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

June 25, 2025

[redacted], EXECUTIVE DIRECTOR
MARIS GROVE INC
500 MARIS GROVE WAY
GLEN MILLS, PA, 19342

RE: MARIS GROVE INC, EVERGREEN POINTE
500 MARIS GROVE WAY
GLEN MILLS, PA, 19342
LICENSE/COC#: 14821

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/08/2025, 04/09/2025 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: *MARIS GROVE INC, EVERGREEN POINTE* **License #**: *14821* **License Expiration**: *07/20/2025*

Address: *500 MARIS GROVE WAY, GLEN MILLS, PA 19342*

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

Administrator

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

Legal Entity

Name: *MARIS GROVE INC*

Address: *500 MARIS GROVE WAY, GLEN MILLS, PA, 19342*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *06/28/2021* **Issued By**: *Concord Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *129* **Waking Staff**: *97*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/09/2025*

Inspection Dates and Department Representative

04/08/2025 - On-Site: [redacted]

04/09/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *132* **Residents Served**: *89*

Special Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *89*

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

Have Mobility Need: *40* **Have Physical Disability**: *0*

Inspections / Reviews

04/08/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/09/2025*

Inspections / Reviews *(continued)*

05/22/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/20/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/27/2025*

05/28/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/20/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/20/2025*

06/25/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/20/2025*

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

17 Record confidentiality

1. Requirements

2800.

17. Confidentiality of Records - 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 4/8/2025, at approximately 9:45 AM, empty medications blister packs containing resident medical and prescription information were observed unlocked, unattended, and accessible on a laptop cart in the 3rd floor common area.

On 4/9/2025 at 11:12 AM, a resident shower information sheet dated 11/2024, was unlocked, unattended, and accessible in a plastic set of drawers in an open out cove on the second floor.

Repeat Violation Date: 6/26/24 et al.

Plan of Correction ***Accept ([redacted] - 05/28/2025)***

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The empty blister packs observed on the medication cart in the 3rd floor common area were immediately removed upon discovery by the Assisted Living Manager and placed in a secured area inaccessible to residents. Additionally, the shower information sheet dated 11/2024, was immediately removed from the open alcove by the Assisted Living Manager and secured in an area inaccessible to residents where it was subsequently placed in the shredder bin.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

The Assisted Living Manager or Designee will complete walking rounds daily throughout the Assisted Living building to ensure there are no blister packs left on medication carts, and in the moment education will be provided as necessary to any staff person identified as leaving a blister pack on a cart. This will be on-going moving forward. Additionally, the Assisted Living Manager or Designee will incorporate checking the alcoves for sensitive information into our weekly environmental rounds. Documentation of any deficient practices will be kept for 4 weeks starting the week of May 19, 2025.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur.

All Medication Technicians and Care Associates coded to the Assisted Living Department will receive education on confidentiality of records by the Assisted Living Manager or Designee.

Goal for completion of this education will be May 31, 2025. Anyone identified as a participant in any future deficient practices after receiving the education, will receive performance counseling per Erickson Senior Living Policy.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

17 Record confidentiality (continued)

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 06/25/2025)

25b Contract signatures and renewal

2. Requirements

2800.
25b . 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. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days notice or by the residence with 30 days notice in accordance with § 2800.228 (relating to transfer and discharge).

Description of Violation

Resident 1, who was admitted to the home on [redacted] did not sign [redacted] contract. There was no indication the resident was given the opportunity to sign.

Plan of Correction ***Accept ([redacted] - 05/28/2025)***

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident 1 is currently in the Hospital and will be given the contract to sign upon returning to the community.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

An audit of all resident contracts, whom reside in Assisted Living, was conducted on 5/9/25 by the Assisted Living Manager to ensure compliance with the regulation. Documentation of this audit will be kept. Any other resident contracts identified as deficient as part of this audit will be presented to the resident to sign by a member of the Admissions team with a goal to have this completed by May 31, 2025.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur.

The Admissions team was educated on regulation 2800.25b on 5/4/25 by the Assisted Living Manager. Email acknowledgements of understanding by each member of the Admissions team will be kept.

The Admissions team or Designee will continue with contract audits twice per month for the next three consecutive months beginning in May 2025. A record of these audits will be kept. Goal for completion of these audits will be July 31, 2025.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

25b Contract signatures and renewal (continued)

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented (- 06/25/2025)

65h 16 hrs annual training

4. Requirements

2800.
65.h. Direct care staff persons shall have at least 16 hours of annual training relating to their job duties. The training required in § 2800.69 (relating to additional dementia-specific training) shall be in addition to the 16 hour annual training.

Description of Violation

Direct care staff person A received only 14.75 hours of annual training relating to job duties during training year 1/1/2024 to 12/31/2024.

Direct care staff person B received only 10.5 hours of annual training relating to job duties during training year 1/1/2024 to 12/31/2024.

Direct care staff person C received only 7.58 hours of annual training relating to job duties during training year 1/1/2024 to 12/31/2024.

Direct care staff person D received only 6.33 hours of annual training relating to job duties during training year 1/1/2024 to 12/31/2024.

Direct care staff person E received only 5.5 hours of annual training relating to job duties during training year 1/1/2024 to 12/31/2024.

Direct care staff person F received only 5.5 hours of annual training relating to job duties during training year 1/1/2024 to 12/31/2024.

Plan of Correction ***Accept (- 05/28/2025)***

What corrective action(s) will be accomplished for those staff found to have been affected by the deficient practice?

Human Resources, the Department Manager, or Designee will re-run each staff person's training transcript that was identified to have been affected by the deficient practice to verify the number of training hours completed for 2024. Staff persons B, C, D, E, and F will be scheduled to complete the missing training by each of their Department managers. Goal for each staff person to complete the missing trainings will be June 5, 2025.

How will you identify other staff having the potential to be affected by the same deficient practice and what corrective action will be taken?

For the training year 2025, The Staff Development Coordinators, Department Managers, or Designee will track

65h 16 hrs annual training (continued)

training progress of all staff working in Assisted Living, by running staff's learning transcripts once monthly, beginning in the month of May in order to identify the number of training hours each staff person still needs, and what training topics each person still need to complete. This practice will be ongoing.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur.

All staff working in Assisted Living identified as not having the required number of training hours, nor having the required training topics, will be scheduled to complete the required trainings. Any staff person working in Assisted Living identified as not completing the required training hours/topics by December 1, 2025, will be removed from the schedule until the training is completed.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 06/25/2025)

65i Training topics

5. Requirements

2800.
65.i. 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, cognitive and neurological 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. Assisted living 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 residence.

Description of Violation

Direct care staff person A did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia, cognitive and neurological impairments, assisted living service needs of the resident, and safe management techniques in the residence during the training year 1/1/2024 to 12/31/2024.

Direct care staff person C did not receive training in medication self-administration training, and care for residents with dementia, cognitive and neurological impairments during the training year 1/1/2024 to 12/31/2024.

65i Training topics (continued)

Direct care staff person D did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, and care for residents with dementia, cognitive and neurological impairments during the training year 1/1/2024 to 12/31/2024.

Direct care staff person F did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia, cognitive and neurological impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, assisted living service needs of the resident, and safe management techniques during the training year 1/1/2024 to 12/31/2024.

Plan of Correction ***Accept ([redacted] - 05/28/2025)***

What corrective action(s) will be accomplished for those staff found to have been affected by the deficient practice?

Human Resources, the Department Manager, or Designee will re-run each staff person's training transcript that was identified to have been affected by the deficient practice to verify the training topics completed for 2024. Staff persons A, C, D, and F will be scheduled to complete the missing training by each of their Department managers. Goal for each staff person to complete the missing trainings will be June 5, 2025.

How will you identify other staff having the potential to be affected by the same deficient practice and what corrective action will be taken?

For the training year 2025, The Staff Development Coordinators, Department Managers, or Designee will track training progress of all staff working in Assisted Living, by running staff's learning transcripts once monthly, beginning in the month of May in order to identify the number of training hours each staff person still needs, and what training topics each person still need to complete. This practice will be ongoing.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

All staff working in Assisted Living identified as not having the required number of training hours, nor having the required training topics, will be scheduled to complete the required trainings. Any staff person working in Assisted Living identified as not completing the required training hours/topics by December 1, 2025, will be removed from the schedule until the training is completed.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

Licensee's Proposed Overall Completion Date: *06/05/2025*

65i Training topics *(continued)*

Implemented ([redacted] - 06/25/2025)

65j Annual training content

6. Requirements

2800.

65.j. 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—10225.708).
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 A did not receive training in 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—10225.708), Falls and accident prevention, and new population groups that are being served at the home that were not previously served, if applicable during training year 1/1/2024 to 12/31/2024.

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 and new population groups that are being served at the home that were not previously served, if applicable during training year 1/1/2024 to 12/31/2024.

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 during training year 1/1/2024 to 12/31/2024.

Staff person F did not receive training in fire safety completed by a fire safety expert or by a 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—10225.708), Falls and accident prevention, and new population groups that are being served at the home that were not previously served, if applicable during training year 1/1/2024 to 12/31/2024.

Plan of Correction ***Accept ([redacted] - 05/22/2025)***

What corrective action(s) will be accomplished for those staff found to have been affected by the deficient practice?

Human Resources, the Department Manager, or Designee will re-run each staff person's training transcript that was identified to have been affected by the deficient practice to verify the training topics completed for 2024. Staff persons A, D, E, and F will be scheduled to complete the missing training by each of their Department managers. Goal for each staff person to complete the missing trainings will be June 30, 2025.

How will you identify other staff having the potential to be affected by the same deficient practice and what corrective action will be taken?

65j Annual training content (continued)

For the training year 2025, The Staff Development Coordinators, Department Managers, or Designee will track training progress of all staff working in Assisted Living, by running staff's learning transcripts once monthly, beginning in the month of May in order to identify the number of training hours each staff person still needs, and what training topics each person still need to complete. This practice will be ongoing.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

All staff working in Assisted Living identified as not having the required number of training hours, nor having the required training topics, will be scheduled to complete the required trainings. Any staff person working in Assisted Living identified as not completing the required training hours/topics by December 1, 2025, will be removed from the schedule until the training is completed.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

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

Implemented ([redacted] - 06/25/2025)

65l Record of training

7. Requirements

2800.
65.l. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The residence's record of direct care staff training for their "Training Fair" does not include the length of each course.

Plan of Correction ***Accept ([redacted] - 05/22/2025)***

What corrective action(s) will be accomplished for those staff found to have been affected by the deficient practice?

The length of the training fair was added to the sign in sheet upon discovery of the missing information. However, the length of the training fair was noted on each staff person's training transcript that was presented to the Surveyors during the annual survey - total hours were 3.5.

How will you identify other staff having the potential to be affected by the same deficient practice and what corrective action will be taken?

The Assisted Living Manager or Designee will audit all in person trainings to ensure the sign in sheets indicate the length of each course, monthly beginning in May 2025. This audit will be ongoing.

What measures will be put into place or what system changes will you make to ensure that the deficient practice

65l Record of training (continued)

does not recur?

The Assisted Living Manager or Designee will ensure the length of each in person training is noted on the sign in sheet moving forward, If the length of the training is missing, it will be added to the sign in sheet upon discovery of the missing information.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

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

Implemented ([redacted] - 06/25/2025)

69 Dementia training

10. Requirements

2800.
69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Staff person B, date of hire [redacted], received 0 hours of dementia-specific training relating during training year 1/1/2024-12/31/2024

Staff person C, date of hire [redacted], received 0 hours of dementia-specific training relating during training year 1/1/2024-12/31/2024

Staff person D, date of hire [redacted] received 0 hours of dementia-specific training relating during training year 1/1/2024-12/31/2024

Staff person E, date of hire [redacted], received 0 hours of dementia-specific training relating during training year 1/1/2024-12/31/2024

Staff person F, date of hire [redacted] received 0 hours of dementia-specific training relating during training year 1/1/2024-12/31/2024

Plan of Correction ***Accept ([redacted] - 05/28/2025)***

What corrective action(s) will be accomplished for those staff found to have been affected by the deficient practice?

69 Dementia training (continued)

The Staff Development Coordinator or Designee will assign 2 hours of Dementia training into Workday for each staff person identified during the survey to complete. The expected completion date for each staff person identified will be June 30, 2025.

How will you identify other staff having the potential to be affected by the same deficient practice and what corrective action will be taken?

For the training year 2025, The Staff Development Coordinators, Department Managers, or Designee will track training progress of all staff working in Assisted Living, by running staff's learning transcripts once monthly, beginning in the month of May in order to identify the number of training hours each staff person still needs, and what training topics each person still need to complete. This practice will be ongoing.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

All staff working in Assisted Living identified as not having the required number of training hours, nor having the required training topics, will be scheduled to complete the required trainings. Any staff person working in Assisted Living identified as not completing the required training hours/topics by December 1, 2025, will be removed from the schedule until the training is completed.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 06/25/2025)

81b Resident equip – good repair

11. Requirements

2800.
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 3 has a half bed rail attached to [redacted] bed. On 4/9/2025 at approximately 10:41 AM, the rail was in the down position attached to the bed and skewed away from the bed at an odd angle. Staff persons in the room were unable to easily raise the bar. Staff person [redacted] the maintenance supervisor confirmed the device was not installed properly.

Plan of Correction ***Accept ([redacted] - 05/28/2025)***

What corrective action(s) will be accomplished for those resident's found to have been affected by the deficient practice?

The maintenance supervisor immediately fixed the bed rail upon discovery on 4/9/25.

81b Resident equip – good repair (continued)

How will you identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken?

The Assisted Living Manager or Designee will incorporate inspection of bed rails and other mobility devices into weekly environmental rounds moving forward beginning the week of May 19, 2025.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

Any resident whom has a bed rail or other mobility device found not to be in good repair during weekly environmental rounds, will have a work order placed with General Services, by the Assisted Living Manager, immediately to ensure the device is fixed. If General Services is unable to fix the device that is not in good repair, then the company from where the device came from will be contacted to repair the device.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 06/25/2025)

91 Telephone Numbers

12. Requirements

2800.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and assisted living residence 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 the AL pantry kitchen.

Plan of Correction ***Accept ([redacted] - 05/22/2025)***

What corrective action(s) will be accomplished for those found to have been affected by the deficient practice?

The Assisted Living Manager immediately placed a phone tag with the required numbers on the phone upon discovery.

How will you identify others having the potential to be affected by the same deficient practice and what corrective action will be taken?

Phone tags with the required numbers are checked routinely by the Assisted Living Manager's during weekly environmental rounds to ensure there is one posted on or near each phone. This practice will continue.

91 Telephone Numbers (continued)

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

Any phone identified during weekly environmental rounds will immediately have a phone tag placed on or near the phone with the required numbers by the Assisted Living Manager or Designee.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

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

Implemented ([redacted] - 06/25/2025)

103g Storing food

13. Requirements

2800.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 4/8/2025 a container of chocolate ice cream, a tray of brownies, several cherry pies and a bag of chocolate chip cookies were in the walk-in freezer and were opened and unsealed.

On 4/8/25, in dry storage there was a bag of pine nuts that was open and unsealed.

Plan of Correction ***Accept ([redacted] - 05/22/2025)***

What corrective action(s) will be accomplished for those staff found to have been affected by the deficient practice?

All food identified as open and not sealed on 4/8/25, were immediately removed and discarded by the Dining General Manager upon discovery.

All Dining employees working in Assisted Living were in-serviced by the Dining General Manager on the following policies: Food Storage Guidelines and Food Safety Protocol. This in-service was completed on May 11, 2025.

How will you identify other food having the potential to be affected by the same deficient practice and what corrective action will be taken?

Dining team members working in the Continuing Care kitchen will complete audits of all food storage areas on a daily, weekly, and monthly basis.
Daily and weekly audits will be logged in the Dining Services Redbook which will be kept on file for a period of 1 year.

103g Storing food (continued)

Monthly operational assessment audits will be completed by the Dining General Manager or Executive Chef; they will be kept on file for a period of 1 year.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

Audits will continue with no end date; they will be incorporated into each Dining leader's daily responsibilities effective in May of 2025.

Compliance will be monitored by the Dining General Manager with corrective action taken as needed. This will be ongoing.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

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

Implemented ([redacted] - 06/25/2025)

107d Procedure EMA submission

14. Requirements

2800.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The residence's written emergency procedures were submitted on 1/16/2023 and then not again until 4/19/2024.

Plan of Correction ***Accept ([redacted] - 05/22/2025)***

What corrective action(s) will be accomplished for those found to have been affected by the deficient practice?

The Assisted Living Manager or Designee will be sure to send the residence's emergency procedures annually moving forward. Annually is defined by the regulatory compliance guide as within a 12 month period allotting for a 15 day grace period. Additionally, the residence's emergency procedures were sent to the Concord Township Fire Marshall on 4/18/2025 to ensure compliance for the current year. The Assisted Living Manager will keep a record of the acknowledgement in the neighborhood's emergency preparedness binder.
What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

A calendar reminder will be placed on the computer for April of 2026 by the Assisted Living Manager to ensure the deficient practice does not recur.

107d Procedure EMA submission (continued)

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

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

Implemented ([redacted] - 06/25/2025)

121a Unobstructed egress

15. Requirements

2800.
121.a. Stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed.

Description of Violation

On 4/8/2025, at approximately 10:00 AM, a code for a keypad was needed to exit through the door near the Evergreen dining room. There was no code posted by the door.

Plan of Correction ***Accept ([redacted] - 05/22/2025)***

What corrective action(s) will be accomplished for the door found to have been affected by the deficient practice?

The Assisted Living Manager placed the code on the door on 4/10/2025.

How will you identify other doors having the potential to be affected by the same deficient practice and what corrective action will be taken?

Key pads on exit doors will be checked to ensure the code is posted as part of weekly environmental rounds that are conducted by the Assisted Living Managers. This will be ongoing.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

If an exit door is found during weekly environmental rounds to have no code posted, the code will be immediately posted on the key pad by the Assisted Living Manager.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

121a Unobstructed egress *(continued)*

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

Implemented ([redacted] - 06/25/2025)

183d Current medications

17. Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

On 4/9/2025, triple antibiotic ointment prescribed for resident 7, was in the residence's medication cabinet; however, the medication was discontinued on 3/13/2025.

Plan of Correction ***Accept ([redacted] - 05/28/2025)***

What corrective action(s) will be accomplished for those resident's found to have been affected by the deficient practice?

The triple antibiotic ointment was immediately removed from resident 7's medication cabinet upon discovery by the Assisted Living Manager on 4/9/25.

How will you identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken?

The Wellness Manager, Nurse, Assisted Living Manager or Designee will run a report of discontinued medications once per week, beginning the week of May 19, 2025 for a period of 6 weeks. Additionally, any resident listed on the report with a discontinued medication, their medication cabinet will be checked after running the report to ensure the medication has been removed.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur.

Re-education will be provided to the medication technicians and Nurses working in Assisted Living on ensuring that medications are removed from a resident's medication cabinet once the medication has been discontinued. This education will be provided by the Assisted Living Manager or Designee. The goal for this re-education to be completed will be June 5, 2025.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 06/25/2025)

183e Storing Medications

18. Requirements

2800.
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 4/9/2025, blister pack of oxycodone immediate 5 mg tablet for resident 8, was punctured at pills 3, 15 and 21. The pills remained inside the packaging.

Repeat violation: 1/17/24 et al

Plan of Correction ***Accept ([redacted] - 05/28/2025)***

What corrective action(s) will be accomplished for those resident's found to have been affected by the deficient practice?

Pills 3, 15, and 21 were destroyed by the Nurse and the Wellness Manager on 4/9/25.

How will you identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken?

The Assisted Living Manager or Designee will resume Narcotic Cabinet audits 3 times a week, beginning the week of 5/19/25, and will continue with the audits for a period of 6 weeks, to ensure no resident pills are punctured. Additionally, a random sample of 4 resident medication cabinet's will be audited 3 times a week by the Assisted Living Manager or Designee, beginning the week of 5/19/25, and will continue for a period of 6 weeks. Any punctured pills will be brought to the nurse immediately to be destroyed.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

Re-education to occur with all medication technicians by the Assisted Living Manager or Designee working in the Assisted Living building on ensuring any blister packs with punctured pills be removed and brought to the nurse immediately to have the pills destroyed. Goal for completion of this re-education will be June 5 2025.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 06/25/2025)

184a Resident meds labeled

19. Requirements

184a Resident meds labeled *(continued)*

2800.

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

1. The resident's name.
2. The name of the medication.
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 4/9/2025 resident 9's had two bottles of nystatin topical powder in [redacted] medication cabinet. The resident has a current order to apply powder under [redacted] two times daily. The pharmacy label of the first bottle that was filled on 8/22/2024 reads "Apply topically for 10 days" there was no direction change sticker on the bottle. The second bottle is undated and does not have a pharmacy label.

Resident 10 is prescribed alprazolam .5 mg twice daily by mouth as needed as of 3/3/2025, however the pharmacy label for this medication reads "1 tablet by mouth every 12 hours as needed". There was no direction change sticker on this medication.

Resident 11 is prescribed tramadol 50 mg tablet every 6 hours as needed, however the pharmacy label for this medication reads "Take 1 tablet orally 3 times a day for 30 days". The was no direction change sticker on this medication.

Plan of Correction ***Accept ([redacted] - 05/28/2025)***

What corrective action(s) will be accomplished for those resident's found to have been affected by the deficient practice?

Direction change stickers were immediately added to all medications identified by the Wellness Manager on 4/9/25. Additionally, the Nystatin powder that did not have a pharmacy label was removed from resident #9's cabinet upon discovery and discarded by the residence.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

The Assisted Living Manager or Designee will run a 24 hour order report once per week to identify orders that have had frequency changes, and will ensure a direction change sticker has been applied to those medications. This process will be ongoing.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

Re-education to occur with all Nurses working in Assisted Living by the Assisted Living Manager or Designee to ensure they understand the process of placing direction change stickers on medications when orders change. Goal for completion of this re-education will be June 5, 2025.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality

184a Resident meds labeled (continued)

assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 06/25/2025)

185a Storage procedures

20. Requirements

2800.
185.a. The residence 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 9 is prescribed senna 8.6 mg tablet orally two times daily as needed. On 4/9/2025, this medication was not available in the residence.

Plan of Correction ***Accept ([redacted] - 05/28/2025)***

What corrective action(s) will be accomplished for those resident's found to have been affected by the deficient practice?

The medication for resident 9 was re-ordered by the Medication Technician immediately upon discovery on 4/9/25.

How will you identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken?

A random sample of 5 resident medication cabinet's will be audited 2 times per month by the Assisted Living Manager or Designee, beginning the week of 5/19/25, and will continue for a period of 2 months, to ensure all medications prescribed for the resident is in the building.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

Re-education will occur by the Assisted Living Manager or Designee with all medication technicians working in Assisted Living, to ensure they are following the re-order process. Goal for completion of this education will be June 5, 2025. Any medication technician identified as not following the re-order process after receiving the education will be performance managed by the Assisted Living Manager moving forward.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

185a Storage procedures *(continued)*

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 06/25/2025)

21. Requirements

2800.
185.a. The residence 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 4/7/2025 resident's 1's 4/2025 Medication Administration Record (MAR) list a reading of 193 taken at 8:13 AM, however the resident's glucometer shows that this reading was taken at 2:37 AM. On 4/8/2025 resident's 1's 4/2025 MAR list a reading of 135 taken at 7:21 AM, however the resident's glucometer shows that this reading was taken at 1:40 AM. Resident 1's glucometer was not properly calibrated at the time of these reading.

According to resident 12's 3/2025 MAR, the resident was administered oxycodone 5 mg tablet on 3/29/2025 at 9 PM. The resident's narcotic control utilization log does not contain the initials of the person that signed out this medication. According to the residence's medications and controlled substance policy, documentation of the administration of a controlled substance recorded twice, on the Resident's MAR/eMAR and on the Resident's Controlled Medication Utilization Record

Plan of Correction ***Accept ([redacted] - 05/28/2025)***

What corrective action(s) will be accomplished for those resident's found to have been affected by the deficient practice?

All medication technicians working in Assisted Living will be re-educated by the Assisted Living Manager or Designee on Calibrating Glucometers every time one is used. Goal for this education to be completed will be June 5, 2025.

All medication technicians working in Assisted Living will be re-educated by the Assisted Living Manager on proper Narcotic documentation. Goal for completion of this education will be June 5, 2025.

How will you identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken?

A random sample of 2 resident glucometers will be audited 3 times a week by the Assisted Living Manager or Designee, beginning the week of 5/19/25, and will continue for a period of 6 weeks, to ensure all glucometers are calibrated to the correct date and time.

The Assisted Living Manager or Designee will resume Narcotic Cabinet audits 3 times a week, beginning the week of 5/19/25, and will continue with the audits for a period of 6 weeks, to ensure the documentation of administration is on not only the Controlled Medication Utilization Record, but also on each resident's MAR.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

Any staff person identified in either deficient practice after having been re-educated, will be performance managed

185a Storage procedures (continued)

by the Assisted Living Manager or Designee moving forward.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 06/25/2025)

187a Medication record

22. Requirements

2800.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

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

Description of Violation

Resident 4 is prescribed Lidocaine 4% patches, apply 1 patch to the lower back every morning, remove at bedtime. However, resident's 4's 4/2025 medication administration record does not include the correct frequency of administration and reads "1 adhesive patch, medicated topical two times daily"

Resident 9 is prescribed Ammonium lactate 12% lotion apply twice daily. However, resident's 4/2025 medication administration record does not include diagnosis or purpose for the medication, including pro re nata (PRN).

Plan of Correction ***Accept ([redacted] - 05/28/2025)***

What corrective action(s) will be accomplished for those resident's found to have been affected by the deficient practice?

Please see attached order for resident 4's Lidocaine 4% patches. There is not another way to enter this into our eMAR system. The notes which each Medication technician sees, says Apply to low back in am. Remove at hs. This was

187a Medication record (continued)

shown to the surveyor on the day of survey. A change of direction sticker was added to resident 4's Lidocaine 4% patches on 5/22/25 in order to ensure all medication technicians are carefully reviewing the order.

The indication for resident 9's Ammonium lactate 12% lotion apply twice daily was added upon discovery by the Wellness Manager on 4/9/25.

How will you identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken?

A random sample of 5 resident medication cabinet's will be audited 2 times per month by the Assisted Living Manager or Designee, beginning the week of 5/19/25, and will continue for a period of 2 months, to ensure all indications are on the resident's orders and the medications.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

All nurses working in Assisted Living will be re-educated by the Wellness Manager or Designee on ensuring the indication for each resident's medication is entered with each order. Goal for completion of this education will be June 5, 2025.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 06/25/2025)

187b Date/time of med admin

23. Requirements

2800.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident 13 is prescribed hydrocodone 10 mg acetaminophen 325 mg tablet as needed every 6 hours. This medication was signed out of resident 13's narcotic log on 3/17/2025 at 8:40 PM and 3/18/2025 at 9:00 PM. Resident 13's 3/2025 medication administration record does not include the initials of the staff person who administered this medication on 3/17/2025 at 8:40 PM and 3/18/2025 at 9:00 PM.

Repeat violation: 6/26/24 et al and 1/17/24 et al

Plan of Correction ***Accept ([redacted] - 05/28/2025)***

What corrective action(s) will be accomplished for those resident's found to have been affected by the deficient

187b Date/time of med admin (continued)

practice?

The Staff person identified as not documenting the administration on resident 13's MAR on both 3/17/25, and 3/18/25 received medication remediation education by the Assisted Living Manager on 5/12/25.

Additionally, the staff person identified will have a medication observation competency completed by the Wellness Manager or Designee to ensure the staff person is following the 5 rights. Goal for this medication observation to be completed will be May 31, 2025.

Lastly, all medication technicians working in Assisted Living will be re-educated by the Assisted Living Manager on proper Narcotic documentation. Goal for completion of this education will be June 5, 2025.

How will you identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken?

The Assisted Living Manager or Designee will resume Narcotic Cabinet audits 3 times a week, beginning the week of 5/19/25, and will continue with the audits for a period of 6 weeks, to ensure the documentation of administration is on not only the Controlled Medication Utilization Record, but also on each resident's MAR.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

Any medication technician working in Assisted Living identified in either deficient practice after having been re-educated, will be performance managed by the Assisted Living Manager or Designee moving forward.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented ([redacted] - 06/25/2025)

203 Bedside rails

24. Requirements

2800.
203. Bedside Rails
- a. Bedside rails may not be used unless the resident can raise and lower the rails on his own. Bedside rails may not be used to keep a resident in bed. Use of any length rail longer than half the length of the bed is considered a restraint and is prohibited. Use of more than one rail on the same side of the bed is not permitted.
- b. Half-length rails are permitted only if the following conditions are met:

203 Bedside rails *(continued)*

1. The resident's assessment or support plan, or both, addresses the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails.
2. The residence has attempted to use less restrictive alternatives.
3. The resident or legal representative consented to the use of half-length rails after the risk, benefits and alternatives were explained.

Description of Violation

On 4/9/2025, resident 3 had 1/2 bed rail improperly attached to [redacted] bed. Resident 3's [redacted] stated that resident 3 cannot lift or lower the rail on [redacted] own and that staff lifts and lowers the rail and must help resident 3 in and out of bed each time.

Half-length rails are used on resident 3's bed; however, resident 3's assessment and support plan does not address the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails.

Plan of Correction ***Accept ([redacted] - 05/28/2025)***

What corrective action(s) will be accomplished for those staff found to have been affected by the deficient practice?

Resident 3's bed rail was immediately fixed by the Maintenance Supervisor upon discovery on 4/9/25.

Resident 3's assessment and support plan was updated by the Assisted Living Manager on 4/9/25 to address the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails.

Lastly, Resident 3, along with any other resident with half length bed rails, will be assessed by Occupational Therapy to determine if each can raise and lower the rail on their own. Goal will be to have these assessment's completed by May 31, 2025.

How will you identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken?

Resident 3, along with any other resident with half length bed rails, will be assessed by Occupational Therapy to determine if each can raise and lower the rail on their own. Goal will be to have these assessment's completed by May 31, 2025. All resident's identified as being able to raise and lower the rail independently, will have documentation by Occupational Therapy added to their chart, and the resident's Assessment and Support plan will be updated with this information by the Assisted Living Manager. Additionally, any resident identified as not being able to raise and lower the rail on their own, but will still benefit from having a bedside mobility device, will be asked to purchase a Halo Safety Ring.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur.

Effective immediately, no resident will be permitted to be admitted to the Assisted Living residence with hospital bed side rails. A bed mobility assessment will occur with each resident as necessary by Occupational Therapy and if it is identified that a resident would benefit from a bedside mobility device, and benefits of a bedside mobility device outweighs the risks, then the resident will be asked to purchase a Halo Safety Ring.

203 Bedside rails (continued)

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

Licensee's Proposed Overall Completion Date: *06/05/2025*

Implemented (- 06/25/2025)

251b Record entries - legible

28. Requirements

2800.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction tape was used on resident 4's assessment and support plan, dated

Correction tape was used on resident 14's assessment and support plan, dated

Plan of Correction ***Accept (- 05/28/2025)***

What corrective action(s) will be accomplished for those resident's found to have been affected by the deficient practice?

The new Assisted Living Manager, was re-educated by the other Assisted Living Manager on regulation 2800.251b on 5/12/25.

How will you identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken?

The Assisted Living Manager or Designee will complete and audit of all Assisted Living resident's ASP's to ensure no other forms have correction tape on them. Goal for completion of this audit will be May 31, 25.

What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?

If a mistake is made on a resident's Assessment and Support Plan moving forward, the Assisted Living Manager will correct the mistake by drawing a line through the incorrect documentation, and adding their initials and date., and writing in the correct information. This process will be ongoing.

How will the corrective action will be monitored to ensure that the deficient practice will not recur i.e. what quality assurance programs will be established?

Compliance will be monitored by the Assisted Living Manager or Designee monthly, starting in May 2025, for three consecutive months as part of the facility Quality Assurance Program.

251b Record entries - legible *(continued)*

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

Implemented ([redacted] - 06/25/2025)