





**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: APRIL 4, 2025

Haven at Springwood OPCO LLC  
2321 Freedom Way  
York, Pennsylvania 17402

RE: Seaton Springwood  
2321 Freedom Way York,  
Pennsylvania 17402  
License #: 335031

Dear Haven at Springwood OPCO LLC:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on September 10, 2024, September 11, 2024, and December 10, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summaries (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby **REVOKES** your certificate of compliance 335030 dated February 12, 2025 to February 12, 2026 and issues you a **FIRST PROVISIONAL** license to operate the above facility. A **FIRST 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) and 55 Pa. Code §20.71(a)(2);(4) (relating to conditions for denial, nonrenewal or revocation). Your **FIRST PROVISIONAL** license is enclosed and is valid from April 4, 2025 to October 4, 2025.

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.


Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
2600.16(c)	III	109	\$3	\$327	15 calendar days from mailing date of this letter
2600.185(a)	II	109	\$5	\$545	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

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. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

  
 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.

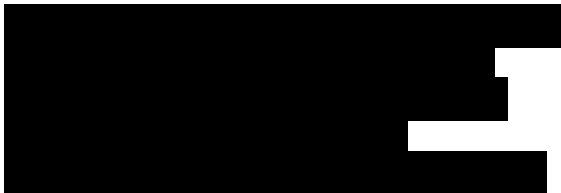
Sincerely,



Juliet Marsala  
Deputy Secretary  
Office of Long-term Living

Enclosure  
Licensing Inspection Summaries

cc:



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

**Facility Information**

Name: SEATON SPRINGWOOD License #: 33503 License Expiration: 02/12/2025  
Address: 2321 FREEDOM WAY, YORK, PA 17402  
County: YORK Region: CENTRAL

**Administrator**

Name: [REDACTED]

**Legal Entity**

Name: HAVEN AT SPRINGWOOD OPCO LLC  
Address: 2321 FREEDOM WAY, YORK, PA, 17402  
Phone: [REDACTED]

**Certificate(s) of Occupancy**

Type: C-2 LP Date: 01/20/2004 Issued By:

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 118 Waking Staff: 89

**Inspection Information**

Type: Full Notice: Unannounced BHA Docket #: 0  
Reason: Renewal, Complaint, Incident Exit Conference Date: 09/11/2024

**Inspection Dates and Department Representative**

09/10/2024 - On-Site: [REDACTED]  
09/11/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: 123 Residents Served: 103

**Secured Dementia Care Unit**

In Home: Yes Area: Memory care Capacity: 13 Residents Served: 11

**Hospice**

Current Residents: 6

**Number of Residents Who:**

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 103  
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 1  
Have Mobility Need: 15 Have Physical Disability: 0

**Inspections / Reviews**

**09/10/2024 - Full**

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 10/10/2024

10/21/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/04/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 10/28/2024

10/30/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/04/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 12/01/2024

03/31/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/04/2024

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department’s personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [REDACTED]/24 at approximately 1 AM, Resident 8 experienced an unwitnessed fall and was transported to the ER, which resulted in a diagnosis of a hip fracture. The home did not report this incident to the department until 4/17/24.

[REDACTED]

Withdrawn  
ACC 3/31/25

Repeated Violation - 11/1/23 and 6/6/23, et al

Plan of Correction

[REDACTED] - 10/29/2024)

- Immediately, the LPN who was the reporter was counseled on reporting requirements by the Administrator.
- Training with the medication technicians and care managers on incident reporting requirements, reviewing details of 2600.16c, and community internal notification process was provided by the Director of Health & Wellness on 10/9/24. See attached.
- Beginning January 2025, continued education will be provided on a quarterly basis by the Director of Health and Wellness, or another designated alternate that is PCHA licensed, to the medication technicians and care managers
- Daily, Administrator, or designated alternate, will review reportable incidents and verify that Department require reporting is submitted. This daily review will begin effective 10.17.24

Proposed Overall Completion Date: 11/01/2024

Licensee's Proposed Overall Completion Date: 11/01/2024

Not Implemented ([REDACTED]) - 02/06/2025)

18 - Compliance With Laws

2. 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

The Care Facility Carbon Monoxide Standards Act requires that an approved carbon monoxide alarm be installed in close proximity of, but not less than 15 feet from, any fossil fuel-burning device or appliance. The home has a gas fireplace in the lobby. However, on 9/10/24 during the initial walkthrough, there was no carbon monoxide detector nearby.

Plan of Correction

Directed [REDACTED] 10/29/2024)

- Immediately, on 9.11.24 a carbon monoxide alarm was installed by director of facilities within 15 feet of the gas fireplace located in the lobby.
- Immediately, on 9.10.24 the Director of Facilities was counseled on 2600.18 related to carbon monoxide alarms by

18 - Compliance With Laws (continued)

the Administrator.

-On 9/11/24, a request was placed by the Director of Facilities to add a task to the community's building management system to include carbon monoxide alarm checks on a monthly basis.

-On an ongoing, monthly basis, beginning October 2024, the Director of Facilities will document verifying that each carbon monoxide alarm is present and functioning.

Proposed Overall Completion Date: 11/01/2024

[Directed]

In addition to the above plan of correction:

- By no later than 11/15/24, the carbon monoxide alarm will be placed by in close proximity but no less than 15 feet from the gas fireplace. This will be completed by the Director of Facilities or designee.

Directed Completion Date: 11/15/2024

Not Implemented (████) - 02/06/2025)

25b - Contract Signatures

3. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated █████/23, for Resident 2 was not signed by the resident.

Plan of Correction

Accept (████) - 10/29/2024)

-On October 1, 2024, the resident signature was ascertained on the contract by the business office manager.

-Immediately, on 9.11.24, the business office manager was counseled on this item by the Administrator.

-The business office manager will complete a full audit of all contracts to verify that resident signature or mark is present. This audit was completed on 10/14/24. See attached.

-On an ongoing basis, the business office manager will utilize a checklist to verify all required items on the resident-home contract, to include resident signature, is present prior to submission and filing. See attached. This checklist will be utilized with any new contract signed beginning October 2024.

Proposed Overall Completion Date: 11/01/2024

Licensee's Proposed Overall Completion Date: 11/01/2024

Not Implemented (████) - 02/06/2025)

51 - Criminal Background Check

4. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

51 - Criminal Background Check (continued)

Description of Violation

Staff Member A was hired on [redacted]/24. Staff Member A's criminal background check was completed on 9/10/24.

Plan of Correction

Accept [redacted] - 10/29/2024)

- Immediately, the business office manager was provided with counseling on regulatory requirements for new hire background checks by the Administrator.
- The business office manager will complete a full audit of all staff files to verify that background checks, appropriately dated, are present. This audit was completed on 10/14/24. See attached.
- The business office manager and Administrator will revise the new hire process. The new hire process was amended to include background checks to be completed at the time of contingent offer of employment is provided and prior to start date of employment. The business office manager has attested that this practice will be implemented effective 10/15/24. See attached.

Proposed Overall Completion Date: 11/01/2024

Licensee's Proposed Overall Completion Date: 11/01/2024

Not Implemented ([redacted] - 02/06/2025)

65a - FS Orientation 1st Day

5. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, hired on [redacted] 23, did not complete training on the following topics until 3/8/24:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Plan of Correction

Accept [redacted] - 10/29/2024)

- Immediately, the business office manager was provided counseling on this item by the Administrator on 9.11.24.

65a - FS Orientation 1st Day (continued)

-The business office manager will complete a full audit of staff files to verify the 1st day requirements have been completed within the required time frame. The business office manager completed this audit on 10/14/24.

- The orientation documentation will be revised by the business office manager by 10.14.24 to include a training verification form to reflect the specific Department required education within the first day of employment, which includes:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

-The checklist was created by the business office manager on 10//9/24 and will be implemented with the next scheduled orientation, estimated to be held on 11/15/24. See attached.

Proposed Overall Completion Date: 11/15/2024

Licensee's Proposed Overall Completion Date: 11/15/2024

Not Implemented (█) - 02/06/2025)

65b - Rights/Abuse 40 Hours

6. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Person B, hired on █/23, did not complete training on the following topics until 3/8/24:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Plan of Correction

Accept (█) - 10/29/2024)

- Immediately, the business office manager was provided counseling on this item by the Administrator on 9.11.24.
- The business office manager will complete a full audit of staff files to verify the 1st 40 hours of work requirements have been completed within the required time frame. The business office manager completed this audit on 10/14/24.
- The orientation documentation will be revised by the business office manager by 10.14.24 to include a training verification form to reflect the specific Department required education within the 40 working hours of employment, which includes:

65b - Rights/Abuse 40 Hours (continued)

- 1. Resident rights.
- 2. Emergency medical plan.
- 3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
- 4. Reporting of reportable incidents and conditions  
 -The checklist was created on 10//9/24 and will be implemented with the next scheduled orientation, estimated to be held on 11/15/24. See attached.

Proposed Overall Completion Date: 11/15/2024

Licensee's Proposed Overall Completion Date: 11/15/2024

Not Implemented (█ - 02/06/2025)

81b - Resident Personal Equipment

7. 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

Resident 10 utilizes a bed side mobility device to aid in positioning and transferring in and out of bed. However, on 9/11/24, the mobility device was not securely fastened to the bed, posing an entrapment risk.

Plan of Correction

Accept (█ - 10/29/2024)

- Immediately, on 9.11.24, the Director of Health & Wellness was provided counseling on 2600.81b by the Administrator.
- The LPN completed a full audit of all bedside mobility devices within the community on 10/3/24
- The Director of Health & Wellness, with support from the Director of Facilities and consultation from Occupational Therapist corrected any deficiencies found as a result of the bedside mobility device audit and provided signed verification of the corrections on 10/11/24.
- The Director of Health & Wellness will complete an inspection of all bedside mobility devices on an ongoing and monthly basis starting in November 2024.
- The inspections will be monitored by the Administrator and included with QA review on a monthly basis.

Proposed Overall Completion Date: 12/01/2024

Licensee's Proposed Overall Completion Date: 12/01/2024

Not Implemented (█ - 02/06/2025)

82c - Locking Poisonous Materials

8. 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.

82c - Locking Poisonous Materials (continued)

Description of Violation

On 9/10/24, during the initial walkthrough, a bathroom containing a housekeeping cart with multiple cleaning supplies including Lysol disinfectant cleaner and a can of Raid bug spray, with a manufacture's label indicating "contact poison control if swallowed ", were unlocked, unattended, and accessible to residents in the secured dementia care unit (SDCU). These residents have been assessed as incapable of recognizing and using poisons safely.

Plan of Correction

Accept [redacted] - 10/29/2024)

- Immediately, the door to the bathroom was secured by Memory Care Director.
- The Memory Care Director submitted a work order on 9.11.24, immediately, to service the lock of the door to ensure security of the hazardous materials.
- The Director of Facilities will service the doors that allow access to hazardous materials to ensure locking mechanisms by 10/30/24.
- Education on hazardous materials will be provided by the Memory Care Director to include medication technicians and care managers responsible for maintaining compliance with this regulation. This training was completed on 9/24/24.
- On a weekly basis, beginning 10.15.24, the Memory Care Director will complete a safety inspection of the unit to include security of hazardous/poisonous material.
- The safety inspections will be monitored by the Administrator on an ongoing basis beginning 10.25.24 on a monthly frequency.

Proposed Overall Completion Date: 11/08/2024

Licensee's Proposed Overall Completion Date: 11/08/2024

Implemented [redacted] - 02/06/2025)

85a - Sanitary Conditions

9. Requirements

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

Description of Violation

On 9/10/24, there were no paper towels or other hand drying options available in the secured dementia care unit (SDCU) communal bathroom.

On 9/10/24 at approximately 10:15 am, a pungent odor of feces was detected upon entry into the women's bathroom by dining hall. A trash can full of soiled sanitary pads and other items were observed in the bathroom.

On 9/11/24, room #29 contained a soiled handheld urinal hanging on the grab bar in the bathroom.

Plan of Correction

Accept [redacted] - 10/29/2024)

- Immediately, the Memory Care Director and Housekeeping Supervisor were provided coaching on the observed items by the Administrator. The observed items were immediately addressed by the Housekeeping Supervisor.
- A tracking form for bathroom servicing will be developed and posted in all common restrooms to monitor frequency of cleaning. The tracking form was developed to be completed daily by the assigned housekeeper. See attached. This service monitoring process will be implemented 10/15/24. The tracking forms will be collected

85a - Sanitary Conditions (continued)

monthly and records will be maintained by the Housekeeping Supervisor.

- Training and education will be provided by the Housekeeping supervisor to the housekeeping personnel on the details of 2600.85a,d,e, 2600.86b, 2600.88a, 2600.91, 2600.102i, 2600.105g. This training was completed on 10/2/24
- Compliance and records monitoring will be completed by the Administrator beginning 11/1/24 on a monthly basis.

Proposed Overall Completion Date: 11/01/2024

Licensee's Proposed Overall Completion Date: 11/01/2024

Implemented [redacted] - 02/06/2025)

85d - Trash Receptacles

10. Requirements

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 9/10/24, during the initial walkthrough, there was a full, uncovered, unattended trash can in the kitchen, common bathroom in the secured dementia care unit (SDCU) and in the women's bathroom across from the elevators.

Plan of Correction

Accept [redacted] - 10/29/2024)

-Immediately, the Director of Culinary Services, Memory Care Director and Housekeeping Supervisor were provided coaching by the Administrator on the observed items. The observed items were immediately addressed by the Housekeeping Supervisor.

- A tracking form for bathroom servicing will be developed and posted in all common restrooms to monitor trash receptacles having lids in place. To be completed by the assigned housekeeper on a daily basis. The tracking form was developed. See attached. This trash receptacle monitoring process will be implemented 10/15/24. The tracking forms will be collected monthly and records will be maintained by the Housekeeping Supervisor.

- Training and education will be provided by the Housekeeping supervisor to the housekeeping personnel on the details of 2600.85a,d,e, 2600.86b, 2600.88a, 2600.91, 2600.102i, 2600.105g. This training was completed on 10/2/24

-Compliance and records monitoring will be completed by the Administrator beginning 11/1/24 on a monthly basis.

Proposed Overall Completion Date: 11/01/2024

Licensee's Proposed Overall Completion Date: 11/01/2024

Implemented [redacted] - 02/06/2025)

85e - Trash Outside Home

11. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 9/10/23, during the initial walkthrough, there were no lids on the dumpsters outside the home.

Plan of Correction

Accept [redacted] - 10/29/2024)

-Immediately, the Director of Culinary Services, Memory Care Director and Housekeeping Supervisor were provided

85e - Trash Outside Home (continued)

coaching on the observed items by the administrator. The observed items were immediately addressed by the Housekeeping Supervisor.

- Training and education will be provided by the Housekeeping supervisor to the housekeeping team on the details of 2600.85a,d,e, 2600.86b, 2600.88a, 2600.91, 2600.102i, , 2600.105g. This training was completed on 10/2/24
- A dumpster monitoring checklist will be developed by the Director of Facilities. This checklist was completed on 10/28/24. The checklist will be implemented beginning 11/1/24 and will be completed on a weekly basis by the Director of Facilities, Housekeeping supervisor, or other alternate designee. See attached
- Compliance and records monitoring will be completed by the Administrator beginning 11/1/24 on a monthly basis.

Proposed Overall Completion Date: 11/01/2024

Licensee's Proposed Overall Completion Date: 11/01/2024

Implemented (████) 02/06/2025)

91 - Telephone Numbers

14. 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

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in in rooms #124 and #217.

Plan of Correction

Directed (████) - 10/29/2024)

- Immediately, the Director of Facilities and Housekeeping Supervisor were provided coaching by the Administrator on the observed item. The observed item was immediately addressed by the Housekeeping Supervisor.
- Training and education will be provided by the Housekeeping supervisor to the housekeeping team on the details of 2600.85a,d,e, 2600.86b, 2600.88a, 2600.91, 2600.102i, 2600.105g. This training was completed on 10/2/24
- New emergency telephone number tags will be implemented on all resident phones. The phone numbers will be on a laminated card and affixed to the telephone equipment. An example is provided- see attached. Phone tags will be created and installed in all rooms by 11/1/24 by the housekeeping supervisor.
- An audit tool will be developed by the housekeeping supervisor by 11/15/24.
- The audit tool will be completed on a monthly basis by the housekeeping supervisor beginning December 2024.
- Compliance and records monitoring will be completed by the Administrator on a monthly basis beginning December 2024.

Proposed Overall Completion Date: 12/31/2024

[Directed]

In addition to the above plan of correction:

- Beginning no later than 12/1/24, the Housekeeping Supervisor will utilize the audit tool on a monthly basis.
- Beginning no later than 11/1/24, compliance and records monitoring will be completed by the Administrator on a monthly basis.

91 - Telephone Numbers (continued)

Directed Completion Date: 12/01/2024

Not Implemented [redacted] - 02/06/2025)

96a - First Aid Kit

15. Requirements

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the kitchen does not include a thermometer.

The first aid kit in the secured dementia care unit (SDCU) does not include eye covering.

Plan of Correction

Accept [redacted] - 10/29/2024)

- Immediately, the Director of Culinary Services and Memory Care Director were coached on the observed items by the Administrator.
- Immediately, replacements for the missing first items were provided by the Administrator to complete first aid kits.
- New first aid kits that include all required items to satisfy 2600.96a were purchased on 10/16/24 by the Administrator.
- Upon delivery of new first aid kits, they will be zip tied by the Administrator to indicate they are complete kits. A broken seal will be required to be reported to the Department Leader that the kit is assigned to. Once all required items are verified, the first aid kit will be zip tied again by the department director/leader. Delivery of the new first aid kit is estimated for 10/19/24
- A monthly inspection will be completed by the Department Leader of each area that a first aid kit is assigned. The inspection will be submitted to the Administrator beginning November 2024.
- Education on this process will be provided to Department Leaders by the Administrator by 11/1/24.
- The Administrator will maintain record of monthly inspection. See attached for inspection form to be utilized.

Proposed Overall Completion Date: 11/30/2024

Licensee's Proposed Overall Completion Date: 11/30/2024

Not Implemented [redacted] - 02/06/2025)

102i - Soap Dispenser

16. Requirements

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 9/10/24, during the initial walkthrough, the communal bathroom of the secured dementia care unit (SDCU) did not have soap in the soap dispenser.

Plan of Correction

Accept [redacted] - 10/29/2024)

- Immediately, the Memory Care Director and Housekeeping Supervisor were provided with coaching on the observed item by the Administrator.

102i - Soap Dispenser (continued)

- Immediately, soap was refilled in the dispenser by the Memory Care Director.
- Training and education will be provided by the Housekeeping supervisor to the housekeeping team on the details of 2600.85a,d,e, 2600.86b, 2600.88a, 2600.91, 2600.102i, 2600.105g. This training was completed on 10/2/24.
- A bathroom check tool will be developed by the Memory Care Director. This tool was developed on 10/14/24.
- The bathroom check tool will be used by staff on each shift to verify that it is clean, has paper towels, soap, and trash receptables are covered.
- The bathroom check tool will be implemented no later than 10/21/24. The records of the bathroom check will be verified and maintained by the Memory Care Director.

Proposed Overall Completion Date: 11/01/2024

Licensee's Proposed Overall Completion Date: 11/01/2024

Implemented (████) - 02/06/2025)

105g - Lint Removal and Duct Cleaning

17. 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 9/10/24, during the initial walkthrough, there was an approximate 2-inch accumulation of lint in the lint trap of the dryer located in the basement and in the residents' dryer on the second floor of the home. There were no clothes in the dryers at the time.

Plan of Correction

Accept (████) - 10/29/2024)

- Immediately, the Housekeeping Supervisor was provided coaching on the observed items by the Administrator. The observed item was immediately addressed by the Housekeeping Supervisor.
- A tracking form for dryer vent/lint checks will be developed by the housekeeping supervisor. The dryer check will be completed once per shift, daily. The tracking form was developed. See attached. This dryer check tracking will be implemented 10/15/24. The tracking forms will be completed by the housekeeper assigned to that floor. It will be collected weekly and records will be maintained by the Housekeeping Supervisor.
- Training and education will be provided by the Housekeeping supervisor to the housekeeping team on the details of 2600.85a,d,e, 2600.86b, 2600.88a, 2600.91, 2600.102i, 2600.105g. This training was completed on 10/2/24
- Compliance and records monitoring will be completed by the Administrator on a monthly basis beginning December 2024

Proposed Overall Completion Date: 11/01/2024

Licensee's Proposed Overall Completion Date: 11/01/2024

Implemented (████) - 02/06/2025)

121a - Unobstructed Egress

18. Requirements

121a - Unobstructed Egress (continued)

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 9/10/24, during the initial walkthrough, the metal exterior door in personal care leading to an outside concrete ramp was difficult to open. Staff was unable to open just using the push bar. Staff had to ram [redacted] r shoulder into it. A second attempt to open the door resulted in the same outcome. Rust was observed around the hinges of the door.

Repeated Violation - 6/6/23, et al

**Plan of Correction**

**Directed [redacted] - 10/29/2024)**

- Immediately, the Director of Facilities was provided coaching on the observed item by the Administrator.
- The Director of Facilities placed a call to request service from an outside vendor to service the door on 9/20/24. The vendor was on-site at the home on 10/4/24 to ascertain information in order to provide a quote for service. The vendor has confirmed that a quote will be provided no later than 10/21/24 so the service can be scheduled following that date. See attached email confirmation from vendor.
- It was noted that atypical volume of rainfall had occurred leading to the day of on-site visit. The challenge noted with opening the door was inspected daily following the on-site visit and there were no issues present at that time. A daily door inspection checklist will be developed to record verification of continued absence of issues with the exterior door in question. The checklist was developed on 9/12/24 by the Director of Facilities and is in place for monitoring until service request is complete. The daily inspection will be completed by the Director of Facilities, or designated alternate.
- On a monthly basis, all exterior doors will be inspection to verify operation and unobstructed egress by the Director of Facilities, or designated alternate. Inspections will be documented and records will be maintained by the Director of Facilities.
- Compliance and records monitoring will be completed by the Administrator on a monthly basis beginning December 2024

Proposed Overall Completion Date: 12/06/2024

[Directed]

In addition to the above plan of correction:

- Beginning no later than 11/15/24, all exterior doors will be inspection to verify operation and unobstructed egress by the Director of Facilities, or designated alternate, on a monthly basis. Inspections will be documented, and records will be maintained by the Director of Facilities.
- Beginning no later than 12/1/24, compliance and records monitoring will be completed by the Administrator on a monthly basis.

Directed Completion Date: 12/01/2024

**Not Implemented [redacted] - 02/06/2025)**

125a - Combustible Storage

**19. Requirements**

2600.

125a - Combustible Storage (continued)

125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 9/10/24, a cardboard box was stored near the third gas-powered hot water heater located in the home's mechanical room.

Plan of Correction

Directed (████) - 10/29/2024)

- Immediately, the Director of Facilities was provided with coaching on the observed item by the Administrator.
- Immediately, the cardboard box was removed and the mechanical room was inspected to verify the absence of any other flammable materials by the Director of Facilities.
- Education related to 2600.125a was provided to current vendors that have access to the mechanical room for service related needs on 10/1/24 by the Administrator.
- On an ongoing and continuous basis, a memo will be issued beginning 10.15.24 by the Director of Facilities to all vendors providing service in the home related to 2600.125a and other best practices for maintaining safety.
- On an ongoing and daily basis, the Director of Facilities will ensure there are no combustible or flammable materials near the hot water heaters in the mechanical room by completing a walkthrough upon arrival to shift.

Proposed Overall Completion Date: 11/01/2024

[Directed]

In addition to the above plan of correction:

- Beginning no later than 11/1/24, the Director of Facilities will ensure there are no combustible or flammable materials near the hot water heaters in the mechanical room by completing a daily walkthrough upon arrival to shift.

Directed Completion Date: 11/15/2024

Not Implemented (████) - 02/06/2025)

141b1 - Annual Medical Evaluation

20. Requirements

2600.

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

Description of Violation

Resident 1's most recent annual medical evaluation, dated █████/23, does not include immunization history.

Resident 5's most recent annual medical evaluation, dated █████/24, does not include immunization history.

Repeated Violation - 6/6/23, et al

Plan of Correction

Directed (████) 10/29/2024)

- Immediately, the Director of Health and Wellness was provided with counseling on the items observed by the Administrator.
- The Director of Health and Wellness contacted the evaluating physician for correction of the annual medical evaluations for Resident 1 and Resident 5 to include immunization history. The medical evaluation are corrected as of 10/15/24.

141b1 - Annual Medical Evaluation (continued)

- The Director of Health and Wellness will complete a full 100% audit of all current residents annual medical evaluation to verify that immunization history information is completed. The audit will be completed by 11/1/24. Any deficiencies as a result of the completed audit will be corrected with the evaluating physician within 30 days.
- The Director of Health and Wellness will provide education to the physicians completing the annual medical evaluation via faxed or emailed notification. This was completed on 10/15/24.
- On an ongoing, monthly basis beginning December 2024, the Director of Health and Wellness, or designated alternate will complete a 10% audit of resident's annual medical evaluations. The 10% will include, at minimum, the residents that have had annual medical evaluations completed within the last 30 days to ensure that all fields are completed appropriately and signed by the physician.

Proposed Overall Completion Date: 12/01/2024

[Directed]

In addition to the above plan of correction:

- Beginning no later than 12/1/24, the Director of Health and Wellness, or designated alternate, will complete a 10% audit of current resident annual medical evaluations. The 10% will include, at minimum, the residents that have had annual medical evaluations completed within the last 30 days to ensure that all fields are completed appropriately and signed by the physician. This will be complete on a monthly basis.

Directed Completion Date: 12/01/2024

Not Implemented [REDACTED] - 02/06/2025)

183d - Prescription Current

22. 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 9/11/24, Escitalopram 5mg prescribed for Resident 6 was observed in the home's medication cart; however, this medication was discontinued on 9/5/24

On 9/11/24, Cephalexin 500mg prescribed for Resident 7 was observed in the home's medication cart; however, this medication was discontinued on 9/4/24.

Plan of Correction

Directed [REDACTED] - 10/29/2024)

-Immediately, the Director of Health and Wellness was provided coaching on the observed items by the Administrator.

-Immediately, the discontinued medications were pulled from the medication cart by the LPN.

-The Director of Health and Wellness will complete a full cart audit of all resident medications. The full cart audit will verify inspection and correction, if applicable, of the following areas of compliance: 2600.183d, 2600.183e, 2600.184a, 2600.185a, 2600.187d. The complete 100% audit will be completed by 11/1/24.

-On an ongoing, monthly basis beginning December 2024 the Director of Health and Wellness will complete a 1 cart audit, to include a minimum of a 25% resident sample. This audit will be documented to include any items of

183d - Prescription Current (continued)

corrected and will verify compliance.

- The Director of Health and Wellness will maintain records demonstrating compliance beginning December 2024
- On an ongoing basis, the Administrator will monitor record completion and all audit results will be reviewed with regular QA meetings beginning January 2025

Proposed Overall Completion Date: 01/31/2025

[Directed]

In addition to the above plan of correction:

- Beginning no later than 11/15/24, the Director of Health and Wellness will complete 1 cart audit monthly, to include a minimum of a 25% resident sample. This audit will be documented to include any items of corrected and will verify compliance.
- Beginning no later than 12/1/24, the Director of Health and Wellness will maintain records demonstrating compliance.
- Beginning 1/1/25, the Administrator will monitor record completion, and all audit results will be reviewed with regular QA meetings.

Directed Completion Date: 12/01/2024

Not Implemented [redacted] - 02/06/2025)

183e - Storing Medications

23. 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

On 9/11/24, 5 loose pills were observed in two of the home's medication carts.

Plan of Correction

Directed [redacted] - 10/29/2024)

- Immediately, the Director of Health and Wellness was provided coaching on the observed items by the Administrator.
- Immediately, the loose pills were pulled from the medication cart by LPN.
- The Director of Health and Wellness will complete a full cart audit of all resident medications. The full cart audit will verify inspection and correction, if applicable, of the following areas of compliance: 2600.183d, 2600.183e, 2600.184a, 2600.185a, 2600.187d. The complete 100% audit will be completed by 11/1/24.
- On an ongoing, monthly basis beginning December 2024, the Director of Health and Wellness will complete a 1 cart audit, to include a minimum of a 25% resident sample. This audit will be documented to include any items of corrected and will verify compliance.
- The Director of Health and Wellness will maintain records demonstrating compliance beginning December 2024
- On an ongoing basis, the Administrator will monitor record completion and all audit results will be reviewed with regular QA meetings beginning January 2025.

Proposed Overall Completion Date: 01/31/2025

183e - Storing Medications (continued)

[Directed]

In addition to the above plan of correction:

- Beginning no later than 11/15/24, the Director of Health and Wellness will complete 1 cart audit monthly, to include a minimum of a 25% resident sample. This audit will be documented to include any items of corrected and will verify compliance.
- Beginning no later than 12/1/24, the Director of Health and Wellness will maintain records demonstrating compliance.
- Beginning 1/1/25, the Administrator will monitor record completion, and all audit results will be reviewed with regular QA meetings.

Directed Completion Date: 12/01/2024

Not Implemented [redacted] - 02/06/2025)

184a - Resident's Meds Labeled

24. Requirements

2600.

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

1. The resident's name.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

A tube of Poly Bacitracin antibiotic and a tube of Clobetasol Propionate cream did not include the following:

- The resident's name.
- The date the prescription was issued.
- The prescribed dosage and instructions for administration.
- The name and title of the prescriber.

Repeated Violation - 6/6/23, et al

Plan of Correction

Directed [redacted] - 10/29/2024)

-Immediately, the Director of Health and Wellness was provided coaching on the observed items by the Administrator.

-Immediately, the medication was labelled with the required items and replaced in the cart by LPN.

-The Director of Health and Wellness will complete a full cart audit of all resident medications. The full cart audit will verify inspection and correction, if applicable, of the following areas of compliance: 2600.183d, 2600.183e, 2600.184a, 2600.185a, 2600.187d. The complete 100% audit will be completed by 11/1/24.

-On an ongoing, monthly basis beginning December 2024 the Director of Health and Wellness will complete a 1 cart audit, to include a minimum of a 25% resident sample. This audit will be documented to include any items of corrected and will verify compliance.

-The Director of Health and Wellness will maintain records demonstrating compliance beginning December 2024

-On an ongoing basis, the Administrator will monitor record completion and all audit results will be reviewed with regular QA meetings beginning January 2025

184a - Resident's Meds Labeled (continued)

Proposed Overall Completion Date: 01/31/2025

[Directed]

In addition to the above plan of correction:

- Beginning no later than 11/15/24, the Director of Health and Wellness will complete 1 cart audit monthly, to include a minimum of a 25% resident sample. This audit will be documented to include any items of corrected and will verify compliance.
- Beginning no later than 12/1/24, the Director of Health and Wellness will maintain records demonstrating compliance.
- Beginning 1/1/25, the Administrator will monitor record completion, and all audit results will be reviewed with regular QA meetings.

Directed Completion Date: 12/01/2024

Not Implemented ( ) - 02/06/2025

185a - Implement Storage Procedures

25. 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 9/11/24, the following discrepancies were observed between Resident 1's blood sugar reading in the resident's glucometer and the blood sugar reading documented in the resident's medication administration record (MAR):

On 9/2/24 at noon, a blood sugar reading of 329 was documented in the resident's MAR. However, the reading was not found in the resident's glucometer.

On 9/3/24 in the am, a blood sugar reading of 220 was documented in the resident's MAR. However, the reading in the glucometer was 219.

On 9/3/24 at noon, a blood sugar reading of 250 was documented in the resident's MAR. However, the reading in the glucometer was 256.

On 9/11/24, the following discrepancies were observed between Resident 5's blood sugar reading in the resident's glucometer and the blood sugar reading documented in the resident's medication administration record (MAR):

On 9/6/24 in the am, a blood sugar reading of 186 was documented in the resident's MAR. However, the reading in the glucometer was 183.

On 9/6/24 at noon, a blood sugar reading of 157 was documented in the resident's MAR. However, the reading in the glucometer was 257.

On 9/7/24 in the am, a blood sugar reading of 300 was documented in the resident's MAR. However, the reading in the glucometer was 242.

Resident 1 is prescribed Cold & Flu tabs, Diabetic Tussin, Ibuprofen 600mg and Loperamide 2mg as needed.

On 9/11/24, these medications were not available in the home.

Repeated Violation - 7/25/23 and 6/6/23, et al

## 185a - Implement Storage Procedures (continued)

**Plan of Correction****Directed** [REDACTED] **10/29/2024)**

-Immediately, the Director of Health and Wellness was provided coaching on the observed items by Administrator

-Immediately, Resident 1's medications were discontinued by the physician on 9.11.24

-The Director of Health and Wellness completed an audit of glucometer readings compared to MAR documentation. The audit was completed on 10/11/24. A summary of the results is attached.

-The Director of Health and Wellness will complete supplemental training on glucose monitoring and insulin documentation. This training was provided to the medication technicians by the Director of Health and Wellness on 10/8/24.

-The Director of Health and Wellness, or Designated Alternate, will complete a monthly audit of all glucometer readings. This audit will be completed on a monthly basis beginning November 2024. See attached Blood Glucose Monitoring Sheet.

-The Director of Health and Wellness will complete a full cart audit of all resident medications. The full cart audit will verify inspection and correction, if applicable, of the following areas of compliance: 2600.183d, 2600.183e, 2600.184a, 2600.185a, 2600.187d. The complete 100% audit will be completed by 11/1/24.

-On an ongoing, monthly basis beginning December 2024 the Director of Health and Wellness will complete a 1 cart audit, to include a minimum of a 25% resident sample. This audit will be documented to include any items of corrected and will verify compliance.

-The Director of Health and Wellness will maintain records demonstrating compliance beginning December 2024

-On an ongoing basis, the Administrator will monitor record completion and all audit results will be reviewed with regular QA meetings beginning January 2025.

Proposed Overall Completion Date: 12/31/2024

[Directed]

In addition to the above plan of correction:

- Beginning no later than 11/1/24, the Director of Health and Wellness, or designated alternate, will complete a monthly audit of all glucometer readings.
- Beginning no later than 11/15/24, the Director of Health and Wellness will complete 1 cart audit monthly, to include a minimum of a 25% resident sample. This audit will be documented to include any items of corrected and will verify compliance.
- Beginning no later than 12/1/24, the Director of Health and Wellness will maintain records demonstrating compliance.
- Beginning 1/1/25, the Administrator will monitor record completion, and all audit results will be reviewed with regular QA meetings.

Directed Completion Date: 12/01/2024

**Not Implemented** [REDACTED] **- 02/06/2025)**

## 187d - Follow Prescriber's Orders

**26. Requirements**

2600.

187d - Follow Prescriber's Orders (continued)

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

**Description of Violation**

Resident 1 is prescribed Capsaicin cream 0.1% three times daily. However, this medication was not administered to Resident 1 on [redacted]/11/24 at 8 am because the medication was not available in the home.

Resident 5 is prescribed Metformin 500mg twice a day. However, Resident 5 did not receive this medication [redacted]/3/24 at 5 pm.

Resident 5 is prescribed insulin LISIP on a sliding scale of 1 unit for blood sugars 150-200, 2 units for 201-250, and 3 units for 251-300.

On 9/6/24, the resident's noon blood sugar reading was 257. However, the resident was administered 1 unit of insulin.

On 9/7/24, the resident's am blood sugar reading was 242. However, the resident was administered 3 units of insulin.

Resident 11 is prescribed Quetiapine 50mg daily. However, this medication was not administered to Resident 11 on 9/1/24 at 2 pm because the medication was not available in the home.

Repeated Violation - 11/1/23 and 6/6/23, et al

**Plan of Correction**

**Directed [redacted] - 10/29/2024)**

-Immediately, the Director of Health and Wellness was provided coaching on the observed items by the Administrator

-Immediately, Resident 1's medications were discontinued by the physician on 9.11.24

-The Director of Health and Wellness completed an audit of glucometer readings compared to MAR documentation. The audit was completed on 10/11/24. A summary of the results is attached.

-The Director of Health and Wellness will complete supplemental training on glucose monitoring and insulin documentation. This training was provided by the Director of Health and Wellness on 10/8/24.

-The Director of Health and Wellness, or Designated Alternate, will complete a monthly audit of all glucometer readings. This audit will be completed on a monthly basis beginning November 2024. See attached Blood Glucose Monitoring Sheet.

-The Director of Health and Wellness will complete a full cart audit of all resident medications. The full cart audit will verify inspection and correction, if applicable, of the following areas of compliance: 2600.183d, 2600.183e, 2600.184a, 2600.185a, 2600.187d. The complete 100% audit will be completed by 11/1/24.

-On an ongoing, monthly basis beginning December 2024 the Director of Health and Wellness will complete a 1 cart audit, to include a minimum of a 25% resident sample. This audit will be documented to include any items of corrected and will verify compliance.

-The Director of Health and Wellness will maintain records demonstrating compliance beginning December 2025.

-On an ongoing basis, the Administrator will monitor record completion and all audit results will be reviewed with regular QA meetings beginning January 2025.

Proposed Overall Completion Date: 01/31/2025

[Directed]

187d - Follow Prescriber's Orders (continued)

In addition to the above plan of correction:

- Beginning no later than 11/1/24, the Director of Health and Wellness, or designated alternate, will complete a monthly audit of all glucometer readings.
- Beginning no later than 11/15/24, the Director of Health and Wellness will complete 1 cart audit monthly, to include a minimum of a 25% resident sample. This audit will be documented to include any items of corrected and will verify compliance.
- Beginning no later than 12/1/24, the Director of Health and Wellness will maintain records demonstrating compliance.
- Beginning 1/1/25, the Administrator will monitor record completion, and all audit results will be reviewed with regular QA meetings.

Directed Completion Date: 12/01/2024

Not Implemented [REDACTED] - 02/06/2025)

225a - Assessment 15 Days

27. Requirements

2600.

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

Description of Violation

Resident 2's initial assessment, dated [REDACTED] 2/24, does not include supervision, mobility and medications.

Resident 4's initial assessment, dated [REDACTED] /24, does not include supervision and medications.

Repeated Violation - 6/6/23, et al

Plan of Correction

Directed ([REDACTED] - 10/29/2024)

-Immediately, the Director of Health and Wellness was provided with counseling on the items observed by the Administrator

-The Director of Health and Wellness reviewed and made corrections to Resident 2 and Resident 4's assessment The assessments are corrected as of 10/15/24.

-The Director of Health and Wellness will complete a full 100% audit of all current residents RASPS to verify that information is completed. The audit will be completed by 11/1/24. Any deficiencies as a result of the completed

225a - Assessment 15 Days (continued)

audit will be corrected with the Director of Health and Wellness within 30 days.

-The Director of Health and Wellness will provide education to Memory Care Director and Health Care Coordinator, who have responsibility to develop, maintain and ensure completion of the residents RASP, on the requirements of 2600.225a as well as the completion and accuracy requirements of the RASP. This was completed on 10/11/24.

-On an ongoing, monthly basis beginning November 2024 the Director of Health and Wellness, or designated alternate will complete a 10% audit of resident's assessments. The 10% will include, at minimum, the residents that have had assessments completed within the last 30 days to ensure that all fields are completed.

Proposed Overall Completion Date: 11/30/2024

[Directed]

In addition to the above plan of correction:

- Beginning no later than 11/1/24, the Director of Health and Wellness, or designated alternate, will complete a 10% audit of resident's assessments on a monthly basis. The 10% will include, at minimum, the residents that have had assessments completed within the last 30 days to ensure that all fields are completed.

Directed Completion Date: 11/30/2024

Not Implemented (████ - 02/06/2025)

231c - Preadmission Screening

28. Requirements

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident 4 was admitted to the secure dementia care unit (SDCU) on █████ 24. However, the Resident 4's written cognitive preadmission screening was not completed.

Repeated Violation - 6/6/23, et al

Plan of Correction

Directed (████ - 10/29/2024)

-Immediately, the Memory Care Director was provided coaching on the observed item by the Administrator

-Immediately, the prescreen for Resident 4 was corrected by the Memory Care Director.

-The Director of Health and Wellness will complete a 100% audit of all residents of the SDCU to verify that all cognitive preadmission screening were completed. This audit was completed on 10/11/24.

-On an ongoing basis, the Memory Care Director will ensure that all chart requirements are complete for internal transfers to the SDCU and new residents to community. The Memory Care Director will utilize a developed checklist to verify that all items are present beginning 10/15/24. The checklist will be complete prior to the physical arrival of any SDCU resident. The checklist will be maintained in the residents chart.

-The Director of Health and Wellness will complete a 100% audit of the SDCU resident charts on a quarterly basis

231c - Preadmission Screening (continued)

to ensure continued compliance beginning 1st quarter, January 2025

Proposed Overall Completion Date: 01/31/2025

[Directed]

In addition to the above plan of correction:

- Beginning no later than 11/1/24, the Director of Health and Wellness will complete a 100% audit of the SDCU resident charts on a quarterly basis to ensure continued compliance

Directed Completion Date: 12/01/2024

Not Implemented [redacted] - 02/06/2025)

233c - Key-Locking Devices

29. Requirements

2600.

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

Description of Violation

On 9/10/24, during the initial walkthrough, the directions for operating the home's locking mechanism were not conspicuously posted near the door of the main entrance into the secure dementia care unit (SDCU).

Repeated Violation - 6/6/23, et al

Plan of Correction

Directed [redacted] - 10/29/2024)

- Immediately the Memory Care Director was provided coaching on the observed item by the Administrator
- Immediately, the instructions for the main entrance gate of the SDCU were replaced and positioned in a conspicuous location near the device by the Memory Care Director
- The Memory Care Director will include the verification of the instructions/code compliance with 2600.233c in a safety checklist. This was completed on 10/11/24.
- The Memory Care Safety checklist will be completed on a weekly basis by the Memory Care Director, or designated alternate, beginning 11/1/24
- Any deficiencies with the safety checklist will immediately be reported to the Administrator.
- The Administrator will complete compliance and record monitoring on an ongoing basis beginning November 2024

Proposed Overall Completion Date: 11/30/2024

[Directed]

In addition to the above plan of correction:

- Beginning no later than 11/1/24, the Administrator will complete compliance and record monitoring.

Directed Completion Date: 11/30/2024

233c - Key-Locking Devices (*continued*)

*Not Implemented* [REDACTED] - 02/06/2025)

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

**Facility Information**

Name: SEATON SPRINGWOOD License #: 33503 License Expiration: 02/12/2025  
Address: 2321 FREEDOM WAY, YORK, PA 17402  
County: YORK Region: CENTRAL

**Administrator**

Name: [REDACTED]

**Legal Entity**

Name: HAVEN AT SPRINGWOOD OPCO LLC  
Address: 2321 FREEDOM WAY, YORK, PA, 17402  
[REDACTED]

**Certificate(s) of Occupancy**

Type: C-2 LP Date: 01/01/2004 Issued By: Labor & Industry

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 131 Waking Staff: 98

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #: 0  
Reason: Complaint, Interim Exit Conference Date: 12/10/2024

**Inspection Dates and Department Representative**

12/10/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: 123 Residents Served: 109

**Secured Dementia Care Unit**

In Home: Yes Area: Memory care Capacity: 13 Residents Served: 12

**Hospice**

Current Residents: 3

**Number of Residents Who:**

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 109  
Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 1  
Have Mobility Need: 22 Have Physical Disability: 1

**Inspections / Reviews**

**12/10/2024 - Partial**

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 12/30/2024

Inspections / Reviews (*continued*)

12/31/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/04/2025

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 02/03/2025

03/31/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/04/2025

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department’s personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted]/24, at approximately 11:00PM, Resident 1 experienced an unwitnessed fall and was transported to the emergency room. The resident sustained a fractured hip as a result from the fall. The home did not report this incident to the Department until 10/29/24.

On [redacted] 24, at approximately 11:18AM, Resident 2 [redacted] to breath. The home did not report this incident to the Department until 12/4/24.

Repeated Violation - 11/1/23 and 6/6/23, et al

Plan of Correction

Accept [redacted] - 12/31/2024)

- Immediately, the reporter was counseled on reporting requirements by the Administrator.
- The internal reporting process will be updated to include a rotation of identified leaders for weekend and holidays to be responsible for submitting incident reports in accordance with the guidelines in 2600.15. The process will be updated and effective 1/1/2025.
- Training with the medication technicians and care managers on incident reporting requirements, reviewing details of 2600.16c, and the updated community internal notification process will be provided by the Director of Health & Wellness no later than 1/15/2025
- Training with managers on incident reporting requirements, reviewing details of 2600.16c, and the updated community internal notification process will be provided by the Administrator no later than 1/15/2025
- Beginning 1/1/2025, continued education will be provided on a quarterly basis by the Director of Health and Wellness, or another designated alternate that is PCHA licensed, to the medication technicians and care managers
- Daily, Administrator, or designated alternate, will review reportable incidents and verify that Department require reporting is submitted. This daily review will begin effective 1/1/2025.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: 01/31/2025

Not Implemented [redacted] - 02/06/2025)

51 - Criminal Background Check

2. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff Member A was hired on [redacted]/24. Staff Member A has lived in PA for less than [redacted]. An FBI background check was not completed for Staff Member A.

51 - Criminal Background Check (continued)

Plan of Correction

Accept (█ - 12/31/2024)

-Immediately, the business office manager was provided with counseling on regulatory requirements for new hire background checks including new hires who have not been a resident of Pennsylvania for a minimum of █ years by the Administrator.

-The business office manager and Administrator will revise the new hire process. The new hire process was amended to include state background checks to be completed at the time of contingent offer of employment is provided and prior to start date of employment. Additionally, any new hires that have out of state residence or have not resided in the state of Pennsylvania for at least █ years will be required to produce evidence of FBI background check results or initiation of the FBI background check. The business office manager has attested that this practice will be implemented effective 1/1/2025.

-The business office manager will conduct an initial audit of all employee background checks to verify compliance. The audit will be completed by no later than 1/31/25.

-The business office manager will conduct a monthly audit for 3 months of all new hires to ensure compliance with 2600.51 beginning 2/1/25.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: 01/31/2025

Not Implemented (█ - 02/06/2025)

81b - Resident Personal Equipment

3. 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

[Redacted description of violation]

Resident 9 utilizes a bed side mobility device to aid in positioning and transferring in and out of bed. However, on 12/10/24, the mobility device was not securely fastened to the bedframe, posing an entrapment risk.

Plan of Correction

Accept (█ - 12/31/2024)

-Immediately, the Director of Health & Wellness was provided counseling on 2600.81b by the Administrator.

-The LPN will complete full audit of all bedside mobility devices within the community by no later than 1/15/25.

-The Director of Health & Wellness, with support from the Director of Facilities and consultation from Occupational Therapist will correct any deficiencies found as a result of the bedside mobility device audit and provided signed verification of the corrections by no later than 1/31/25.

- The Director of Health & Wellness will complete an inspection of all bedside mobility devices on a weekly basis for 4 weeks beginning 1/31/25, then on a monthly basis beginning 3/1/25.

-The inspections will be monitored by the Administrator and included with QA review beginning no later than 2/28/25.

Proposed Overall Completion Date: 02/01/2025

81b - Resident Personal Equipment (continued)

Licensee's Proposed Overall Completion Date: 02/01/2025

Not Implemented [redacted] - 02/06/2025)

183d - Prescription Current

5. 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 12/10/24, Sertraline 25mg prescribed for Resident 3 was observed in the home's medication cart; however, this medication was discontinued according to staff.

On 12/10/24, Diphenhydramine 25mg prescribed for Resident 4 was observed in the home's medication cart; however, this medication is not listed in the resident's medication administration record (MAR) or the medical evaluation form (DME).

Plan of Correction

Accept [redacted] - 12/31/2024)

-Immediately, the Director of Health and Wellness was provided coaching on the observed items by the Administrator.

-Immediately, the discontinued medications were pulled from the medication cart by the LPN.

-The Director of Health and Wellness will complete a full cart audit of all resident medications. The full cart audit will verify inspection and correction, if applicable, of the following areas of compliance: 2600.183d, 2600.183e, 2600.184a, 2600.185a, 2600.187d. The complete 100% audit will be completed by 1/31/2025

-On a monthly basis, for 3 months, beginning no later than 2/28/2025, the Director of Health and Wellness will complete a 100% cart audit, to include all current residents. This audit will be documented to include any items of corrected and will verify compliance.

-On a monthly basis, for 3 months, beginning no later than 5/31/2025, the Director of Health and Wellness will complete a 50% cart audit, to include 50% of all current residents. This audit will be documented to include any items of corrected and will verify compliance.

-On an ongoing monthly basis, beginning no later than 8/31/2025, the Director of Health and Wellness will complete a 25% cart audit, to include 25% of all current residents. This audit will be documented to include any items of corrected and will verify compliance.

-The Director of Health and Wellness will maintain records demonstrating compliance beginning no later than 1/31/2025

-On an ongoing basis, the Administrator will monitor record completion and all audit results will be reviewed with regular QA meetings beginning no later than 1/31/2025.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: 01/31/2025

Not Implemented [redacted] - 02/06/2025)

183e - Storing Medications

6. Requirements

2600.

183e - Storing Medications (continued)

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

On 12/10/24, 2 loose pills were observed in two of the home's medication carts.

Plan of Correction

Accept (redacted) - 12/31/2024)

-Immediately, the Director of Health and Wellness was provided coaching on the observed items by the Administrator.

-Immediately, the loose pills were pulled from the medication cart by the LPN.

-The Director of Health and Wellness will complete a full cart audit of all resident medications. The full cart audit will verify inspection and correction, if applicable, of the following areas of compliance: 2600.183d, 2600.183e, 2600.184a, 2600.185a, 2600.187d. The complete 100% audit will be completed by 1/31/2025

-On a monthly basis, for 3 months, beginning no later than 2/28/2025, the Director of Health and Wellness will complete a 100% cart audit, to include all current residents. This audit will be documented to include any items of corrected and will verify compliance.

-On a monthly basis, for 3 months, beginning no later than 5/31/2025, the Director of Health and Wellness will complete a 50% cart audit, to include 50% of all current residents. This audit will be documented to include any items of corrected and will verify compliance.

-On an ongoing monthly basis, beginning no later than 8/31/2025, the Director of Health and Wellness will complete a 25% cart audit, to include 25% of all current residents. This audit will be documented to include any items of corrected and will verify compliance.

-The Director of Health and Wellness will maintain records demonstrating compliance beginning no later than 1/31/2025

-On an ongoing basis, the Administrator will monitor record completion and all audit results will be reviewed with regular QA meetings beginning no later than 1/31/2025.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: 01/31/2025

Not Implemented (redacted) - 02/06/2025)

184a - Resident's Meds Labeled

7. 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

Resident 5 was prescribed 8 units of Lantus Solos 100/ml in the morning; however, the prescription was change to 12 units in the morning on 12/2/24. The pharmacy label on the medication does not reflect this change.

Repeated Violation - 6/6/23, et al

Plan of Correction

Accept (redacted) - 12/31/2024)

-Immediately, the Director of Health and Wellness was provided coaching on the observed items by the Administrator.

184a - Resident's Meds Labeled (continued)

- Immediately, the pharmacy label change was requested by the LPN.
- The Director of Health and Wellness will complete a full cart audit of all resident medications. The full cart audit will verify inspection and correction, if applicable, of the following areas of compliance: 2600.183d, 2600.183e, 2600.184a, 2600.185a, 2600.187d. The complete 100% audit will be completed by 1/31/2025
- On a monthly basis, for 3 months, beginning no later than 2/28/2025, the Director of Health and Wellness will complete a 100% cart audit, to include all current residents. This audit will be documented to include any items of corrected and will verify compliance.
- On a monthly basis, for 3 months, beginning no later than 5/31/2025, the Director of Health and Wellness will complete a 50% cart audit, to include 50% of all current residents. This audit will be documented to include any items of corrected and will verify compliance.
- On an ongoing monthly basis, beginning no later than 8/31/2025, the Director of Health and Wellness will complete a 25% cart audit, to include 25% of all current residents. This audit will be documented to include any items of corrected and will verify compliance.
- The Director of Health and Wellness will maintain records demonstrating compliance beginning no later than 1/31/2025
- On an ongoing basis, the Administrator will monitor record completion and all audit results will be reviewed with regular QA meetings beginning no later than 1/31/2025.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: 01/31/2025

Not Implemented ( ) - 02/06/2025

185a - Implement Storage Procedures

8. 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 12/10/24, the following discrepancies were observed between Resident 5's blood sugar readings in the resident's glucometer and the blood sugar readings documented in the resident's medication administration record (MAR):

- On 12/3/24, at 12:00PM, the resident's MAR had a documented blood sugar reading of 176. However, this reading was not in the resident's glucometer.
- On 12/4/24, at 12:00PM, the resident's MAR had a documented blood sugar reading of 121. However, the reading in the resident's glucometer was 126.
- On 12/8/24, in the morning, the resident's MAR had a documented blood sugar reading of 226. However, this reading was not in the resident's glucometer.
- On 12/8/24, at 12:00PM, the resident's MAR had a documented blood sugar reading of 190. However, this reading was not in the resident's glucometer.

Resident 6 is prescribed Acidophilus 100mg as needed and Ventolin HFA inhaler as needed. On 12/10/24, these medications were not available in the home.

Repeated Violation - 7/25/23 and 6/6/23, et al

185a - Implement Storage Procedures (continued)

Plan of Correction

Accept [redacted] - 12/31/2024)

-Immediately, the Director of Health and Wellness was provided coaching on the observed items by the Administrator.

-Immediately, the medication technician with the observed glucometer/MAR documentation errors was removed from medication administration responsibilities.

-Immediately, the identified medications not available were requested from the pharmacy by the LPN.

-The Director of Health and Wellness will complete a full cart audit of all resident medications. The full cart audit will verify inspection and correction, if applicable, of the following areas of compliance: 2600.183d, 2600.183e, 2600.184a, 2600.185a, 2600.187d. The complete 100% audit will be completed by 1/31/2025

-On a monthly basis, for 3 months, beginning no later than 2/28/2025, the Director of Health and Wellness will complete a 100% cart audit, to include all current residents. This audit will be documented to include any items of corrected and will verify compliance.

-On a monthly basis, for 3 months, beginning no later than 5/31/2025, the Director of Health and Wellness will complete a 50% cart audit, to include 50% of all current residents. This audit will be documented to include any items of corrected and will verify compliance.

-On an ongoing monthly basis, beginning no later than 8/31/2025, the Director of Health and Wellness will complete a 25% cart audit, to include 25% of all current residents. This audit will be documented to include any items of corrected and will verify compliance.

-The Director of Health and Wellness will maintain records demonstrating compliance beginning no later than 1/31/2025

-On an ongoing basis, the Administrator will monitor record completion and all audit results will be reviewed with regular QA meetings beginning no later than 1/31/2025.

-The Director of Health and Wellness will complete an initial audit of glucometer readings compared to MAR documentation by no later than 1/15/2025.

-A diabetes and insulin certification training will be scheduled with a trainer certified as a diabetes care education specialist for all medication administering staff to participate in. The training was requested by the Administrator on 12/26/2025 to be scheduled with trainer's soonest availability.

-The Director of Health and Wellness, or Designated Alternate, will complete a weekly audit of all glucometer readings. This audit will be completed on a weekly basis beginning 1/20/2025 for a period of 8 weeks.

-The Director of Health and Wellness, or Designated Alternate, will complete a monthly audit of all glucometer readings on an ongoing basis. This audit will be completed on a monthly basis beginning 3/17/2025.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: 01/31/2025

Not Implemented [redacted] - 02/06/2025)

187d - Follow Prescriber's Orders

9. Requirements

2600.

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

## 187d - Follow Prescriber's Orders (continued)

**Description of Violation**

*Resident 6 is prescribed Duloxetine 60mg daily. However, this medication was not administered to the resident on 12/4/24 through 12/10/24 because the medication was not available in the home.*

*Resident 3 is prescribed Losartan 50mg twice daily and to hold if systolic pressure is < 110 or heart rate is < 60. On 12/4/24, during the evening shift, the resident's heart rate was 49. However, the medication was administered to the resident. On 12/7/24, in the morning, the resident's heart rate was 54. However, the medication was administered to the resident. On 12/7/24, in the evening, the resident's heart rate was 56. However, the medication was administered to the resident.*

*Repeated Violation - 11/1/23 and 6/6/23, et al*

**Plan of Correction**

Accept [REDACTED] - 12/31/2024)

*-Immediately, the Director of Health and Wellness was provided coaching on the observed items by the Administrator.*

*-Immediately, the medication technician with the observed medication administration errors was removed from medication administration responsibilities.*

*-Immediately, the identified medications not available were requested from the pharmacy by the LPN.*

*-The Director of Health and Wellness will complete a full cart audit of all resident medications. The full cart audit will verify inspection and correction, if applicable, of the following areas of compliance: 2600.183d, 2600.183e, 2600.184a, 2600.185a, 2600.187d. The complete 100% audit will be completed by 1/31/2025*

*-On a monthly basis, for 3 months, beginning no later than 2/28/2025, the Director of Health and Wellness will complete a 100% cart audit, to include all current residents. This audit will be documented to include any items of corrected and will verify compliance.*

*-On a monthly basis, for 3 months, beginning no later than 5/31/2025, the Director of Health and Wellness will complete a 50% cart audit, to include 50% of all current residents. This audit will be documented to include any items of corrected and will verify compliance.*

*-On an ongoing monthly basis, beginning no later than 8/31/2025, the Director of Health and Wellness will complete a 25% cart audit, to include 25% of all current residents. This audit will be documented to include any items of corrected and will verify compliance.*

*-The Director of Health and Wellness will maintain records demonstrating compliance beginning no later than 1/31/2025*

*-On an ongoing basis, the Administrator will monitor record completion and all audit results will be reviewed with regular QA meetings beginning no later than 1/31/2025.*

*-An audit tool for monitoring the administration of medications with identified prescriber ranges will be implemented by the Director of Health and Wellness no later than 1/15/2025.*

*-Medications with identified administration ranges will be reviewed using the audit tool on a weekly basis by the Director of Health and Wellness, or alternate designee, beginning 1/20/2025 for a period of 8 weeks, then monthly beginning on 3/17/2025.*

**Licensee's Proposed Overall Completion Date: 01/31/2025**

Not Implemented [REDACTED] - 02/06/2025)

187d - Follow Prescriber's Orders (continued)

225a - Assessment 15 Days

10. Requirements

2600.

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

Description of Violation

Resident 7's initial assessment, dated [redacted]/24, does not include mobility.

Repeated Violation - 6/6/23, et al

Plan of Correction

Accept [redacted] - 12/31/2024)

-Immediately, the Director of Health and Wellness was provided with counseling on the items observed by the Administrator

-The Director of Health and Wellness reviewed and made corrections to Resident 7's assessment. The assessments are corrected as of 12/11/24.

-The Director of Health and Wellness will complete a full 100% audit of all current residents RASPS to verify that information is completed. The audit will be completed by 1/15/25. Any deficiencies as a result of the completed audit will be corrected with the Director of Health and Wellness within 30 days.

-On an ongoing, monthly basis beginning 2/1/2025 the Director of Health and Wellness, or designated alternate will complete a 100% audit of resident's assessments for a period of 3 months.

-On an ongoing, monthly basis beginning 5/1/2025 the Director of Health and Wellness, or designated alternate will complete a 50% audit of resident's assessments for a period of 3 months. The 50% will include, at minimum, the residents that have had assessments completed within the last 30 days to ensure that all fields are completed.

-On an ongoing, monthly basis beginning 8/1/2025 the Director of Health and Wellness, or designated alternate will complete a 25% audit of resident's assessments for a period of 3 months. The 25% will include, at minimum, the residents that have had assessments completed within the last 30 days to ensure that all fields are completed.

-On an ongoing, monthly basis beginning 11/1/2025 the Director of Health and Wellness, or designated alternate will complete a 10% audit of resident's assessments for a period of 3 months. The 10% will include, at minimum, the residents that have had assessments completed within the last 30 days to ensure that all fields are completed.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: 01/31/2025

Not Implemented ([redacted] - 02/06/2025)