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

March 8, 2024

[redacted], ADMINISTRATOR
227 EVERGREEN ROAD OPERATIONS LLC
227 EVERGREEN ROAD
POTTSTOWN, PA, 19464

RE: SANATOGA COURT
227 EVERGREEN ROAD
POTTSTOWN, PA, 19464
LICENSE/COC#: 13614

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/15/2023, 11/16/2023 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: *SANATOGA COURT* **License #**: *13614* **License Expiration**: *06/20/2024*

Address: *227 EVERGREEN ROAD, POTTSTOWN, PA 19464*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *227 EVERGREEN ROAD OPERATIONS LLC*

Address: *227 EVERGREEN ROAD, POTTSTOWN, PA, 19464*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *03/10/1998* **Issued By**: *Dept. of L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *84* **Waking Staff**: *63*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *11/16/2023*

Inspection Dates and Department Representative

11/15/2023 - On-Site [redacted]

11/16/2023 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* **Residents Served**: *64*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care Unit* **Capacity**: *15* **Residents Served**: *14*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *62*

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

Have Mobility Need: *20* **Have Physical Disability**: *3*

Inspections / Reviews

11/15/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/15/2023*

12/18/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/23/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/22/2023*

Inspections / Reviews *(continued)*

02/23/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/23/2024*

Reviewer: [redacted] **Follow Up Type:** *Bypass Document Submission*

03/08/2024 Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *02/23/2024*

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Personal care and assisted living homes must post the required influenza information in a public place in the home year-round as required by the Influenza Awareness Act (HB 1785). The home did not have an influenza poster anywhere.

On 11/16/2023, there was no influenza poster posted in a conspicuous and public place throughout the home.

Plan of Correction ***Accept [redacted] - 12/18/2023)***

On 11/27/2023, immediate actions were taken to post the influenza posters placed conspicuously throughout the public places in the community.

Residents will see the posters in public spaces throughout the community.

Residents had an ADHOC Resident Council Meeting on 12.14.24. Residents were given an informational handout.

Weekly audits for three months or until compliance is determined in QAPI of these posters will be verified by the administrator or designee.

This monthly monitoring will ensure that the posters will be visible year-round throughout the community.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented [redacted] - 02/23/2024)

28e - Death of a Resident

2. Requirements

2600.
28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident 1 passed away on [redacted]. Resident 1's personal belongings were removed from his/her room on [redacted]; however, the refund check was issued on [redacted]

Resident 2 passed away on [redacted]. Resident 2's personal belongings were removed from his/her room on [redacted]; however, the refund check was issued on [redacted]

Resident 3 passed away on [redacted]. Resident 3's personal belongings were removed from his/her room on [redacted]; however, the refund check was issued on [redacted]

Resident 4 passed away on [redacted]. Resident 4's personal belongings were removed from his/her room on [redacted] however, the refund check was issued on [redacted].

Resident 5 passed away on [redacted]. Resident 5's personal belongings were removed from his/her room on [redacted]; however, the refund check has not been issued as of [redacted].

Resident 6 passed away on [redacted]. Resident 6's personal belongings were removed from his/her room on [redacted] however, the refund check has not been issued as of [redacted].

28e - Death of a Resident *(continued)*

Plan of Correction ***Accept [redacted] - 12/18/2023)***

BOM that failed to submit the refunds no longer works for the home as of April 2023.
Current BOM and Back Up team members educated on the refund process on December 12, 2023. Audit completed on December 12, 2023. No other residents identified with deficient practice.
BOM will request a resident refund as required per regulations within one week of discharge. Community established a back up team member to complete task as needed
Executive Director / Design will audit weekly for three months or until compliance is determined then monthly. Findings will be presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented [redacted] - 02/23/2024)

29 Hospice Care

3. Requirements

2600.
29. Hospice Care and Services - Hospice care and services that are licensed by the Department of Health as a hospice may be provided in a personal care home.

Description of Violation

Hospice services are being provided to residents by [redacted] Healthcare Corporation. However, their license expired on [redacted]

Accept [redacted] - 12/18/2023)

This community is in receipt of Vitas Healthcare active/current licenses and the certification of Limited Liability page of insurance policies on December 11, 2023 . Documentation is stored in the contracted vendor's binder.
Audit completed on Dec 11, 2023 and the community Hospice vendors have current licenses and insurance policies.
Contracted providers have been asked to provide copies of the license and insurance policy prior to expiration.
The BOM created a vendor contract list that includes the next expiration of license and insurance policies.
The Executive Director will audit monthly for 3 months or until compliance is determined.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented ([redacted] - 02/23/2024)

41c - Rights Poster

4. Requirements

2600.
41.c. The Department’s poster of the list of resident’s rights shall be posted in a conspicuous and public place in the home.

Description of Violation

The Department's resident's rights poster is not posted in a conspicuous and public place in the Memory Care Unit or the 2nd floor of the home.

Plan of Correction ***Accept ([redacted] - 12/18/2023)***

On 11/28/2023, immediate actions were taken to post Residents Rights notifications placed conspicuously throughout the public places..

41c Rights Poster (continued)

Residents will see the notifications in public spaces.
Residents had an ADHOC Resident Council Meeting on 12.14.24. Residents were given an informational handout.
Weekly audits for three months or until compliance will be completed by the ED / Designee and presented to QAPI.
Monthly audit of these notifications will be verified by the administrator and or designee. This monthly monitoring will ensure that the resident rights notification will be visible year round.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented ([redacted] - 02/23/2024)

44g - Telephone Number

5. Requirements

2600.
44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

The telephone numbers of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Disability Rights Pennsylvania (DRP) the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline is not posted in a conspicuous and public place in the Memory Care Unit and the 2nd floor of the home.

Plan of Correction ***Accept [redacted] - 12/18/2023)***

On 11/28/2023, immediate actions were taken to post the important telephone numbers including the Department's personal care home regional office, the local ombudsman/protective services unit in the area agency on aging, disability Rights Pennsylvania (DRP), the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline are posted in conspicuous places throughout the community including the memory care unit and second floor.
December 13, 2023, residents were reminded about these important numbers, copies of posting were individually shared with the residents and requested to share with family members/ POA.
Residents had an ADHOC Resident Council Meeting on 12.14.24. Residents were given an informational handout.
Direct care staff have been educated by 12.13.23 to monitor each resident's room daily to ensure these important numbers are posted visibly.
Weekly audits for three months or until compliance will be completed by the DHW/Designee and presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented ([redacted] - 02/23/2024)

81b - Resident Personal Equipment

6. Requirements

2600.

81b - Resident Personal Equipment *(continued)*

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On November 16, 2023, bedrooms 112, 137, 200, 210, and 241 had enablers without covers that measured 35 ½ inches tall from the floor to the top of the enabler, 11 inches wide, and 16 inches from the top of the bed to the top of the enabler.

Plan of Correction ***Accept ([redacted] - 12/18/2023)***

Residents in rooms 112, 137, 200,210and 241 had bed enablers immediately covered.
Audit completed on 12.12.23 to Identify resident rooms who currently use enablers. Each enabler noted on the audit had a cover immediately placed over the enabler as needed.
Residents not residing in the memory care neighborhood were educated by 12.14.23 on keeping their enabler covered.
Direct care staff have been educated on how to cover the enablers by 12.13.23
Weekly audits for three months or until compliance will be completed by the DHW/Designee and presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented [redacted] - 02/23/2024)

85a - Sanitary Conditions

7. Requirements

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

Description of Violation

On 11/16/2023, the rugs in bedroom 210 had big brown stains that looked like water marks or spills.
On 11/16/2023, there was a strong smell of cat odor in bedroom 252.

Plan of Correction ***Accept ([redacted] - 12/18/2023)***

Sherwin Williams visited and assessed the unit on December 11, 2023. The community is waiting on Sherwin Williams availability to replace the rug in bedroom 210.
Community contracted Healthcare Services Group (HCSG) audited resident rooms for carpets that are stained and need to be cleaned or replaced on 12.14.2023.
Housekeeping have been educated to review carpet in units to determine floor needs on 12.12.2023
The resident's cat in room 252 has been removed.
Housekeeping performed a deep clean of the room on 12/15/23.
Housekeeping staff have been educated to review carpet in units to determine floor needs on 12.12.23.
Weekly audits for three months or until compliance will be completed by the Director of Maintenance/ Designee and presented to QAPI.

85a - Sanitary Conditions (continued)

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented [redacted] - 02/23/2024)

97 - Elevators/Lifting Devices

8. Requirements

2600.
97. Elevators and Stair Glides - Each elevator and stair glide must have a certificate of operation from the Department of Labor and Industry or the appropriate local building authority in accordance with 34 Pa. Code Chapter 405 (relating to elevators and other lifting devices).

Description of Violation

The elevators did not have a certificate of operation from the Department of Labor and Industry or the appropriate local building authority since 3/31/2023 until 11/15/2023.

Plan of Correction ***Accept ([redacted] - 12/18/2023)***

The certificate of operation from the Department of Labor and Industry has been received for its elevators that cover the range o 2.27.23 -3.31.25. The certificate is posted in each elevator. A copy of the certificate is stored in survey ready binder and documented in TELs.
Maintenance Director was educated to post active elevator certifications and placed in binder
Weekly audits for three months or until compliance will be completed by the ED/Designee and presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented ([redacted] - 02/23/2024)

100a - Exterior - Free of Hazards

9. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 11/16/2023, there were two old broken wood pallets, one old black rug, and wet cardboard outside of the facility dumpsters.

Plan of Correction ***Accept ([redacted] - 12/18/2023)***

On 11/27/2023, immediate actions were taken to clear outside of the facility dumpster from all debris.
Evaluation of grounds completed on 12.12.23. No other debris noted.
The Dietary department has been educated by 12.15.2023 on proper disposal of pallets immediately after delivery supplies are unloaded.
The Maintenance Director has been educated 12/12/23 to ensure that the facility grounds are free of hazards.
Weekly audits for three months or until compliance will be completed by the ED/Designee and presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented [redacted] - 02/23/2024)

102h - Toilet Paper

10. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 11/16/2023, there was no toilet paper for the toilet in bathroom 138. The toilet paper was sitting on top of a cabinet, unreachable to the resident in the memory care unit.

Plan of Correction ***Accept [redacted] - 12/18/2023)***

On 11/16/2023, immediate action was taken to provide toilet paper to residents in room 138. Direct care and housekeeping staff were educated by 12.13.2023 to ensure that all residents have toilet paper on the spool and within reach.
Weekly audits for three months or until compliance will be completed by the DHW/ Designee and presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented ([redacted] - 02/23/2024)

103e - Left Overs

11. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 11/16/2023, there was an unlabeled, undated bag of potato fries in the main kitchen freezer.

Repeat Violation - 06/27/2022.

Plan of Correction ***Accept ([redacted] - 12/18/2023)***

On 11/16/23, the bag of potato fries found in the main kitchen freezer was disposed of immediately.
The dietary employee responsible for labeling/ dating food items in the freezer is no longer an employee of Sanatoga Court as of November 16, 2023.
Dietary staff were educated on 12/12/23 to inspect foods items are labeled and dated.
The current community and dietary staff will use audit sheets to ensure that food items are labeled and dated.
Weekly audits for three months or until compliance will be completed by the Dietary Manager/ Designee and presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented ([redacted] - 02/23/2024)

103i - Outdated Food

12. Requirements

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

Description of Violation

On 11/16/2023, there were 3 dented cans of Mandarins oranges in the facility's emergency food storage.

103i Outdated Food *(continued)*

Plan of Correction ***Accept (12/18/2023)***

The three (3) dented cans of Mandarin oranges in the facility's emergency food storage were disposed of on November 15, 2023.
Current community and dietary staff were educated on 12/12/23 to check the facility's emergency food storage for dented and compromised food packages.
Weekly audits for three months or until compliance will be completed by the Dietary Manager/ Designee and presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented (- 02/23/2024)

105g - Lint Removal and Duct Cleaning

13. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 11/16/2023, there was a large accumulation of lint in the lint trap of the main laundry dryer. There were no clothes in the dryer at the time.

Plan of Correction ***Accept - 12/18/2023)***

On 11/16/2023, immediate action was taken to clean out the lint trap of the main clothes dryer.
The lint trap in the community dryers will be checked prior to every use.
Community completed an audit of dryers on 12.12.23. No other deficient practice noted.
Housekeeping and current community staff have been educated 12/12/23 to ensure that lint trap is free of accumulated lint.
The Director of Housekeeping will monitor weekly for three months or until compliance is determined. Findings will be presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented - 02/23/2024)

107b - Emergency Procedures

14. Requirements

2600.
107.b. The home shall have written emergency procedures that include the following:
1. Contact information for each resident's designated person.
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.
5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.

107b Emergency Procedures *(continued)*

6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

The home's written emergency procedures do not include the contact information for each resident's designated person.

Plan of Correction ***Accept (- 12/18/2023)***

The home's written emergency procedure to add the contact information of each resident's designated person was completed 12.12.23
The receptionist was educated on 12.12.23 to add the contact information of each resident's designated person.
The Executive Director will monitor home written emergency procedures to ensure that contact information for each resident's designated person weekly for three months or until compliance is determined. Findings will be presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented - 03/08/2024)

124 - Notice to Fire Department

15. Requirements

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

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction ***Accept (- 12/18/2023)***

On 12.14.23 Notice of Fire Department was hand delivered to the Sanatoga Fire Department located at 2222 East High Street Pottstown, PA 19464. The letter included the home's location, locations of the bedrooms (diagram of the building), and the assistance needed to evacuate in an emergency.
Executive Director will audit weekly for three months or until compliance to validate evacuation status for each resident has not changed and presented to QAPI. The Fire Department will receive an updated list as needed.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented - 02/23/2024)

132d - Evacuation

16. 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 maximum safe evacuation time specified in writing within the past year by a fire safety expert dated August 16,

132d Evacuation (continued)

2023, is 7 minutes, 15 seconds. However, the fire drill completed on August 19, 2023, evacuation time was 9 minutes and 23 seconds.

Plan of Correction ***Accept (- 12/18/2023)***

Current staff was educated on 12.13.23 on the evacuation policy, safety zones, where the evacuation policy is located.
Evacuation drills will be completed monthly.
Monthly audits will be completed for three months or until compliance will be completed by the ED/Designee and presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented (- 02/23/2024)

144c1 - Smoking Area Guidelines

17. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On 11/16/2023, in the home's designated smoking area outside of the home, there were two wood chairs and one wood table.

Plan of Correction ***Accept - 12/18/2023)***

The employees of Sanatoga Court are not allowed to smoke on the premises. The table and chairs were removed on November 15, 2023.
Staff were educated on December 12, 2023 that the building is smoke free.
There are two residents who smoke.
These residents were informed on December 14, 2023 of the designated smoke area. The support plans for these two residents were updated December 14, 2023 to include that they are residents who smoke.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented (- 02/23/2024)

162c - Menus Posted

18. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

162c - Menus Posted *(continued)*

Description of Violation

The home's menu for 11/16/2023 was posted on the first floor, close to the dining area. Additionally, there was an undated monthly menu, which doesn't match with the daily menu that was posted on the first floor near the mailboxes. However, the menu for 11/12/2023 to 11/18/2023 or the following week of 11/19/2023 to 11/25/2023 was not posted in a conspicuous and public place in the home or the memory care unit.

Plan of Correction ***Accept (- 12/18/2023)***

On 11/27/2023, resident menus were properly dated and posted conspicuously throughout the community.
Residents had an ADHOC Resident Council Meeting on 12.14.24. Residents were given an informational handout.
The Director of Dietary Service was educated on 12/12/23 to date resident menus and place in designated public places throughout the community.
The Executive Director will audit the menus weekly for three months or until compliance is determined. Findings will be presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented (SW - 02/23/2024)

185a - Implement Storage Procedures

19. 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 , the glucometer for resident 7 has a reading of but it was documented as .

Plan of Correction ***Accept (- 12/18/2023)***

The glucometer reading for resident 7 was immediately corrected on the MAR.
MedTech immediately educated on validating accu checks when entering on MAR.
Community Med Techs were educated 12/13/23 to correctly document glucometer readings.
The Director of Health and Wellness will audit weekly for three months or until compliance is determined. Findings will be presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented - 02/23/2024)

227g -Support Plan Signatures

20. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

227g -Support Plan Signatures *(continued)*

Description of Violation

Resident 8 participated in the development of his/her support plan on [redacted] However, the resident did not sign the support plan.

Plan of Correction ***Accept ([redacted] - 12/18/2023)***

Resident 8 refused to sign his/ her support plan.
The LPN staff and Director of Health and Wellness signed the incorrect line of the support plan.
The LPN staff and Director of Health and Wellness were educated on 12/12/23 to sign appropriately on the support plan.
The Executive Director will perform post admission audits for three months or until compliance is determined. Findings will be presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented [redacted] - 02/23/2024)

227h - Support Plan Refuse Sign

21. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident 8 participated in the development of his/her support plan on [redacted]. The home did not make a notation regarding the resident's refusal or inability to sign.

Plan of Correction ***Accept ([redacted] - 12/18/2023)***

Resident 8 refused to sign his/ her support plan
PCC progress note entered on 12.14.23 indicating the resident did not want to sign but agreed with the plan of care.
The Licensed Nursing staff and Memory Care Director will be educated by 12.14.24 to document residents files of refusal or inability to sign.
The Executive Director will audit weekly for three months or until compliance is determined. Findings will be presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented [redacted] - 02/23/2024)

231e - No Objection Statement

22. Requirements

2600.

231e No Objection Statement *(continued)*

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 9 was 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.

Resident 10 was 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] - 12/18/2023)***

The Director of Admission was educated on 12/12/23 to ensure the objection statements are part of the admission packet.
Audit completed of current residents on Memory Care for No objection statements completed on 12.15.23. Audit determined that 12 residents did not have statements in file.
The Executive Director will audit weekly for three months or until compliance is determined. Findings will be presented to QAPI.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented ([redacted] - 02/23/2024)

233c - Key-Locking Devices

23. 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 directions for operating the home's locking mechanism are not conspicuously posted near the door to the Secure Dementia Care Unit (SDCU) patio or gate.

Plan of Correction ***Accept ([redacted] - 12/18/2023)***

The direction for operating the home's locking mechanism was immediately corrected to both doors exiting the Secure Dementia Care Unit (SDCU).
The Director of Maintenance was educated on 12.12.23 on ensuring codes to doors exiting community to a secure location have codes in a visible area
Community staff educated on the courtyard exit gate releases on fire alarm on 12.13.23.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented ([redacted] - 02/23/2024)