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

June 23, 2025

[redacted] AUTHORIZED PERSON
BH GLEN MILLS MANAGEMENT PA LLC
[redacted]

RE: MERRILL GARDENS AT GLEN MILLS
52 BALTIMORE PIKE
GLEN MILLS, PA, 19342
LICENSE/COC#: 14670

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/25/2025, 02/26/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MERRILL GARDENS AT GLEN MILLS* **License #**: *14670* **License Expiration**: *10/16/2025*

Address: *52 BALTIMORE PIKE, GLEN MILLS, PA 19342*

County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

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

[redacted]

Name: *BH GLEN MILLS MANAGEMENT PA LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *11/20/2019* **Issued By**: *chester heights borough*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *119* **Waking Staff**: *89*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/26/2025*

Inspection Dates and Department Representative

02/25/2025 - On-Site: [redacted]

02/26/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *120* **Residents Served**: *71*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Garden House* **Capacity**: *20* **Residents Served**: *16*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *71*

Diagnosed with Mental Illness: *18* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *48* **Have Physical Disability**: *31*

Inspections / Reviews

02/25/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/07/2025*

04/16/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/30/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/21/2025*

Inspections / Reviews *(continued)*

04/22/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/30/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/31/2025*

06/23/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/30/2025*

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

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 2/9/2025, Resident 1 was not administered their Eye Multivitamin Tab Sodium at 5:00 pm. The medication was not available in the home. The home did not report this incident to the Department.

Plan of Correction ***Accept (- 04/10/2025)***

This was identified during Day 2 of survey, 2.26.25. Reportable incident completed and submitted to the Department on 2.26.25 upon being identified. This was an isolated incident, as we have a weekly Pharmacy cycle fill.
New Health Services Director is in process of completing an in-service with all Med Techs to review protocol to follow if a medication is not available at the time of administration.
In-services to be completed by HSD by 4.12.25.
Med cart audits will be conducted weekly by HSD and GHD (Memory Care Director) to ensure all meds are available for the next 3 months, starting 4.14.25 through 7.14.25.
General Manager will review weekly med cart audits for 3 months, 4.14.25 through 7.14.25. Regional Director of Health Services will conduct random med car audits,, two/month, to ensure compliance for 3 months, 4.14.25 through 7.14.25

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented (- 06/23/2025)

25b - Contract Signatures

2. 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 , for resident 2 was not signed by the resident.

Plan of Correction ***Accept (- 04/16/2025)***

This was identified during an audit that was conducted for a POC completed in notes were present on the contract.
We respectfully request that this violation be reconsidered.
A re-audit of all resident contracts will be conducted to ensure all contracts have been signed and/or 2 attempts have been made to obtain required signatures. To be completed by GM/designee by 5.31.25.
Contracts for new admissions will be reviewed weekly by BOD/designee upon completion for 3 months starting 4.14.25 through 7.14.25.
GM will review audit weekly for accuracy for the next 3 months, 4.14.25 through 7.15.25.
Regional Director of Health Services will conduct monthly random audit to ensure compliance for 3 months, 4.14.25 to 7.14.25.

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented (- 06/23/2025)

41e - Signed Statement

3. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident 2's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept (- 04/16/2025)***

This was identified during an audit that was conducted for a POC completed in notes were present on the contract.
We respectfully request that this violation be reconsidered.

A re-audit of all resident contracts will be conducted to ensure all contracts have been signed and/or 2 attempts have been made to obtain required signatures. To be completed by GM/designee by 5.31.25.
Contracts for new admissions will be reviewed weekly by BOD/designee upon completion for 3 months starting 4.14.25 through 7.14.25.
GM will review audit weekly for accuracy for 3 months, 4.14.25 through 7.14.25.
Regional Director of Health Services will conduct monthly random audit to ensure compliance for 3 months, 4.14.25 to 7.14.25.

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented (- 06/23/2025)

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).

Description of Violation

Staff person A hired with a start date of did not have a criminal background check completed until

Staff person B did not have a criminal background check completed.

Plan of Correction ***Accept (- 04/16/2025)***

Staff person A – We respectfully request this violation be reconsidered as it was noted in Staff person A's HR file that the criminal background check had not been completed until for a prior POC in . (see attached document)
All employee files have the attached New Employee file checklist, and it is being used.
Staff person B was a – was not the regular scheduled aide – Staff person B will not be returning to the community.

Licensee's Proposed Overall Completion Date: *05/31/2025*

51 - Criminal Background Check *(continued)*

Implemented ([redacted] - 06/23/2025)

63a - First Aid/CPR Training

5. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 2/17/2025, from 7:00 am to 3:00 pm, 71 residents were present in the home. During this time 0 staff persons were present in the home who were certified in CPR/first aid.

Plan of Correction ***Accept ([redacted] - 04/16/2025)***

2-17 no CPR on 7-3 shift
The Personal Care schedules did not reflect the Nurses that are on duty for the day. We respectfully request this violation be reconsidered as there were two LPN' s on dayshift for 2-17-25 [redacted], LPN– PT Nurse, [redacted] LPN, Wellness Nurse as well as [redacted] Maintenance Director, [redacted], Receptionist all present for day shift. (Time sheets and certifications attached.)
Nurses will be added to daily schedule starting 4-8-25
GM will review schedules weekly to ensure adequate # of CPR certified staff x 3 months starting 4-8-25 through 7-8-25
Regional Director of Health Services to conduct random audits 2/month x 3 months to verify compliance.
4-8-25 through 7-8-25.

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented ([redacted] - 06/23/2025)

65f - Training Topics

7. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person C did not receive training in medication self-administration training, care for residents with mental illness or an intellectual disability, or both, if the population is served in the home, safe management techniques , instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2024.

65f - Training Topics (continued)

Direct care staff person D did not receive training in medication self-administration training, care for residents with mental illness or an intellectual disability, or both, if the population is served in the home, safe management techniques , instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2024.

Plan of Correction ***Accept ([redacted] - 04/10/2025)***

Staff Person C – will complete required training by 4.18.25
Staff Person D – was a transfer in November 2024 from another Merrill Gardens community, without any interruption in employment. All 2024 required trainings were completed. See attached.
Staff Person D has completed all [redacted] 2024 training.
Department Directors will be responsible to review monthly trainings for each of their direct reports and must provide proof of completed trainings to GM for review monthly for the next 3 months through 7.14.25.
Regional Director of Health Services will conduct monthly audits on random departments for the next 3 months, starting 4.14.25 through 7.14.25.

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented ([redacted] - 06/23/2025)

65g - Annual Training Content

8. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, if applicable during training year 2024 to 2025.

Staff person E did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, new population groups that are being served at the home that were not previously served, if applicable during training year 2024 to 2025.

65g - Annual Training Content *(continued)*

Plan of Correction ***Accept (- 04/22/2025)***

Staff Person E-will complete their annual DHS mandatory trainings by 4/30/25.
Department Directors will be responsible to review monthly trainings for each of their direct reports and must provide proof of completed trainings to GM for review monthly for the next 3 months through 7.14.25.
Regional Director of Health Services will conduct monthly audits on random departments for the next 3 months, starting 4.14.25 through 7.14.25.

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented (- 06/23/2025)

81b - Resident Personal Equipment

9. 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

On 2/26/2025, resident 3 had a bedside mobility device that was not secured to the bed frame. The device slid under the mattress.

Plan of Correction ***Accept (- 04/11/2025)***

This was an isolated incident. Bedside Mobility device was removed. Physical Therapist on site was contacted immediately and mobility device was reattached securely per DHS regulations.
HSD/GHD will conduct weekly audits of all bedside mobility devices for the next 3 months beginning 4/11/25 through 7/11/25.
GM will review audits monthly x3 months until 7/11/25.
Regional Director of Health Services will conduct random audits, 2x's month for 3 months to ensure compliance, from April through July 11, 2025.

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented (- 06/23/2025)

85a - Sanitary Conditions

10. Requirements

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

Description of Violation

On 2/26/2025, there was an unlabeled washcloth in the shared bathroom in room 214.

Plan of Correction ***Accept (- 04/11/2025)***

Washcloth in shared MC room immediately removed.
This was an isolated incident as there is only one shared room in Memory Care and the towel bars are labeled with each resident's name.
Garden House Director/designee will check room daily to ensure washcloths and towels are on the designated

85a - Sanitary Conditions (continued)

towel bars x 3 months 4-7-25 through 7-7-25.
GM will conduct random audit weekly to ensure compliance x 3 months. 4-7–25 to 7-7-25
Regional Director of Health Services to conduct random audits 2/month x 3 months. To ensure compliance. 4-7-25 through 7-7-25

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented (- 06/23/2025)

101j7 - Lighting/Operable Lamp

11. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident 4 does not have access to a source of light that can be turned on/off at bedside.

Resident 5 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept (- 04/11/2025)***

LIght bulbs were immediately replaced in both lamps by Maintenance Director.
Weekly housekeeping room cleaning checklist will be updated to include ensuring light next to bed is in working order by 4-14-25.
GSD will review weekly housekeeping checklists weekly x 3 months starting 4-18-25 through 7-18-25.
General Manager reviewed regulation 101j7 at the all staff meeting on March 18th and will continue to review at the all staff meetings x 3 months. 3-18-25 through 6-30-25. General Manager will review weekly housekeeping audits monthly for 3 months, 4.14.25 through 7.14.25.
Regional Director of Health Services will conduct random audits 2/month x 3 ,months to verify compliance. starting 4-14-25 through 7-14-25

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented (- 06/23/2025)

103f - Refrigerator/Freezer Temps

12. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There was no thermometer in the Activity kitchen refrigerator.

Plan of Correction ***Accept (- 04/11/2025)***

Thermometer was immediately placed in the Activity kitchen refrigerator.
Weekly checks to be conducted by Executive Chef/Designee to ensure thermometers are in all refrigerators and freezers beginning 4/8/25 and audit template will be completed and continued through 7/8/25.
GM will conduct random weekly audit for the next 3 months, 4/8/25 through 7/8/25.

103f - Refrigerator/Freezer Temps (continued)

Random audit to be conducted by Regional Director of Health Services 2/month x 3 months- 4/8/25 through 7/8/25.

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented ([redacted] - 06/23/2025)

103g - Storing Food

13. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

There was a cut lemon in the refrigerator opened and unsealed.

Plan of Correction ***Accept ([redacted] - 04/11/2025)***

The cut lemon was immediately removed from the refrigerator.
Executive Chef provided training to the team regarding 103.g, 103.f, 103.1 on 3.3.2025.
Audits to be conducted weekly by Executive Chef/Designee to ensure all food is sealed and dated for the next 3 months, beginning 4.8.25 through 7.8.25.
Audits will be reviewed by GM monthly x 3 months. 4/8/25 through 7/8/25.
Regional Director of Health Services will conduct random audits 2/month x 3 ,months to verify compliance. starting 4-14-25 through 7-14-25.

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented ([redacted] - 06/23/2025)

103i - Outdated Food

14. Requirements

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

Description of Violation

There were two unlabeled, undated deserts in the activity refrigerator.

Plan of Correction ***Accept ([redacted] - 04/11/2025)***

The 2 unlabeled, undated desserts were immediately removed from the activity refrigerator and discarded.
Executive Chef provided training to the team regarding 103.g, 103.f, 103.1 on 3.3.2025.

Audits to be conducted weekly by Executive Chef/Designee to ensure all food is sealed and dated beginning 4.8.25 through 7.8.25.
Audits will be reviewed by GM monthly x 3 months. 4.8.25 through 7.8.25.
Regional Director of Health Services will conduct random audits 2/month x 3 ,months to verify compliance. starting 4.14.25 through 7.14.25.

103i - Outdated Food *(continued)*

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented (- 06/23/2025)

144d - Smoking Outside

15. Requirements

2600.
144.d. Smoking outside of the smoking room is prohibited.

Description of Violation

On 2/25/2025, at 9:00 am, Department Representatives observed two individuals smoking in front of the building where the handicap parking spots are located, which is not the home's designated smoking area. The home's designated smoking area is the open hut area behind the home.

Plan of Correction ***Accept (- 04/11/2025)***

General Manager has presented the attached slide regarding the smoking policy each month since January 2025. A letter was sent to all residents and families on 3/20/25 to remind all of the smoking policy and the consequences for violations of this policy, an initial written warning and a second offense resulting in a 30 day notice of eviction.
General Manager will continue to communicate the smoking policy to residents during monthly Resident's Council for the next 3 months.
General Manager will reinforce the need for monitoring by all staff of residents smoking in the designated smoking areas and reporting any violations at the All Staff Meetings each month for the next 3 months, April through June 2025.

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented (- 06/23/2025)

183d - Prescription Current

16. 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 2/26/2025, resident 2 who self-administers their medications had a bottle of Advil 200 mg that was not included on the medication administration record.

On 2/26/2025, resident 2 who self-administers their medications had two containers of pain-relieving gel that was not included on the medication administration record.

Plan of Correction ***Accept (- 04/15/2025)***

Orders were immediately obtained for the Advil and muscle rub cream from Resident #2's PCP and included in the medication administration record.
HSD provided education to resident to inform nursing if new medication received so it can be added to orders for accuracy.
All residents who self – administer medications will be re-evaluated for compliance with regulation by Wellness Nurse/HSD/Designee every 6 months.
HSD will provide detailed instructions in accordance with DHS regulations by 4/11/25 by GM.

183d - Prescription Current (continued)

Regional Director of Health Services will conduct random audit monthly for 3 months beginning 4.11.25 through 7.11.25 and will share audit findings with General Manager.

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented (- 06/23/2025)

183e - Storing Medications

17. 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 2/26/2025, there was a Wixela Inhaler belonging to resident 6 that did not have an open date. According to the manufacturer's instructions this medication is to be discarded 30 days after opening.

Plan of Correction ***Accept (- 04/15/2025)***

The inhaler was immediately removed and replaced with an unopened one.
Med cart audits will be conducted weekly by HSD and GHD (Memory Care Director) to ensure all meds are available for the next 3 months, starting 4.14.25 through 7.14.25.
General Manager will review weekly med cart audits for 3 months beginning 4.14.25 through 7.14.25. Regional Director of Health Services will conduct random med cart audits, two/month, to ensure compliance for 3 months, 4.14.25 through 7.14.25.

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented (- 06/23/2025)

185a - Implement Storage Procedures

18. 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 2/25/2025, resident 1 reported that they usually have their Albuterol Inhaler, and their eye drops in their room but that they were removed today. Resident 1 is not able to self-administer their medications.

On 2/25/2025, resident 4 had a bottle of Refresh Eye drops in their room. Resident 4 is not able to self-administer their medications.

Plan of Correction ***Accept (- 04/15/2025)***

Resident #1 does not self-administer eye drops or inhaler and they are kept in the med cart, not in apartment.
Resident #4 educated by HSD on 2.26.25 regarding the process of purchasing meds and informing nursing. PCP was contacted and order received for resident to self-admin Refresh Tears as needed.

185a - Implement Storage Procedures (continued)

Med cart audits will be conducted weekly by HSD and GHD (Memory Care Director) to ensure all meds are available for the next 3 months, starting 4.14.25 through 7.14.25.

General Manager will review weekly med cart audits for 3 months from 4.14.25 through 7.14.25. Regional Director of Health Services will conduct random med car audits,, two/month, to ensure compliance for 3 months, 4.14.25 through 7.14.25.

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented ([redacted] - 06/23/2025)

187d - Follow Prescriber's Orders

19. Requirements

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

Description of Violation

On 2/9/2025, at 5:00 pm, resident 1 was not administered their Eye Multivitamin Tab Sodium. The medication was not available in the home.

Resident 3 is prescribed Zyrtec 10 mg chewable. However, resident 3 was administered Zyrtec 10 mg tablet beginning 2/5/2025 thru 2/25/2025.

Plan of Correction ***Accept ([redacted] - 04/15/2025)***

This was identified during Day 2 of survey, 2.26.25. Reportable incident completed and submitted to the Department on 2.26.25 upon being identified. This was an isolated incident, as we have a weekly Pharmacy cycle fill.
New Health Services Director is in process of completing an in-service with all Med Techs to review protocol to follow if a medication is not available at the time of administration.
In-services to be completed by HSD by 4.12.25.
Med cart audits will be conducted weekly by HSD and GHD (Memory Care Director) to ensure all meds are available for the next 3 months, starting 4.14.25 through 7.14.25.
General Manager will review weekly med cart audits for 3 months from 4.14.25 through 7.14.25.
Regional Director of Health Services will conduct random med car audits,, two/month, to ensure compliance for 3 months, 4.14.25 through 7.14.25

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented ([redacted] - 06/23/2025)

188b - Medication Error Reporting

20. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident 1 is prescribed eye multivitamin Tab Sodium. However, resident 1 was not administered this medication on

188b - Medication Error Reporting (continued)

2/9/2025 at 5:00 pm. The medication error was not reported to the prescriber, designee or to the resident.

Plan of Correction ***Accept (- 04/15/2025)***

This was identified during Day 2 of survey, 2.26.25. Reportable incident completed and submitted to the Department on 2.26.25 upon being identified. This was an isolated incident, as we have a weekly Pharmacy cycle fill.
New Health Services Director is in process of completing an in-service with all Med Techs to review protocol to follow if a medication is not available at the time of administration.
In-services to be completed by HSD by 4.12.25.
Med cart audits will be conducted weekly by HSD and GHD (Memory Care Director) to ensure all meds are available for the next 3 months, starting 4.14.25 through 7.14.25.
General Manager will review weekly med cart audits for 3 months from 4.14.25 through 7.14.25.
Regional Director of Health Services will conduct random med car audits,, two/month, to ensure compliance for 3 months, 4.14.25 through 7.14.25

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented (- 06/23/2025)

191 - Resident Right to Refuse

21. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident 2, admitted , has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept (- 04/16/2025)***

This was identified during an audit that was conducted for a POC completed in November 2024, notes were present on the contract.
We respectfully request that this violation be reconsdered.

A re-audit of all resident contracts will be conducted to ensure all contracts have been signed and/or 2 attempts have been made to obtain required signatures. To be completed by GM/designee by 5.31.25.
Contracts for new admissions will be reviewed weekly by BOD/designee upon completion for 3 months starting 4.14.25 through 7.14.25.
General Manager will review audits for 3 months from 4.14.25 through 7.14.25.
Regional Director of Health Services will conduct monthly random audit to ensure compliance for 3 months, 4.14.25 to 7.14.25.

Licensee's Proposed Overall Completion Date: *05/31/2025*

Implemented (- 06/23/2025)