pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **AL ONE PA INVESTMENTS OPCO LLC**
LEGAL ENTITY

To operate **SUNRISE OF EXTON**
NAME OF FACILITY OR AGENCY

Located at **200 SUNRISE BOULEVARD, EXTON, PA 19341**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **106** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 39**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **June 7,** **2024** until **December 7,** **2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **144892**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JUNE 7, 2024

[redacted]
[redacted]
AL One PA Investments Opco, LLC
[redacted]
[redacted]

RE: Sunrise of Exton
200 Sunrise Boulevard
Exton, Pennsylvania 19341
License #: 144892

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection December 6 and 7, 2023 and April 15, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from June 7, 2024 to December 7, 2024.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

[redacted]

If you decide to appeal your SECOND PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *SUNRISE OF EXTON* **License #**: *14489* **License Expiration**: *04/06/2024*

Address: *200 SUNRISE BOULEVARD, EXTON, PA 19341*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] *com*

Legal Entity

Name: *AL ONE PA INVESTMENTS OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/19/2018* **Issued By**: *West Whiteland Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *68* **Waking Staff**: *51*

Inspection Information

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

Reason: *Provisional, Incident, Fine* **Exit Conference Date**: *12/07/2023*

Inspection Dates and Department Representative

12/06/2023 - On-Site: [redacted]

12/07/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *106* **Residents Served**: *44*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reminiscence* **Capacity**: *39* **Residents Served**: *24*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *44*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *24* **Have Physical Disability**: *1*

Inspections / Reviews

12/06/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/10/2024*

01/17/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/10/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/22/2024*

05/02/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/18/2024*

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

05/03/2024 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *05/02/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

15d - Resident Abuse-Notification

1. Requirements

2600.
15.d. The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

Description of Violation

On 10/15/2023 around 03:30 PM, the home became aware of the absence of resident #1 from the home's Secured Dementia Care Unit (SDCU). The home did not notify the resident's designated person of [redacted]r absence immediately.

Repeat Violation: 03/13/2023

Plan of Correction ***Accept [redacted] - 01/17/2024)***

A. With respect to the specific resident/situation cited:
Resident family was notified of resident elopement from Secured Dementia Unit.
B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:
Upon notice of any resident missing from Secured Dementia Unit, elopement procedures will be enacted, and resident family will be notified immediately.
C. With respect to what systemic measures have been put into place to address the stated concern:
Staff will be educated on elopement procedures and importance of family notification. Executive Director and Care Coordinators will initiate a re-training of staff on elopement procedures to include immediate notification of family of elopement to be completed by January 15th 2024.
D. With respect to how the plan of correction will be monitored:
Any reportable incident will be monitored at monthly QAPI meeting for 3 months to ensure any elopement was properly monitored and reported.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Not Implemented ([redacted] 05/03/2024)

42b - Abuse

2. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #1, who resided in the home's Secure Dementia Care Unit (SDCU), eloped from the unit unnoticed on [redacted]15/2023 around 02:45 PM. The resident walked for approximately 3 miles down a busy, 6 lane highway with a speed limit of 45 mph, crossed over 3 busy intersections, and was found in the resident's former neighborhood around 04:42 PM. The home was alerted about a possible missing resident by member of the public around 03:30 PM. The home's elopement procedure was initiated and the staff members started looking for the resident inside and outside of the home. The home failed to report this incident to the police or to the family immediately, as required by the home's procedure. The resident had not been accounted for at shift change as required. The oncoming shift was told that resident #1 was in [redacted]room but never physically checked on the resident, and according to staff interviews, memory care residents are supposed to be checked at least hourly. Resident #1 required regular supervision due to the resident's cognitive impairment and lack of safety awareness; however, the resident did not receive the required supervision for about 2 hours on [redacted]5/2023.

42b - Abuse (continued)

Repeat Violation: 03/13/2023

Plan of Correction ***Directed [redacted] - 01/19/2024)***

• On 10/15/2023, Ensured resident was safe and returned to the secured neighborhood.
• On 10/15/2023, Door codes for secured neighborhood were changed. Team members were re-educated on elopement procedures.
• Beginning 1/25/2024, the POC and monitoring results will be discussed & evaluated by ED & coordinators at quality management meeting to verify effectiveness for 3 months.

Directed Plan of Correction (slw 1/19/24):

- *In addition to the Plan of Correction steps noted above, the ED will conduct a training with all staff on neglect/abuse and why/how elopement is neglect of care by 1/31/24. Documentation of the all staff training will be maintained for the Departments review.*
- *The RD/SDCU Coordinator will conduct monthly elopement drills with the staff, starting 1/31/24, for the next three months.*
- *The RD/SDCU Coordinator will conduct monthly physical site inspections of the home to ensure all doors are secure, starting 1/31/24, for the next three months.*
- *The RD will discuss elopement at the monthly staff meetings for the next three months, starting 1/31/24. A copy of the staff meeting agenda will be maintained for the Departments review.*

Proposed Overall Completion Date: 03/31/2024

Directed Completion Date: *02/05/2024*

Not Implemented [redacted]/03/2024)

82c - Locking Poisonous Materials

3. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Crest toothpaste, with a manufacture's label indicating "if more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away," was unlocked, unattended, and accessible to residents in the shared bathroom of resident room #306. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 01/19/2024)***

• On 12/7/2023, Toothpaste was removed and secured in locked cabinet.
• On 12/7/2023, Care staff completed sweep of secured dementia unit and ensured there were no other unsecured poisonous materials.
• By 1/22/2024, Care coordinators retrained care staff and housekeepers on identification of poisonous materials

82c - Locking Poisonous Materials (continued)

and removal / security of such items in locked cabinets.

• Beginning 1/25/2024, the POC and monitoring results will be discussed & evaluated by ED & coordinators at quality management meeting to verify effectiveness for 3 months.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Not Implemented [redacted] - 05/03/2024)

102j - Towels/Wash Cloths Access

4. Requirements

2600.
102.j. Towels and washcloths shall be in the possession of the resident in the resident's living space unless the resident has access to the home's linen supply.

Description of Violation

A pink shower puff was observed in the shower shared by two residents in resident room [redacted] The puff had no label identifying who it belonged to.

Plan of Correction ***Accept [redacted] /19/2024)***

• On 12/7/2023, Loofah was returned to resident possessions secured in resident properly bin.

• On 12/7/2023, Staff ensured that residents who were in shared suites had all towels and washcloths stored in appropriately labeled bins.

• By 1/22/2024, Care Coordinators will reeducate all care staff on the storage of towels and cloths of residents in shared suites.

• Beginning 1/25/2024, the POC and monitoring results will be discussed & evaluated by ED & coordinators at quality management meeting to verify effectiveness for 3 months.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Not Implemented [redacted] - 05/03/2024)

121a - Unobstructed Egress

5. 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 12/06/2023 at 10:00 AM, a paper notice which was printed with a red stop sign and which read "This door is alarmed and locked at all times" blocked egress from the home's back door leading to the memorial garden.

Plan of Correction ***Accept [redacted] - 01/19/2024)***

• On 12/7/23, Stop sign was removed from egress door immediately.

• On 12/7/23, Maintenance coordinator audited all egress doors to ensure no stop signs were in place.

• On 1/4/24, Maintenance staff educated on necessity of no signs that could potentially prevent egress.

• Beginning 1/25/2024, the POC and monitoring results will be discussed & evaluated by ED & coordinators at quality management meeting to verify effectiveness for 3 months.

121a - Unobstructed Egress *(continued)*

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] 05/03/2024)

131f - Fire Extinguisher Inspection

6. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the home has not been inspected by a fire safety expert since November 2022.

Plan of Correction ***Accept [redacted] - 01/19/2024)***

• On 12/7/23, Fire inspection company came to location and services / tagged all fire extinguishers with expired tags.
• On 12/7/2023, Maintenance coordinator audited all fire extinguishers in building to ensure proper expiration tags.
• On 1/4/23, ED educated MC on state expectations of fire extinguishers.
• Beginning 1/25/2024, the POC and monitoring results will be discussed & evaluated by ED & coordinators at quality management meeting to verify effectiveness for 3 months.

Licensee's Proposed Overall Completion Date: *01/31/2024*

Implemented [redacted] - 05/03/2024)

183d - Prescription Current

7. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 12/07/2023, a blister pack of Acetamin 325 mg tabs with an expiration date of 10/07/2023 was in the home's 1st floor medication cart.

Plan of Correction ***Accept [redacted] 01/19/2024)***

• On 12/7/2023, the RCD removed expired Tylenol from med carts & properly destroyed in a safe manner.
• On 12/7/23, RCD completed a 100% audit of all med carts and verified there was no expired medication present in med carts.
• On 1/5/24, RCD educated staff on identification of any expired medication, to include removal and reordering of medication as needed. Medication Care Managers will conduct monthly audits to ensure there are no expired medications present in carts.
• Beginning 1/25/24, the POC and monitoring results will be discussed & evaluated by the ED & coordinators at quality management meeting to verify effectiveness ongoing for 3 months.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Not Implemented [redacted] /03/2024)

184a - Resident's Meds Labeled

8. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

The pharmacy label for resident #2's Tresiba Flextouch insulin pen does not include the prescribed dosage and instructions for administration.

Plan of Correction ***Accept [redacted] 01/19/2024)***

• On 12/7/2023, RCD immediately removed the insulin pen from the med card, affixed the proper label, and replaced the insulin in the cart.
• On 12/7/2023, RCD performed a 100% med cart audit and confirmed all medication labels were proper and matched MAR.
• On 1/5/2024, RCD completed training with nursing and med care managers to include three checks and five rights of medication administration. This also includes matching the medication label to the MAR.
• Beginning 1/25/24, the POC and monitoring results will be discussed & evaluated by the ED & coordinators at quality management meeting to verify effectiveness ongoing for 3 months.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Not Implemented [redacted] - 05/03/2024)

185a - Implement Storage Procedures

9. 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 #3 is prescribed Tramadol 50 mg (2 tabs) twice a day. On 12/07/2023 at 11:30 AM, the remaining pill count was 84. However, the controlled medication record indicated that this medication was last signed out on 12/06/2023 at 08:00 PM with a remaining balance of 86 pills. This discrepancy was due to staff A not logging the 08:00 AM administration on 12/07/2023.

Plan of Correction ***Accept [redacted] - 01/19/2024)***

• On 12/7/2023, The medication care manager immediately signed out 2 tramadol pills that were administered.
• On 12/7/2023, RCD conducted a 100% audit of narcotic countdown sheets to ensure that narcotics are being accurately signed out.
• On 1/5/23, RCD educated wellness nurses and medication care managers in the proper process for signing out narcotics after administration.
• Beginning 1/25/2024, the POC and monitoring results will be discussed & evaluated by ED & coordinators at quality management meeting to verify effectiveness for 3 months.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Not Implemented [redacted] - 05/03/2024)

187b - Date/Time of Medication Admin.

10. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #4 is prescribed Tramadol 50 mg every 8 hours as needed (PRN). Staff B signed out and administered this med on 11/30/2023 at 01:31 AM; however, staff B did not enter the time of the administration and the initials until 12/07/2023 after this omission was pointed out by the licensing representative.

Repeat Violation: 05/10/2023

Plan of Correction ***Accept [redacted] - 01/19/2024)***

• On 12/7/2023, RCD Verified that the med was administered and documented the administration of tramadol.
• On 12/7/2023, RCD conducted audit of PRN narcotics to ensure that narcotics signed out were properly documented in EMAR.
• On 1/5/2024, RCD educated wellness nurses and medication care managers in the proper process for administration & documenting of PRN narcotics.
• Beginning 1/25/2024, the POC and monitoring results will be discussed & evaluated by ED & coordinators at quality management meeting to verify effectiveness for 3 months.

Licensee's Proposed Overall Completion Date: *03/31/2024*

Not Implemented [redacted] - 05/03/2024)

202 - Prohibitions

11. Requirements

2600.
202. The following procedures are prohibited:
4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

Description of Violation

Resident #5 is prescribed Seroquel 25 mg every 24 hours as needed (PRN) for agitation. The resident was administered this medication on 12/05/2023 at 04:00 PM to control behaviors.

Resident #6 is prescribed Lorazepam 1 mg every 4 hours PRN for terminal agitation. The resident was administered this medication on 12/05/2023 at 08:30 PM.

Plan of Correction ***Accept [redacted] - 01/19/2024)***

• On 12/7/2023, The RCD immediately spoke to the physician & received new orders for diagnosis of anxiety.
• On 12/7/2023, the RCD completed 100% med cart audit and found no further diagnosis of agitation in relation to PRN medications.
• On 1/5/2024, the RCD educated Wellness Nurses & Med Care Managers to immediately report diagnosis that include agitation regarding PRN medications.
• Beginning 1/25/24, the POC and monitoring results will be discussed & evaluated by the ED & coordinators at quality management meeting to verify effectiveness ongoing for 3 months.

202 - Prohibitions *(continued)*

Licensee's Proposed Overall Completion Date: *03/31/2024*

Implemented [redacted] - 05/03/2024)

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

Facility Information

Name: *SUNRISE OF EXTON* **License #**: *14489* **License Expiration**: *04/06/2024*

Address: *200 SUNRISE BOULEVARD, EXTON, PA 19341*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *AL ONE PA INVESTMENTS OPCO LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/19/2018* **Issued By**: *West Whiteland Twp*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *57* **Waking Staff**: *43*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *04/15/2024*

Inspection Dates and Department Representative

04/15/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *106* **Residents Served**: *39*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reminiscence* **Capacity**: *39* **Residents Served**: *9*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *39*

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

Have Mobility Need: *18* **Have Physical Disability**: *0*

Inspections / Reviews

04/15/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/12/2024*

Inspections / Reviews *(continued)*

05/15/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/20/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/20/2024*

05/20/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/20/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

187a - Medication Record

1. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident 1 is prescribed .5 mg Lorazepam, 1 tablet by mouth every 4 hours as needed. However, resident's 4/2024 medication administration record does not indicate diagnosis or purpose for the medication, including pro re nata (PRN).

Plan of Correction ***Directed ([redacted] - 05/20/2024)***

On behalf of Morningside House of Exton, previously Sunrise of Exton, we ask that you reconsider the violation for 187a. After Licensing Representative left the community on 4/15/24, Executive Director & Health & Wellness Director were reviewing the MAR. HWD was able to learn how to print the report in a different format to show that the medication did have a diagnosis attached to the medication. An email was sent to the licensing representative on 4/15/24 at 4:52pm with information on the new report. We have also attached a plan of correction incase this violation is reconsidered.

On 4/15/24, Executive Director & Health & Wellness Director were reviewing the MAR. HWD was able to learn how to print the report in a different format to show that the medication did have a diagnosis attached to the medication. An email was sent to the licensing representative on 4/15/24 at 4:52pm with information on the new report.

The Health & Wellness Director has been a part of the initial onboarding trainings with ECP on a variety of dates. The Health & Wellness Director also verified on 5/14/24 that all medications have a diagnosis. On 5/20/24 and moving forward, The Health & Wellness Director or designee will provide training for all current and new LPNs or med techs on how to pull the MAR correctly.

Health & Wellness Director has been a part of onboarding calls for the new program: ECP to ensure she is pulling accurate information for DHS. The Health & Wellness Director also has the support of the Morningside Corporate team to assist her in the new program.

If this violation stands, then we will start reviewing on 5/31/24 and ongoing, This Plan of Correction. The Executive Director or designee will ask an employee of the Wellness team to print a MAR to ensure the proper form is being pulled correctly. This audit will continue for a time period of three months. The Plan of Correction will be

187a - Medication Record (continued)

discussed and evaluated for three months by the ED and Coordinators at the Quality Management meeting to verify it is still effective. If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Proposed Overall Completion Date: 06/30/2024

In addition to the above plan of correction, within 10 days of receipt of the plan of correction, the Executive Director or designee will ask 25 percent of employees of the Wellness team to print a MAR to ensure the proper form is being pulled correctly on a weekly basis. The employees asked to demonstrate printing a MAR will be rotated each week to ensure all Wellness staff know how to properly pull up a MAR. This will continue for a period of three months.

Directed Completion Date:

187d - Follow Prescriber's Orders

2. Requirements

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

Description of Violation

Resident 1 is prescribed MURO 128 Sodium Chloride Opthalmic Solution 5%. However, this medication was not administered to resident 1 on 4/5/24, 4/6/24 and 4/7/24 because the medication was not available in the home.

Plan of Correction ***Accept [redacted] - 05/20/2024)***

Resident 1 moved into the community on 4/3/2024 and had a prescription for MURO 128 Sodium Chloride Opthalmic Solution 5%; however, the family was not able to provide this to the community until 4/8/24. The Health and Wellness Director was communicating with the family, pharmacy, and physician regarding the delay of the new medication. The delay was due to a special order OTC medication due to its specific percentage. There was no contra indications of not receiving this medication.

The Health & Wellness Director audited all MARs from 4/1/24 to 5/8/24 to look for any other trends or concerns with medications not being available in the home. She found no additional concerns.

Health & Wellness Director and all other med certified individuals in the community have been educated on regulation 187d to ensured regulation is followed.

On 5/31/24 and ongoing, The Health & Wellness Director or designee will audit weekly, for three months that all medication are in the home. This Plan of Correction will be discussed and evaluated quarterly for three months by the ED and Coordinators at the Quality Management meeting to verify it is still effective If not effective, it will be amended and a new POC and training will be implemented and monitored to verify the violation does not occur.

Licensee's Proposed Overall Completion Date: *07/30/2024*