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

April 21, 2023

[redacted]
SPIRITRUST LUTHERAN
1802 FOLKEMER CIRCLE
YORK, PA, 17404

RE: SPIRITRUST LUTHERAN - THE VILLAGE AT SPRENKLE DRIVE
1802 FOLKEMER CIRCLE
YORK, PA, 17404
LICENSE/COC#: 33236

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/15/2023, 03/16/2023, 03/17/2023 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: *SPIRITRUST LUTHERAN - THE VILLAGE AT SPRENKLE DRIVE* **License #**: *33236* **License Expiration**: *11/01/2023*

Address: *1802 FOLKEMER CIRCLE, YORK, PA 17404*

County: *YORK* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *SPIRITRUST LUTHERAN*

Address: *1802 FOLKEMER CIRCLE, YORK, PA, 17404*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *09/12/2014* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *75* **Waking Staff**: *56*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *03/17/2023*

Inspection Dates and Department Representative

03/15/2023 - On-Site: [redacted]
03/16/2023 - On-Site:
03/17/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *56* **Residents Served**: *48*

Special Care Unit

In Home: *Yes* **Area**: *Red/Pin Oak* **Capacity**: *24* **Residents Served**: *20*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *48*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *27* **Have Physical Disability**: *0*

Inspections / Reviews

03/15/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/02/2023*

Inspections / Reviews *(continued)*

04/07/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/20/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/14/2023*

04/20/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/20/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/27/2023*

04/21/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/20/2023*

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

65a Fire Safety-1st day

1. Requirements

2800.

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

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

Description of Violation

Staff Member B's date hire was [redacted], however the staff member did not complete the 1st day orientation until [redacted].

Plan of Correction ***Accept (SK - 04/20/2023)***

Human resources will include the First Day/First 40 in the Supervisor orientation folder that new staff members are given. This document includes all of the DHS required trainings Department heads were notified on 3/25/23 that all staff will need to have the First Day/First 40 completed on the first day of work by the Administrator and the Department Supervisor. Administrator has contacted department heads to complete the First Day/First 40 with current staff who do not have all of the required training already. First Day /First 40 attached. Email to staff attached.

Employee file audit completed on 3/21/23
All current staff will have their 1st day/1st 40 completed by 4/21/23

Licensee's Proposed Overall Completion Date: *04/12/2023*

Implemented (SK - 04/21/2023)

65e Rights/Abuse 40 Hours

2. Requirements

2800.

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

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.
5. Safe management techniques.
6. Core competency training that includes the following:
   i. Person-centered care.
   ii. Communication, problem solving and relationship skills.
   iii. Nutritional support according to resident preference.

65e Rights/Abuse 40 Hours *(continued)*

Description of Violation

Staff Member B was hired on [redacted], however the staff member's first 40 hours of training were not completed until 03/10/2022.

Plan of Correction ***Accept (SK - 04/20/2023)***

Human resources will include the First Day/First 40 in the Supervisor orientation folder that new staff members are given. This document includes all of the DHS required trainings. Department heads were notified on 3/25/23 that all staff will need to have the First Day/First 40 completed on the first day of work by the Administrator and the Department Supervisor. First Day/First 40 attached. Email to staff about First Day/First 40 attached.

Employee file audit completed on 3/21/23
All current staff will have their 1st day/1st 40 completed by 4/21/23

Licensee's Proposed Overall Completion Date: *04/12/2023*

Implemented (SK - 04/21/2023)

65g Initial direct care training

3. Requirements

2800.
65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Staff Member C's date of hire (DOH) was [redacted], however the staff member did not complete and pass the Department approved direct care training course and competency test until [redacted].

Staff Member D's DOH was 1[redacted], however the staff member did not complete and pass the Department approved direct care training course and competency test until [redacted]

Plan of Correction ***Accept (SK - 04/20/2023)***

Administrator added the direct care training course and competency test to the training checklist that is used as well as the First Day/First 40 document that is used to document the trainings that are required on the first day and within the first 40 hours. Human resources will include the First Day/First 40 in the Supervisor orientation folder that new staff members are given. First Day/First 40 and training checklist attached

Employee file audit completed on 3/21/23
All current staff will have their 1st day/1st 40 completed by 4/21/23
On the training checklist that HSM and ALA created, day 10 will include the HSM or ALA to audit employee's file to ensure the entire 1st day/1st 40 is completed. The 1st day/1st 40 has the DHS comp. test listed on it

Licensee's Proposed Overall Completion Date: *04/12/2023*

65g Initial direct care training *(continued)*

Implemented (SK - 04/21/2023)

65j Annual training content

4. 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 Member A has no documentation for completing any of the following required annual trainings for the 2022 year:

- *Fire safety*
- *Emergency preparedness procedures*
- *Resident rights*
- *The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.708).*
- *Falls and accident prevention*
- *New population groups that are being served at the home*

Staff Member B has a [redacted] *training listed as basic fire safety, however, this training is not specific to the building/residence. An observed fire drill was conducted by a Fire Safety Expert (FSE) in 2022, but no training was offered by the FSE to include building-specific training.*

Plan of Correction ***Accept (SK - 04/20/2023)***

All assisted living staff will be required to attend the monthly assisted living meetings in which these topics are reviewed. Staff members will sign in on a sign in sheet to receive credit.

Starting 5/4/23, all assisted living staff will be required to attend a monthly assisted living staff meeting in which annual training topics will be discussed. The training plan will be followed. All staff members will sign in and out of these meetings which will be kept in [redacted] *staff training binder with the training plan. If a staff member is unable to attend the meeting, a new date will be assigned.*

By 5/31/23, Administrator will get with Director of Maintenance and develop a safety training plan that meets the annual fire safety training by an expert regulation. Administrator has emailed a potential person to complete this training. If this individual is not available, Administrator is trained by a fire safety expert so it will be added to the yearly trainings and on the training plan.

Licensee's Proposed Overall Completion Date: *04/12/2023*

65j Annual training content *(continued)*

Implemented (SK - 04/21/2023)

125b Combustible res. access

5. Requirements

2800.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

Located inside the cabinet of the Kitchenette of Short Hall, across from Resident Room 122, there was an 11oz can of Krylon Color Maxx Clear spray/aerosol paint, labeled to be highly combustible and flammable. This product was unsecured and unlocked in the cabinet which residents have access to.

Plan of Correction ***Accept (SK - 04/20/2023)***

Product was removed immediately on 3/17/23. Life Enrichment and Nursing staff educated on the regulation about combustible materials. An education was prepared by the Administrator and given to the Health Services Manager and Life Enrichment Director. Each person will provide the education to their staff and sign the Staff Education form. Administrator will ensure compliance is met by 4/14/23

Life Enrichment Director and HSM were provided the education on 3/28/23. Life enrichment team was educated on 3/28/23 through 4/3/23

When doing resident room audits, HSM/ALA/Charge LPN will check for these types of items which will be done monthly. Added to checklist on 4/13/23

Licensee's Proposed Overall Completion Date: *04/13/2023*

Implemented (SK - 04/21/2023)

141a Medical evaluation

6. Requirements

2800.
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:
10. Mobility assessment, updated annually or at the Department's request.
11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.

Description of Violation

Resident 1's annual Assisted Living Documentation of Medical Evaluation (ADME) completed from [redacted] *does not have the section under Mobility Needs completed and this section was left blank on the form.*

Resident 2's annual ADME completed from [redacted] *does not have the section under Tuberculosis Testing completed and this section, specifically the "Does resident require a new TB skin test or chest x-ray at this time?" and "TB Skin test or Chest X-Ray Date:" are left blank on the form.*

141a Medical evaluation (continued)

Plan of Correction ***Accept (SK - 04/20/2023)***

Administrator and Health Services manager did a chart audit on 3/20/23 of all current residents. Chart audit consisted of checking all ADMEs and ASPs for completion. The ADMEs and ASPs were also reviewed to ensure the information on the ADME such as mobility and diet are match what is on the ASP. The Health Services manager will provide Administrator with completed ADMEs for new admissions and the yearly or significant changes for review to ensure all parts are filled in. Administrator will initial ADME once checked. Chart audit to review ASPs already in place. Will add auditing the ADMEs for completion and matching ASPs to monthly audit process.

Licensee's Proposed Overall Completion Date: *04/12/2023*

Implemented (SK - 04/21/2023)

181d Self-administer Storing medication

7. Requirements

2800.
181.d. If the resident does not need assistance with medication, medication may be stored in a resident's living unit for self-administration. Medications stored in the resident's living unit shall be kept locked in a safe and secure location to protect against contamination, spillage and theft. The residence shall provide a lockable storage unit for this purpose.

Description of Violation

Resident 3's Sodium Chloride 0.65% Saline Nasal Spray and Nystatin Cream USP were unsecured on the nightstand in the resident's bedroom. The resident's door was open and unlocked.

Plan of Correction ***Accept (SK - 04/20/2023)***

The medication was immediately removed from the nightstand and put in the locked drawer on 3/16/23. Resident will no longer be self administering medications due to decline and inability to administer medications safely. PC)P updated ADME to reflect the inability to self administer medications on [redacted]. Significant change An education was prepared by the Administrator and given to the Health Services Manager. The Health Services Manager will provide the education to their staff and sign the Staff Education form. Administrator will ensure compliance is met by 4/14/23.

HSM/Charge Nurse/ALA will audit resident's rooms monthly starting 5/1/23. This will be documented on the audit currently being used to check the ADMEs and ASPs.

ALA/HSM currently audit charts monthly to ensure ADMEs and ASPs are completed, accurate and match. It will be added to the audit to make sure information is present and matches in regards to self admin meds. This was completed with the 3/20/23 audit and will be done monthly after that.

Licensee's Proposed Overall Completion Date: *04/13/2023*

Implemented (SK - 04/21/2023)

182a Medication administration services

8. Requirements

182a Medication administration services *(continued)*

2800.
182.a. A residence shall provide medication administration services for a resident who is assessed to need medication administration services in accordance with § 2800.181 (relating to self-administration) and for a resident who chooses not to self-administer medications

Description of Violation

Resident 2 is prescribed Ammonium Lac 12% OTC LOT, to be applied once daily. The home reported that the medication is kept in the resident's room to self-administer. Per the resident's ADME, dated 2/28/2023 and the 2022 Assessment-Support Plan (ASP), Resident 2 has been assessed as not being capable of self-administering their medication.

Plan of Correction ***Accept (SK - 04/20/2023)***

Medication was removed immediately from the resident's room on 3/16/23. An education was prepared by the Administrator and given to the Health Services Manager. The Health Services Manager will provide the education to their staff and sign the Staff Education form. Administrator will ensure compliance is met by 4/14/23

HSM/Charge Nurse/ALA will audit resident's rooms monthly starting 5/1/23. This will be documented on the audit currently being used to check the ADMEs and ASPs. It will be added to the audit to make sure information is present and matches in regards to self admin meds. This was completed with the 3/20/23 audit and will be done monthly after that.

Licensee's Proposed Overall Completion Date: *04/12/2023*

Implemented (SK - 04/21/2023)

184a Resident meds labeled

9. Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident 3 has an order for Gabapentin 100mg cap (take 100 mg by mouth at bed time) located on the medication administration record (MAR), however, the prescription label states, "Take one capsule by mouth 2x a day."

Resident 3 has an order for Ibuprofen 400 mg tab x1 every day per MAR, however, the label on the medication states, "Every other day."

Resident 3 has a prescription for Triamcinolone 0.1% cream and apply topically to hands and feet daily per MAR, however, the medication/ pharmacy label states apply "3x a day."

Resident 2 has a prescription for Latanoprost SOL 0.005%, 1 drop both eyes at bedtime. The MAR states that the medication expires 6 weeks after opening, However the pharmacy label on the medication does not indicate that the medication needs to be discarded 6 weeks after opening.

Plan of Correction ***Accept (SK - 04/06/2023)***

Meeting with [redacted] pharmacy requested to see what can be done about the MAR not matching medication bottles. The pharmacy is going to go through all of the MARs and the medications that are sent to ensure

184a Resident meds labeled (continued)

everything matches. Pharmacy said this will be done by 4/7/23.

[redacted] *contacted to see if a "directions changed refer to chart" sticker or printing out the P.O. to secure to the medication bottle is acceptable and it is. When an order is changed, the charge LPN will ensure a sticker is placed on the medication.*

LPNs/Med Techs will be educated on expiration dates and putting them on the container of medications when opened. An education was prepared by the Administrator and given to the Health Services Manager. The Health Services Manager will provide the education to their staff and sign the Staff Education form. Administrator will ensure compliance is met by 4/14/23

Third shift will be doing weekly med cart audits to ensure all medications are present and labels match. There will be a form that is signed off on and turned into the Health Services Manager. An education was prepared by the Administrator and given to the Health Services Manager. The Health Services Manager will provide the education to their staff and sign the Staff Education form. Administrator will ensure compliance is met by 4/14/23

Licensee's Proposed Overall Completion Date: *03/30/2023*

Implemented (SK - 04/21/2023)

185a Storage procedures

10. 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 3 is insulin dependent and uses a glucometer:
On the MAR for 03/05/2023 there is a reading at 1900 hours for a Blood Sugar Level of 102, however in the glucometer, the reading for that date and time is 155.
On the MAR there is a documented glucometer reading of 74 that occurred on 03/15/2023 at 22:33, however this reading cannot be found in the glucometer's History.

-Resident 2 has a pro re nata (PRN) medication order of Hydrocort Cream 1%, however there is no medication in the medication cart and the residence does not have any on hand for the resident if needed.
-Resident 1 has a PRN medication order on the MAR for Fleet Enema; however, this medication is not located in the med cart and not available for the resident.
-Resident 1 has a PRN medication order on the MAR for Ketoconazole SHA 2% (shampoo); however, this medication is not located in the medication cart and not available for the resident.
-Resident 1 has a PRN medication order on the MAR for Diclofenac Gel 1%; however, this medication is not located in the medication cart and not available for the resident.

Plan of Correction ***Accept (SK - 04/20/2023)***

Email sent to LPNs and Med Techs regarding glucometer readings. Email attached and sent on 3/17/23

Glucometer audit to be completed by HSM or ALA every Monday, Wednesday, and Friday starting 3/27/23 for 1

185a Storage procedures (continued)

month. If glucometer readings have improved, HSM or ALA will complete them once a week. Currently audits are being done monthly. If documentation is incorrect, HSM or ALA will do a one on one education with the LPN or Med Tech who made the error on a "Performance Notation" form, see attached. If errors occur after the education, individual will receive a verbal warning on the "Corrective Action" form and will continue the corrective action process. Corrective Action form attached. Education to the staff regarding glucometer and audits attached entitled "Glucometers".

LPNs and Med Techs will be educated on having all medications available for all residents and reordering medications when the supply is exhausted, it expires, or an order changes. An education was prepared by the Administrator and given to the Health Services Manager. The Health Services Manager will provide the education to their staff and sign the Staff Education form. Administrator will ensure compliance is met by 4/14/23

Third shift staff will do weekly medication cart audits and reorder medications not present, expired or low on supply. Spreadsheet will be given to Nicole and kept for 3 months at a time. An education was prepared by the Administrator and given to the Health Services Manager. The Health Services Manager will provide the education to their staff and sign the Staff Education form. Administrator will ensure compliance is met by 4/14/23

LPNs and Med Techs were educated that if the last of a PRN medication is used, it expires or the order changes, they must reorder the medication or send it back to the pharmacy for it to be repacked with the correct label. An education was prepared by the Administrator and given to the Health Services Manager. The Health Services Manager will provide the education to their staff and sign the Staff Education form. Administrator will ensure compliance is met by 4/14/23

Licensee's Proposed Overall Completion Date: *04/12/2023*

Implemented (SK - 04/21/2023)

187d Follow prescriber's orders

11. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 3 has an order on the MAR for a cleanse of their left knee with normal saline solution for a skin tear. There is no documentation or log that this cleanse/ order was fulfilled by staff on the dates of 3/08/2023 and 3/09/2023. There was also no log or documentation of a cleanse of a skin tear located on the resident's left inner thigh.

Plan of Correction ***Accept (SK - 04/20/2023)***

Staff member who did not sign off the EMAR was given a verbal warning on 3/21/23. See attached

HSM will be required to run a report from Point Click Care at the end of every shift to ensure EMAR is documented and there are no missing signatures. Report will be turned into HSM and corrective action to follow if not complete. An education was prepared by the Administrator and given to the Health Services Manager. The Health Services Manager will provide the education to their staff and sign the Staff Education form. Administrator will ensure compliance is met by 4/14/23.

187d Follow prescriber's orders *(continued)*

Licensee's Proposed Overall Completion Date: *04/12/2023*

Implemented (SK - 04/21/2023)

225b Assessment content

12. Requirements

2800.
225.b. The assessment must, at a minimum include the following:
6. The resident's need for special diet or meal requirements.

Description of Violation

Resident 3's most recent ADME from [redacted] has a special diet indicator checked by a physician with the description being, "Consistent Carb." However, on the resident's most recent ASP, dated [redacted], Resident 3 is identified as having a "Regular Diet."

Plan of Correction ***Accept (SK - 04/20/2023)***

Administrator and Health Services manager did a chart audit on 3/20/23 of all current residents. Chart audit consisted of checking all ADMEs and ASPs for completion. The ADMEs and ASPs were also reviewed to ensure the information on the ADME such as mobility and diet are match what is on the ASP. The Health Services manager will provide Administrator with completed ADMEs for new admissions and the yearly or significant changes for review to ensure all parts are filled in. Administrator will initial ADME once checked. Chart audit to review ASPs already in place. Will add auditing the ADMEs for completion and matching ASPs to monthly audit process.

Resident 3's ASP was updated to include the diet during [redacted].

Dietary department was provided with a list of all resident diets on 3/20/23 and HSM educated dietary on definitions of diets such as consistent carb on 3/20/23

Licensee's Proposed Overall Completion Date: *04/12/2023*

Implemented (SK - 04/21/2023)

226a Mobility – assessment

13. Requirements

2800.
226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

On Resident 2's ADME from [redacted], lists the resident as having mobility needs, however both of the current ASP's state that the resident is mobile.

226a Mobility – assessment *(continued)*

Plan of Correction ***Accept (SK - 04/20/2023)***

On [redacted] HSM updated ASP to reflect the same information, including mobility needs to reflect the same information from the ADME. Administrator and Health Services manager did a chart audit on 3/20/23 of all current residents. Chart audit consisted of checking all ADMEs and ASPs for completion. The ADMEs and ASPs were also reviewed to ensure the information on the ADME such as mobility and diet are match what is on the ASP. The Health Services manager will provide Administrator with completed ADMEs for new admissions and the yearly or significant changes for review to ensure all parts are filled in. Administrator will initial ADME once checked. Chart audit to review ASPs already in place. Will add auditing the ADMEs for completion and matching ASPs to monthly audit process.

Licensee's Proposed Overall Completion Date: *04/13/2023*

Implemented (SK - 04/21/2023)

227e Self-administer medication

14. Requirements

2800.
227.e. The resident's final support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration and the ability of the resident to safely operate key-locking devices. Strategies that promote interactive communication on the part of and between direct care staff and individual residents shall also be included in the final support plan.

Description of Violation

According to a physician's order from [redacted], Resident 3 is able to self-administer Sodium Chloride 0.65% Saline Nasal Spray and Nystatin Cream USP (from 02/11/2023). However, Resident 3's most recent ADME and ASP [redacted]) state that the resident does not/ can't self-administer medication.

Plan of Correction ***Accept (SK - 04/20/2023)***

Administrator and Health Services manager did a chart audit on 3/20/23 of all current residents. Chart audit consisted of checking all ADMEs and ASPs for completion. The ADMEs and ASPs were also reviewed to ensure the information on the ADME such as mobility and diet are match what is on the ASP. The Health Services manager will provide Administrator with completed ADMEs for new admissions and the yearly or significant changes for review to ensure all parts are filled in. Administrator will initial ADME once checked. Chart audit to review ASPs already in place. Will add auditing the ADMEs for completion and matching ASPs to monthly audit process.

Requested order from PCP to discontinue the order that states resident can self administer. Resident was discharged from facility prior to order coming back.

Licensee's Proposed Overall Completion Date: *04/12/2023*

Implemented (SK - 04/21/2023)

231c1 Preadmit screening

15. Requirements

2800.
231.c.1. Special care unit for residents with Alzheimer's disease or dementia.

231c1 Preadmit screening *(continued)*

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

Description of Violation

Resident 4 was admitted into the special care unit (SCU), for which a preadmission screening form was completed on [redacted]. However, the Department's cognitive preadmission screening for special care units form was not completed.

Plan of Correction ***Directed (SK - 04/20/2023)***

Pre-admission screening completed and placed in resident's chart on [redacted].

Administrator and Health Services manager did a chart audit on 3/20 to ensure all preadmission screenings were present. HSM and or ALA will take a preadmission screenings to new resident assessments to ensure it is completed for each new admission.

Directed-
Furthermore, ALA and/or HSM will audit all new SCU resident admissions within 72 hours to ensure the Department's cognitive preadmission screening form is completed within the regulatory timeframe.

Directed Completion Date: *04/12/2023*

Implemented (SK - 04/21/2023)

254a Records – discharge/active

16. Requirements

2800.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

The medication cart for Long Hall, located in the unlocked Spa Room, held a red binder on top of the medication cart, labeled "Controlled Substance Elm Tree Count Book, Long Hall." Resident names, as well as diagnoses and narcotic medication records were located inside the binder.

Plan of Correction ***Accept (SK - 04/20/2023)***

Information was removed from the med cart on 3/16/23. Staff were educated about HIPAA and not keeping the narc books on top of the medication carts. All resident related information was removed immediately and locked in medication carts. Random med cart checks will be done by HSM and ALA and documented. For the first month, cart checks will be done Monday, Wednesday and Friday at random times through the day. After that, cart checks will be done twice a week. An education was prepared by the Administrator and given to the Health Services Manager. The Health Services Manager will provide the education to their staff and sign the Staff Education form. Administrator will ensure compliance is met by 4/14/23. Staff were educated between the dates of 3/29/23 and 4/11/23

Licensee's Proposed Overall Completion Date: *04/13/2023*

Implemented (SK - 04/21/2023)