 2023. Executive Director will perform audits on a quarterly basis to ensure staff remain in compliance. Training is held during staff meeting once a month. Staff who do not attend staff meeting will be required to review the information and sign a signature sheet to verify that they did indeed review the information. Resident Care Director and Executive Director will be responsible to make sure all staff complete the required training each month.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Update: *06/02/2023*

Please send proof of Staff A, B, and C's training for 2022.

For training year 2022:
Staff A did not receive training in infection control and safe management techniques.
Staff B did not receive training in instruction on meeting the needs (DME and RASP), care for residents with dementia & cognitive impairment, and safe management techniques.
Staff C did not receive training in safe management techniques. Staff D did not receive training in personal care service needs of the resident and safe management techniques.

65g - Annual Training Content

8. 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:

Description of Violation

For training year 2022:
Staff A and Staff B did not receive training in emergency preparedness, resident rights, and falls & accident prevention.
Staff C and Staff D did not receive training in emergency preparedness, and resident rights.

Plan of Correction ***Do Not Accept ([redacted] - 05/18/2023)***

Training is held during staff meeting once a month. Staff who do not attend staff meeting will be required to review the information and sign a signature sheet to verify that they did indeed review the information. Resident Care Director and Executive Director will be responsible to make sure all staff complete the required training each month.

Licensee's Proposed Overall Completion Date: *10/01/2023*

Update: *05/18/2023*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix it?
What action that person will take, and when that action will happen - ***(must have date).***

Was this training completed?
For training year 2022:
Staff A and Staff B did not receive training in emergency preparedness, resident rights, and falls & accident prevention.
Staff C and Staff D did not receive training in emergency preparedness, and resident rights.

Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Do Not Accept [redacted] - 06/02/2023)***

Staff A, B, C, D have been given the immediate task of completing their required trainings yearly as required. This training is to be completed by July 1st. Training is held during staff meeting once a month. Staff who do not attend staff meeting will be required to review the information and sign a signature sheet to verify that they did indeed review the information. Resident Care Director and Executive Director will be responsible to make sure all staff complete the required training each month.

Licensee's Proposed Overall Completion Date: *07/01/2023*

Update: *06/02/2023*

Training identified below needs to be completed as soon as possible.
Please send proof of training for 2022 when completed.

For training year 2022:

65g - Annual Training Content (continued)

Staff A and Staff B did not receive training in emergency preparedness, resident rights, and falls & accident prevention.
Staff C and Staff D did not receive training in emergency preparedness, and resident rights.

Plan of Correction ***Accept ([redacted] - 06/13/2023)***

Staff A, B, C, D have been given the immediate task of completing their required trainings yearly as required. This training is to be completed by July 1st. Training is held during staff meeting once a month. Staff who do not attend staff meeting will be required to review the information and sign a signature sheet to verify that they did indeed review the information. Resident Care Director and Executive Director will be responsible to make sure all staff complete the required training each month. All training records were reviewed by Administrative Assistant and anyone who has not received their annual training will have it completed by July 1, 2023.

Within 15 days of receipt of this directed plan of correction:
Staff identified below will have required training completed by 6-28-2023.
For training year 2022:
Staff A and Staff B did not receive training in emergency preparedness, resident rights, and falls & accident prevention.
Staff C and Staff D did not receive training in emergency preparedness, and resident rights.

Also, the administrator will develop a staff training plan that includes the following information:
(1) The name, position and duties of each direct care staff person, ancillary staff person, substitute personnel and regularly-scheduled volunteer
(2) The required training courses for each person identified in (1).
(3) The dates, times and locations of the scheduled training for each person identified in (1) for the upcoming year.

The training plan will include, at a minimum, the topics required by 2600.65f and 2600.65g. The administrator shall be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/26/2023*

65i - Training Record

9. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

Staff training record did not include date of projected date and time of training, clock hours, location of training, and course instructor for Safe Management techniques, emergency procedures, fire safety, resident rights, falls & accident prevention, dementia, OAPSA, and 6 hours of dementia training.

65i - Training Record *(continued)*

Plan of Correction ***Do Not Accept ([redacted] - 05/18/2023)***

Staff training plan was provided to inspector the day of our annual inspection. There was no mention that this was a violation or was not in compliance with regulations.

Licensee's Proposed Overall Completion Date: *10/01/2023*

Update: *05/18/2023*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix it?
What action that person will take, and when that action will happen - (must have date).
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Do Not Accept [redacted] - 06/02/2023)***

Staff training plan was provided to inspector the day of our annual inspection. There was no mention that this was a violation or was not in compliance with regulations. Executive Director is responsible to schedule monthly trainings and track to ensure all staff are present or review training materials to ensure compliance.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Update: *06/02/2023*

Please send proof of compliance for review.

Staff training record did not include date of projected date and time of training, clock hours, location of training, and course instructor for Safe Management techniques, emergency procedures, fire safety, resident rights, falls & accident prevention, dementia, OAPSA, and 6 hours of dementia training.

Plan of Correction ***Directed ([redacted] - 06/13/2023)***

Staff training plan was provided to inspector the day of our annual inspection. There was no mention that this was a violation or was not in compliance with regulations. Executive Director is responsible to schedule monthly trainings and track to ensure all staff are present or review training materials to ensure compliance. Training record was reviewed to include projected date and time of training by Executive Director and will continue to be monitored by Director.

Within 10 days of receipt of this plan of correction:
The administrator will develop a staff training plan that includes the following information:
(1) The name, position and duties of each direct care staff person, ancillary staff person, substitute personnel and regularly scheduled volunteer.
(2) The required training courses for each person identified in (1).
(3) The dates, times and locations of the scheduled training for each person identified in (1) for the upcoming year.

The training plan will include, at a minimum, the topics required by 2600.65f and 2600.65g. The administrator shall be responsible for ongoing compliance.

Directed Completion Date: *06/23/2023*

132c - Fire Drill Records

10. 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 record does not include route of evacuation for any fire drill completed from 10/6/22 to 3/11/23.

Plan of Correction ***Do Not Accept [redacted] - 05/18/2023)***

Each fire drill record will now contain evacuation route used during the drill. Maintenance Director will be responsible for conducting the drill as well as completing the fire drill logs. Executive Director will conduct audits on the logs to make sure every column is completed.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Update: *05/18/2023*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix it?
What action that person will take, and when that action will happen - (must have date).

Was staff trained regarding the regulation - if so, when, by whom?

Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] - 06/02/2023)***

All Maintenance personnel were educated on the important of completing the record of drills in its entirety. Each fire drill record will now contain evacuation route used during the drill. Maintenance Director will be responsible for conducting the drill as well as completing the fire drill logs. Executive Director will conduct monthly audits on the logs to make sure every column is completed.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Update: *06/02/2023*

Please send fire drill log for April and May 2023.

All Maintenance personnel were educated on the important of completing the record of drills in its entirety. ***--***
When did this training take place and who provided the training?

141a 1-10 Medical Evaluation Information

11. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

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

Description of Violation

Resident #3's initial DME, dated [redacted]/23, did not include prescribed medications.

Plan of Correction ***Do Not Accept [redacted] 05/18/2023)***

Medication list was still in resident chart behind the medical evaluation form. The violation was given because the medication list was not stapled to the actual form. Resident Care Director will be responsible for making sure the medication list is attached to medical evaluation. Random audits will be performed by Executive Director to ensure compliance.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Update: *05/18/2023*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix it?
What action that person will take, and when that action will happen - (must have date).
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept ([redacted] 06/02/2023)***

Resident #3 medication list was attached to the DME the day of our annual survey. Medication list was still in resident chart behind the medical evaluation form. The violation was given because the medication list was not stapled to the actual form. Resident Care Director will be responsible for making sure the medication list is attached to medical evaluation. Random audits will be performed by Executive Director to ensure compliance.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Update: *06/02/2023*

Please send completed DME for resident #3.

231c - Preadmission Screening

12. 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 #3 was admitted on [redacted]/23. On [redacted]/23, a cognitive prescreen was completed by a physicians for admission

231c - Preadmission Screening (continued)

to a secured unit.

Plan of Correction ***Do Not Accept (- 05/18/2023)***

Resident Care Director inadvertently wrote /23 when completing the prescreen when the prescreen was actually completed on /23. Resident Care Director will be more careful when dating forms to be in line with regulations. Executive Director will audit all admission paperwork for accuracy.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Update: *05/18/2023*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix it?
What action that person will take, and when that action will happen - (must have date).
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept (- 06/02/2023)***

Resident Care Director inadvertently wrote /23 when completing the prescreen when the prescreen was actually completed on 23. Resident Care Director will be more careful when dating forms to be in line with regulations. Executive Director will audit all admission paperwork for accuracy. Resident Care Director wrote incorrect date on pre admission screen. All charts were reviewed by RCD to ensure all preadmission screens are completed timely and according to regulatory requirements.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Update: *06/02/2023*

All charts were reviewed by RCD to ensure all preadmission screens are completed timely and according to regulatory requirements. ***-- When did this take place?***

231e - No Objection Statement

13. Requirements

2600.
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 #3 was admitted on /23 and resident #4 was admitted on /22. The home did not have documentation that Resident #3 & #4, along with their designee did not object to the resident's admission to the secure dementia care home.

Plan of Correction ***Do Not Accept - 05/18/2023)***

The contract for Resident #3 was emailed to who were both Power of Attorneys. The signed all documents with the exception of the contract because the handles the finances. Contract was reviewed with both parties by Executive Director and the was still undecided on financial plan but gave verbal approval on admission date. Contract was returned via email with signature and date of admission of /22. Effective immediately, all new admissions will not be permitted to be admitted until all documents are signed.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Update: *05/18/2023*

Please include in plan of correction:

231e - No Objection Statement (continued)

Who is responsible for fixing the problem (title) and what did they do to fix it?
What action that person will take, and when that action will happen - ***(must have date).***

Were all resident records audited for compliance with this regulation?

Was this completed for Resident's #5 and #6?
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.

Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Do Not Accept [redacted] - 06/02/2023)***

The contract for Resident #3 was emailed to [redacted] who were both Power of Attorneys. The [redacted] signed all documents with the exception of the contract because the [redacted] handles the finances. Contract was reviewed with both parties by Executive Director and the [redacted] was still undecided on financial plan but gave verbal approval on admission date. Contract was returned via email with signature and date of admission of [redacted]/22. Resident #5 and #6 would not sign contract. Note on contracts made by Executive Director reflecting the fact that attempt was made without success to get signature or an X on the admission paperwork, Effective immediately, all new admissions will not be permitted to be admitted until all documents are signed.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Update: *06/02/2023*

Were all resident records audited for compliance with this regulation?

Was this completed for Resident's #5 and #6?
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.

Plan of Correction ***Accept ([redacted] - 06/13/2023)***

The contract for Resident #3 was emailed to [redacted] who were both Power of Attorneys. The [redacted] signed all documents with the exception of the contract because the [redacted] handles the finances. Contract was reviewed with both parties by Executive Director and the [redacted] was still undecided on financial plan but gave verbal approval on admission date. Contract was returned via email with signature and date of admission of [redacted]/22. Resident #5 and #6 would not sign contract. Note on contracts made by Executive Director reflecting the fact that attempt was made without success to get signature or an X on the admission paperwork, Effective immediately, all new admissions will not be permitted to be admitted until all documents are signed. All contracts were reviewed by Executive Director during the week of June 1st and any that are missing resident signatures will be reviewed with the resident to obtain either their signature or marks. Executive Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: *06/30/2023*

233c - Key-Locking Devices

14. 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

The gate located in the courtyard did not have instruction how to operate the locking device.

Plan of Correction ***Do Not Accept [redacted] - 05/18/2023)***

All doors are checked daily to make sure that door codes are still attached. The sign blew off after morning rounds leaving tape still there. Maintenance immediately posted a new sign. Maintenance will continue to do rounds each day to make sure signs are still visible and replace as necessary. Executive Director will also double check when rounding the facility daily.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Update: *05/18/2023*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix it?
What action that person will take, and when that action will happen - ***(must have date).***
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] - 06/02/2023)***

All doors are checked daily to make sure that door codes are still attached. The sign blew off after morning rounds leaving tape still there. Maintenance immediately posted a new sign. during the annual survey. Maintenance will continue to do rounds each day to make sure signs are still visible and replace as necessary. Executive Director will also double check when rounding the facility daily.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Update: *06/02/2023*

Please send proof of compliance (picture).

234b - Support Plan Needs Elements

15. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

Resident #5 has a bed enabler attached to the bed. Resident #5's assessment and support plan does not indicate what the resident uses this device for.

Plan of Correction ***Do Not Accept [redacted] - 05/18/2023)***

Resident #5 has had an enabler for several years. Current Resident Care Director did not realize it was not listed in the plan of care. Plan of Care was updated to reflect the use of the enable bar. Resident Care Director will review all resident care plans of those individuals who use an enable bar to make sure they are addressed in the plan of care.

Licensee's Proposed Overall Completion Date: *05/31/2023*

Update: *05/18/2023*

Please include in plan of correction:

234b - Support Plan Needs Elements (continued)

Who is responsible for fixing the problem (title) and what did they do to fix it?
What action that person will take, and when that action will happen - (must have date).
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Do Not Accept [redacted] - 06/02/2023)***

Resident #5 has had an enabler for several years. Current Resident Care Director did not realize it was not listed in the plan of care. Plan of Care was updated to reflect the use of the enable bar. Physician order also obtained. Resident Care Director reviewed all resident care plans of those individuals who use an enable bar to make sure they are addressed in the plan of care.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Update: *06/02/2023*

Resident Care Director reviewed all resident care plans of those individuals who use an enable bar to make sure they are addressed in the plan of care. ***--When did this action/audit take place?***
Who (title) will monitor ongoing compliance?

Plan of Correction ***Accept [redacted] - 06/13/2023)***

Resident #5 has had an enabler for several years. Current Resident Care Director did not realize it was not listed in the plan of care. Plan of Care was updated to reflect the use of the enable bar during the survey. Physician order also obtained. Resident Care Director reviewed all resident care plans of those individuals who use an enable bar to make sure they are addressed in the plan of care. This audit was completed the last week in June 2023 by [redacted] Resident Care Diector.

Licensee's Proposed Overall Completion Date: *06/08/2023*

236 - Staff Training

16. 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

Staff B and Staff C did not complete 6 hours of dementia training for training year 2022.

Plan of Correction ***Do Not Accept [redacted] - 05/18/2023)***

Training is held during staff meeting once a month. Staff who do not attend staff meeting will be required to review the information and sign a signature sheet to verify that they did indeed review the information. Resident Care Director and Executive Director will be responsible to make sure all staff complete the required training each month.

Licensee's Proposed Overall Completion Date: *10/01/2023*

Update: *05/18/2023*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix it?
What action that person will take, and when that action will happen - (must have date).
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

236 - Staff Training *(continued)*

Plan of Correction ***Do Not Accept [redacted] - 06/02/2023)***

Staff B and C were informed they were required to completer training before July 1st. Training is held during staff meeting once a month. Staff who do not attend staff meeting will be required to review the information and sign a signature sheet to verify that they did indeed review the information. Resident Care Director and Executive Director will be responsible to make sure all staff complete the required training each month.

Licensee's Proposed Overall Completion Date: *07/01/2023*

Update: *06/02/2023*

Training identified below needs to be completed as soon as possible.
Staff B and Staff C did not complete 6 hours of dementia training for training year 2022.
Please send proof of training for 2022 when completed.

Plan of Correction ***Accept [redacted] - 06/13/2023)***

Staff B and C were informed they were required to completer training before July 1st. Training is held during staff meeting once a month. Staff who do not attend staff meeting will be required to review the information and sign a signature sheet to verify that they did indeed review the information. Resident Care Director and Executive Director will be responsible to make sure all staff complete the required training each month.

Licensee's Proposed Overall Completion Date: *06/28/2023*

252 - Record Content

17. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

Description of Violation

Resident #3's record did not include color of eyes.

Plan of Correction ***Do Not Accept [redacted] - 05/18/2023)***

This was not discussed as a violation during exit interview. We strive hard to ensure all items on the resident face sheet are completed. Resident #3's face sheet was updated to include color of eyes and an audit was completed by the Resident Care Director for all residents to ensure that all face sheets are completed in it's entirety.

Licensee's Proposed Overall Completion Date: *05/12/2023*

Update: *05/18/2023*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix it?
What action that person will take, and when that action will happen - (must have date).
Who (title) will monitor ongoing compliance?

252 - Record Content (continued)

All POC's at a minimum must include the above information.

Plan of Correction ***Accept ([redacted] - 06/02/2023)***

This was not discussed as a violation during exit interview. We strive hard to ensure all items on the resident face sheet are completed. Resident #3's face sheet was updated to include color of eyes and an audit was completed by the Resident Care Director for all residents to ensure that all face sheets are completed in it's entirety. Resident Care Director reviewed all face sheets to ensure all blanks are filled in. RCD will perform quarterly audits to ensure compliance.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Update: *06/02/2023*

When was this audit completed - date and by whom?

--an audit was completed by the Resident Care Director for all residents to ensure that all face sheets are completed in it's entirety.