



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to STERLING HOME LLC

LEGAL ENTITY

To operate STERLING HOME

NAME OF FACILITY OR AGENCY

Located at 1318 ARCH STREET, MCKEESPORT, PA 15132

(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide Personal Care Homes

TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed 42
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions: _____

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes

(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from December 6, 2021 until December 6, 2022,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **452690**


ISSUING OFFICER


DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable
and should be posted in a conspicuous place in the facility.

HS 628 – 01/21



Emailing Date: December 6, 2021



Sterling Home, LLC
320 Roebling Street, #628
Brooklyn, New York 11211

RE: Sterling Home
1318 Arch Street
McKeesport, Pennsylvania 45269
License #:45269

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on August 18, 2021, August 19, 2021, August 20, 2021, and November 19, 2021, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in black ink that reads "Jamie L. Buchenauer". The signature is written in a cursive, flowing style.

Jamie L. Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

Facility Information

Name: *STERLING HOME* License #: *45269* License Expiration Date: *11/20/2021*
Address: *1318 ARCH STREET, MCKEESPORT, PA 15132*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: *412-672-4545*

Email: [REDACTED]

Legal Entity

Name: *STERLING HOME LLC*

Address: [REDACTED]

Phone: [REDACTED]

Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP*

Date: *01/30/2003*

Issued By: *L & I*

Staffing Hours

Resident Support Staff: *0*

Total Daily Staff: *18*

Waking Staff: *14*

Inspection

Type: *Partial*

Notice: *Unannounced*

BHA Docket #:

Reason: *Renewal,Provisional*

Exit Conference Date: *08/20/2021*

Inspection Dates and Department Representative

08/18/2021 - On-Site: [REDACTED]

08/19/2021 - On-Site: [REDACTED]

08/20/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *42*

Residents Served: *18*

Secured Dementia Care Unit

In Home: *No*

Area:

Capacity:

Residents Served:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *10*

Are 60 Years of Age or Older: *8*

Diagnosed with Mental Illness: *12*

Diagnosed with Intellectual Disability: *4*

Have Mobility Need: *0*

Have Physical Disability: *2*

Inspections / Reviews

10/21/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow Up Type: *Document Submission*Follow-Up Date: *11/05/2021*

VIOLATION WITHDRAWN - 12/2/21

1. Requirements

Description of Violation

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

On 8/18/2021 at 12:55 pm, there were multiple resident documents and mail unlocked, unattended, and accessible in bedroom #17 to include:

- * Several pieces of mail for residents #1 and #2*
- * A folder with medication administration records (MARs) indicating controlled substances prescribed to multiple residents, including residents #3 and #4 for June 2021.*

Plan of Correction

Accept

Administrator immediately retrieved the folder and mail listed within the violation and secured the items in the administration office which is a locked area and is inaccessible to unauthorized persons. This violation was an oversight due to room #17 was under renovations. Administration will complete weekly checks to ensure that all 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. Administration also reiterated the guidelines of record confidentiality to entire staff to prevent any future breach of record confidentiality. Please see attached documentation.

Completion Date: 10/05/2021

Implemented

18 - Compliance With Laws

1. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance.

On 8/18/2021, there were no carbon monoxide detectors near either of the gas furnaces in hallway #1.

On 8/18/2021, the carbon monoxide detector in the laundry room was only 3 feet from the gas dryer.

Plan of Correction

Accept

Due to facility renovations, the carbon monoxide detectors were temporarily removed to paint and were immediately replaced for onsite inspectors to verify in hallway #1. The carbon monoxide detector in the laundry room was removed due to there was a second operable carbon monoxide detector outside the laundry room in the hallway which is installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance and onsite inspectors were shown this carbon monoxide detector to verify it was indeed in place and operable at the time of inspection. The detector inside the laundry room was only in place per recommendation of the McKeesport fire department during the previous facility fire safety inspection. Moving forward, administration will perform weekly checks to ensure that all carbon monoxide detectors are in place and operable in compliance with the Care Facility Carbon Monoxide Alarms Standards Act to prevent further potential violations. Please see attached documentation and photos of installed carbon monoxide monitor outside the furnace room of hallway #1 and the existing carbon monoxide monitor outside of the laundry room as verified of placement by onsite department inspectors.

Completion Date: 10/04/2021

42c - Treatment of Residents

1. Requirements

2600.

- 42.c. A resident shall be treated with dignity and respect.

Description of Violation

At 9:05 on 8/18/2021, there were crumpled disposable incontinent pads on the blue love seat in the back TV room.

Plan of Correction

Accept

The incontinent pads were immediately disposed of. Administration has re-educated all staff regarding this violation and that disposable incontinent pads are not to be used on common furniture. Administration will include in weekly checks that there are no incontinence pads on common furniture so that all residents will continue to be treated with dignity and respect. Please see attached supporting documentation.

Completion Date: 10/05/2021

Implemented

1

VIOLATION WITHDRAWN - 12/2/21

VIOLATION WITHDRAWN - 12/2/21

85a - Sanitary Conditions**1. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 8/18/2021, the following unsanitary conditions were observed:

At approximately 3:35 pm, there was a sticky brown substance on the bottom of the small refrigerator in the storage room.

A strong odor of urine in both the back bathroom of hallway #2 and the bathroom in hallway #3.

A strong, pungent body odor in bedroom #5.

The ceiling light cover at the end of hallway #2 by the emergency door was full of dead insects.

Soap scum and debris measuring an area of about 16" by 3" strips on the left and right side of the non skid mat in the shower of the first bathroom in hallway #2.

10 unclean bedside commodes and 5 bowls in the closet of the second bathroom of hallway #2. The commode lids and bowls were covered with dust and brown speckles which appear to be feces.

Approximately 50 cigarette butts and cigar tips on the ground to the right coming from outside of the building to the smoking deck.

Plan of Correction**Accept**

All violations were immediately corrected for verification to on site inspectors. The refrigerator was cleaned, the odors in the bathroom were disinfected and removed. The odor in room #5 was not body odor but an odor from a medical foot condition which is being addressed by the resident's physician and the odor was eliminated upon discovery. The ceiling light was cleaned and the non-skid shower mat was replaced. The unused 10 bedside commodes and 5 bowls that were stored in the closet of the #2 hallway bathroom that were dusty and rusted (not fecal matter) were immediately disposed of and all cigarette butts were cleaned up upon notification.

Administration will conduct weekly checks to ensure that all sanitary conditions are maintained (please see attached documentation and photos) and all staff has been re-addressed on the above violations in order to maintain sanitary conditions within and outside the facility.

Completion Date: 10/05/2021**Implemented**

85b - Infestation**1. Requirements**

2600.

85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

There were numerous gnats and flies throughout the building on 8/18/21, 8/19/21 and 8/20/21, including approximately a pest strip covered with dead gnats and 23 live gnats on the walls in the storage room across from bedroom #12, and gnats on the walls near the exit and the end of hallway #2.

Plan of Correction**Accept**

Due to the renovations, doors are open at a constant which contributed to flies and gnats being within the home. A professional pest and rodent company is contracted to service the facility on a monthly and as needed basis to prevent any form of "infestation" within the home. The professional pest/rodent company performed a routine and extensive specialty pest inspection with treatments on 6/4/2021, 7/13/2021 and 8/30/2021 and documented that no infestation was found. Preventative treatments are completed during these services in prevention of any kind of infestation. Please see attached supporting documentation.

Preventative and routine treatments will continue to be performed as deemed necessary. The pest strip was immediately removed and disposed of. Administration will continue to ensure that if any evidence of a pest/rodent concern arises that the contracted pest/rodent control company is notified and dispatched immediately to rectify the issue so that there may be no evidence of infestation of insects or rodents in the home. Administration also reiterated to staff to continue to report immediately any potential evidence of pest/rodent concerns.

Completion Date: 10/05/2021

Implemented**85e - Trash Outside Home****1. Requirements**

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 8/18/2021, there was an accumulation of trash outside by the side of the building including food containers, drink cups, bottles and plastic grocery bags full of trash.

On 8/18/2021, at approximately 3:00 pm, the right side of the dumpster at the back of the home was open and overflowing with full trash bags.

85e - Trash Outside Home (continued)**Plan of Correction****Accept**

During the days of the department inspection, full cosmetic renovations were being completed, which included deliveries of new furniture and kitchen equipment and the other trash on the side of the building was in process of being disposed of in the side dumpster by the hired contractors which was explained to the on site inspectors by administration. Due to the renovations, excessive trash was existent and was to be picked up by the contracted trash removal service on 8/19/2021, which onsite inspectors could verify.

The facility trash pickup is scheduled 2x weekly to prevent an overabundance of trash in the dumpster area. To clarify, the back dumpster lid was propped open approximately 4"-6" due to the trash bags that were within the dumpster caused the lid not to close completely. This violation is not a reoccurring concern but temporary due to the current renovations.

Administration will complete weekly checks to ensure that the dumpster area is clear and that the lid is closed. Administration also re-iterated to all staff that the dumpster area is to be clear, trash is properly placed within the dumpster and the lid is closed.

Completion Date: 10/05/2021

Implemented**88a - Surfaces****1. Requirements**

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Repeat Violation

The 36" window glass in the emergency exit door from the back TV room was replaced by two sheet metal inserts. The top piece of the sheet metal overlaps the bottom piece and ends approximately 3" above the push bar to open the door. The edge of the sheet metal is sharp and the edge is turned up posing a laceration hazard.

There was a 1/2" gap between the floor and the bottom of the emergency door at the end of hallway #2 leading out to the dumpster. This opening poses a risk for pests to enter the home under the door.

There was a 30" crack across the middle of the window in bedroom #14.

Repeat Violation 4/6/2021

88a - Surfaces (continued)

Plan of Correction

Accept

The overlap in the sheet metal was immediately covered with contractor tape to prevent any kind of hazard for onsite inspector to verify. This door is to be replaced completely during next phase renovations. A replacement cover is to be placed over the area that will not pose any safety hazard. A barrier strip was placed on the inside base of the emergency door to cover the gap to prevent any pest from entering. The window of room #14 was replaced in a timely manner.

Administration to conduct weekly inspections that include all windows and doors for any safety hazards, damages and or related concerns and administration to ensure that any repairs will be completed in a timely manner. Please see attached supporting documentation and photos. Administrator also reiterated to all staff to immediately report any damages or safety concerns regarding windows and doors. A maintenance repair form is accessible to all staff per need to aid in reporting concerns that is located in a folder on the utility shelf in the laundry room.

Completion Date: 10/08/2021

Implemented

92 - Windows

1. Requirements

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

There were no screens in the following windows:

- * Bedroom #17*
- * Bedroom #19*
- * Bedroom # 13*
- * 2 windows in the living room: the window on the right by the outside door and the window on the left on the side wall.*
- * The small 12" by 18" louvered window in the glass block in the laundry room*

Plan of Correction

Accept

Bedrooms #17 and #19 and the living room in this violation were under renovation and were at that time were all occupied by contracting supplies and newly delivered furniture. Screens were present in the windows but were not secured due to they were to be replaced during such renovations which onsite inspectors could so verify. A screen was immediately installed in room #13 by the housekeeper upon notification that it was not properly in place. The louvered part of the glass block window has a screen and was immediately shown to onsite inspectors that it was in place and secured.

Administration will complete weekly checks to ensure that all screens are securely in place of all windows and reiterated to staff to continue to immediately report if there are any concerns related to screen placement and security to be timely rectified. A maintenance repair form is accessible to all staff per need to aid in reporting concerns that is located in a folder on the utility shelf in the laundry room. Please see attached documentation and photos that support this plan to correct.

Completion Date: 10/05/2021

Implemented

95 - Furniture and Equipment

1. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 8/18/21, the following items were in disrepair:

- There were pipes coming from the wall that were dripping water into a bucket in the back TV room.*
- The smoke detectors in the kitchen and in the furnace room were hanging approximately 5" from the ceiling by the wires.*
- The ceiling light in the kitchen was hanging approximately 6" from the ceiling by the wire.*
- The fluorescent light in the bathroom in hallway #3 was very dim and flickering making it difficult to see.*

Plan of Correction

Accept

Due to facility cosmetic renovations, the kitchen was under remodeling during the department inspection which was apparent to the onsite inspectors. New, upgraded smoke detectors were being installed in the kitchen and furnace room reason being they were hanging and were replaced during the inspection for onsite inspectors to verify. New, upgraded light fixtures were also being installed in the kitchen reason being they were hanging and were replaced during the inspection for onsite inspectors to verify. The water fountain in the back TV room was removed and is to be replaced and a contracted plumber was servicing the leaking valve of the pipe during the time of inspection coinciding the facility renovations. The valve was repaired for onsite inspectors to verify and the water fountain is to be reinstalled upon awaiting delivery. The fluorescent light bulb of the main light fixture in hallway #3 was replaced in a timely manner to ensure proper lighting.

Administration will complete weekly checks to ensure that all light fixtures are secure and equipped with operable light sources, smoke detectors are also secure and operable and that no pipes or other plumbing fixtures are leaking or loose and will seek immediate repairs/replacements per need. Administrator reiterated to staff to continue to immediately report if there are any concerns related to light fixtures and light sources (bulbs), smoke detectors and plumbing fixtures in need of any repair to be timely rectified. A maintenance repair form is accessible to all staff per need to aid in reporting concerns that is located in a folder on the utility shelf in the laundry room. Please see attached documentation and photos that support this plan to correct.

Completion Date: 10/08/2021

Implemented

100a - Exterior - Free of Hazards

1. Requirements

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Repeat Violation

There was a 8" by 8" hole in the deck by the wall of the building across from the door to the smoking deck, posing a trip and fall hazard.

Repeat Violation 4/6/2021

100a - Exterior - Free of Hazards (*continued*)**Plan of Correction****Accept**

On 4/6/2021, the same onsite inspector addressed the exact cracked wooden slat named in this violation and did not cite this area of the deck due to it did not have a hole nor did it pose a trip or fall hazard due to its location on the deck, which was not hindering an egress. In the initial violation, the wooden slat was replaced and if there was a potential hazard with the wooden slat in this violation it would have been easily replaced as well to prevent this alleged repeat violation. This particular wooden slat was in the same condition during both inspections as addressed by the administrator to the onsite inspectors. To clarify, the crack in the deck was not an 8" x 8" hole due to the wooden slat is less than 6" in diameter (please see attached supporting photos of the replaced wooden slat that is neighbored on both sides by original wooden slats that were not replaced and are fully intact) which clearly contradicts this violation.

Administrator had the wooden slat in this violation replaced to prevent any potential future discrepancies and/or violations. Administrator reiterated to all staff to continue to report to administration any potential hazards including outside decks and walkways that are in need of replacement or immediate repair to ensure safety. Administrator also included in documented weekly physical site inspections all outside areas which include the wooden decks and will enforce immediate repairs so that no hazards are present. Please see attached documentation.

Completion Date 10/11/2021**Implemented**

101j3 Bed/Linens/Pillows/Blankets

1. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Repeat Violation

On 8/18/2021, resident #1's sheets were worn and speckled with small holes.

Repeat violation 4/6/2021

Plan of Correction**Accept**

The flat sheet in this violation that had 2 small holes was immediately disposed of and replaced with a new sheet for onsite inspectors to verify. Administration has instructed all staff to discard any linens that are in any kind of disrepair to prevent the linens from being re-used. Administration will conduct weekly checks to ensure that all resident linens are free from holes and tears and will replace linens per need. Please see supporting documentation.

Completion Date: 10/05/2021**Implemented**

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

1. Requirements

2600.

102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface *(continued)***Description of Violation**

The grab bars on the over the toilet seat in the first common bathroom of hallway #2 were not securely bolted and lifted completely up away from the toilet.

There were no grab bars for the toilet or the urinal in the bathroom off of the furnace room by the kitchen.

Plan of Correction**Accept**

Administrator explained to onsite inspectors upon notification that the bathroom off of the furnace room by the kitchen was under renovation at the time of inspection and was not accessible to be utilized by anyone at this time. Also, this bathroom is a staff only bathroom that is locked and can only be accessed with a key that only staff has access to. This particular restroom is not for resident or public use.

The toilet seat in the first common bathroom was repaired same day for onsite inspectors to verify.

Weekly checks are to be completed by administration to ensure that all bathroom toilets and accessories surrounding (handrails) are present and are in complete good repair. Administration has reminded staff to continue to report any concerns related to toilet and bath areas and they must have grab bars, hand rails or assist bars that are in good repair. Toilet and bath areas must have grab bars, hand rails or assist bars and that bathtubs and showers must have slip-resistant surfaces. A maintenance repair form is accessible to all staff per need to aid in reporting concerns that is located in a folder on the utility shelf in the laundry room. Please see attached documentation and photos that support this plan to correct.

Completion Date: 10/05/2021

Implemented

102i - Soap Dispenser

1. Requirements

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 8/18/2021, there was no soap at the following bathroom sinks:

- * the common shower room across from bedroom #15 in hallway 2*
- * the common shower room by bedroom #10 in hallway 3*

Plan of Correction**Accept**

This violation was immediately corrected and on site inspectors verified. Administrator has reiterated and re-educated all staff that a dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Weekly checks are to be completed by administration to ensure that all bathroom sinks are equipped with a dispenser that contains soap. Please see attached supporting documentation.

Completion Date: 10/04/2021

Implemented

103a - Kitchen**1. Requirements**

2600.

- 103.a. A home shall have access on the grounds to an operable kitchen with a refrigerator, sink, stove, oven, cooking equipment and cabinets or shelves for storage. If the kitchen is not in the home, the home shall have a kitchen area with a refrigerator, cooking equipment, a sink and food storage space.

Description of Violation

On 8/18/21 and 8/19/21, there was no operable stove or oven in the home, sink for food preparation or sufficient space to prepare meals. Meals have been cooked in the private home of a staff person and transported to the home. There has not been a fully operable kitchen in the home since sometime in June 2021. The food preparation sink had no water hookups.

At 10:30 am on 8/18/21, agents of the Department observed staff person A slicing ham and onions on a blue tray on top of a medication cart in the front hallway amidst construction activity.

Plan of Correction**Accept**

Due to renovations, the kitchen underwent complete remodeling which in turn deemed it temporarily inoperable. The remodeling of the kitchen is completed and is now fully functioning. Please see attached photos and documentation. This violation will not reoccur due to the kitchen is operable and completed. Administrator addressed staff to continue to report any concerns related to the kitchen including issues with any appliance, plumbing, etc. so that immediate attention and repairs can be completed. Administrator also addressed staff that all food must be prepared in the kitchen. Administrator implemented weekly checks to ensure that the kitchen is operable always and that staff is preparing food in the kitchen only.

Completion Date: 10/11/2021

Implemented**103e - Left Overs****1. Requirements**

2600.

- 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 Repeat Violation

On 8/18/2021, at 3:35, there was an open and undated 5 pound bag of shredded cheese, 3/4 full, in the small refrigerator in the storage room.

On 8/18/2021, there was a zip lock bag of flour which was not labeled or dated when opened in the food pantry in the first hallway.

Repeated Violation 4/6/2021

103e - Left Overs (*continued*)**Plan of Correction****Accept**

Neither of the food items named in the above violation are "left over" food due to it was not "food served and returned from an individual's plate" or referred to as "prepared food" as described in 2600.103.e. The opened shredded cheese in the violation was dated on the manufacturer's label of the date opened. Both food items were disposed of for onsite inspectors to verify.

Moving forward, administrator will complete weekly checks to ensure that all food items are sealed properly, labeled and dated and reiterate to staff that all food items must be labeled, dated, sealed and stored to prevent any spoilage, infestation or cross contamination. Please see attached documentation that supports this plan to correct.

Completion Date: 10/05/2021

Implemented

103g - Storing Food

1. Requirements

2600.

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

Description of Repeat Violation

There was an open and unsealed 5 pound bag of shredded cheddar cheese, , 3/4 full, in the small refrigerator in the storage room.

On 8/18/2021, there were 2 bags of tortilla chips and a bag inside of the box of corn flakes not sealed or dated when opened in the food pantry in the first hallway. Each were 1/2 to 3/4 full.

Repeat Violation 4/6/2021

Plan of Correction**Accept**

The shredded cheese, tortilla chips and corn flakes were all immediately disposed of upon notification by inspectors that they were not properly sealed. Administrator will complete weekly checks to ensure that all food items are sealed properly, labeled and dated and reiterated to staff that all food items must be labeled, dated, sealed and stored to prevent any spoilage, infestation or cross contamination. Please see attached documentation that supports this plan to correct.

Completion Date: 10/05/2021

Implemented

103i - Outdated Food

1. Requirements

2600.

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

Description of Violation

On 8/18/2021, the following open, unlabeled and undated food was in the upright freezer in the storage room across from bedroom #12:

- * 1/2 bag of breaded meat patties*
- * a bag with 3 pieces of breaded fish*
- * a bag of rib patties*

103i - Outdated Food (continued)**Plan of Correction****Accept**

All food items listed in this violation were immediately disposed of for onsite inspectors to verify. Moving forward, administration will complete weekly checks to ensure that all food items are labeled and dated and reiterate to staff that all food items must be labeled and dated or they may not be used for consumption. Please see attached documentation that supports this plan to correct.

Completion Date: 10/08/2021

Implemented**103j - Utensils Cleaning****1. Requirements**

2600.

103.j. Eating, drinking and cooking utensils shall be washed, rinsed and sanitized after each use by a method specified in 7 Pa. Code Chapter 46, Subchapter D (relating to equipment, utensils and linen).

Description of Violation

The home has not had an operable dishwasher since June 2021 and the kitchen sink has no water hookups. Cooking utensils are being washed by hand and rinsed in the utility sink in the laundry room; however, they are not being sanitized.

Plan of Correction**Accept**

The dishwasher and sink were removed and replaced due to renovations and a full remodeling of the home's kitchen at the time of and prior to inspection. Administrator clarified to on site inspectors that this violation only occurred due to such renovations and a full remodeling of the home's kitchen. The kitchen was completed with a new commercial sink with fully operable water hook ups and a new dishwasher that is equipped with a heat dry sanitizing feature so that moving forward all eating, drinking and cooking utensils shall be washed, rinsed and sanitized after each use by a method specified in 7 Pa. Code Chapter 46, Subchapter D (relating to equipment, utensils and linen). This violation is corrected.

Administrator educated staff that all eating, drinking and cooking utensils shall be washed, rinsed and sanitized after each use by utilizing the sink for washing and rinsing and the dishwasher for sanitizing purposes and that no other sink in the home is to be used for washing of dishes/cookware/utensils of any kind. All staff was also reiterated on reporting of any concerns related to plumbing (such as leaks) and any appliances so that administration can immediately have repairs completed to ensure the kitchen equipment remains functional and operable always. Please see attached photos and documentation.

Completion Date: 10/08/2021

Implemented**123c - Evacuation Diagrams****1. Requirements**

2600.

123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

On 8/18/2021, the evacuation diagram in the hallway by bedroom #12 does not include the location of fire extinguishers or pull stations.

123c - Evacuation Diagrams (continued)**Plan of Correction****Accept**

Attached is the master copy (exact replica) of the evacuation diagram that is posted throughout the home, where the fire extinguishers (labeled with a circled number 4) and pull stations (labeled with a circled number 9) which is dictated on the lower left hand corner of the evacuation diagram. Administrator identified and clarified the attached evacuation diagram to both onsite department inspectors during the exit interview. To avoid future discrepancies, administrator revised the approved evacuation diagram to more clearly identify the locations of the fire extinguishers and pull stations within the home and posted them in their designated locations in the home. Please refer to the attached evacuation diagrams (original and revised).

Completion Date: 10/08/2021**Implemented****125a - Combustible Storage****1. Requirements**

2600.

125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 8/18/2021, there was a cardboard box stored approximately 16 inches from the hot water tank in the furnace closet to the left of the front door.

Plan of Correction**Accept**

This violation was immediately corrected for on site inspectors to verify.

Administrator to reiterate and educate all staff that combustible and flammable materials may not be located or stored near heat sources or hot water heaters. Administration will conduct weekly checks to ensure that there are not any combustible and flammable materials located near heat sources or hot water heaters. Please see supporting documentation of this violation.

Completion Date: 10/08/2021**Implemented****130a - Smoke Detector 15 ft Bedroom****1. Requirements**

2600.

130.a. There shall be an operable automatic smoke detector located within 15 feet of each bedroom door.

Description of Violation

All of the smoke detectors in hallway #1 were taken down during the renovations. There were no smoke detectors near bedrooms 1 through 3 and 16 through 21.

There was no battery in the smoke detector on the ceiling next to bedroom #5 in hallway #3. The smoke detector would "chirp" intermittently.

130a - Smoke Detector 15 ft Bedroom (continued)**Plan of Correction****Accept**

At the time of inspection, there were operable smoke detectors inside of rooms 1 through 3 and 16 through 21 that were located on the ceilings of each room within 15 feet of each bedroom door. Administrator identified the detectors that were in place and the hallway detectors were temporarily removed to paint the hallway walls (as part of the renovations) and were reinstalled during the inspection, also for inspectors to verify. The battery was replaced in the smoke detector next to bedroom #5 in hallway #3 during the inspection for inspectors to verify.

Moving forward, administration will perform weekly checks to ensure that all smoke detectors are operable and are dated with the battery installation date. Administration reiterated to all staff to immediately report any concerns regarding smoke detectors which include placement and any 'chirping' sounds so that they can be maintenance in a timely manner. Please see supporting documentation and photos of this violation.

Completion Date: 10/05/2021**Implemented****131f - Fire Extinguisher Inspection****1. Requirements**

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the laundry room has not been inspected by a fire safety expert since June 2020.

Plan of Correction**Accept**

This violation was an oversight and was corrected. Administrator notified the contracted company that inspects, maintains and supplies the home with fire extinguishers to inspect the extinguisher named in this violation. All extinguishers (including the extinguisher within the violation) were inspected June 8, 2021 and were tagged accordingly with the accidental omission of the extinguisher in the laundry room per the contracted company (please see attached inspection report). The same technician from the June 8, 2021 re-checked all extinguishers and updated the tag on the omitted extinguisher in the laundry room.

Moving forward, administrator will accompany the contracted company technician that inspects, maintains and supplies the home with fire extinguishers during the annual and as needed inspections to ensure that every fire extinguisher is properly tagged and dated during that inspection with supporting documentation. Please see attached photo and document.

Completion Date: 10/08/2021**Implemented****162e - Menu Changes****1. Requirements**

2600.

162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

162e - Menu Changes (*continued*)**Description of Violation**

The dinner menu for 8/18/21 was stuffed peppers, mashed potatoes, corn and ice cream. However, the meal served was breaded chicken patties.

The lunch menu for 8/19/21 was pork chops with rice, gravy, sweet peas with carrots, Jello with fruit and pudding. However, stuffed peppers, mashed potatoes, corn and peas and pudding were served instead.

The menu changes were not posted in a conspicuous and public place in the home in advance of the meals.

Plan of Correction**Accept**

Administrator immediately addressed on site staff and re-educated all staff that any change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal and that verbal notification of meal changes is not acceptable.

Administrator also informed staff that any future menu change must be approved by administration and a reason for any menu change must be provided. Administrator to ensure that all components of each meal are available to staff prior to meal preparation to prevent reason for any abrupt menu alterations.

Administration will also conduct weekly menu checks to ensure that any menu changes are documented and posted. Administrator has also included on the agenda of any menu change concerns with the residents at the next resident council meeting to be held on 10/22/2021. Please see supporting documentation of this plan to correct.

Completion Date: 10/08/2021

Implemented

184a - Labeling OTC/CAM

1. Requirements

2600.

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

Description of Violation

The pharmacy label and physician order for resident #2's Diclofenac Sodium topical gel 1% indicates apply 2 grams topically 4 times daily. The medication administration record (MAR) indicates Diclofenac Sodium topical gel 1%, apply 2 grams topically twice daily as needed.

184a - Labeling OTC/CAM (continued)

Plan of Correction

Accept

Not a violation under 184.a. due to the medication (diclofenac sodium topical gel 1%) is an over the counter medication and does not require a prescription label which is outlined in 184.b.. As shown to onsite inspectors during the inspection, the medication did have the resident's name written on the dispensing container. Though a prescription label was present on the tube, a "change of direction, refer to chart" label was adhered to the tube as well. Administrator did reiterate to med trained staff that OTC medications do not require a prescription label and if one is present that the MAR must correspond with the directions on the label and if there is a discrepancy, administration is to be notified and a "change of direction, refer to chart" label must be adhered to such label.

Administrator will continue to conduct documented weekly cart and MAR audits to ensure that all physician orders match the directions on the MAR, all necessary labels are intact to ensure that the order is followed per MD to avoid any potential misunderstanding and error. Please see attached documentation.

Completion Date 10/11/2021

Implemented