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

August 29, 2023

[redacted], ADMINISTRATOR
CARE HSL HERITAGE HILL OPCO LLC
[redacted]

RE: HERITAGE HILL SENIOR COMMUNITY
800 SIXTH STREET
WEATHERLY, PA, 18255
LICENSE/COC#: 22512

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/12/2023, 07/13/2023 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: *HERITAGE HILL SENIOR COMMUNITY* **License #**: *22512* **License Expiration**: *04/18/2024*

Address: *800 SIXTH STREET, WEATHERLY, PA 18255*

County: *CARBON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *CARE HSL HERITAGE HILL OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *12/05/2000* **Issued By**: *DLI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *120* **Waking Staff**: *90*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *07/13/2023*

Inspection Dates and Department Representative

07/12/2023 On Site: [redacted]

07/13/2023 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *143* **Residents Served**: *92*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *42* **Residents Served**: *27*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *92*

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

Have Mobility Need: *28* **Have Physical Disability**: *1*

Inspections / Reviews

07/12/2023 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *08/07/2023*

Inspections / Reviews *(continued)*

08/15/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/21/2023*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *08/22/2023*

08/18/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/21/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/25/2023*

08/29/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/21/2023*

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

28f - Resident's Funds and 30-day Refund

1. Requirements

2600.
28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident #1 was discharged from the facility on [redacted] after cleaning out their room and belongings on the same day. They were not mailed a refund check until [redacted].

Plan of Correction ***Accept ([redacted] - 08/15/2023)***

Beginning 8/7/2023, BOM will copy ED in communication with corporate office requesting resident refund at time of resident discharge. ED will sign off on Resident Discharge Checklist (Attachment C). ED will be final reviewer of Discharge Checklist and will verify that refund has been obtained within 30 days. Ongoing: ED will review all discharge files within 30 days of discharge to ensure ongoing compliance. Findings and trends will be reviewed at quarterly QA meetings beginning September 2023.

Licensee's Proposed Overall Completion Date: *08/07/2023*

Implemented [redacted] - 08/29/2023)

29a SOPb4 - Hospice Care: Inform Non-Participating

2. 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:
4. During a fire drill, the one designated person at the home who has knowledge in advance of the fire drill is to immediately upon setting off the fire alarm to begin the fire drill, go to the room of the resident who meets the conditions of paragraphs (1)—(3), and notify the affected resident and any staff person who attempts to evacuate the resident, that this is a fire drill and the resident is not to be evacuated.

Description of Violation

Resident #2 was not evacuated during the fire drill conducted on [redacted] and Resident #3 was not evacuated during the fire drill conducted on [redacted] due to actively dying. The staff member who knows in advance the home is conducting a fire drill did not immediately go to the residents rooms and notify staff that it was a fire drill and the residents are not to be evacuated.

Plan of Correction ***Accept ([redacted] - 08/15/2023)***

Beginning 8/7/2023, A Fire Drill Record Addendum (Attachment F) will be completed at the conclusion of each Fire Drill, which will include a checklist for residents with a Do Not Evacuate order, including written verification that immediate response to the resident room was conducted and staff was informed of the drill. ED will be final reviewer of Fire Drill Record and Fire Drill Record Addendum. ED will review and sign off on Fire Drill Record including Fire Drill Record Addendum checklist for residents with a Do Not Evacuate Order. Ongoing: ED will immediately respond during Fire Drills to resident room with Do Not Evacuate Order and notify staff that a drill is occurring and not to evacuate the resident. At the conclusion of the Fire Drill, ED will review the Fire Drill Record and Fire Drill Record Addendum and sign-off verifying compliance. Findings and trends will be reviewed during quarterly QA meetings beginning September 2023.

Licensee's Proposed Overall Completion Date: *08/07/2023*

29a SOPb4 Hospice Care: Inform Non Participating *(continued)*

Implemented [redacted] - 08/29/2023)

29a SOPb11 Hospice Care: Records

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:

11. Documentation of compliance with this section is to be kept in the fire drill record, as well as in the resident's record. The documentation is to include the following:
    i. A copy of the Department of Health license for the hospice agency.
    iv. Written documentation of the home's consideration of relocation of the resident's bedroom as specified in paragraph (3)

Description of Violation

Resident #2 was not evacuated during the fire drill conducted on [redacted] and Resident #3 was not evacuated during the fire drill conducted on [redacted] due to actively dying. The home did not include the hospice agency license and documentation of the home's consideration of relocation of the resident's bedrooms with the fire drill logs.

Plan of Correction ***Accept [redacted] - 08/15/2023)***

Beginning 8/7/2023, A Fire Drill Record Addendum (Attachment F) will be completed at the conclusion of each Fire Drill, which will include a checklist for residents with a Do Not Evacuate order. Checklist will include attaching Hospice Agency License and consideration of Resident room relocation. Do Not Evacuate During Fire Drill Consent Form (Attachment G) will be updated to include a statement indicating family and PCP discussion regarding resident room relocation. ED will be final reviewer of Fire Drill Record and Addendum. Ongoing: At the conclusion of each Fire Drill, ED will review Fire Drill Record and Addendum and will sign-off verifying compliance, including the attachment of Hospice Agency License and record of consideration of resident room relocation. Findings and trends will be reviewed at quarterly QA Meetings beginning September 2023.

Licensee's Proposed Overall Completion Date: *08/07/2023*

Implemented [redacted] - 08/29/2023)

42c Treatment of Residents

4. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Resident #4 indicated that Staff Member A was not always respectful toward them and would often yell and raise their voice at the resident.

Plan of Correction ***Accept [redacted] - 08/18/2023)***

On 3/17/23, Executive Director immediately suspended the agency staff member accused of violating a resident's right to dignity and respect. After investigation on 3/17/23, it was determined to be a founded allegation and the Executive Director immediately terminated the agency staff member involved in the allegation of violating a resident's right to dignity and respect. Beginning 8/7/2023, all Agency contracted staff members will receive additional observation with an existing staff person and review and sign off on a copy of Resident Rights. Supervising staff person will immediately notify Resident Care Director in the event of any concern for resident rights violations.

42c - Treatment of Residents (continued)

Executive Director will meet weekly beginning 8/7/2023 with the Resident Care Director, with weekly discussion to include resident rights concerns. Staff members will be subject to immediate suspension and possible termination in the event of a founded allegation of resident rights violations.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented [redacted] - 08/29/2023)

89b - Hot Water Temperature

5. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

Room 28 hot water temperature measured 125.2 degrees F. It was then measured with a different thermometer and registered 125.4F. Temperature was then taken approximately 30 minutes later and registered 125.1 F.

Plan of Correction ***Accept ([redacted] - 08/18/2023)***

On 7/12/2023, immediately upon discovery of water temperature in excess of acceptable limits, Maintenance Director immediately adjusted water temperature to safe limits and contacted Plum-Air for service. A malfunction was found and replacement parts ordered. Installation occurred immediately upon receipt on 8/11/2023.
Maintenance Director and Assistant Maintenance Director will conduct weekly monitoring of water temperatures in rooms directly nearby water boilers for safe water temperature and update the Weekly Water Temperature Monitoring Log (Attachment L) to include checklists for those areas.
Beginning 8/7/2023, ED will be immediately notified of results outside of safe temperature range. ED will review checklists monthly with Maintenance Director. Findings and trends will be reviewed at quarterly QA meetings beginning September 2023.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented (RY - 08/29/2023)

103i - Outdated Food

6. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

Two boxes of Cream of Wheat hot cereal were out of date in the Kitchen. One was open and one was not. Both items displayed an expiration date of 6/23/2023.

Plan of Correction ***Accept ([redacted] - 08/18/2023)***

On 7/12/2023, immediately upon finding expired food items, the Food Service Director disposed of items and inventoried remaining supplies in stockroom, kitchen, coolers and freezers to ensure all items were within use-by dates. Cooks and Cook Supervisors will complete weekly monitoring of stockrooms, kitchen, coolers and freezers to remove outdated food and/or damaged items from circulation. A Weekly Food Expiration Checklist (Attachment O) will be completed and submitted to the ED. Beginning 8/7/2023, ED will review Weekly Food Expiration Checklist (Attachment O). Findings and trends will be reviewed at quarterly QA meetings beginning September 2023.

103i - Outdated Food (continued)

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented [redacted] - 08/29/2023)

121a - Unobstructed Egress

7. 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

The exit doors to the outside parking lot, located in rooms 25, 27 and 28, were fitted with locked slide locks that were located out of reach of the residents and would not permit immediate egress from the room in the event of an emergency.

The exit door to the outside parking lot located in room 26 was blocked by a pink armchair and would prevent immediate egress from the room in the event of an emergency

Plan of Correction ***Accept [redacted] - 08/18/2023)***

On 7/12/2023, upon discovery of obstructed egress, Maintenance Director immediately removed misplaced chairs preventing egress, and removed slide locking mechanisms on external doors. Beginning 8/7/2023, Maintenance Director and Assistant Maintenance Director will conduct daily monitoring of chair placement in resident bedrooms and verification of unlocked doorways preventing immediate egress, and complete Daily Maintenance Walkthrough sheet (Attachment R), including notation on rooms with unsafe chair placement or rooms found with locked doorways preventing immediate egress.
Beginning 8/7/2023, ED will be immediately notified of rooms found during Daily Maintenance Walkthrough to have unsafe chair placement or locked doorways preventing immediate egress. Daily Maintenance Walkthrough sheet (Attachment R) will be submitted to ED monthly, with findings and trends reviewed at quarterly QA meetings beginning September 2023.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented (RY - 08/29/2023)

132c - Fire Drill Records

8. 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 for drills conducted on 2/23/2022, 3/14/2022, and 5/31/2022 did not indicate 'am' or 'pm' on the log.

132c - Fire Drill Records *(continued)*

Plan of Correction ***Accept (- 08/15/2023)***

Beginning 8/7/2023, Fire Drill Record Addendum Page (Attachment F) will be completed and include verification that AM/PM is noted on Fire Drill Record. Ongoing: Executive Director will review Fire Drill Record Addendum (Attachment F) at the conclusion of each fire drill, including verification that AM/PM is noted on Fire Drill Record. Findings and trends will be reviewed at quarterly QA meetings, beginning September 2023.

Licensee's Proposed Overall Completion Date: *08/07/2023*

Implemented - 08/29/2023)

132d - Evacuation

9. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home has a safe evacuation time of 14 minutes and 53 seconds designated by a fire safety expert on 8/29/22. The fire drills conducted on 10/25/22 and 1/27/23 exceeded the evacuation time designated by a fire safety expert.

Plan of Correction ***Accept (- 08/15/2023)***

Beginning 8/7/2023, Fire Drill Record Addendum Page (Attachment F) will be completed at the conclusion of each fire drill and include verification that the evacuation time is below the maximum allowable limit. Drills which exceed maximum allowed evacuation time will be repeated. Ongoing: Executive Director will review Fire Drill Record Addendum (Attachment F) at the conclusion of each fire drill, including verification that the evacuation time was at or below the maximum allowable time limit. Drills above maximum allowable evacuation time will be repeated. Findings and trends will be reviewed at quarterly QA meetings beginning September 2023.

Licensee's Proposed Overall Completion Date: *08/07/2023*

Implemented (- 08/29/2023)

132h - Designated Meeting Place

10. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During a fire drill conducted on resident Resident #5 did not evacuate to the outside of the building or a fire safe area.

Plan of Correction ***Accept (- 08/18/2023)***

Immediately upon resident refusal to evacuate during fire drill held on , the Executive Director contacted both the Resident and Resident's Power of Attorney to discuss violation of home rules relating to required fire drill participation. Executive Director will in-service Maintenance Director, Assistant Maintenance Director, Resident Care Director and Housekeeping Director on completion of Fire Drill Record Addendum (Attachment F) at the conclusion of each fire drill. The addendum will include notation of any residents who did not evacuate. Family follow-up will

132h - Designated Meeting Place (continued)

be made. Beginning 8/7/2023, at the conclusion of each Fire Drill, the ED will review and sign off on Fire Drill Record Addendum (Attachment F) and follow up with the resident and POA of any resident who refused to evacuate during the drill, and issue a 30-day notice to vacate due to home rule violation.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented [redacted] - 08/29/2023)

184b - Labeling OTC/CAM

11. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

Resident #6's [redacted] and [redacted] were not labeled with the residents name.

Resident #7's vitamin [redacted] and [redacted] were not labeled with the residents name.

Plan of Correction ***Accept ([redacted] - 08/18/2023)***

On 7/13/2023, immediately upon discovery of unlabeled resident medications, an LPN labeled each medication found to be missing resident name. On 8/3/2023, Resident Care Director held in-service for all Med Trained staff on the requirement that all medication bottles be labeled with Resident name prior to being placed in the Med Cart. Beginning 8/7/2023, Med Techs will be required to submit a daily Shift Change Responsibility Sheet (Attachment W) to RCD, including indication that all OTC medications are labeled. Beginning 8/7/2023 Med Techs will complete weekly Med Cart Audit Sheet (Attachment X) and submit to the RCD with an indication that all OTC Medications are labeled with Resident Name. Beginning 8/7/2023, RCD will submit weekly Med Cart Audit Sheets to ED, including verification that all OTC Medications are labeled with Resident name. Findings and trends will be reviewed at quarterly QA meetings beginning September 2023.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented ([redacted] - 08/29/2023)

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

Resident #8's glucometer was not calibrated to the correct time.

Resident #9's PRN [redacted] was not available at the time of the inspection.

Plan of Correction ***Accept ([redacted] 08/18/2023)***

On 7/13/2023, immediately upon discovery that a resident's benzonatate was not available at the time of inspection, the resident's PCP was contacted to discontinue medication due to the medication not being used. On 7/13/2023, immediately upon discovery that a resident's glucometer was not calibrated with the correct date and time, an LPN

185a - Implement Storage Procedures (continued)

recalibrated the device to reflect accurate time and date. On 8/3/2023, Resident Care Director RCD held in-service for all Med Trained staff on the requirement that a resident's ordered medications be available in the facility, and that glucometers be calibrated with accurate time and date. Beginning 8/7/2023, Med Techs will be required to submit a daily Shift Change Responsibility Sheet (Attachment W) to RCD, including notation of mediations ordered from pharmacy but not yet received, and daily glucometer memory and calibration check. On 8/7/2023, A weekly Med Cart Audit Form (Attachment X) will be completed by a Med Tech including verification that all resident medication with a low supply has been reordered or discontinued, and that glucometers are calibrated with accurate time and date. Beginning 8/7/2023 RCD will submit weekly Med Cart Audit Form (Attachment X) to ED, including verification that all resident medication with a low supply has been reordered or discontinued, and that glucometers are calibrated with accurate time and date.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented (- 08/29/2023)

187a - Medication Record

13. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #9 has an order for [redacted] as needed. The medication was administered on [redacted] The staff person's initials who administered the medication were not indicated on the medication administration record (MAR).

Resident #10's MAR notes vitamin[redacted] take one tablet daily. The bottle notes [redacted]. The MAR is incorrect.

Plan of Correction ***Accept - 08/15/2023)***

Beginning 8/7/2023, Med Techs will be required to submit a daily Shift Change Responsibility Sheet (Attachment W) to RCD, including notation that any medications received into the facility during shift are checked against Prescriber Order before approval in the MAR. Ongoing: RCD will be alerted at the end of each shift of any inconsistencies found between received medications and Prescriber Orders. RCD will clarify order with Pharmacy and Prescriber before approval in the MAR. Findings and trends will be reviewed at quarterly QA meetings beginning September 2023.

Licensee's Proposed Overall Completion Date: *08/07/2023*

Implemented (- 08/29/2023)

187d - Follow Prescriber's Orders

14. Requirements

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

Description of Violation

Resident #10 has an order for [redacted] caplets take one daily. The bottle to the medication is [redacted]

187d - Follow Prescriber's Orders (continued)

caplets. From 7/11-7/13/23 5000iu caplets were administered instead of 2000iu caplets.

Resident #11 has an order for [redacted] daily hold if systolic blood pressure is less than [redacted]. On [redacted] the blood pressure was [redacted] 8, on [redacted] the blood pressure was [redacted] and on [redacted] the blood pressure was [redacted]. The medication was administered and should have been held.

Resident #8 has an order for blood glucose readings three times daily per a sliding scale of insulin. On [redacted] at 5:30pm the blood glucose reading was [redacted] The home administered [redacted] units of insulin and it should have been [redacted] units per the sliding scale.

Plan of Correction ***Accept ([redacted] - 08/18/2023)***

On 7/13/2023, immediately upon discovery of medication errors, resident responsible parties were contacted to alert of medication errors and Reportable Incident Reports were completed and submitted for each occurrence. On 8/3/2023, Resident Care Director held in-service for all Med Techs, Charge Persons, and LPNs relating to Plan of Correction: Labeling of OTC/CAM Medications, Medication Availability, Glucometer Calibration, Medication Records and Recording, and Following Prescriber's Orders (Attachment U) . Beginning 8/7/2023, Med Techs will be required to submit a daily Shift Change Responsibility Sheet (Attachment W) to RCD, including notation and verification that medications with parameters were administered per order, notation that any medications received into the facility during shift are checked against Prescriber Order before approval in the MAR and storage in Med Cart, and verification that insulin units administered are correct per the physician's order. Beginning 8/7/2023, RCD will be alerted at the end of each shift of any inconsistencies found between ordered medication parameters and medication administration, inaccurate insulin administration, and/or inconsistencies found between received medications and Prescriber Orders. Findings and trends will be reviewed at quarterly QA meetings.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented ([redacted] - 08/29/2023)

228b - Discharge or Transfer

15. Requirements

2600.
228.b. If the home initiates a discharge or transfer of a resident, or if the legal entity chooses to close the home, the home shall provide a 30-day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. This shall be stipulated in the resident-home contract. A 30-day advance written notice is not required if a delay in discharge or transfer would jeopardize the health, safety or well-being of the resident or others in the home, as certified by a physician or the Department. This may occur when the resident needs psychiatric or long-term care or is abused in the home, or the Department initiates closure of the home.

Description of Violation

Resident #1 was mailed a 30-day discharge notice on [redacted] effective [redacted] The post office paperwork indicates an estimated delivery date of [redacted] which would not give the resident a full 30 days of notice.

Plan of Correction ***Accept ([redacted] - 08/15/2023)***

Beginning 8/7/2023, When a resident is issued a 30 Day Notice of Discharge, the date of discharge will be calculated to include the consideration for postal delivery times and pickup. At resident discharge, BOM will complete Resident Discharge Checklist (Attachment C), which will include verification that a resident provided a 30 Day Notice to Discharge received or exceeded 30 days of advance notice. Ongoing: ED will be final reviewer of Discharge Checklist and will verify that a resident provided a 30 Day Notice to Discharge received or exceeded 30 days of advance notice.

228b Discharge or Transfer *(continued)*

Licensee's Proposed Overall Completion Date: *08/07/2023*

Implemented ([redacted] 08/29/2023)

233c - Key-Locking Devices

16. 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 framed directions to operate the key pads to the 3 doors located in the Secure Dementia Care Unit were turned backwards in their frames. The directions were not conspicuously posted near the key pads.

Plan of Correction ***Accept ([redacted] - 08/18/2023)***

On 7/12/2023, immediately upon discovery of missing key pad code in the Secure Dementia Unit, the Maintenance Director replaced code signage and checked all remaining doors with key pad locks for placement of exit code. On 8/2/2023, Executive Director held in service with Maintenance Director, Assistant Maintenance Director, and Memory Care Director relating to Plan of Correction: Key Locking Devices (Attachment AA). Beginning 8/7/2023, Maintenance Director and Assistant Maintenance Director will conduct daily monitoring for presence and conspicuous placement of directions to operate key pads to locked doors to the Secure Dementia Unit, and complete Daily Maintenance Walkthrough sheet (Attachment R) which includes notation of the same. Beginning 8/7/2023, ED will be immediately notified of doors found during Daily Maintenance Walkthrough to have missing or inconspicuously placed key pad operation instructions. Deficiencies will be immediately resolved. Daily Maintenance Walkthrough sheet (Attachment R) will be submitted to ED monthly, with findings and trends reviewed at quarterly QA meetings beginning September 2023.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented ([redacted] - 08/29/2023)