Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

July 24, 2024

ADMINISTRATOR
VS WOODS LLC

RE: THE WOODS AT CEDAR RUN
824 LISBURN ROAD
CAMP HILL, PA, 17011
LICENSE/COC#: 33132

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/11/2024, 06/12/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE WOODS AT CEDAR RUN* **License #**: *33132* **License Expiration**: *12/31/2024*

Address: *824 LISBURN ROAD, CAMP HILL, PA 17011*

County: *CUMBERLAND* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *VS WOODS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *07/18/2014* **Issued By**: *Lower Allen Township*

Type: *C-2 LP* **Date**: *02/19/1997* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *66* **Waking Staff**: *50*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *06/12/2024*

Inspection Dates and Department Representative

06/11/2024 - On-Site: [redacted]

06/12/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* **Residents Served**: *43*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *LifeStories* **Capacity**: *19* **Residents Served**: *12*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *67*

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

Have Mobility Need: *23* **Have Physical Disability**: *0*

Inspections / Reviews

06/11/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/27/2024*

Inspections / Reviews *(continued)*

06/24/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *07/22/2024*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *07/03/2024*

07/02/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *07/22/2024*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *07/22/2024*

07/24/2024 - Document Submission

Submitted By: [redacted]
Date Submitted: *07/22/2024*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 6/11/24, the home's current licensing inspection summaries, dated 2/1/24 and 4/4/23, were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (- 07/02/2024)***

ACTION: On 6/12/24, Executive Operations Officer posted the most current licensing inspection summaries on the 2nd floor common area bulletin board and on the bulletin board located in the Memory Care Unit. On 6/20/24, Executive Operations Officer placed all required documents noted in Regulation 3c in binders and placed a binder in the common area of both the Personal Care and Memory Care Units, where they will remain.
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 3c (See attached documentation)
ONGOING: Upon issuance of each renewed license and new inspection summary from the Department, the Executive Operations Officer (or Designee, in absence of the EOO) will post all updated documents in each of the binders referred to above. Documentation will be kept. Beginning on 7/1/2024, Executive Operations Officer (or Designee) will audit these binders monthly to ensure that all required summaries under regulation 3c are present within each binder.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 07/24/2024)

54a - Direct Care Staff

2. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct Care Staff Member A attended a non-U.S. educational institution and provides assistance with ADL's. The home does not have a Department-issued waiver for Staff Member A's employment.

Plan of Correction ***Accept (- 06/24/2024)***

ACTION: Staff member A terminated employment with the facility on On 6/17/24, an audit of all staff files was completed by the Business Officer Manager. The audit verified that all staff requiring a GED or high school diploma meet the requirements of Regulation 54a.
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 54.a (See attached documentation)
ONGOING: Beginning on 6/17/24, the Business Officer Manager will ensure that new employees have a GED or High School diploma prior to allowing them to work as a direct care staff. The Executive Operations Officer will verify the presence of a GED or High School diploma upon each new hire. Documentation of GED/diploma will be kept in the employee file.

Licensee's Proposed Overall Completion Date: *06/30/2024*

54a - Direct Care Staff *(continued)*

Implemented (█ - 07/24/2024)

63a - First Aid/CPR Training

3. 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

From 11:00 PM on 6/2/24 until 6:30 AM on 6/3/24, fifty-five (55) residents were present in the home. During this time, only one (1) staff member was present in the home with a current certification in CPR and first aid.

Repeated Violation - 4/4/23, et al

Plan of Correction ***Accept (█ - 06/24/2024)***

ACTION: Resident Wellness Director had notified Executive Operations Officer on 6/10/24 that an audit of CPR/First Aid status showed that the facility was short on CPR certified night shift staff members. First Aid/CPR courses for untrained staff are scheduled for 7/26/24 and 8/12/24. (see attached email).
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 63a (See attached documentation). The policy for CPR/First Aid training for The Woods at Cedar Run dictates that all staff over the age of 18 will be trained in both.
ONGOING: Resident Wellness Director will ensure that the requirements under Regulation 63a are met for each Beginning on 6/10/24, Resident Wellness Director began an audit of all staff to ensure that the appropriate number of trained staff are present in the community for each shift. If this is not the case, the schedule will be revised to meet Regulation 63a. Resident Wellness Director will continue to audit monthly for compliance. Beginning on 9/1/24, CPR/First Aid classes will be held as needed, based on the number of new staff hired and the number of recertifications required for current staff. Documentation will be kept (see attached audit).

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (█ - 07/24/2024)

81b - Resident Personal Equipment

4. Requirements

2600.
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

The bed located in resident #236 has an uncovered enabler device with an opening measuring 11.5 inches in width and more than 4 3/4 inches in height, posing a potential risk of entrapment.

Repeated Violation - 4/4/23, et al

Plan of Correction ***Accept (█ - 06/24/2024)***

ACTION: On 6/12/24, the enabler was removed from apartment number 236 by Resident Wellness Director (the enabler was previously removed by the Safety and Maintenance Director upon arrival of Resident's hospital bed, but was unknowingly placed back on the resident's bed by a family member).

81b - Resident Personal Equipment (continued)

TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 81b (See attached documentation) On 6/14/24, Resident Wellness Director educated Resident and family members on the safety concerns that arise with the type of enabler they had placed on their [redacted] bed. Resident Wellness Director confirmed that the enabler was removed from the facility by Resident's [redacted]
ONGOING: A facility-approved enabler device has been put into place effective 6/18/2024 (see attached). Beginning on 6/17/24, the Safety and Maintenance Director/Maintenance Assistant will assist the family/resident in the installation of the facility-approved enabler for any new or current residents who have a physician's order to utilize this personal equipment. This is to ensure that the device is installed correctly and safely. Beginning on 7/1/24, a weekly check will be put into TELS (the facility's maintenance system) to ensure that the Safety and Maintenance Director/Maintenance Assistant are checking all enablers installed in the facility to ensure proper installation and appropriate usage. Documentation will be kept within the TELS system.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 07/24/2024)

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

On 6/12/24, three (3) drawers in the Third Floor East medication cart were observed to contain dirt, dust, loose strands of hair and trash particles. The debris in the drawers created unsanitary storing conditions for medications and disposable medication cups.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

ACTION: On 6/12/24, medication cart was thoroughly cleaned by the med tech assigned to that cart and inspected/approved by the Resident Wellness Director.
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 85a (See attached documentation). On 6/19/24, all Med Techs were trained on Regulation 85a, by Executive Operations Officer and Resident Wellness Director (documentation of training is attached)
ONGOING: Beginning on 6/17/24, a weekly audit will be completed on all medication carts by the Resident Wellness Director, LPN, or Executive Operations Officer. Documentation will be kept. (See attached audit)

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented ([redacted] - 07/24/2024)

86b - Bathroom

6. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathroom ventilation fan in resident room #112 was inoperable when the switch was activated; there is no

86b - Bathroom (continued)

window in the bathroom.

Plan of Correction ***Accept (█ - 06/24/2024)***

ACTION: On 6/12/24, Safety and Maintenance Director assigned a maintenance assistant to inspect the state of the bathroom ventilation fan in resident room #112. Parts were ordered and a new ventilation fan was installed by a maintenance assistant on 6/14/24. On 6/14/24, Safety and Maintenance Director and 2 Maintenance Assistants checked every bathroom ventilation fan in the facility. All fans were functioning.
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 86b (See attached documentation)
ONGOING: Beginning on 7/1/24, a monthly check of all bathroom ventilation fans will be performed by the Safety and Maintenance Director/Maintenance Assistant, as scheduled in TELS (facility maintenance documentation system). Documentation will be kept in TELS.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (█ - 07/24/2024)

91 - Telephone Numbers

7. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

The emergency phone numbers posted in bedrooms #322 and #236 did not include the correct number for the poison control hotline.

The hallway phone located outside of bedroom #311 dials outside of the home. On 6/12/24, there were no emergency service numbers posted on or near the phone.

Plan of Correction ***Accept (█ - 06/24/2024)***

ACTION: On 6/13/24, Safety and Maintenance Director verified the correct phone number for the Poison Control Center and updated the emergency phone number sheet. On 6/14/24, updated emergency phone number sheets were placed in every resident apartment, as well as by every phone in the community that is accessible to residents. (See attached updated emergency phone numbers list).
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 91 (See attached documentation)
ONGOING: Beginning on 6/17/24, Executive Operations Officer or Safety and Maintenance Director will verify that the emergency phone numbers are still present beside every community phone accessible to residents. This will be completed 2 times per month. Any missing emergency phone number lists will be immediately replaced at that time if needed.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (█ - 07/24/2024)

105g - Lint Removal and Duct Cleaning

8. 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

Resident room #322 contains an in-unit washer and dryer. On 6/12/24, there was a heavy accumulation of lint in the lint trap of the dryer; there were no clothes in the dryer at the time.

Plan of Correction ***Accept (- 06/24/2024)***

ACTION: On 6/12/24, lint from the dryer in room #322 was removed by the Inspector. On 6/13/24, all resident rooms containing dryers were checked for lint and lint traps were cleaned by the Housekeeping staff.
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 105g (See attached documentation)
ONGOING: Housekeeping is scheduled to clean all resident room dryer lint traps weekly during regular housekeeping visits. In addition, on 6/17/24, the Safety and Maintenance Director put signs on every resident room laundry room door reminding all residents/families/staff to empty the lint after every load of laundry. A checklist is included on each resident dryer, to sign off on the date the lint is cleaned. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (- 07/24/2024)

132c - Fire Drill Records

9. 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

The fire drill records for the drills conducted on 6/4/24, 5/30/24, 4/29/24, 3/27/24, and 2/20/24 only document the evacuation time in exact minutes and do not record the actual evacuation time (minutes/seconds).

The home's fire drill records did not include the number of residents in the home at the time of the drill. Per staff interview, the documentation indicates the number of residents residing at the home rather than the number of residents physically present when the alarm sounded.

Plan of Correction ***Accept (- 06/24/2024)***

ACTION: On 6/11/24, the Inspector from the Department provided on-site education to the Safety and Maintenance Director, regarding the correct way in which to complete the monthly fire drill record.
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 132c (See attached documentation)
ONGOING: Beginning on 7/1/24, Safety and Maintenance will provide a copy of the monthly fire drill record to the Executive Operations Officer at the completion of each fire drill conducted in the facility. Executive Operations Officer will verify that all information is correct under Regulation 132c. Documentation of all fire drills will be kept.

132c - Fire Drill Records (continued)

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 07/24/2024)

141b1 - Annual Medical Evaluation

10. Requirements

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

Description of Violation

Resident #1's most recent medical evaluation was completed on . The resident's previous medical evaluation was completed on .

Plan of Correction ***Accept (- 06/24/2024)***

ACTION: Upon the hiring of the current Resident Wellness Director in January, 2024, an audit of all resident medical evaluations was completed. It was discovered that Resident #1's medical evaluation was overdue, and it was completed on 2/1/24 by the current Resident Wellness Director.
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 141b (See attached documentation)
ONGOING: As of Feburary, 2024, all medical evaluation due dates are pulled electronically each month to ensure that every resident has an annual (or more frequently as needed) medical evaluation completed. (See attached report as example). Documentation is kept electronically

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (- 07/24/2024)

162c - Menus Posted

11. 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.

Description of Violation

The home's menu for the week of 6/9/24 through 6/15/24 was posted in the secured unit. However, on 6/11/24, the home did not have a menu posted for 1 week in advance.

Plan of Correction ***Accept (- 07/02/2024)***

ACTION: On 6/12/24, Executive Operations Officer posted Week 2 menu in the Memory Care Unit
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 162c (See attached documentation)
ONGOING: Beginning on 6/17/24, Director of Dining or Designee will ensure that the menu for the current week and the menu for the next week are present in the designated areas outside of both the Personal Care and Memory Care dining rooms. Beginning on 6/17/24, Executive Operations Officer or Designee will check each dining room weekly to verify that 2 weeks of menus are posted.

Licensee's Proposed Overall Completion Date: *07/01/2024*

162c - Menus Posted *(continued)*

Implemented (█ - 07/24/2024)

171b4 - Staff Training

12. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
4. At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation).

Description of Violation

On 6/11/24, Staff Member B transported residents to and from a grocery store without the support of another staff member. Staff member B has not completed the initial new hire direct care staff person training.

Plan of Correction ***Accept (█ - 07/02/2024)***

ACTION: On 6/14/24, Staff member B completed the Direct Care Staff Person training (certificate is attached). On 6/17/24, Business Officer Manager verified that all other current employees that provide direct care had a completed Direct Care Training certificate in their employee file.
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 171(b)4 (See attached documentation)
ONGOING: Beginning on 6/17/24, Executive Operations Officer will verify that each newly hired employee has completed the Direct Care Staff training (as applicable) by auditing each new employee record prior to creating the new employee file. All new employee records will be reviewed by the Executive Operations Officer within the first 7 days of hire to ensure compliance with regulation 171b(4). Documentation of employee files/training will be kept.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (█ - 07/24/2024)

183a - Original Containers and Injections

13. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

On 6/12/24, there were six (6) various colored plastic medication containers with 5 separate storage boxes for each container found in the bottom drawer of the medication cart. Various medication tablets/capsules were observed in the containers.

Plan of Correction ***Accept (█ - 06/24/2024)***

ACTION: On 6/12/24, Med Tech removed all medication containers from the medication cart and destroyed them using a drug buster in the presence of the Resident Wellness Director.
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 183.a (See attached documentation). On 6/19/24, all Med Techs were trained on Regulation 183.a, by Executive Operations Officer and Resident Wellness Director (documentation of training is attached)

183a - Original Containers and Injections (continued)

ONGOING: Beginning on 6/17/24, a weekly med cart audit will be completed by the lead Med Tech, LPN, or Resident Wellness Director, to ensure that the medication carts are in compliance will Regulation 183a. (see attached audit). Documentation will be kept in the Wellness Office.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (█ - 07/24/2024)

183e - Storing Medications

14. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

During the inspection on 6/12/24, two (2) loose white pills were found in the second floor east medication cart. A small round white pill with an identifier of #244 was found in the 2nd drawer, and a small oval white pill with an identifier of e7 was found in the bottom drawer.

Repeated Violation - 2/1/24

Plan of Correction ***Accept (█ - 06/24/2024)***

ACTION: On 6/12/24, Med Tech removed the loose pills from the medication cart and destroyed them using a drug buster in the presence of the Resident Wellness Director.
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 183.e (See attached documentation). On 6/19/24, all Med Techs were trained on Regulation 183.e, by Executive Operations Officer and Resident Wellness Director (documentation of training is attached)
ONGOING:Beginning on 6/17/24, a weekly med cart audit will be completed by the lead Med Tech, LPN, or Resident Wellness Director, to ensure that the medication carts are in compliance will Regulation 183.e. (see attached audit). Documentation will be kept in the Wellness Office.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (█ - 07/24/2024)

184a - Resident's Meds Labeled

15. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

On 6/12/24, a bottle containing approximately thirty (30) white round pills was observed in the bottom drawer of a medication cart. There was no label identifying the the pills or to whom they belonged.

184a - Resident's Meds Labeled *(continued)*

Plan of Correction ***Accept (- 06/24/2024)***

ACTION: On 6/12/24, Med Tech removed the unlabeled pills from the medication cart and destroyed them using a drug buster in the presence of the Resident Wellness Director.
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 184a (See attached documentation). On 6/19/24, all Med Techs were trained on Regulation 184a, by Executive Operations Officer and Resident Wellness Director (documentation of training is attached)
ONGOING: Beginning on 6/17/24, a weekly med cart audit will be completed by the lead Med Tech, LPN, or Resident Wellness Director, to ensure that the medication carts are in compliance with Regulation 184a. (see attached audit). Documentation will be kept in the Wellness Office.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (- 07/24/2024)

185a - Implement Storage Procedures

16. 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 #7 receives blood sugar checks as needed. The documentation for May 2024 medication administration records indicates the resident's blood sugar was checked on 5/20/24, 5/22/24 and 5/24/24. The glucometer indicates the corresponding blood sugars were checked on 7/18, 7/20 and 7/22. The glucometer was not calibrated to the correct date and time.

Repeated Violation - 4/4/23, et al

Plan of Correction ***Accept (- 06/24/2024)***

ACTION: On 6/12/24, Resident Wellness Director contacted Resident #7's who then provided a new glucometer to the facility on 6/14/24.
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 185a (See attached documentation). On 6/19/24, all Med Techs were trained on Regulation 185a, by Executive Operations Officer and Resident Wellness Director (documentation of training is attached)
ONGOING: Beginning on 6/17/24, a weekly glucometer audit will be completed by the lead Med Tech, LPN, or Resident Wellness Director, to ensure that all resident glucometers are in compliance will Regulation 185a. (see attached audit). Documentation will be kept in the Wellness Office.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (- 07/24/2024)

187a - Medication Record

17. Requirements

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

187a - Medication Record *(continued)*

Description of Violation

Resident's prescribed medications are missing a diagnosis or purpose on the June 2024 Medication Administration Record (MAR) for the following:

- *Resident #6 - Polyethylene Glycol, Senna-s, Medi-honey*
- *Resident #7 - Atorvastatin, Bethanechol 5mg, Cefuroxime 500mg*
- *Resident #8 - Acetaminophen 500mg, Escitalopram 10mg, Melatonin 10mg*

Plan of Correction ***Accept (- 06/24/2024)***

ACTION: From 6/12/24 through 6/14/24, Resident Wellness Director and LPN audited every resident MAR to ensure that diagnoses were added for each medication listed. All diagnoses were added to the electronic MAR for every resident medication listed. (see attached audit).
TRAINING: On 6/12/24 Resident Wellness Director contacted the pharmacy utilized by the facility and educated them on Regulation 187a. On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 187a (See attached documentation). On 6/19/24, all Med Techs were trained on Regulation 187a, by Executive Operations Officer and Resident Wellness Director (documentation of training is attached)
ONGOING: Beginning on 6/15/24, Med Techs are to alert Resident Wellness Director or LPN if any new medications are missing diagnoses on Resident Medication Administration Records. Beginning on 6/17/24, a weekly audit of each medication cart will include a check for diagnoses listed on the MAR for each resident. Any missing diagnoses will be added by the Resident Wellness Director. Documentation will be kept in the electronic MAR.

Licensee's Proposed Overall Completion Date: *06/21/2024*

Implemented (- 07/24/2024)

227d - Support Plan Medical/Dental

18. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #7 utilizes a bedside mobility device. The resident's current RASP, dated does not include the specific need for the device, the intended use and any risks associated with the use, the residents' ability to use the device safely for the purpose it was intended or the identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Resident #9 utilizes a bedside mobility device. The resident's current RASP, dated , does not include the specific need for the device, the intended use and any risks associated with the use, the residents' ability to use the device safely for the purpose it was intended or the identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

227d - Support Plan Medical/Dental (continued)

Plan of Correction ***Accept (█ - 07/02/2024)***

ACTION: Resident #7's bedside utility device was removed on 6/12/24.
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 227d (See attached documentation).
ONGOING: Resident #9's RASP was updated by facility LPN on 7/1/2024. (See Attached) On 7/1/24, a full audit of all RASP's was completed by the Executive Operations Officer for all Residents who have personal equipment within their rooms. (See attached). All missing information will be added to the RASP's by the Resident Wellness Director or Designee by 7/15/24. Beginning on 7/15/24, the Executive Operations Officer or Designee will audit the RASP's of all residents who are utilizing enabler bars within the facility. This audit will be conducted on a bi-weekly basis and documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/15/2024*

Implemented (█ - 07/24/2024)

233c - Key-Locking Devices

19. 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 home posts directions for egress from the Secured Dementia Care Unit's locking mechanism in a public and conspicuous place. However, the directions are disguised in a manner that does not permit visitors to obtain immediate egress without assistance. The codes are not posted in an order that is able to be deciphered by visiting guests nor does the posted code include the required use of the asterisk symbol.

Plan of Correction ***Accept (█ - 06/24/2024)***

ACTION: On 6/13/24, Safety and Maintenance Director revised the posted codes to be more easily deciphered by guests and added an asterisk to the outside gate code. These were posted in the SDCU on 6/13/24. (see attached photos).
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 233c (See attached documentation)
ONGOING: Starting 6/17/24, anytime the code is changed, at least 3 members of the staff will test the new code without prior instruction to ensure that the code is deciphered by guests.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (█ - 07/24/2024)

252 - Record Content

20. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
3. A photograph of the resident that is no more than 2 years old.

252 - Record Content *(continued)*

Description of Violation

The Resident record for Residents #2, #3, #4, #5, and # 6 do not include a photograph of the resident that is no more than 2 years old.

Plan of Correction ***Accept (- 07/02/2024)***

ACTION: Beginning on 6/11/24, Marketing Assistant began audit of photographs of all current Residents. By 6/17/24, each current Resident had an updated photograph filed in their chart by the Resident Wellness Director. (see attached audit).
TRAINING: On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 252 (See attached documentation)
ONGOING: Beginning on 6/17/24, Marketer or Marketing Assistant will obtain a photograph of each new resident upon move in. This photograph will then be provided to the Executive Operations Officer to verify the policy, and to the Resident Wellness Director, to file in each new resident's chart. Documentation of each photo will be kept in the resident file. Beginning on 7/1/24, Executive Operations Officer will begin keeping an audit of all resident photo due dates (see attached). When a resident is due for a new photo, Executive Operations Officer or Designee will take an updated photo and place in the resident's file. Audit will be kept on file.

Licensee's Proposed Overall Completion Date: *07/02/2024*

Implemented (- 07/24/2024)

254a - Records Discharge/Active

21. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 6/11/24, at approximately 9:50 AM and again at 1:10 PM, the Medication Office containing all of the resident medical files was unlocked, unattended, and accessible.

Plan of Correction ***Accept (- 06/24/2024)***

ACTION: On 6/11/24, the Safety and Maintenance Engineer ordered a new lock for the Wellness Office. On 6/13/24, the Safety and Maintenance Engineer installed the new keyless entry lock on the Wellness Office.
TRAINING: On 6/13/24, the Safety and Maintenance Engineer provided directions to all relevant staff to ensure that everyone was aware of how to operate the new lock. On 6/14/24, Executive Operations Officer educated all Leadership Team members on Regulation 254a (See attached documentation)
ONGOING: Beginning on 6/14/24, Resident Wellness Director, Executive Operations Officer, and Safety and Maintenance Director will perform daily spot checks of the new locking system to ensure that the Wellness Room remains locked when unoccupied. If the room is found to be unlocked, staff will be re-educated on the spot.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (- 07/24/2024)