Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY PUBLIC

February 28, 2025

VS WOODS LLC
INTEGRACARE CORPORATION

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

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/20/2024, 12/05/2024 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 Twnship*

Type: *C-2 LP* **Date**: *02/19/1997* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *93* **Waking Staff**: *70*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *12/05/2024*

Inspection Dates and Department Representative

11/20/2024 - On-Site: [redacted]

12/05/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* **Residents Served**: *70*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *LifeStories* **Capacity**: *19* **Residents Served**: *17*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *69*

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

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

Inspections / Reviews

11/20/2024 Partial

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

Inspections / Reviews *(continued)*

01/10/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/17/2025*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *01/16/2025*

01/17/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/17/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/17/2025*

02/28/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/17/2025*

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

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted], at approximately 9AM, Staff Member B received a telephone call from Resident [redacted] family member, recounting alleged abuse from Staff Member A to Resident [redacted] on [redacted] Staff Member B relayed this information to Staff Member C via email the same day. However, this allegation of abuse was never reported to AAA.

Plan of Correction ***Directed [redacted] - 01/17/2025)***

ACTION: Staff Member A was immediately suspended on [redacted], when allegation of abuse of Resident [redacted] was reported to the Executive Operations Officer. Staff Member A was terminated on 10/29/24, after the facility completed its internal investigation and determined that the action was to dismiss Staff Member A from [redacted] position with the facility.
Staff Member B relayed this information to Staff Member C at approximately 4pm on 10/25/24. Staff Member C instructed Staff Member B to file the report to AAA for Resident [redacted] as Staff Member C was in the midst of filing another report to AAA concerning the actions of Staff Member A towards a different resident. Staff Member B stated that [redacted] would make the report and complete all other abuse report procedures. It was discovered on 11/20/24 that there was no written evidence that Staff Member B ever filed the allegation of abuse as required. Staff Member B was under disciplinary action with the facility and was on a 3-day suspension during the department's visit on 11/20/24, due to failure to comply with state regulations and facility expectations. As a result of progressive discipline and continued failure to comply with state regulations and facility expectation, Staff Member B's employment with the facility was terminated on 12/11/2024 by Staff Member C. On 1/15/25, the incident involving Resident #11 was submitted to the department (see attached). On 1/16/25, the incident involving Resident [redacted] was submitted to the department (see attached).

TRAINING: On 11/20/24 and 11/21/24, as part of a mandatory all-staff meeting, the Executive Operations Officer reviewed the requirements for reporting resident abuse with all staff. (See attached)

ONGOING: As of 11/21/24, The Executive Operations Officer has taken complete responsibility for reporting suspected resident abuse. Upon the hiring of a new Resident Wellness Director, Executive Operations Officer will provide full training regarding alleged resident abuse, to include the facility's expectations and procedures for reporting. Beginning 12/12/24, the EOO and/or Director of Memory Care review missed medications from the previous day, as well as caregiver/nurse's notes from the previous day. Any Department reportable incidents are then completed by either the EOO or Director of MC, and sent to the department, within the 24-hour timeframe required. In the absence of the Executive Operations Officer, the Manager on Duty or the Director of Memory Care (or other member of Management) is responsible for submitting all required incident reports with a 24-hour time-frame. All incident report documentation will be kept on file at the facility

(Directed)
In addition to the above plan of correction:

15a - Resident Abuse Report (continued)

- *On 1/15/25, the incident involving Resident [redacted] was submitted to the AAA. On [redacted] the incident involving Resident [redacted] was submitted to AAA.*
- *Beginning 12/12/24, the EOO and/or Director of Memory Care will review missed medications from the previous day, as well as caregiver/nurse's notes from the previous day. Any Department reportable incidents are then completed by either the EOO or Director of MC, and sent to AAA, within the 48-hour timeframe required. In the absence of the Executive Operations Officer, the Manager on Duty or the Director of Memory Care (or other member of Management) is responsible for submitting all required incident reports with a 48-hour time-frame. All incident report documentation will be kept on file at the facility.*

Directed Completion Date: *01/17/2025*

Implemented [redacted] 02/28/2025)

16c - Written Incident Report

2. 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] Resident [redacted] fell in the home, hitting their head in the process, and was unable to move on the ground. The resident was sent to the hospital and was diagnosed with a broken clavicle. The home did not report this incident to the Department.

On [redacted], at approximately 9AM, Staff Member B received a telephone call from Resident [redacted]s family member, recounting alleged abuse from Staff Member A to Resident [redacted] on [redacted]. Staff Member B relayed this information to Staff Member C via email the same day. However, this allegation of abuse was never reported to the Department.

A medication technician was aware Resident [redacted] was not administered their Qvar inhaler at 8PM on [redacted] due to the medication not being available in the home. The resident continued to miss subsequent doses of [redacted], twice daily from [redacted] The home did not report the medication errors to the Department until [redacted].

Resident [redacted] was not administered their [redacted] as prescribed on [redacted] and subsequent omissions for a few days after due to the medication not being available in the home. These medication errors were not reported to the Department until [redacted].

On [redacted] at approximately 4PM, Staff Member G witnessed Staff Member H laughing at Resident [redacted] who was crying in the wellness office. The witness reported that Staff Member H "got in the resident's face" and said, "go ahead" (in reference to the resident shaking [redacted] fist at alleged [redacted] This incident was not reported to Department until [redacted].

16c Written Incident Report *(continued)*

Plan of Correction ***Accept [redacted] - 01/17/2025)***

ACTION: All of the above incidents were never reported to Staff Member B from Staff Member C. Staff Member C was fully responsible for reporting all of the above mentioned incidents but failed to do so, either in a timely manner or Staff Member B completely failed to report the incident to the department. As a result of progressive discipline and continued failure to comply with state regulations and facility expectation, Staff Member B's employment with the facility was terminated on [redacted] by Staff Member C. On [redacted], the incident involving Resident [redacted] was submitted to the department (see attached). On 1/16/25, the incident involving Resident [redacted] was submitted to the department (see attached).

TRAINING: Executive Operations Officer provided training to all Med Techs and both LPN Supervisors (who are responsible for documenting resident concerns/incidents/medication errors) between [redacted] and [redacted] (See Attached). Documentation of training will be kept on file at the facility.

ONGOING: As of 12/6/24, Executive Operations Officer took responsibility of reporting all incidents to the department as required by regulation 16c. Beginning 12/12/24, the EOO and/or Director of Memory Care review missed medications from the previous day, as well as caregiver/nurse's notes from the previous day. Any Department reportable incidents are then completed by either the EOO or Director of MC, and sent to the department, within the 24 hour timeframe required. In the absence of the Executive Operations Officer, the Manager on Duty or the Director of Memory Care (or other member of Management) is responsible for submitting all required incident reports with a 24 hour time frame. All incident report documentation will be kept on file at the facility

Licensee's Proposed Overall Completion Date: *01/17/2025*

Implemented [redacted] - 02/28/2025)

17 - Record Confidentiality

3. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On [redacted], at 9:29AM, Resident [redacted]s record information to include medication orders, medical appointments, assessment and care plans, etc. were unlocked, unattended, and accessible on the computer on the medication cart in the secure unit.

On [redacted], at 4PM, all residents' records (approximately 51 residents) were unlocked, unattended, and accessible in the 2nd floor wellness office. The door was unlocked, and no staff were present in the office.

17 Record Confidentiality *(continued)*

Plan of Correction ***Accept 01/17/2025)***

ACTION: On 11/20/24, the Executive Operations Officer immediately closed the computer on the med cart and addressed the concern in the moment with the Med Tech on duty. On 12/17/24, a new lock was professionally installed on the door to the Wellness Office by Duty's Lock and Key. This lock requires a code to access the room, and automatically locks when the door is shut. See attached description and picture of lock.
TRAINING: Between 12/23/24 and 1/3/25 , all Med Techs were provided with education on regulation 17 (see attached). All relevant staff were provided with the code to the Wellness Office door by the Executive Operations Officer via the facilities secure messaging system on 12/18/24. See attached.
ONGOING: Safety and Maintenance Director will monitor battery life on the lock and will change batteries as needed. See attached information regarding battery replacement of this lock. The door will alert staff when the battery is getting low so that replacement can occur immediately. Beginning on 11/21/24, the Executive Operations Officer and Director of MC check placement of computers on each med cart upon walking past them in the community. Staff will be immediately reprimanded if resident confidentiality is being violated.

Licensee's Proposed Overall Completion Date: *01/17/2025*

Implemented - 02/28/2025)

42b - Abuse

4. Requirements

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

Description of Violation

Approximately 2 months ago, Staff Member I was witnessed by Staff Member D screaming and cursing at Resident making the resident scared and causing the resident to cry.

From during the 11PM 8AM shift, Staff Member A refused to clean Resident change their bedding, and assist Resident into clean adult briefs and clothing for approximately 8 hours, after requests for assistance from the resident who was reporting being wet, soaked in urine and needing help. The resident requires assistance with incontinence care. On , Resident reported Staff Member A was rude, mean, refused to help and the resident was crying when recalling the neglect to staff the next day. Staff Member A was also reported to have yelled at Resident and called the resident "filthy". Additionally, on , Staff Member B received a telephone call from Resident s family member, recounting alleged abuse from Staff Member A to Resident on . Per staff interviews, Resident reported Staff Member A is mean to Resident and the resident felt safe when Staff Member A wasn't at the home. Staff Member A was terminated on

On , at approximately 4PM, Staff Member G witnessed Staff Member H laughing at Resident who was crying in the wellness office. The witness reported that Staff Member H "got in the resident's face" and said, "go ahead" (in reference to the resident shaking fist at alleged perpetrator).

Plan of Correction ***Directed - 01/10/2025)***

ACTION: After it was reported by Staff Member I that Staff Member D was "screaming" (there was no report of cursing) at Resident the Executive Operations Officer immediately interviewed Resident who adamantly

42b - Abuse (continued)

denied that Staff Member D was acting inappropriately (yelling) towards [redacted] in any way. Resident [redacted] stated that [redacted] did not feel unsafe around or threatened by Staff Member D at any time. Resident [redacted] is cognitively aware, and historically and consistently makes [redacted] needs and concerns known to the Executive Operations Officer. It should be mentioned that Staff Member I and Staff Member D did not have a positive working relationship and were rarely placed on the same floor to work together, due to this fact. Staff Member D was terminated on 11/21/24 for reasons unrelated to this violation. Staff Member B relayed this information to Staff Member C at approximately 4pm on 10/25/24. Staff Member C instructed Staff Member B to file the report to AAA for Resident [redacted] as Staff Member C was in the midst of filing another report to AAA concerning the actions of Staff Member A towards a different resident. Staff Member B stated that [redacted] would make the report and complete all other abuse report procedures. It was discovered on 11/20/24 that there was no written evidence that Staff Member B ever filed the allegation of abuse as required. Staff Member B was under disciplinary action with the facility and was on a 3-day suspension during the department's visit on 11/20/24, due to failure to comply with state regulations and facility expectations. As a result of progressive discipline and continued failure to comply with state regulations and facility expectation, Staff Member B's employment with the facility was terminated on 12/11/2024 by Staff Member C. Staff Member A was terminated on 10/29/24, after an internal investigation. Staff Member H was terminated on 12/6/24 after an internal investigation.

TRAINING: On 11/20/24 and 11/21/24, as part of a mandatory all-staff meeting, the Executive Operations Officer reviewed the definition of abuse, and the requirements for reporting resident abuse with all staff. See Attached.

ONGOING: Beginning on 1/1/25, Executive Operations Officer will review the definition of abuse, as well as the requirements for reporting it, with all staff on a quarterly basis (at mandatory all staff meetings). In addition, the Executive Operations Officer reviews abuse and abuse reporting with all new staff members during new hire orientation. A general overview of abuse and abuse reporting is also completed for every newly hired staff via video on Day 1 of new hire orientation. SEE ATTACHED Documentation of trainings is kept on file at the community.

Directed Completion Date: *01/10/2025*

Implemented ([redacted] - 02/28/2025)

54a - Direct Care Staff

5. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

On [redacted], Staff Member B recognized a strong odor of marijuana in the wellness office and reported this to Staff Member C.

On [redacted] at 10:43AM, 3:10PM, and 4PM, an odor of marijuana was detected in the wellness office. The Department was unable to determine who was responsible for the odor however, the presence indicates staff are using illegal drugs on that shift.

54a - Direct Care Staff (continued)

On [redacted] at 3:49PM, an odor of marijuana was detected in the wellness office. Staff Member B reports smelling an odor of marijuana in the wellness office today. Per staff interviews, multiple staff have reported smelling marijuana on staff working in the home, or in the wellness office. The Department was unable to determine who was responsible for the odor however, the presence indicates staff are using illegal drugs on that shift.

Plan of Correction ***Directed ([redacted] 01/17/2025)***

ACTION: On 10/22/24, Staff Member C instructed Staff Member B to identify where/who the smell was coming from and Staff Member B was unable to do so. Staff Member C went into the Wellness Office on 3 separate occasions on 10/22/24 after this was reported, and did not smell marijuana at any time. On 11/20/24, the Executive Operations Officer was also present numerous times throughout the day in the Wellness office and at no time was the odor of marijuana detected. The Executive Operations Officer was not present in the facility on 12/5/24, nor did Staff Member B ever report to the EOO that [redacted] had smelled the odor of marijuana. On 12/11/24, Staff Member B was terminated from [redacted] position with the facility, due to failure to comply with state regulations and facility expectations.
TRAINING: All employees of the facility are aware of the Drug and Alcohol policy, which is reviewed with them during orientation. On 12/6/24, the Executive Operations Officer reviewed the policy with the Leadership team. See attached
ONGOING: Executive Operations Officer and entire Leadership team will continue to follow the Drug and Alcohol policy set forth by the facility. On 2/26/25, during the next scheduled mandatory all-staff quarterly meeting, the Executive Operations Officer will re-review the facility's Drug and Alcohol Policy and Procedures. Documentation of the training will be kept.

(Directed)
In addition to the above plan of corrections, all staff will receive re-education on the home's Drug and Alcohol policy no later than 2/15/2025.

Directed Completion Date: *02/15/2025*

Implemented [redacted] - 02/28/2025)

65d - Initial Direct Care Training

6. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care Staff Member A, hired on [redacted], began providing unsupervised ADL services by [redacted]. However, Staff Member A did not complete and pass the Department-approved direct care training course and pass the competency test until [redacted]

Plan of Correction ***Accept ([redacted] - 01/10/2025)***

ACTION: As part of a previous plan of correction (deemed implemented on 7/24/24) in June, 2024, the Executive Operations Officer and Business Office Manager conducted a full audit of all employee files, to ensure that those who required the Direct care training course had completed it. During that audit, it was discovered that Staff Member A had not completed competency test upon hire and instructed the Staff Member to complete the training. This was completed by Staff Member A on 7/26/24.

65d - Initial Direct Care Training (continued)

TRAINING: As part of a prior plan of correction, the Business Officer Manager and Executive Operations Officer do not allow any newly hired direct care staff persons to provide unsupervised ADL services prior to completing and passing the Direct Care competency test.
ONGOING: As of 6/17/24, the Executive Operations Officer verifies that each newly hired employee has completed the Direct Care staff training as applicable and maintains a spreadsheet of all staff. All new employee records are reviewed by the Executive Operations Officer within 7 days of hire to ensure compliance with regulation 65d. Documentation of employee files/training will be kept.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented [redacted] - 02/28/2025)

141a 1-10 Medical Evaluation Information

7. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident [redacted] initial [redacted] medical evaluation did not include medical information pertinent to diagnosis and treatment in case of an emergency.

Plan of Correction ***Accept [redacted] - 01/17/2025)***

ACTION: On 12/11/24, the Resident Wellness Director was terminated from [redacted] position with the facility, due to failure to comply with state regulations and facility expectations, such as discussed under regulation 141a above. Resident [redacted] was re-admitted to the facility on 12/13/24, after a brief hospital stay due to a Urinary Tract Infection. Resident returned to the facility with a change of condition and was admitted to both the SDCU at the facility, and Grane Hospice. (see attached updated DME, dated 12/12/2024)

TRAINING: Upon hire of a new Resident Wellness Director, the Executive Operations Officer will educate that employee on Regulation 225c. In the interim, the Executive Operations Officer will continue to review all completed medical evaluations to ensure completion prior to filing in every resident chart.

141a 1-10 Medical Evaluation Information (continued)

ONGOING: As of 6/17/24, the Executive Operations Officer reviews all resident's completed medical evaluations to ensure that they are complete as per regulation 225c prior to filing in the resident chart. Documentation is kept on file at the facility. The Executive Operations Officer will complete a full audit of every Resident's DME to ensure proper completion on/before 2/15/25.

Licensee's Proposed Overall Completion Date: *02/15/2025*

Implemented [redacted] 02/28/2025)

183b - Meds and Syringes Locked

8. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On [redacted], at 1:05PM, a bottle of [redacted] was unlocked, unattended, and accessible in Resident [redacted]s bedroom. Resident [redacted] is not assessed to self-administer medications.

Repeated Violation - [redacted]

Plan of Correction ***Accept [redacted] - 01/10/2025)***

ACTION: On [redacted] the bottle of [redacted] in Resident [redacted]s apartment was immediately removed by the Resident Wellness Director. The eye drops were returned to the Resident's POA on 12/7/24.
TRAINING: Executive Operations Officer provided 1:1 training regarding regulation 183.b to all Med Techs between 12/23/24 and 1/3/25 (See Attached). An additional mandatory Med Tech training is scheduled for 1/9/25 at 2pm. This training will be conducted by a representative from Polaris pharmacy (the facility's contracted pharmacy) and the Wellness and Operations Specialist for the facility. Family and residents were notified of regulation 183b via family email sent by the Executive Operations Officer on 1/3/25. See attached
ONGOING: Beginning on 1/6/25, Executive Operations Officer or Designee will spot check 10 resident rooms per week for the presence of unlocked/unauthorized prescription medications, OTC medications, CAM and syringes.

Licensee's Proposed Overall Completion Date: *01/09/2025*

Implemented [redacted] - 02/28/2025)

183d - Prescription Current

9. 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 [redacted] the following medications were available in the 3rd floor medication cart for Resident [redacted], however they

183d Prescription Current (continued)

are no longer prescribed including: , and .

On , for Resident #25 were stored in the 3rd floor medication cart, with a medication label that read to stop on

On , at approximately 10AM, (and) were in a box on a medication cart in the wellness room belonging to Resident who is no longer a resident at the home.

On , at approximately 10AM, the following medications for Resident were stored in the bottom drawer of the medication cart in the wellness room and Resident does not have current orders for the medications: and .

Plan of Correction ***Accept (- 01/10/2025)***

ACTION: On and , all medications referred to above were removed from the medication carts by the Resident Wellness Director, Unit Clerk, and LPN Supervisor. The medications found for Residents # , and were destroyed as per facility policy on 12/5/24 and 12/6/24 by the Resident Wellness Director and Unit Clerk. In addition, on 12/11/24, the Resident Wellness Director was terminated from position with the facility, due to failure to comply with state regulations and facility expectations. Between the dates of 12/9/24 and 12/11/24, each med cart and Resident MAR in the facility was audited, either by the Executive Operations Officer, Wellness and Operations Specialist, Area General Manager and/or Memory Care Director, to ensure that there were no expired medications, no medications that belonged to discharged residents and no medications lacking current orders in any of the facility med carts. All medications found to be in any of these categories was destroyed by the Unit Clerk and LPN Supervisor as per facility policy. SEE ATTACHED
TRAINING: Executive Operations Officer provided 1:1 training regarding regulation 183.d to all Med Techs between 12/23/24 and 1/3/25 (See Attached). An additional mandatory Med Tech training is scheduled for 1/9/25 at 2pm. This training will be conducted by a representative from Polaris pharmacy (the facility's contracted pharmacy) and the Wellness and Operations Specialist for the facility.
ONGOING: Beginning on 1/6/25, weekly med cart audits will be put into effect by the Executive Operations Officer. These audits will be completed by the Executive Operations Officer, Memory Care Director, Unit Clerk, Area General Manager, LPN Supervisor or Wellness and Operations Specialist. Documentation will be kept on file at the facility. See Attached

Licensee's Proposed Overall Completion Date: *01/09/2025*

Implemented (- 02/28/2025)

183e - Storing Medications

10. 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 in the narcotic lock box within the 3rd floor medication cart, a bottle of Resident containing 8 pills, was present. However, the bottle had a piece of tape on the bottle with the words, "expired" written on it and the medication label reads, expires: .

On a bottle of prescribed to Resident with orders to take by mouth every 6 hours as needed for agitation was located in the 3rd floor medication cart. The label reads, expires .

On , for Resident was in the second-floor medication cart. The manufacturer's instructions on the medication indicates the medication expired in November 2024.

On , an orange oblong capsule was loose in a drawer in the second-floor medication cart.

On , in the unlocked cabinet above the sink in the wellness office, there are 2 blister cards for Resident that are expired including:

- *with an expiration date of*
- *with an expiration date of*

On in the pink bin in the unlocked cabinets above the sink in the wellness office, the following medication for Resident was found to be expired including:

- *tablets that expired .*
- *that expired .*

Resident is prescribed , inhale 1 puff by mouth once daily. This medication is labeled to discard after 6 weeks. On , the medication located in the medication cart is not dated so it cannot be determined when the medication was opened.

On at approximately 10AM, for Resident was in the bottom drawer of the medication cart in the wellness room. The pharmacy-issued medication label read to discard after .

On at approximately 10AM, the wellness room contained medication cabinets that are overflow of current medications for residents. There was a pink tub of medications in the overflow cabinets labeled with room number . However, as of the resident residing in room number was not the same resident as the medications discovered in this pink tub.

Repeated Violation - et al.,

183e - Storing Medications *(continued)*

Plan of Correction ***Accept (- 01/10/2025)***

ACTION: On 12/5/24 and 12/6/24, all medications referred to above were removed from the medication carts by the Resident Wellness Director, Unit Clerk, and LPN Supervisor and were destroyed as per facility policy on 12/5/24 and 12/6/24 by the Resident Wellness Director and Unit Clerk. In addition, on 12/11/24, the Resident Wellness Director was terminated from position with the facility, due to failure to comply with state regulations and facility expectations. Between the dates of 12/9/24 and 12/11/24, each med cart and Resident MAR in the facility was audited, either by the Executive Operations Officer, Wellness and Operations Specialist, Area General Manager and/or Memory Care Director, to ensure that there were no expired medications in any of the facility med carts. All medications found to expired were destroyed by the Unit Clerk and LPN Supervisor as per facility policy.

TRAINING: Executive Operations Officer provided 1:1 training regarding regulation 183.e to all Med Techs between 12/23/24 and 1/3/25 (See Attached). An additional mandatory Med Tech training is scheduled for 1/9/25 at 2pm. This training will be conducted by a representative from Polaris pharmacy (the facility's contracted pharmacy) and the Wellness and Operations Specialist for the facility.

Beginning on 1/6/25, weekly med cart audits will be put into effect by the Executive Operations Officer. These audits will be completed by the Executive Operations Officer, Memory Care Director, Unit Clerk, Area General Manager, LPN Supervisor or Wellness and Operations Specialist. Documentation will be kept on file at the facility. See Attached

Licensee's Proposed Overall Completion Date: *01/09/2025*

Implemented - 02/28/2025)

184a - Resident's Meds Labeled

11. 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

On , was in the top drawer of the second-floor medication cart, but did not contain a medication label that included the resident's name, the date the prescription was issued, the prescribed dosage and instructions for administration, or the name and title of the prescriber.

On , at 10AM, an unlabeled , approximately 1/3rd full, was found in a medication cart in the wellness room. Per staff interview, the home did not know who the insulin vial belonged to or how long it was stored in this room.

Repeated Violation - , et al.

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

Plan of Correction ***Accept - 01/10/2025)***

ACTION: On the unlabeled and were removed from the medication carts by the Resident Wellness Director and were destroyed as per facility policy on 12/5/24 by the Resident Wellness Director and Unit Clerk. In addition, on 12/11/24, the Resident Wellness Director was terminated from position with the facility, due to failure to comply with state regulations and facility expectations. Between the dates of 12/9/24 and 12/13/24, each med cart and Resident MAR in the facility was audited, either by the Executive Operations Officer, Wellness and Operations Specialist, Area General Manager and/or Memory Care Director, to ensure that all medications were properly labeled.
TRAINING: Executive Operations Officer provided 1:1 training regarding regulation 184a to all Med Techs between 12/23/24 and 1/ 3/25 (See Attached). An additional mandatory Med Tech training is scheduled for 1/9/25 at 2pm. This training will be conducted by a representative from Polaris pharmacy (the facility's contracted pharmacy) and the Wellness and Operations Specialist for the facility.

Beginning on 1/6/25, weekly med cart audits will be put into effect by the Executive Operations Officer. These audits will be completed by the Executive Operations Officer, Memory Care Director, Unit Clerk, Area General Manager, LPN Supervisor or Wellness and Operations Specialist. Documentation will be kept on file at the facility. See Attached

Licensee's Proposed Overall Completion Date: *01/09/2025*

Implemented - 02/28/2025)

184b - Labeling OTC/CAM

12. Requirements

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

Description of Violation

On Resident s over-the-counter was not labeled with the resident's name.

On , in a pink bin in the unlocked cabinets above the sink in the wellness office, there was an unlabeled bottle of tablets.

On in a plastic bag above Staff Member F's desk, the following reportedly resident's medications were unlabeled:

- *Spring Valley Brand supplement- .*
- *Spring Valley Brand supplement- .*

Resident is prescribed and the over-the-counter bottle in the 3rd floor medication cart did not include the resident's name.

On in an open, unsealed Ziplock baggie stored in the unlocked cabinets above the sink in the wellness office, there is a bottle of unlabeled .

184b - Labeling OTC/CAM *(continued)*

Plan of Correction ***Accept - 01/10/2025)***

ACTION: On 12/5/24, Resident s Zeassorb-af powder was labeled by the Resident Wellness Director. On 12/5/24, all other unlabeled medications referred to above were removed from the medication carts by the Resident Wellness Director, Unit Clerk, and LPN Supervisor and were destroyed as per facility policy on 12/5/24 by the Resident Wellness Director and Unit Clerk. In addition, on 12/11/24, the Resident Wellness Director was terminated from position with the facility, due to failure to comply with state regulations and facility expectations. Between the dates of 12/9/24 and 12/11/24, each med cart and Resident MAR in the facility was audited, either by the Executive Operations Officer, Wellness and Operations Specialist, Area General Manager and/or Memory Care Director, to ensure that all medications were properly labeled.
TRAINING: Executive Operations Officer provided 1:1 training regarding regulation 184b to all Med Techs between 12/23/24 and 1/3/25 (See Attached). An additional mandatory Med Tech training is scheduled for 1/9/25 at 2pm. This training will be conducted by a representative from Polaris pharmacy (the facility's contracted pharmacy) and the Wellness and Operations Specialist for the facility.

Beginning on 1/6/25, weekly med cart audits will be put into effect by the Executive Operations Officer. These audits will be completed by the Executive Operations Officer, Memory Care Director, Unit Clerk, Area General Manager, LPN Supervisor or Wellness and Operations Specialist. Documentation will be kept on file at the facility. See Attached

Licensee's Proposed Overall Completion Date: *01/09/2025*

Implemented 02/28/2025)

185a - Implement Storage Procedures

13. 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 is prescribed blood sugar monitoring and record blood sugar before meals at bedtime, for their diagnosis of diabetes mellitus. Resident level recorded on their medication administration record (mar) at 8:30PM, is but the blood sugar level stored in the resident's meter is .

Resident is prescribed hydrocortisone cream, apply twice daily to rash as needed. On , the medication is not available at the home.

Resident is prescribed take one tablet by mouth every morning as needed. On , this medication prescription was not present in the home.

On , at approximately 10AM, an unlabeled, clear bag filled with approximately 13 different sized injection needles (25G, 23G, etc.) was in the medication cart in the wellness room. Per staff interview, they do not know which resident(s) they belong to, or how long they have been in this medication cart.

On , at approximately 10AM, a grocery bag of the following medications was stored above Staff Member F's desk in the wellness room, and per staff interview the home was unsure if the medications were current orders:

- *For Resident 3 full blister cards of*

185a - Implement Storage Procedures (continued)

and Weis Rx bottle [redacted] tablets.

- *For Resident [redacted] Sam's club bottle of [redacted].*
- *Two unlabeled bottles of Spring Valley Brand supplements including: [redacted] and [redacted] and [redacted]*

Plan of Correction ***Accept ([redacted] 01/17/2025)***

ACTION: On 12/5/24, the clear unlabeled bag and grocery bag were removed from the medication cart and wellness room and destroyed by the Resident Wellness Director and Unit Clerk. The medications for Resident [redacted] and Resident [redacted] were confirmed to be current orders by the Resident Wellness Director on 12/6/24 and were placed in the medication cart. For Resident [redacted], the [redacted] level recorded on the MAR is [redacted], which matches the resident's meter (see attached). The prn Hydrocortisone cream for resident [redacted] had not been administered since 9/18/24, and the medications are provided by the family, so it is unknown where the cream was on 12/5/24. On 1/16/25, the Executive Operations Officer reached out to Resident #9's PCP via fax to request an updated order. The prn Alprazolam .25mg for Resident 11 was delivered by the pharmacy on 12/3/24 and was locked in the overflow medication cabinet in the Unit Clerk's office, so the medication was available in the home on 12/5/24 (see attached) but was not administered on 12/5/24 because it was not needed. The unlabeled bottles were destroyed by the Unit Clerk and Resident Wellness Director on 12/25/24. In addition, on 12/11/24, the Resident Wellness Director was terminated from [redacted] position with the facility, due to failure to comply with state regulations and facility expectations.
TRAINING: Executive Operations Officer provided 1:1 training regarding regulation 185a to all Med Techs between 12/23/24 and 1/3/25 (See Attached). An additional mandatory Med Tech training is scheduled for 1/9/25 at 2pm. This training will be conducted by a representative from Polaris pharmacy (the facility's contracted pharmacy) and the Wellness and Operations Specialist for the facility.
ONGOING: Beginning on 12/9/24, the Executive Operations Officer will audit the Wellness Office to ensure that no unlocked medications are present. Documentation will be kept if any medications are found and if destruction is warranted as per facility policy.

Licensee's Proposed Overall Completion Date: *01/17/2025*

Implemented [redacted] - 02/28/2025)

187a - Medication Record

14. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident [redacted] is prescribed [redacted] 5MG, give one tablet by mouth once daily and [redacted], take one tablet by mouth once daily. However, Resident [redacted]s December 2024 medication administration record (mar) does not

187a - Medication Record (continued)

include the diagnosis or purpose for administration of these medications.

Resident is prescribed , inhale 1 puff by mouth twice daily. However, Resident s December 2024 mar does not include the diagnosis or purpose for administration for this medication.

Resident is prescribed , take once daily in the morning. However, Resident November and December 2024 mars do not include the diagnosis or purpose for administration for this medication.

Repeated Violation - et al.

Plan of Correction ***Accept - 01/10/2025)***

ACTION: On 12/10/24, Executive Operations Officer printed off each resident's medication orders and reviewed them one-by-one. Any missing diagnoses were noted, and the resident's PCP was notified and a diagnosis was requested as needed.
TRAINING: Executive Operations Officer provided 1:1 training regarding regulation 187a to all Med Techs between 12/23/24 and 1/3/25 (See Attached). An additional mandatory Med Tech training is scheduled for 1/9/25 at 2pm. This training will be conducted by a representative from Polaris pharmacy (the facility's contracted pharmacy) and the Wellness and Operations Specialist for the facility.
ONGOING: Once confirmed diagnoses from each physician is received, the MAR will be updated by the Executive Operations Officer or the pharmacy to reflect the correct diagnoses. Beginning on 1/6/25, the Executive Operations Officer or Designee will audit all resident MARs once per week to confirm that diagnoses are present for each medication.

Licensee's Proposed Overall Completion Date: *01/09/2025*

Implemented (- 02/28/2025)

187d - Follow Prescriber's Orders

15. Requirements

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

Description of Violation

Resident is prescribed , take 1 container by mouth once daily for nutrition. The home did not offer or administer the nutritional supplement to Resident in December 2024 and only lists the order on the resident's medication administration record (mar) as, PRN, or as needed.

On , Resident was prescribed , inhale 1 puff by mouth twice daily. However, at the time of the inspection, this medication had not been administered to resident since then because the medication was not available in the home.

Resident was administered tablets on for their of . However, the home reports not having a physician's order for the administration of glucose to Resident at that time.

187d Follow Prescriber's Orders (continued)

Since , Resident is prescribed , take once daily in the morning. However, Resident was administered sertraline at 8PM on November and November through December

Resident medication label reads, take 1 and a half tablets by mouth every night at 8pm. Resident was administered at 8AM in November and December 2024.

Resident is prescribed 1 drop in each eye every evening. However, Resident was administered at 8AM from .

From February 2024 until November 2024, the home failed to administer the following medications to the following residents due to the medications not being available in the home:

- *Resident wasn't administered at 8PM from , and 8AM from .*
- *Resident #8 wasn't administered at 8AM on*
- *Resident wasn't administered at 8AM on*
- *Resident wasn't administered at 9AM and 1PM on and at night on*
- *Resident wasn't administered on and*
- *Resident wasn't administered at 8AM on*
- *Resident wasn't administered at 8PM on*
- *Resident wasn't administered their as prescribed on and subsequent omissions for a few days after, at least until the home caught the error on .*

Repeated Violation

Plan of Correction ***Accept - 01/10/2025)***

ACTION: Between the dates of 12/9/24 and 12/11/24, each med cart and Resident MAR in the facility was audited, either by the Executive Operations Officer, Wellness and Operations Specialist, Area General Manager and/or Memory Care Director, to ensure that all prescribed medications were in the facility. As of 10/14/24, the facility's agreement with Polaris pharmacy continues to be that if a medication is unable to be delivered by them, it will be filled and delivered by a local pharmacy (as per the previous POC submitted for department visit on 10/3/24). The for Resident was not delivered to the facility as prescribed due to high cost of co pay, which was not approved by Resident POA. Resident wasn't administered Qvar inhaler 80mcg at 8PM from 11/15 17/24 because the pharmacy had not received an updated prescription from the Resident's physician. (SEE ATTACHED INCIDENT REPORTS)

TRAINING: Executive Operations Officer provided 1:1 training regarding regulation 187d to all Med Techs between 12/23/24 and 1/3/25 (See Attached). An additional mandatory Med Tech training is scheduled for 1/9/25 at 2pm. This training will be conducted by a representative from Polaris pharmacy (the facility's contracted pharmacy) and the Wellness and Operations Specialist for the facility.
ONGOING: Beginning on 1/6/25, weekly med cart audits will be put into effect by the Executive Operations Officer. These audits will be completed by the Executive Operations Officer, Memory Care Director, Unit Clerk, Area General Manager, LPN Supervisor or Wellness and Operations Specialist. Documentation will be kept on file at the facility. See Attached

187d Follow Prescriber's Orders (continued)

Licensee's Proposed Overall Completion Date: *01/10/2025*

Implemented - 02/28/2025)

225c - Additional Assessment

16. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident date of admission , has had increased and almost daily confusion and episodes of crying, frequent recurring falls, added medication for psychiatric diagnoses, and suffered a broken clavicle in the home all changing the level of support needed from staff in every area. However, Resident resident assessment and support plan (rasp) was never updated to include a new assessment of the resident's needs and a support plan to assist the resident. Examples include:

- *The resident's medical evaluation documents the resident is prescribed as a psychotropic, on they were prescribed for anxiety with subsequent increased dosages since then, is prescribed sertraline for depression. Their 2/28/24 rasp does not include a psychiatric diagnosis or a plan to support the resident in this area.*
- *Since staff have documented numerous times, the resident is frequently crying, very hard to redirect, crying all day, having so much anxiety, crying daily, confused and unable to redirect, found wandering the hallway at night, refusing care, and may not be able to report pain. However, their 2/28/24 rasp reads, the resident is independent with anxiety, does not resist care, and has no problems with wandering, judgment, irritability, and communication of needs. Additionally, the rasp does not include the resident's daily crying and confusion or a plan to support them in these areas.*
- *The resident's rasp reads they are independent with toileting, transferring, ambulating, turning and positioning in bed and does not include support plans. However, the resident is diagnosed with frequent falls, fell on 8/29/24 and suffered a broken clavicle which required in increase in staff physical assistance needed as the resident could no longer complete tasks independently. Per staff interview, Resident #11 requires physical assistance from staff to assist with bathing, dressing, and ambulating with their walker. Additionally, Resident #11 is diagnosed with ambulatory dysfunction and as of 9/6/24 was to do activity with assistance only. This change in the resident's need and a support plan was never updated on their rasp.*

Plan of Correction ***Accept - 01/17/2025)***

ACTION: On 12/11/24, the Resident Wellness Director was terminated from position with the facility, due to failure to comply with state regulations and facility expectations, such as discussed under regulation 225c above. Resident #11 was re admitted to the facility on 12/13/24, after a brief hospital stay due to a Urinary Tract Infection. Resident returned to the facility with a change of condition and was admitted to both the SDCU at the facility, and Grane Hospice. (see attached updated DME and RASP (completed by Director of Memory Care on 12/15/24)
TRAINING: Upon hire of a new Resident Wellness Director, the Executive Operations Officer will educate that employee on Regulation 225c. In the interim, the Executive Operations Officer will continue to review all completed medical evaluations to ensure completion prior to filing in every resident chart.

225c - Additional Assessment (continued)

ONGOING: As of 6/17/24, the Executive Operations Officer reviews all resident's completed medical evaluations to ensure that they are complete as per regulation 225c prior to filing in the resident chart. Documentation is kept on file at the facility. The Executive Operations Officer and Director of Memory Care will audit the content of all Resident RASP's by 2/15/25. Beginning on 12/13/24, the Leadership team discusses and reviews all Resident caregiver/nursing notes from the previous day, in order to monitor changes in resident status. Beginning on 12/13/24, the Executive Operations Officer and Director of Memory Care have been completing all RASP's when a change of condition/needs/supports occurs. Upon hiring of a new Resident Wellness Director, EOO and Director of MC will continue to monitor when a Status Change RASP is needed, and this will be completed by the RWD, and reviewed by the EOO/Director of MC prior to reviewing with the Resident and Family for accuracy.

Licensee's Proposed Overall Completion Date: *02/15/2025*

Implemented ██ - 02/28/2025)

233c - Key-Locking Devices

17. 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 ████ and ████ the directions for operating the home's locking mechanism for the door to the Secure Dementia Care Unit (SDCU) were indecipherable and visitors could not exit the SDCU without requesting assistance from staff in the home.

Repeated Violation - ████ et al.

Plan of Correction ***Accept (██ - 01/10/2025)***

ACTION: Despite the fact that the department previously accepted the exact posting of the SDCU code directions present on 12/5/2024 on the prior Plan of Correction (accepted on 7/24/24), the Executive Operations Officer updated the posting on 12/6/2024. A picture of the updated SDCU door code is attached.
TRAINING: N/A
ONGOING: The current code directions will continue to be posted near all key locking devices in the SDCU. The code will be changed by the Safety and Maintenance Director as required, and any updated codes will be posted by the key locking devices by the Executive Operations Officer.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented ██ - 02/28/2025)