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

January 19, 2024

[redacted]
QUINCY RETIREMENT COMMUNITY
[redacted]

RE: PARKER HOUSE ASSISTED LIVING
6596 ORPHANAGE ROAD
WAYNESBORO, PA, 17268
LICENSE/COC#: 33317

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/11/2023, 10/12/2023, 10/13/2023 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: *PARKER HOUSE ASSISTED LIVING* **License #**: *33317* **License Expiration**: *04/24/2024*

Address: *6596 ORPHANAGE ROAD, WAYNESBORO, PA 17268*

County: *FRANKLIN* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *QUINCY RETIREMENT COMMUNITY*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *01/18/2017* **Issued By**: *Quincy Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *64* **Waking Staff**: *48*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *10/13/2023*

Inspection Dates and Department Representative

10/11/2023 - On-Site: [redacted]
10/12/2023 - On-Site: [redacted]
10/13/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *47*

Special Care Unit

In Home: *Yes* **Area**: *Building #2* **Capacity**: *16* **Residents Served**: *16*

Hospice

Current Residents: [redacted]

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *47*

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

Have Mobility Need: *17* **Have Physical Disability**: *0*

Inspections / Reviews

10/11/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/06/2023*

Inspections / Reviews *(continued)*

11/09/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/12/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/16/2023*

11/20/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/12/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/29/2023*

01/19/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/12/2024*

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

25b Contract signatures and renewal

1. 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

The contracts for Resident [redacted] and [redacted], dated [redacted] and [redacted] respectively, were signed by the personal care home and the power of attorney. Neither of the contracts are signed by the resident, nor is there any indication that they were given the opportunity to sign.

Repeat Violation - 9/13/22

Plan of Correction ***Accept[redacted] - 11/08/2023)***

Residents [redacted] & [redacted] have dementia diagnosis and reside in our SDU, making it difficult for them to comprehend the content of the contract. ALRA printed out the contract signature page and had Resident[redacted] make an x. Resident [redacted] signed and ALRA dated both for them.
On [redacted] ALRA performed education with the Sales Counselor ([redacted] signs contracts with residents and families) regarding the need for residents to sign their contracts or we must be able to demonstrate we offered them the opportunity to sign the contract. 'Signatures on Contracts' has been added to the Paperwork Audit to be performed by the ALRA/designee each time a contract is scanned into system upon new admission. All staff educated on contract signatures by ALRA on [redacted] Audit results will be presented at the QM meeting.

Licensee's Proposed Overall Completion Date: *11/05/2023*

Implemented[redacted] - 01/16/2024)

26b Quality management plan content

2. Requirements

2800.
26.b. The quality management plan shall address the periodic review and evaluation of the following:

Description of Violation

The residence's quality management review provided to the Department is labeled "October". It should be noted that this was meeting minutes from the entire campus (IL, PC, AL, and various other departments). This report did not address complaint procedures nor licensing violations / actions regarding previous plans of correction.

Plan of Correction ***Accept[redacted] - 11/08/2023)***

ALRA provided staff education on [redacted] regarding the Quality Management meeting requirements. QM meeting form which contains all 5 required areas to be completed and presented for all QM meetings. This report will be kept in the QM/Resident Council Meeting binder in the ALRA office. ALRA responsible for reporting all required content. This form can double as an audit tool.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented[redacted] - 01/16/2024)

63a First Aid/CPR 1:35

3. Requirements

2800.
63.a. For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

Description of Violation

On [redacted] and [redacted], from [redacted] to [redacted] 47 residents were present in the residence. During this time, there were no staff present in the residence who were trained in first aid and certified in obstructed airway techniques and CPR.

On [redacted] and [redacted] from [redacted] to [redacted] 47 residents were present in the residence. During this time, there was one staff person present in the residence who was trained in first aid and certified in obstructed airway techniques and CPR.

Plan of Correction ***Accept [redacted] - 11/08/2023)***

ALRA identified staff members without current first aid/CPR and scheduled them for classes on 11/1/23 and 11/2/23. First aid/CPR added to HR NEO requirement list of items needed to be completed prior to first day working on the floor. On 11/1&11/2/23 ALRA provided education to all staff members and HR staff on DHS requirements for first aid/CPR. Tracking form to log all staff certification dates/renewal dates created and will be monitored/audited monthly by ALRA.. Audit results to be presented at QM meeting.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented [redacted] - 01/16/2024)

65g Initial direct care training

4. 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 persons A, B, C and D have not completed the Department approved direct care training course and passed the competency test as of the date of inspection. Each of these staff people have been providing unsupervised assisted living services prior to the completion of the required training.

REPEAT VIOLATION - 9/13/22

Plan of Correction ***Accept [redacted] - 11/08/2023)***

Staff members A,C,and D direct caregiver training certifications attached. Staff member B has not completed it and will not be on the schedule until such time it is completed.
On [redacted] ALRA identified all staff members who were non-compliant with the direct care staff training and scheduled them to take the on-line training. Direct Caregiver Staff training added to HR NEO requirement list of items needed to be completed prior to first day working on the floor. On 11/1&11/2/23 ALRA provided education to all staff members and HR staff on DHS requirements for direct caregiver staff training. Tracking form to log all staff certification dates created and will be monitored/audited with each new hire by ALRA..

65g Initial direct care training (continued)

Audit results will be reported at QM.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented [redacted] - 01/16/2024)

103e Leftovers

5. Requirements

2800.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At approximately 10:30 AM on 10/11/23, there was an unlabeled, undated, and unsealed bag containing approximately 5 pre-shelled hard boiled eggs (as a yellowish liquid spilled out upon lifting.

Also, the following items were found undated: an opened half-gallon container of milk and an opened half gallon container of Orange juice, 3 bags of sliced American cheese, and a metal tin of what appears to be broccoli cheese soup loosely covered with plastic wrap.

Repeat Violation - 9/13/22,1/5/23

Plan of Correction ***Accept [redacted] - 11/08/2023)***

All unlabeled/undated foods and containers were removed by ALRA on 10/12/23. Staff education on proper food storage provided by ALRA on 11/1&11/2/23. Audit of refrigerator to be completed by night shift staff each night. ALRA/designee to perform random audit weekly. Audit results to be reported at QM meeting.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented [redacted] - 01/16/2024)

121a Unobstructed egress

6. 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

The courtyard gates leading from the courtyard to the exterior of the property in buildings 1 and 3 are locked by a magnetic locking system, causing an obstructed egress from the courtyards to the exterior of the property. In addition, there are no codes posted at these doors. These courtyards are locked at all times.

Plan of Correction ***Accept [redacted] - 11/08/2023)***

Patio gate codes were placed by the ALRA on 11/3/23 at each patio in house 1&3.
Patio gate locks release when the fire alarm sounds giving egress to anyone who would need it. Manufacture letter provided. Education performed by ALRA on 11/1&11/2 to all staff on the need for codes to be placed at the locked

121a Unobstructed egress (continued)

gates. Audit codes at patio doors added to Environmental Rounds Audit by ALRA. Audit results to be presented at QM meeting.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented [redacted] - 01/16/2024)

132h Designated meeting place

7. Requirements

2800.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill conducted on 3/25/23, at 3:55 AM, [redacted] residents in Building One did not evacuate to a designated meeting place away from the building or within the fire-safe area.

During the fire drill conducted on 4/26/23, at 2:38 PM, [redacted] residents in Building One did not evacuate to a designated meeting place away from the building or within the fire-safe area.

During the fire drill conducted on 6/15/23, at 5:40 AM, [redacted] residents in Building Two did not evacuate to a designated meeting place away from the building or within the fire-safe area.

During the fire drill conducted on 2/23/23, at 4:42 PM, [redacted] resident in Building Three did not evacuate to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction ***Accept[redacted] - 11/08/2023)***

Drill completed on 2/23/23 was recorded in error. Resident in [redacted] was out with family and was counted in the census. Drill completed on 4/26/23 was recorded in error as residents from room [redacted] and [redacted] were both in the hospital at the time of the drill and were counted in the census.
On 11/1&11/2/23 ARLA completed education to all staff regarding safe evacuation during an emergency. ALRA will perform audits on a monthly basis to ensure 100% compliance with regulation. 'Fire Drills' added to Environmental Rounds Audit form to be completed by ALRA monthly. Results to be shared at QM meeting.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented [redacted] - 01/16/2024)

141a Medical evaluation

8. 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:
5. Allergies.
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.

141a Medical evaluation *(continued)*

Description of Violation

The medical evaluation for Resident [redacted], dated [redacted], does not include allergies. This area of the form is blank. The form also does not include an indication that a [redacted] test has been administered with [redacted] results within 2 years; or if the [redacted] test is [redacted], the result of a [redacted].

The medical evaluation for Resident [redacted] dated 1/16/23, does not include an indication that a [redacted] test has been administered with [redacted] within 2 years; or if the [redacted] test is [redacted], the result of a [redacted].

Plan of Correction ***Accept[redacted] - 11/19/2023)***

Resident [redacted] had a ADME completed on [redacted], [redacted] admission date was [redacted] and [redacted] was completed on [redacted].

ALRA trained all staff on 11/1&11/2/23 on the process of annual medical evaluations.

ARLA on [redacted] added [redacted] Allergies to Paperwork Audit Tool to be completed by the ALRA or designee on a monthly basis, randomly based off of the Resident Tracking Tool. Results will be presented at QM meeting.

Licensee's Proposed Overall Completion Date: *11/14/2023*

Implemented[redacted] - 01/16/2024)

141b1 Annual medical evaluation

9. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

Resident [redacted] most recent medical evaluation was signed on [redacted], by an unknown signatory. There is no indication as to what date the evaluation was actually completed. The resident's previous medical evaluation was signed on [redacted].

Plan of Correction ***Accept[redacted] - 11/08/2023)***

Resident [redacted] scheduled to have another ADME completed [redacted] to make her compliant with regulations.

On 11/1&11/2/23 ARLA performed education with all staff on Annual Medical Evaluation requirements.

'Annual ADME completion' added to the Paperwork Audit to be completed by ALRA or designee on a monthly basis, randomly audit residents from each house. Audit results to be presented at QM meeting.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented[redacted] - 01/16/2024)

182c Medication administration

10. Requirements

2800.
182.c. Medication administration includes the following activities, based on the needs of the resident:
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).

182c Medication administration *(continued)*

Description of Violation

On 10/11/23, at approximately 9:30 AM, staff person E gave [redacted] and an [redacted] to Resident [redacted] to administer them [redacted] and failed to actually administer the medication to the Resident. Resident [redacted] has not been assessed to self-administer any of [redacted] own medications.

Plan of Correction ***Accept [redacted] 11/08/2023)***

On 10/11/23 staff person E was educated by the ALRA upon the sighting of the violation with the inspector present. On 11/1&11/2/23 ALRA completed staff education on Medication Administration. Medication Management Audit Tool (Med pass portion) to be randomly completed by the LPN weekly. ALRA will do 4 random audits monthly using the same tool. Results will be reported at QM meeting.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented [redacted] - 01/16/2024)

183b Medications and syringes locked

11. Requirements

2800.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's living unit.

Description of Violation

On 10/11/23 at approximately 10:15 AM, an open and used tube of [redacted] was unlocked, unattended, and accessible on the nightstand in Room [redacted] being used by Resident [redacted]. Resident [redacted] has been assessed to self-administer their own medications.

Plan of Correction ***Accept [redacted] - 11/09/2023)***

On 10/12/23 LPN discarded the [redacted] belonging to resident [redacted]
On 11/1/&11/2/23 ALRA provided staff education on Medications and syringes locked procedures. Medication Management Audit Tool which includes the overall sweep of the resident room to look for any OTCs or medications that should not be left unattended or without orders. This audit will be completed by the med-tech once a week following the room cleaning schedule. LPN/ALRA will do 4 random audits monthly using the same tool. Results will be reported at QM meeting.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented [redacted] - 01/16/2024)

183d Current medications

12. 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 10/13/23, [redacted] tablets and [redacted] caplets, previously prescribed for Resident [redacted] were still in the residence's medication cabinet. However; these medications were not found on the Medication Administration Record (MAR) as they had been previously discontinued.

183d Current medications (continued)

On 10/13/23, Generic [redacted] which were previously prescribed for Resident [redacted] were still in the residence's medication cabinet. However; this medication was not found on the Medication Administration Record (MAR) as it had been previously discontinued.

Plan of Correction ***Accept [redacted] - 11/09/2023)***

On 10/12/23 LPN discarded all medications for resident [redacted] and [redacted] that had been discontinued. Medicine Chest Audit for each resident was completed by LPNs on 10/30&10/31/23. All orders now match medications in medicine chest.

On 11/1/711/2/23 ALRA provided staff education on Current Medication procedures. Medication Management Audit Tool will be completed by the med-tech once a week following the room cleaning schedule. LPN/ALRA will do 4 random audits monthly using the same tool. Results will be reported at QM meeting.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented [redacted] - 01/16/2024)

183f Discontinued medications

13. Requirements

2800.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the residence shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the residence, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the residence.

Description of Violation

Resident [redacted] is prescribed [redacted]. Resident [redacted] found in the medicine cabinet, and had an expiration date of [redacted]

The following expired medications were found in the medicine cabinet in the room of Resident [redacted]: [redacted] which Expired on [redacted]; [redacted] which expired on [redacted]; [redacted] which expired on [redacted]; and [redacted] caplet which expired on [redacted].

Plan of Correction ***Accept [redacted] - 11/09/2023)***

LPN discarded all EXPIRED medications that were found by the inspector on 10/12/23. Medicine Chest Audit for each resident was completed by LPNs on 10/30&10/31/23.

On 11/1/&11/2/23 ALRA provided staff education on EXPIRED Medication procedures. As of 10/31/23 all orders now match medications in medicine chest. Medication Management Audit Tool will be completed by the med-tech once a week following the room cleaning schedule. LPN/ALRA will do 4 random audits monthly using the same tool. Results will be reported at QM meeting.

Proposed Overall Completion Date: 11/06/2023

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented [redacted] - 01/16/2024)

184b - Labeling OTC/CAM

14. Requirements

2800.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 10/11/23, a tube of [redacted] belonging to Resident [redacted] was on the nightstand and was not labeled with the resident's name, nor any type of pharmacy label.

Plan of Correction ***Accept [redacted] - 11/09/2023)***

On 10/12/23 LPN discarded the [redacted] due to it not having an "opened on" date.
On 11/1&11/2/23 ALRA provided staff education on Labeling OTC/CAM procedures. Medication Management Audit Tool will be completed by the med-tech once a week following the room cleaning schedule, this will entail an overall sweep of the resident's room for any OTC, CAM or medications that should be labeled, locked up or in need of orders. LPN/ALRA will do 4 random audits monthly using the same tool. Results will be reported at QM meeting.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented [redacted] - 01/16/2024)

185a Storage procedures

15. 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 [redacted] is prescribed [redacted] and Natural Balance [redacted], both as needed. On [redacted], these medications were not available in the residence.

Resident [redacted] is prescribed [redacted], and [redacted] tablets as needed. On 10/13/23, these medications were not available in the residence.

Plan of Correction ***Accept [redacted] - 11/09/2023)***

Medicine Chest Audit for each resident was completed by LPNs on 10/30&10/31/23 using the current IMAR printout. All orders and medications in medicine chest now match.
On 11/1/&11/2/23 ALRA provided staff education on Medication Storage procedures. All orders now match medications in medicine chest. Medication Management Audit Tool will be completed by the med-tech once a week following the room cleaning schedule. LPN/ALRA will do 4 random audits monthly using the same tool. Results will be reported at QM meeting.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented [redacted] - 01/16/2024)

221c Post activity calendar

16. Requirements

2800.
221.c. The week's daily activity calendar shall be posted in advance in a conspicuous and public place in the residence. The residence shall provide verbal cueing and reminders of activities, their start times and locations within the residence.

221c Post activity calendar *(continued)*

Description of Violation

The residence does not have a current weekly activity calendar posted in a public and conspicuous place in any of the buildings on the residence.

Plan of Correction ***Accept - 11/19/2023)***

10/31/23 ALRA created a calendar for November activities, and it is now posted in the bulletin board case, as well as each resident has received a copy. ALRA educated staff on 11/1&11/2 on the importance of activities and resident's ability to have access to viewing what activities are available. ALRA/designee will audit the presence of the posted calendar by the 2nd of each month. Audit results to be presented at QM meeting.

Licensee's Proposed Overall Completion Date: *11/14/2023*

Implemented 01/16/2024)

227c Final support plan - revision

17. Requirements

2800.
227.c. The final support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. The residence shall review each resident's final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

Description of Violation

Resident support plan has not been reviewed on a quarterly basis. There was no review from 1/2022 to 11/2022.

Resident support plan has not been reviewed on a quarterly basis. There was no review from 3/2023 to 9/2023.

Resident support plan has not been reviewed on a quarterly basis. There was no review from 5/2023 to 9/2023.

Plan of Correction ***Accept - 11/09/2023)***

On 11/1&11/2 ALRA provided education to all staff on Final Support Plan process. Support Plan computer tracker was created by the Executive Director and implemented it's use on 11/1/23. Audit for Support Plan Quarterly Review will be added to the Paperwork Audit tool to be performed by the ALRA/designee on a monthly basis based off the tracking tool. Audit results will be presented at QM meeting.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented - 01/16/2024)

227g Support plan - signatures

18. Requirements

2800.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident participated in the development of support plan on However; the resident did not sign and date any of those support plans.

Repeat Violation - 9/13/22, 1/5/23

227g Support plan - signatures *(continued)*

Plan of Correction ***Accept[redacted] - 11/09/2023)***

On 11/1&11/2/23 ALRA provided education to all staff on the importance of getting resident signatures on the support plan. A computer support plan tracking tool was created and ALRA will randomly audit monthly the support plans based off of this tracking tool using the "paperwork audit tool". Audit results to be presented at QM meeting.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented[redacted] - 01/16/2024)

231j Residents who wander

19. Requirements

2800.
231.j. Residents who wander. The residence shall identify measures to address individuals with Alzheimer's disease or dementia or with INRBI who have tendencies to wander.

Description of Violation

The residence does not identify measures to address individuals with Alzheimer's disease or dementia who have tendencies to wander. The home has no policy regarding the assignment or use of the current WonderGuard system.

Plan of Correction ***Accept[redacted] - 11/08/2023)***

On 10/31/23 LPN completed an Elopement Risk Assessment on all residents who wear a wander guard bracelet. On 11/1&11/2 ALRA completed education to all staff on wander guard procedures. [redacted] Elopement risk assessment added to the paperwork audit tool which will be completed by ALRA/designee ongoing and reported at QM meeting.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Implemented[redacted] - 01/16/2024)

233a Lock approval

20. Requirements

2800.
233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The residence does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the magnetic locking system used on the exit doors located throughout Building two, the special care unit.

Plan of Correction ***Accept[redacted] - 11/08/2023)***

On 11/4/23 ALRA located the original written approval letter for key-locking devices. ALRA placed a copy of this approval letter in the DHS survey binder on 11/5/23. 'Key-locking approval letter' has been added the environmental rounds audit tool and will be completed monthly by the ALRA/designee. Audit results will be presented at the QM meeting.

Licensee's Proposed Overall Completion Date: *11/05/2023*

Implemented[redacted] - 01/16/2024)

233b Lock manufact. statement

21. Requirements

2800.
233.b. A residence shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:

Description of Violation

The residence does not have a statement from the manufacturer of the magnetic locking system verifying that the locks will release when the fire alarm system is activated, the residence's power fails, and when the lock releasing device is operated.

Plan of Correction ***Accept [redacted] - 11/08/2023)***

On 10/13/23 a manufacturer letter containing this information was secured and sent to the inspector via email by the ALRA. A copy of this letter has been placed in the DHS survey binder. On 11/1&11/2/23 ALRA educated staff on the importance of having this information handy and in DHS binder.
11/2/23 ALRA added "Manufacturer letter for locking devices to the Environmental Rounds audit form. Audit to be performed monthly by ALRA. Audit results will be presented at QM meeting.

Licensee's Proposed Overall Completion Date: *11/05/2023*

Implemented [redacted] - 01/16/2024)

233c Key-locking devices

22. Requirements

2800.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the residence's locking mechanism are not conspicuously posted near any of the locked egress doors, or the external courtyard gate in the special care unit.

Plan of Correction ***Accept [redacted] - 11/08/2023)***

On 11/3/23 maintenance placed the code plaques at all the exits in Parker House 2.
On 11/1&11/2 ALRA provided education to all staff on the importance of posting the code near the keypad devices. 'Code plaque presence' has been added to the "Environmental Rounds Audit to be performed by the ALRA/designee ongoing monthly. Audit results will be presented at QM meeting.

Licensee's Proposed Overall Completion Date: *11/05/2023*

Implemented [redacted] - 01/16/2024)