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

August 17, 2023

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

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

Dear [redacted] ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/06/2023, 06/07/2023 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: *SEATON SPRINGWOOD* **License #**: *33503* **License Expiration**: *02/12/2024*

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

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

Administrator

Name: [redacted]

Legal Entity

Name: *HAVEN AT SPRINGWOOD OPCO LLC*

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

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *01/20/2004* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *114* **Waking Staff**: *86*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**: *0*

Reason: *Renewal, Complaint* **Exit Conference Date**: *06/07/2023*

Inspection Dates and Department Representative

06/06/2023 - On-Site: [redacted]

06/07/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *123* **Residents Served**: *90*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Beacon* **Capacity**: *13* **Residents Served**: *9*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *90*

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

Have Mobility Need: *24* **Have Physical Disability**: *3*

Inspections / Reviews

06/06/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/25/2023*

07/05/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/07/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/10/2023*

Inspections / Reviews *(continued)*

08/17/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *07/07/2023*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted], at approximately [redacted], an altercation occurred between Resident 3 and Resident 9. The home did not report the incident to the local Area Agency on Aging (AAA).

Plan of Correction ***Accept ([redacted] - 07/05/2023)***

Immediately, the manager involved in incident was provided coaching on reporting guidelines.
Training on incident reporting guidelines was provided by Administrator on 6/27/23. A sign in sheet for the training is attached, see page 1A. A reference tool was developed by the Administrator and distributed on 6/27/23. Reference tool attached, see pages 1B-1D.
Recurring training on incident reporting guidelines will be provided by the Administrator, or designated alternate PCHA licensed employee, on a quarterly basis.

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

Implemented [redacted] - 07/25/2023)

16c - Written Incident Report

2. 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

The home did not report the following medication errors to the Department:

On [redacted], there were several instances where residents failed to receive their prescribed medications to include the following:
Resident 1 is prescribed [redacted]. However, this medication was not administered to resident 1 on [redacted] to [redacted] because the medication was not available in the home.

Resident 2 is prescribed [redacted].
However, these medications were not administered to resident 2 on [redacted] because these medications were not available in the home.

Plan of Correction ***Accept [redacted] - 07/05/2023)***

Immediately, the manager involved in incident was provided coaching on reporting guidelines.
Training on incident reporting guidelines was provided by Administrator on 6/27/23. A sign in sheet for the training is attached, see page 1A. A reference tool was developed by the Administrator and distributed on 6/27/23. Reference tool attached, see pages 1B-1D.

16c - Written Incident Report (continued)

Recurring training on incident reporting guidelines will be provided by the Administrator, or designated alternate PCHA licensed employee, on a quarterly basis.

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

Implemented (- 07/25/2023)

26b - Quality Management Plan Content

3. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:

Description of Violation

The home's last quality management review was completed on 03/31/20.

Plan of Correction ***- 07/05/2023)***

Immediately, a quality management plan was completed on by Administrator. See attached QMP, pages 2A-2B. The Administrator will continue to facilitate quality management plan evaluation and review on a quarterly basis. See attached schedule for QMP meetings for 202, page 2C.

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

Implemented (- 07/25/2023)

63a - First Aid/CPR Training

4. 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

On , from , 90 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid, obstructed airway techniques and CPR.

Plan of Correction ***Accept (- 07/05/2023)***

Immediately, all CPR/1st aid certified employee were identified by Business Office Manager. The schedule template was updated to reflect indication of CPR/1st Aid certification status by the Administrator. Sample included, see page 3A. The responsible staff scheduler will utilize the schedule template effective immediately and thereafter to ensure appropriate number of CPR/1st aid employees are present in the home at all times. The administrator will audit schedule on monthly basis to ensure compliance.

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

Implemented - 07/24/2023)

65g - Annual Training Content

5. Requirements

2600.

65g - Annual Training Content *(continued)*

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 during training year 2022.

Staff person C did not receive training in the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention during training year 2022.

Plan of Correction ***Accept ([redacted] - 07/05/2023)***

Immediately, Staff B completed fire safety training facilitated by Administrator, who is trained by fire safety expert to deliver training on content on 6/21/23. See attached sign in sheet, page 4A. Staff C completed OAPS and resident rights, and fall/accident prevention on 6/27/23 facilitated by physical therapist and management staff. On 6/27/23, Fire safety, OAPS and resident rights, and fall and accident prevention training was delivered to all direct staff facilitated by Administrator (trained by fire safety expert), physical therapist and management staff. See attached sign in sheet on page 4B. Fire safety training materials on pages 4d-4L. Fall prevention sign in sheet and training agenda on pages 4M-4R. OAPS and resident rights sign in sheet and agenda on pages 4S-4T. Training on the required topics are provided immediately upon hire for all direct staff and will be offered quarterly thereafter to ensure compliance with requirement.

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

Implemented ([redacted] - 07/25/2023)

121a - Unobstructed Egress

6. Requirements

2600.

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

Description of Violation

On 6/6/23 at 10:55am, the metal exterior door in the secured care unit (SCU) leading to the outside concrete ramp had a significant buildup of rust and debris on and around the frame of the door, making it very difficult to open and close, creating a blocked egress in the event of an emergency.

Repeated Violation from 09/28/22 et al.

121a - Unobstructed Egress *(continued)*

Plan of Correction ***Accept (- 07/05/2023)***

Immediately, contractor was called to assess and quote replacement of door by Director of Facilities. On 6/22/23, a financial cost was estimated and provided to the Administrator including the an estimated date of installation of 7/28/2023 based on delivery of materials. The Administrator accepted cost of installation and signed agreement on 6/22/23. See attached page 5A.

*Monthly, an inspection of the area will be completed by the Memory Care Director to include checking for condition of exits and egress. Inspection tool attached, see pages 5B-5D, item single * verifying unobstructed egress. Any instance of noncompliance will be immediately reported by Memory Care Director to Director of Facilities. The Director of Facilities will be responsible for planning corrective action within 24 hours of verbal report and submit to Administrator for review.*

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

Implemented - 08/07/2023)

141a - Medical Evaluation

7. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

The medical evaluation for Resident 8 was not complete within 60 days prior to admission date of . The medical evaluation was completed on

Repeated violation from 09/28/2022 et al.

Plan of Correction ***Accept (- 07/05/2023)***

Immediately, an audit of all residents charts was conducted on 6/18/2023 by regional nursing support staff. See attached for complete audit and findings, pages 6A-6D. This audit will be completed on a monthly basis by the health and wellness leadership staff by 7/30/23 and every month thereafter. A new resident chart checklist will be utilized upon the admission of every new resident by the health and wellness leadership or memory care director based on which level of care the resident will be admitted to starting 7/1/2023 and upon each admission thereafter. See attached, page 6E.

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

Implemented (- 08/07/2023)

141b1 - Annual Medical Evaluation

8. Requirements

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

141b1 - Annual Medical Evaluation *(continued)*

Description of Violation

Resident 1's most recent medical evaluation was completed on [redacted]

Resident 4's most recent medical evaluation was completed on [redacted]. *Resident 4's previous, medical evaluation was completed on* [redacted]

Repeated violation from 09/28/2022 et al.

Plan of Correction ***Accept*** [redacted] ***- 07/05/2023)***

Immediately, an audit of all residents charts was conducted on 6/18/2023 by regional nursing support staff. See attached for complete audit and findings, pages 6A-6D. Resident 4's DME was located and was completed 4/10/2023. See attached pages 6F-6I. Resident 1 is scheduled to be seen and DME completed on 6/29/2023. This audit will be completed on a monthly basis by the health and wellness leadership staff by 7/30/23 and every month thereafter.

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

Implemented ([redacted] ***- 08/07/2023)***

171b5 - First Aid Kit

9. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the 2003 Mercury Marquee used to transport residents does not include tweezers, thermometer, breathing shield, and eye coverings.

Plan of Correction ***Accept (*** [redacted] ***- 07/05/2023)***

Immediately, the missing items were purchased and replaced on 6/22/23 by the administrator. See attached for receipt of purchase, page 7A. An inspection tool for DHS required first aid kit items was developed by the administrator on 6/23/23. Beginning July 2023, the Director of Facilities or the Director of Environmental Services will submit the inspection checklist to verify that all required items are present in the vehicles' first aid kit. See attached for inspection tool, page 7B.

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

Implemented ([redacted] ***- 08/07/2023)***

181d -Storing Medication

10. Requirements

2600.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

181d -Storing Medication *(continued)*

Description of Violation

Resident 10 self-administers medications and stores medications in his/her room. On [redacted] at [redacted] am, there were several unlocked, unattended medications to include a prescription bottle which contained several red and gray colored pills in Resident 10's bedroom.

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

Immediately, an agreement for residents responsible for self administering medication was created on [redacted] by health and wellness leadership, affirming that medications would be kept locked and labelled in the resident's room. See attached page 8A. All self-administering residents were identified. The nurse completed an audit of the 3 residents to verify that a lock box was provided or available to each resident and that all medication labels with the required identifying information were correctly affixed on 6/22/23. See attached, page 8B. All residents listed signed the agreement on 6/22/23. See attached pages 8C-8E. On 6/22/23 an additional lock box was purchased by the administrator to have on hand in case of immediate replacement need. See attached page 8F.

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

Implemented ([redacted] - 08/07/2023)

184a - Resident's Meds Labeled

11. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The prescription bottle containing red and gray pills found in resident 10's bedroom does not include the resident's name, the name of the medication, the date the prescription was issued, the prescribed dosage and instructions for administration, the name and title of the prescriber.

Repeated violation from 09/28/22 et al.

Plan of Correction ***Accept [redacted] - 07/05/2023)***

Immediately, an agreement for residents responsible for self administering medication was created on 6/20/23 by health and wellness leadership, affirming that medications would be kept locked and labelled in the resident's room. See attached page 8A. All self-administering residents were identified. The nurse completed an audit of the 3 residents to verify that a lock box was provided or available to each resident and that all medication labels with the required identifying information were correctly affixed on 6/22/23. See attached, page 8B. All residents listed signed the agreement on 6/22/23. See attached pages 8C-8E. On 6/22/23 an additional lock box was purchased by the administrator to have on hand in case of immediate replacement need. See attached page 8F.

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

Implemented [redacted] - 08/07/2023)

185a - Implement Storage Procedures

12. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On [redacted], Resident 5's glucometer was not calibrated with the correct date. The date shown on the resident's glucometer was [redacted].

On [redacted], several discrepancies were observed between Resident 8's glucometer and the electronic medication administration record (eMAR) to include the following:

[redacted]

Repeated violation from 09/28/22 et al.

Plan of Correction ***Accept [redacted] - 07/05/2023)***

Immediately, all residents' glucometers were audited and calibrated by the nurse on [redacted]. See attached, page 9A.
Monthly glucometer calibration will be completed by the assigned medication tech. This will occur on the first Wednesday of each month beginning in July and has been added to the residents' MAR to document and track compliance with requirement. See attached page 9B.
All medication techs also completed a full retraining that included the topic of blood sugar, glucometer and documentation (in addition to other topics listed in agenda of training) on 6/21/23. See attached sign in sheet and agenda, pages 9C-9D. This training will be completed to each med tech on an annual basis or prior if need for retraining is identified by the medication administration trainer. See attached for supplemental training materials and reference sheets provided to trainees, pages 9E+.

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

Implemented ([redacted] - 08/07/2023)

187d - Follow Prescriber's Orders

13. Requirements

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

Description of Violation

Resident 1 is prescribed [redacted]. However, this medication was not administered to resident 1 on [redacted] to [redacted] because the medication was not available in the home.

Resident 2 is prescribed [redacted]. However, these medications were not administered to resident 2 on [redacted] because these medications were not available in the home.

187d - Follow Prescriber's Orders (continued)

Resident 5 is prescribed blood sugar checks 3 times daily. However, resident 5 blood sugar levels were not checked on [redacted]

Resident 6 is prescribed [redacted]*. However, resident 6 was not administered these medications on* [redacted]*.*

Repeated violation from 09/28/22

Plan of Correction ***Accept ([redacted] - 07/05/2023)***

Immediately, all medication techs completed a full retraining that included the topics of
• Administering medications correctly
• Preventing med errors
• Ear drops, eye drops, inhalers
• Handling Narcotics- administering, counting, security
• Reporting medication errors
• Appropriate storage of medication
• Blood sugar, glucometers: documentation and calibration
• Med carts change of shift checklist
on 6/21/23. See attached sign in sheet and agenda, pages 9C-9D. This training will be completed to each med tech on an annual basis or prior if need for retraining is identified by the medication administration trainer. See attached for supplemental training materials and reference sheets provided to trainees, pages 9E+.
A full audit of all medications based on all resident MARs was also completed by health and wellness leadership the week of 6/23/23. A summary of all findings was completed by health and wellness leadership upon the completion of the audit. Please see attached for findings needing resolution, pages 10A-10C.
On a weekly basis, the contracted pharmacy will complete a cart audit and provide the home with any findings. By 7/30/23 another full medication audit will be completed by health and wellness leadership and continue to be conducted on a monthly basis. Findings from the monthly audit will include resolution and be submitted to the administrator.

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

Implemented [redacted] - 08/07/2023)

190a - Completion Medication Course

14. 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 A, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:

[redacted]

190a - Completion Medication Course (continued)

[redacted]

Plan of Correction ***Accept [redacted] - 07/05/2023)***

Immediately, staff A was provided training in accordance with medication administration requirements by a DHS certified med administration course trainer on 6/14/23. See attached for documentation, pages 11A-11B. A full audit of all medication administration certificates will be conducted by the business office manager by 7/30/23 with findings included. To assist with maintaining renewal requirements for med certification, a lead position has been identified to be trained as a practicum observer. This individual will be trained by the DHS certified med admin course trainer and has been registered to begin the course work as of 6/28/23. Medication administration renewals will be scheduled to be completed on a monthly basis by the med admin trainer or practicum observer based on medication course certification maintenance requirements.

Licensee's Proposed Overall Completion Date: *07/30/2023*

Implemented ([redacted] - 08/07/2023)

191 - Resident Right to Refuse

15. Requirements

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

Description of Violation

Resident 4 and 6, admitted [redacted] and [redacted], have not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Repeated violation from 09/28/22 et al.

Plan of Correction ***Accept ([redacted] - 07/05/2023)***

Immediately, an addendum was developed to include resident right to refuse medication by the administrator on 6/13/23. See attached pages 12A-12B. The addendum will be provided to all current residents for signature by the business office manager by 6/30/23. All resident signatures will be collected by the business office manager by 7/30/23. The addendum will continue to be included with all new admissions by the sales and marketing director effective immediately and continuously ongoing until the contract is updated to include the resident right to refuse medication.

Licensee's Proposed Overall Completion Date: *07/30/2023*

Implemented ([redacted] - 08/07/2023)

225a - Assessment 15 Days

16. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident 6 was admitted on [redacted]; however, the resident's assessment was not completed until [redacted].

225a - Assessment 15 Days *(continued)*

Plan of Correction ***Accept [redacted] - 07/05/2023)***

Immediately, an audit of all residents charts was conducted on [redacted] by regional nursing support staff. See attached for complete audit and findings, pages 6A-6D. This audit will be completed on a monthly basis by the health and wellness leadership staff by 7/30/23 and every month thereafter. A new resident chart checklist will be utilized upon the admission of every new resident by the health and wellness leadership or memory care director based on which level of care the resident will be admitted to starting 7/1/2023 and upon each admission thereafter. See attached, page 6E.

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

Implemented ([redacted] - 08/07/2023)

225c - Additional Assessment

17. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident 7's current assessment was completed on [redacted]. However, the resident's previous assessment was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 07/05/2023)***

Immediately, an audit of all residents charts was conducted on 6/18/2023 by regional nursing support staff. See attached for complete audit and findings, pages 6A-6D. This audit will be completed on a monthly basis by the health and wellness leadership staff by 7/30/23 and every month thereafter. A new resident chart checklist will be utilized upon the admission of every new resident by the health and wellness leadership or memory care director based on which level of care the resident will be admitted to starting 7/1/2023 and upon each admission thereafter. See attached, page 6E.

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

Implemented [redacted] - 08/07/2023)

231c - Preadmission Screening

18. 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 2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident 2's written cognitive preadmission screening was completed on [redacted].

Plan of Correction ***Accept ([redacted] - 07/05/2023)***

Immediately, Nurse and memory care director were provided on education related to cognitive preadmission screening completion time frame prior to admission to SCDU by the administrator on 6/26/23. An audit of all residents charts was conducted on 6/18/2023 by regional nursing support staff. See attached for complete audit and findings, pages 6A-6D. This audit will be completed on a monthly basis by the health and wellness leadership staff

231c - Preadmission Screening (continued)

by 7/30/23 and every month thereafter. A new resident chart checklist will be utilized upon the admission of every new resident by the health and wellness leadership or memory care director based on which level of care the resident will be admitted to starting 7/1/2023 and upon each admission thereafter. See attached, page 6E.

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

Implemented [redacted] - 08/07/2023)

231e - No Objection Statement

19. 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

Residents 1 and 2 were admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept ([redacted] - 07/05/2023)***

Immediately, a no objection statement addendum was created by the administrator on 6.21.23. See attached, page 13A. The memory care director will affirm that all current residents in SDCU have not objected to transfer or admission to SDCU and will sign the addendum by 7.14.23. The memory care director will also ensure that the no objection statement is completed immediately and moving forward for each new transfer or admission to the SDCU.

Licensee's Proposed Overall Completion Date: *07/14/2023*

Implemented ([redacted] - 08/07/2023)

233c - Key-Locking Devices

20. Requirements

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

Description of Violation

On 6/6/23 the directions for operating the home's door locking mechanism located at the Main Entrance gate in the Secured Dementia Care Unit (SDCU) were not conspicuously posted near the keypad.

Plan of Correction ***Accept (GR - 07/05/2023)***

*Immediately, the memory care director corrected the violation on site on 6/6/23 by posting the direction in a conspicuous location. Monthly, an inspection of the area will be completed by the Memory Care Director to include checking for posting of exit directions in a conspicuous location. Inspection tool attached, see pages 5B-5D, item double ** (asterisk) posting of direction of operation.*

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

Implemented ([redacted] - 08/17/2023)

252 - Record Content

21. Requirements

2600.

252 - Record Content *(continued)*

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

Records for Residents 2, 5 and 8 do not include color of hair, color of eyes, and identifying marks.

Plan of Correction ***Accept (- 07/05/2023)***

Immediately, the records for residents 2, 5, and 8 were updated on 6/23/23 by the home nurse. See attached pages 14A-14C. A full audit of all residents face sheets was completed to verify the presence of the identifying information in the record content by the nurse on 6/23/23, see pages 14D-14F. On a quarterly basis, the nurse will conduct a full audit to verify record content with identifying information to next be conducted by September 2023.

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

Implemented (- 08/17/2023)