pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ALEXANDRIA MANOR OF ALLENTOWN INC**
LEGAL ENTITY

To operate **ALEXANDRIA MANOR II**
NAME OF FACILITY OR AGENCY

Located at **313 S. WALNUT ST., BATH, PA 18014**
(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 **78**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

PROVISIONAL

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 **May 5, 2023** until **November 5, 2023**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **205261**

ISSUING OFFICER

ACTING 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 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: jburns@alexandriamanor.com
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MAY 5, 2023

[redacted]
Alexandria Manor Allentown Inc
[redacted]

RE: Alexandria Manor II
313 South Walnut Street
Bath, Pennsylvania 18024
License #: 205261

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on August 16, 2022, August 17, 2002, March 29, 2023 and March 30, 2023 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 205260) dated May 7, 2022 to May 7, 2023 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated May 7, 2022 to May 7, 2023 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to <62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3); (4); (5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from May 5, 2023 to November 5, 2023.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code	Class	Fine	Calculated	Mandated

Chapter 2600 or 2800 Section:	of Violation	Census at Inspection	X Per resident Per day	= Fine Per day	Correction Date (to avoid Fine)
162c	III	47	$3	$141	5 calendar days from mailing date of this letter
182b	II	47	$5	$235	15 calendar days from mailing date of this letter
185a	II	47	$5	$235	5 calendar days from mailing date of this letter
187d	II	47	$5	$235	15 calendar days from mailing date of this letter
221c	III	47	$3	$141	15 calendar days from mailing date of this letter
252	III	47	$3	$141	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services

Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary>

cc: [redacted]

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

Facility Information

Name: *ALEXANDRIA MANOR II* **License #**: *20526* **License Expiration**: *05/07/2023*

Addre : *313 S WALNUT ST , BATH, PA 18014*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *ALEXANDRIA MANOR OF ALLENTOWN INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *08/27/1998* **I ued By**: *L&I*

Staffing Hours

Resident Support Staff: *4* **Total Daily Staff**: *33* **Waking Staff**: *25*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *09/02/2022*

Inspection Dates and Department Representative

08/16/2022 On Site [redacted]

08/17/2022 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *78* **Residents Served**: *25*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

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

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

Have Mobility Need: *4* **Have Physical Disability**: *1*

Inspections / Reviews

08/16/2022 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *09/24/2022*

02/22/2023 POC Submi ion

Submitted [redacted] **Date Submitted:** *04/14/2023*

[redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/01/2023*

05/03/2023 Document Submi ion

Submitted By: [redacted] **Date Submitted:** *04/14/2023*

Reviewer: [redacted] **Follow Up Type:** *Enforcement*

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

The home was found to be storing residents' lab and X-ray orders and results outside the Administrator's office door. The location was adjacent to the main entrance into the facility which allowed visitors and others access to residents confidential medical information.

POC Submission ***Accept [redacted] - 02/22/2023)***

Corrected day of inspection

Moving Forward:
Binder containing labs and xray orders were moved to a bin inside the office. All Alexandria Manor staff were made aware. Lab company and x-ray company will come to staff when binder is needed.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not Implemented [redacted] 04/18/2023)

18 - Compliance With Laws

2. 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 Carbon monoxide detector battery located in the facility's kitchen was last changed 5/5/21. The home is required to change the batteries annually per the Care Facilities Carbon Monoxide Standards Act.

POC Submission ***Accept [redacted] - 02/22/2023)***

Corrected day of inspection

Moving forward batteries will be changed 2 weeks prior to expiration date, log will be kept, and signature will be required of person changing batteries.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Implemented [redacted] - 04/18/2023)

41e - Signed Statement

3. Requirements

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

Description of Violation

Resident #1's contract dated 10/06/2006 did not contain the resident's right to refuse medications if they feel the medication is being given in error.

POC Submission ***Accept [redacted] - 02/22/2023)***

Corrected day of inspection

All resident charts were audited by me [redacted] to make sure they had the proper Resident's Rights form attached. All new resident packets that were printed were audited, and PDF file was checked to make sure proper document is what it being used.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Implemented [redacted] - 04/18/2023)

51 - Criminal Background Check

4. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Direct care staff member A hired [redacted] Pennsylvania State Police Criminal Background Check was completed on 5/23/17.

Direct care staff member B hired [redacted] did not have a Pennsylvania State Police Criminal Background Check completed.

POC Submission ***Accept ([redacted] - 02/22/2023)***

Accounting department was contacted regarding the proper and timely fashion criminal background checks are needed to be done in.

Moving Forward:
(administrator) will contact accounting department 1 week following a new hire to make sure criminal background checks are done in proper time frame.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not [redacted] - 04/18/2023)

54a - Direct Care Staff

5. Requirements

54a - Direct Care Staff *(continued)*

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff member B hired [redacted] did not have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

POC Submission ***Accept [redacted] - 02/22/2023)***

Direct Care staff B provided a copy of GED and is now in her file.

Moving forward:

Staff will not start until a high school diploma or GED is provided.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not Implemented [redacted] 04/18/2023)

63a - First Aid/CPR Training

6. Requirements

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

Description of Violation

The home currently serves 25 residents and is required to have one person certified in First Aid and CPR at all times. On 8/13 and 8/14/22 no one was certified in First Aid and CPR from 6:30 pm to 630 am.

POC Submission ***Accept [redacted] - 02/22/2023)***

Moving Forward:

All staff of Alexandria Manor are required to use our CPR instructor as we provide the training. No other CPR/First Aid certification will be permitted, due to the issue of not being able to properly validate certification.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Implemented [redacted] 04/18/2023)

65a - FS Orientation 1st Day

7. Requirements

2600.
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.

65a - FS Orientation 1st Day *(continued)*

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 e tinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff member A hired [redacted] and Direct care staff member B hired [redacted] did not complete the general fire safety training on or before the 1st day they worked in the home.

POC Submission ***Accept [redacted] - 02/22/2023)***

Corrected with staff and training was complete.

Moving Forward:
All new staff will have a training day prior to start day of their actual position to prevent missed trainings or missed document's.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not Implemented ([redacted] - 04/18/2023)

65b Rights/Abuse 40 Hours

8. Requirements

2600.
65.b. 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.

Description of Violation

Direct care staff member A hired [redacted] and Direct care staff member B hired [redacted] did not complete training in resident rights, The Older Adult Protective Services Act, emergency medical plan and reporting of reportable incidents and conditions within the first 40 hours worked.

POC Submission ***Accept ([redacted] - 02/22/2023)***

Corrected with staff and training was complete.

Moving Forward:
All new staff will have a training day prior to start day of their actual position to prevent missed trainings or missed document's.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

65b - Rights/Abuse 40 Hours *(continued)*

Not Implemented (RY - 04/18/2023)

82c - Locking Poisonous Materials

9. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

A spray bottle of OdoBan was found in Room [redacted], the resident is unable to safely handle and identify poisonous materials. The warning label states to seek medical attention if swallowed or in contact with the eyes.

POC Submission ***Accept [redacted] - 02/22/2023)***

Corrected at time of inspection.

Housekeeping was re-educated on the importance of locking poisonous materials. Random audits are being completed while housekeepers are working to make sure they are following proper poisonous material protocol.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not Implemented [redacted] 04/18/2023)

86b - Bathroom

10. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathroom fan in Room #[redacted] was not operable.

POC Submission ***Accept[redacted] - 02/22/2023)***

Fan was replaced day of inspection.

Moving Forward:
All fans in facility bathrooms were audited to make sure they were operable. All staff was re-educated on the mportance of an operable fan and to make administrator or maintenance is aware if an issue with a fan is present. Audits are being done monthly on bathroom fans.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Implemented[redacted] - 04/18/2023)

88a - Surfaces

11. Requirements

88a - Surfaces *(continued)*

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The ceiling of the 2nd floor medication room was water stained. The center of the water stain had a 3 inch circular area with a black raised substance on it.

POC Submission ***Accept ([redacted] - 02/22/2023)***

Maintenance was made aware of ceiling issue day of inspection. Ceiling has been corrected and maintenance has looked into the issue of why it was water stained.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Implemented [redacted] - 04/18/2023)

91 - Telephone Numbers

12. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

The telephones in room #2 and # Hall way 1-A did not have the required emergency numbers posted on or near the telephones.

POC Submission ***Accept [redacted] /22/2023)***

Corrected at time of inspection.

Moving Forward:
All resident room and areas with phones have been audited and all emergency numbers have been corrected and posted.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not Implemented ([redacted] - 04/18/2023)

95 - Furniture and Equipment

13. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

Two couches located in the left front TV lounge area of the facility had large patches of leather material measuring 2 feet long and 2 feet high missing on the front back of the couches.

95 - Furniture and Equipment *(continued)*

POC Submission ***Accept [redacted] 02/22/2023)***

All couches have been replaced in left front TV common area. Pictures can be provided.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Implemented ([redacted] - 04/18/2023)

103f - Refrigerator/Freezer Temps

14. Requirements

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

Description of Violation

The 2 Frigidaire Brand refrigerators located in the dry goods room did not have a thermometer in them at the time of inspection. The combination refrigerator freezer did not have a functional thermometer at the time of inspection.

POC Submission ***Accept [redacted] - 02/22/2023)***

Corrected day of inspection, thermometers were placed in both units.

Moving Forward:

All refrigerators and freezers are being audited weekly to maintain proper compliance.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not Implemented [redacted] 04/18/2023)

121a Unobstructed Egress

15. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

The front emergency exit marked #4 had 2 patio chairs blocking the exit route on the exterior porch, preventing immediate egress in the event of an emergency.

POC Submission ***Accept [redacted] 02/22/2023)***

Corrected day of inspection.

Moving Forward:
All staff were made aware to monitor when residents go outside to make sure chairs are not being placed in front of the doors. Resident council meeting took place to explain to the residents the importance of not having the doors blocked by chairs. Sign is also hanging on the door explaining not to block the doorway.

121a - Unobstructed Egress (continued)

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Implemented [redacted] - 04/18/2023)

144c2 - Smoking Area Distance

16. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

4 chairs with fabric on them were located in the homes designated smoking area, posing a possible fire hazard.

POC Submission ***Accept [redacted] - 02/22/2023)***

Chairs were removed the day of inspection.

Outside smoking area chairs were replaced with metal chairs.

Moving forward:
No other chairs will be allowed in designated smoking.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not Implemented [redacted] - 04/18/2023)

162c - Menus Posted

17. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home had the current week menus posted for week 08/14/22 thru 08/20/22. The home did not have the upcoming week menu posted and available for the residents to review.

Repeat violation: 10/25/21

POC Submission ***Accept [redacted] - 02/22/2023)***

Corrected day of Inspection

Kitchen staff have been re-educated on the importance of having current and upcoming menu posted. It was also explained to them that it is a requirement by our licensing department to have current and upcoming menus posted. Bulletin boards will be audited to make sure proper menus are posted.

162c - Menus Posted (continued)

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not Implemented ([redacted] - 04/18/2023)

182b - Prescription Medication

18. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Direct care staff member C's 2022 annual practicum only had 2 MAR reviews completed.

Direct care staff member A's original medication administration training was completed on 7/19/18. The staff member stopped working at the home on 9/14/18. The staff member did not complete the initial medication administration training upon getting rehired on 3/18/22.

Repeat violation: 10/25/21

POC Submission ***Accept[redacted] - 02/22/2023)***

Moving Forward:

Medtech records were reviewed and audited to stay in proper compliance. When staff are rehired, they will have all trainings including medication and diabetic training redone to stay in proper compliance.

As the administrator I am responsible for proper ongoing compliance.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not Implemented ([redacted] - 04/18/2023)

182c - Medication Administration

19. Requirements

2600.
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).

Description of Violation

Through resident interviews it was determined that the medication trained staff are not always following the required

182c - Medication Administration (continued)

procedures for administering medications. Resident #2 reported that the staff will often place the resident's medications on their bedside table or at their seat during meals, as Resident #2 stated they know they are reliable and will take their medication as directed.

POC Submission ***Accept (02/22/2023)***

All MedTech's were re-educated on the importance of following MARs, prescriber's instructions, proper documentation and mediation administration rights.

Moving Forward:
Random resident interviews are being done by myself (admin) to make sure MedTech's are following proper procedure and to maintain proper compliance.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not Implemented - 04/18/2023)

183a - Original Containers and Injections

20. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

It has been determined through a staff interview that if a resident leaves the building the home will pop the medications needed out of the blister pack and put the medications in a baggie to go out with the resident. The home is taking the medication out of the original container and placing it in another container for administration.

POC Submission ***Accept - 02/22/2023)***

All medtechs have been re-educated on proper LOA procedure.

Moving Forward:
MedTech's will release blister packets to resident or family who is taking resident LOA along with having them sign a medication LOA form. Medication is counted upon leaving and returning to maintain proper compliance.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Implemented (04/18/2023)

184b Labeling OTC/CAM

21. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident s name.

Description of Violation

Resident #3's Vitamin D3 did not have the residents name on the bottle.

184b - Labeling OTC/CAM *(continued)*

POC Submission ***Accept [redacted] 02/22/2023)***

Corrected at time of inspection.

All medication carts were audited to make sure all OTC and CAMs had name properly placed.

As the administrator I am responsible for proper ongoing compliance.

Moving Forward:
All OTC and CAM medications must first come to the office to make sure name is properly placed on container before going into the cart.

Licensee's Plan Completion Date: *01/12/2023*

Implemented ([redacted] 04/18/2023)

185a - Implement Storage Procedures

22. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #3's PRN albuterol HFA inhaler was not available at the time of the inspection.

Resident #4's glucometer was not calibrated to the correct date and time.

Resident #4 has an order for blood glucose readings 4x daily. From 8/10-8/16/22 readings were noted on the MARS for 8pm but no readings were noted in the residents glucometer. On 8/10/22 at 11:30 am a reading of 375 was noted on the MAR but the reading in the glucometer was 376. On 8/10/22 at 6:30 am a reading of 181 was noted on the MAR but the reading in the glucometer was 209.

Repeat violation: 10/25/21

POC Submission ***Accept [redacted] - 02/22/2023)***

Resident #3 corrected day of inspection, inhaler was delivered by pharmacy.

Moving Forward:
All glucometers were audited for calibration. Blood sugar logs are being audited to maintain proper ongoing compliance. Staff was re-educated on the importance of proper glucometer usage and proper documentation.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not Implemented [redacted] - 04/18/2023)

187a - Medication Record

23. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #5's 8 am medications were not initialed as administered on 8/1/22. Resident #5's 8 pm medications were not initialed as administered on 8/2, 8/4, 8/5, 8/8-8/10, 8/13-8/14 and 8/16/22.

Resident #5 has an order for novolog 100 u PRN if blood glucose is more than 180. The MAR notes less than 180, the MAR is incorrect.

Repeat violation: 10/25/21

POC Submission ***Accept ([redacted] - 02/22/2023)***

All MedTech's were re-educated on the importance of following MARs and prescriber's instructions along with proper documentation.

Moving Forward:
MAR's are being audited on a random basis to monitor and maintain proper ongoing compliance.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Implemented [redacted] - 04/18/2023)

187c - Refusal of Medication

24. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #3 refused the prescribed medications on 8/6/22 at 8 am. The prescriber was not notified regarding the refusals.

POC Submission ***[redacted] - 02/22/2023)***

Corrected at time of inspection.

Moving forward:
MedTech's were re-educated on the importance of notifying the prescriber when a resident refuses medication. MARs are being randomly audited to ensure proper compliance.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not Implemented [redacted] - 04/18/2023)

187d - Follow Prescriber's Orders

25. Requirements

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

Description of Violation

Resident #4 has an order for blood glucose readings 4x daily. From 8/10-8/16/22 at 8pm the blood glucose readings were not completed.

Resident #3 has an order for quetiapine fumerate 100 mg at bedtime. The resident did not receive the medication on 8/16/22 at 8 pm.

POC Submission ***Accept [redacted] - 02/22/2023)***

All MedTech's were re-educated on the importance of following MARs and prescriber's instructions along with proper documentation.

Moving Forward:
MAR's are being audited on a random basis to monitor and maintain proper ongoing compliance.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not Implemented [redacted] 04/18/2023)

221c - Post Activity Calendar

26. Requirements

2600.
221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

Description of Violation

On the first day of the inspection 08/16/22 the home's activity calendar that was posted in the facility had a date for June 2022.

Repeat violation: 10/25/21

POC Submission ***Accept [redacted] - 02/22/2023)***

Corrected day of inspection.

Activities director was re-educated on the importance of having an activity calendar posted as it is a state regulation. Bulletin boards are being audited weekly to make sure activity calendars are posted and visible.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not Implemented [redacted] 04/18/2023)

252 - Record Content

27. Requirements

252 - Record Content *(continued)*

2600.
252. Content of Resident Records - Each resident's record must include the following information:
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

Description of Violation

Resident records for Resident #4 did not address if the resident had any identifiable marks.

Repeat violation: 10/25/21 & 6/8/22

POC Submission ***Accept [redacted] - 02/22/2023)***

Corrected at the time of inspection.

Moving Forward:
All resident charts were audited by me (Jackie Burns) to make sure they all had all required information.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Plan Completion Date: *01/12/2023*

Not Implemented [redacted] 04/18/2023)

Department of Human Services
Bureau of Human Service Licensing
PRIVACY CODING

Facility Information

Name: *ALEXANDRIA MANOR II* **License #**: *20526* **License Expiration**: *05/07/2023*
Address: *313 S. WALNUT ST., BATH, PA 18014*

Inspection Information

Start Date: *08/16/2022* **Type**: *Full*

Staff Privacy Coding

De ignation	Staff Member Name	Job Title	Date Hired
Staff Member A	*Johnniece Alvarado*	*Direct Care*	
Staff Member B	*Brenda Robinson*	*Direct Care*	
Staff Member C	*Crystal Bennett*	*Direct care*	

Resident Privacy Coding

De ignation	Re ident' Name
Resident 1	*Peggy Hoffman*
Resident 2	*Carolyn Daniels*
Resident 3	*Drew Bergenback*
Resident 4	*Richard Reinert*
Resident 5	*Kathleen Caulfield*

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

Facility Information

Name: *ALEXANDRIA MANOR II* **License #**: *20526* **License Expiration**: *05/07/2023*

Addre : *313 S WALNUT ST , BATH, PA 18014*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *ALEXANDRIA MANOR OF ALLENTOWN INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *08/27/1998* **I ued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *52* **Waking Staff**: *39*

Inspection Information

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

Reason: *Interim* **Exit Conference Date**: *03/30/2023*

Inspection Dates and Department Representative

03/29/2023 On Site [redacted]

03/30/2023 Off Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *78* **Residents Served**: *47*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

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

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

Have Mobility Need: *5* **Have Physical Disability**: *0*

Inspections / Reviews

03/29/2023 - Partial

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

05/04/2023 POC Submi ion

Submitted By: [redacted] **Date Submitted:** *04/17/2023*

[redacted] **Follow Up Type:** *Enforcement*

51 - Criminal Background Check

1. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Direct care staff member A hired [redacted] did not have a Pennsylvania State Police Criminal Background check completed.

Direct care staff member B hired 10/12/22 did not have a Pennsylvania State Police Criminal Background check completed until 10/27/22. The staff member worked unsupervised in the home prior to the background check being completed.

Plan of Correction ***Directed [redacted] - 05/02/2023)***

Moving Forward:
(administrator) will be handling criminal background checks for my facility. Owner will be providing administration access to a credit card to complete timely criminal background checks. As the administrator I am responsible for proper ongoing compliance.

Within 5 days of receipt of this directed plan of correction:
The home will obtain a valid criminal history check for Staff Member A. Staff Person A will not work or will always be supervised until the results of the check are returned. The administrator will develop and implement a system to ensure that hiring and retention of staff is done in accordance with the Older Adults Protective Services Act. [redacted] 5/1/23)

Directed Completion Date: *05/09/2023*

65d - Initial Direct Care Training

2. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff member A hired [redacted] and B hired [redacted] did not complete the Department approved online direct care competency course, both staff members are working unsupervised.

Plan of Correction ***Directed [redacted] - 05/01/2023)***

Moving Forward:
All new staff will have a training day prior to release to floor date to prevent missed trainings or missed document's along with new hire check sheet.

As the administrator I am responsible for proper ongoing compliance.

65d - Initial Direct Care Training (continued)

Withing 5 days of receipt of this directed plan of correction:
Staff Member A and B will complete the Department approved Direct care online competency course. The administrator will audit all employee files to ensure the training requirements under this regulation are completed. The administrator or designee will monitor employee files moving forward to maintain compliance for new hires. [redacted] 5/1/23)

Directed Completion Date: *05/09/2023*

82c - Locking Poisonous Materials

3. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

A bottle of equate anticavity mouth wash belonging to resident #1 was located on the dresser of the shared bedroom in Room[redacted] The bottle was labeled if swallowed call poison control or get medical help right away. Resident #2 who also lives in the room cannot safely handle and identify poisonous materials.

Plan of Correction ***Directed [redacted]/01/2023)***

Resident number one's son was educated about bringing improper items into room. Resident number one will also be relocated to a different room.

As the administrator I am responsible for proper ongoing compliance.

Within 5 days of receipt of this directed plan of correction:
The identified materials will be moved to a locked area that is inaccessible to residents.
Staff will be instructed to check all areas of the home for poisonous materials at least once per shift. Any poisonous materials not in use will be made locked and inaccessible to residents immediately. The administrator or designee shall monitor daily X's 3 months for ongoing compliance. [redacted] 5/1/23)

Directed Completion Date: *05/09/2023*

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

The toilet in Room [redacted] had dried feces smeared on the seat of the toilet. Dried feces was noted around the inside of the entire rim of the toilet bowl.

Plan of Correction ***Directed [redacted] - 05/01/2023)***

Housekeeper and all staff were re-educated on properly cleaning a toilet.

As the administrator I am responsible for proper ongoing compliance.

Within 3 days of receipt of this directed plan of correction:

85a - Sanitary Conditions (continued)

The home will instruct staff to check all areas of the home for unsanitary conditions at least once per shift. Staff will be instructed to remedy any unsanitary conditions immediately upon detection. The administrator or designee shall monitor weekly X's 3 months for ongoing compliance. ([redacted]Y 5/1/23)

Directed Completion Date: *05/07/2023*

91 Telephone Numbers

5. Requirements

2600.
91. Emergency Telephone Numbers Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

The telephone located in the dining room did not have the emergency phone numbers posted on or near the phone.

Plan of Correction ***Directed [redacted] - 05/01/2023)***

All resident room and areas with phones have been audited and all emergency numbers have been corrected and posted.

As the administrator I am responsible for proper ongoing compliance.

Within 5 days of receipt of this directed plan of correction:
The administrator will check all phones in the home to ensure that the required numbers are placed on or by each phone. Staff will be instructed to monitor phones during their duties and report or replace missing numbers. The administrator or designee shall monitor weekly X's 3 months for ongoing compliance. ([redacted] 5/1/23)

Directed Completion Date: *05/09/2023*

103f Refrigerator/Freezer Temps

6. Requirements

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

Description of Violation

The Frigidaire split freezer/refrigerator located in the dry goods area of the home did not contain a thermometer in the freezer or refrigerator.

Plan of Correction ***Directed [redacted] 05/01/2023)***

Moving Forward:
Staffed re-educated on importance of thermometers in fridge and freezer units. All refrigerators and freezers are being audited weekly to maintain proper compliance.

As the administrator I am responsible for proper ongoing compliance.

Within 5 days of receipt of this directed plan of correction:
Thermometers will be added to the identified areas. The administrator will check all other refrigerators/freezers to ensure thermometers are in place. The administrator will ensure that food is

103f - Refrigerator/Freezer Temps (continued)

stored as required by this regulation. The administrator or designee shall monitor weekly X's 3 months for ongoing compliance. ([redacted] 5/1/23)

Directed Completion Date: *05/09/2023*

141b1 - Annual Medical Evaluation

7. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #3's most recent Documentation of Medical Evaluation (DME) was completed on 2/20/20.

Repeat violation: 1/26/22 & 10/25/21

Plan of Correction ***Directed[redacted] - 05/01/2023)***

MD was contacted with regards to completing an updated DME.

Moving Forward:

Check list/audit sheet were created to ensure proper compliance.

As the administrator I am responsible for proper ongoing compliance.

Within 30 days of receipt of this directed plan of correction:
The administrator will audit all resident records to ensure that each resident has had a medical evaluation within the past year. Any resident whose medical evaluation is overdue will have a new evaluation as soon as possible and annually thereafter. The administrator or designee shall monitor weekly, thereafter X's 3 months. [redacted] 5/1/23)

Directed Completion Date: *06/03/2023*

144c1 - Smoking Area Guidelines

8. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

A can of extinguished cigarette butts and a chair was located on the 2nd floor balcony of the home. Approximately 7 cigarette butts were located on the carpet of the balcony. 2 extinguished cigarette butts were located in the gutter attached to the balcony. Staff interviews indicated that the staff will take Resident #4 out on the balcony to smoke because the resident is not always able to ambulate to the designated smoking area located on the 1st floor. The 2nd floor balcony is not the homes designated smoking area.

144c1 - Smoking Area Guidelines *(continued)*

Plan of Correction ***Directed (RY 05/01/2023)***

Sign was placed on patio door stating not a designated smoking area. All staff were educated to not use this area. Maintenance will be placing some type of lock on the door so that area is not used due to it not being an exit.

As the administrator I am responsible for proper ongoing compliance.

Within 3 days of receipt of this directed plan of correction:
The home will train all staff members that the 2nd floor balcony is not a designated smoking area, as well as where the designated smoking area is and how the area will be maintained. The training will also include a review of the homes smoking policy. Documentation of this training shall be maintained. The home will review and update Resident #4's resident assessment support plan to reflect how the home is going to meet the residents' smoking needs in the homes designated smoking area. The administrator or designee shall monitor daily X's 3 months for ongoing compliance. [redacted] 5/1/23)

Directed Completion Date: *05/07/2023*

182c - Medication Administration

9. Requirements

2600.
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).

Description of Violation

Resident #5 who was admitted to the home on [redacted] indicated that if the resident is sleeping when it is time to get medications, the staff members will leave the medication in a cup on the nightstand.

Plan of Correction ***Directed [redacted] 05/01/2023)***

Med Techs were educated on the importance of making sure residents take their medication when given and not placed on the nightstand.

Random audits with residents will be done to ensure on going compliance.

As the administrator I am responsible for proper ongoing compliance.

Within 10 days of receipt of this directed plan of correction:
The home will administer medications in a manner consistent with these regulations.
(1) Identify the correct resident.
(2) If indicated by the prescriber's orders, measure vital signs, and administer medications accordingly.
(3) Remove the medication from the original container.
(4) Crush or split the medication as ordered by the prescriber.
(5) Place the medication in a medication cup or other appropriate container, or in the resident's hand (for immediate
administration).
(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 182b4.

182c - Medication Administration (continued)

(7) Complete documentation in accordance with 187.

The administrator or designee shall retrain medication staff on the contents of this regulation and shall monitor weekly X's 6 months for ongoing compliance. Documentation of staff training shall be maintained by the home. [redacted] 5/1/23)

Directed Completion Date: *05/14/2023*

183b - Meds and Syringes Locked

10. Requirements

2600.
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 room.

Description of Violation

A tube of capzalsin HP arthritis cream was located in Room [redacted] unlocked and accessible.

Plan of Correction ***Directed [redacted] - 05/01/2023)***

Medications was removed from room [redacted] day of inspection. Family of resident in room [redacted] was educated regarding bringing OTC items into facility and leaving them in the room.

As the administrator I am responsible for proper ongoing compliance.

Within 3 days of receipt of this directed plan of correction:
All medications will be locked and inaccessible to residents and unqualified personnel. The administrator or designee shall monitor daily X's 3 months and ensure ongoing compliance. [redacted] 5/1/23)

Directed Completion Date: *05/07/2023*

184a - Resident's Meds Labeled

11. Requirements

2600.
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 #4's klor-con does not have a pharmacy label attached.

Resident #4 has an order for chlorthalidone 25mg tablet daily, hold for systolic blood pressure less than 110. The pharmacy label to the medication does not include the parameter.

Repeat violation: 10/25/21

184a - Resident's Meds Labeled *(continued)*

Plan of Correction ***Directed [redacted] - 05/01/2023)***

All medication bottles and medications with holds were audited.

Moving Forward:

All medication bottles and medications with holds will be audited when they arrive at the facility to make sure they meet all guidelines.

As the administrator I am responsible for proper ongoing compliance.

Within 5 days of receipt of this directed plan of correction:
The home will ensure that all prescription and sample medication containers are labeled with the required information. The administrator or designee shall audit all medications monthly X's 6 months to ensure ongoing compliance.[redacted] 5/1/23)

Directed Completion Date: *05/09/2023*

185a - Implement Storage Procedures

12. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #6 has an order for blood glucose readings 4 times daily. On 3/25, 3/26 and 3/28/23 at 8pm readings were noted on the Medication Administration Record (MAR) but no readings were noted in the residents glucometer. On 3/26/23 at 6:30am a reading of 353 was noted on the MAR but the reading in the glucometer was 329.

Repeat violation: 10/25/21

Plan of Correction ***Directed [redacted] - 05/01/2023)***

Resident #6's blood glucose machine was replaced day of inspection.

All MedTech's were re-educated on the importance of following directions of prescriber, along with education regarding if they notice an issue with a machine to make me (administrator) aware so proper steps can be taken to remediate or replace machine.

As the administrator I am responsible for proper ongoing compliance.

185a - Implement Storage Procedures (continued)

Within 10 days of receipt of this directed plan of correction:
All staff who administer medications will be trained on the procedures.
The home's policy shall include training on the following:
1. Use of a medication delivery log that documents the receipt of controlled substances and prescription medications.
2. Proper narcotic documentation and accountability. A process to investigate and account for missing medications and medication errors, including who is responsible for completing the investigation, how the investigation will be completed, and how the findings will be reported to the Department.
3. Policy and procedures for locking medications, and which staff persons will have access to the medications.
4. Use of a Medication Administration Record as required by 187a-d.
5. Proper documentation of Glucometer readings and required blood sugar recordings.
Documentation of training will be kept. The administrator or designee shall monitor for ongoing compliance. [redacted] 5/1/23)

Directed Completion Date: *05/14/2023*

187c Refusal of Medication

13. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident s record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #7 refused the prescribed furosemide 40mg tablet on 3/8/23 at 2pm. The prescriber was not notified regarding the refusal.

Resident #8 refused all of the residents prescribed medications from 3/1-3/28/23. The prescriber was not notified regarding the refusals. On 3/24/23 documentation of the refusal was noted.

Plan of Correction ***Directed ([redacted] 05/01/2023)***

All MedTech's were re-educated on the importance of notifying prescriber when a refusal happens. Prescriber was also made aware that any refusals will be faxed to the office.

As the administrator I am responsible for proper ongoing compliance.

Within 10 days of receipt of this directed plan of correction:
All staff that administer medications shall be retrained on the requirements of this regulation.
Documentation of this training shall be maintained by the home. The administrator or designee shall monitor MAR's weekly X's 6 months to ensure ongoing compliance. [redacted] 5/1/23)

187c - Refusal of Medication (continued)

Directed Completion Date: *05/14/2023*

187d - Follow Prescriber's Orders

14. Requirements

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

Description of Violation

Resident #6 has an order for blood glucose readings 4 times daily. On 3/25, 3/26 and 3/28/23 at 8pm the blood glucose readings were not completed.

Resident #7 has an order for metoprolol succ ER 25mg daily, hold for systolic blood pressure less than 110 or heart rate less than 60. On 3/23/23 the blood pressure was 94/64, the medication was administered and should have been with held.

Repeat violation: 10/25/21

Plan of Correction ***Directed [redacted] - 05/01/2023)***

Resident #6's blood glucose machine was replaced day of inspection.

All MedTech's were re-educated on the importance of following directions of prescriber.

Moving Forward:
Blood glucose machines will randomly be audited for ongoing compliance.
Medications with holds will randomly be audited for ongoing compliance.

As the administrator I am responsible for proper ongoing compliance.

Within 10 days of receipt of this directed plan of correction:
The home shall follow the directions of the prescriber. Staff shall be retrained on the requirements of this regulation. Documentation of staff training shall be maintained by the home. The administrator or designee shall monitor MAR's weekly X's 6 months to ensure ongoing compliance. [redacted] 5/1/23)

Directed Completion Date: *05/14/2023*

224a - Preadmission Screen Form

15. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #9's pre-admission screening completed on [redacted] doesn't indicate if the home can meet the residents needs or if the resident can safely use and avoid poisons.

224a - Preadmission Screen Form (continued)

Repeat violation: 10/25/21

Plan of Correction ***Directed [redacted] 05/01/2023)***

Pre-admission screening was corrected day of inspection.

Moving Forward:

A second person will check document to ensure all sections are filled in and complete. Initials of said person will be on the bottom of document.

As the administrator I am responsible for proper ongoing compliance.

Within 30 days of receipt of this directed plan of correction:
The administrator will ensure that all residents have a preadmission screening completed.
The administrator will ensure that the preadmission screening is accurate and completed in its entirety, including signing, and dating the screening form. If the home determines that the resident's needs cannot be met by the home based on the preadmission screening, the home will refer the resident to the appropriate local assessment agency. The administrator shall audit all current resident records to ensure all residents have a completed preadmission screening form. Thereafter, the administrator or designee shall monitor monthly for ongoing compliance. [redacted] 5/1/23)

Directed Completion Date: *06/03/2023*

225a - Assessment 15 Days

16. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #1 was admitted to the home on [redacted], the home did not complete an assessment for the resident.

Repeat violation: 3/21/22

Plan of Correction ***Directed [redacted] - 05/01/2023)***

Resident #1 assessment was completed immediately following inspection.

Moving Forward:
Checklist was created to keep all dates organized.

As the administrator I am responsible for proper ongoing compliance.

225a - Assessment 15 Days (continued)

Within 30 days of receipt of this directed plan of correction:
The administrator will complete new assessments for all residents on the Department's required form. The assessments will be detailed, comprehensive, and filled out in their entirety, including signatures and dates. Thereafter, the administrator or designee shall monitor monthly for ongoing compliance. [redacted] 5/1/23)

Directed Completion Date: *06/03/2023*

225c - Additional Assessment

17. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #2's most recent assessment portion of the Resident assessment support plan was completed in 2021.

Plan of Correction ***Directed [redacted] - 05/01/2023)***

Resident #2 assessment was updated immediately following inspection.

Moving Forward:
Checklist was created to keep all dates organized.

As the administrator I am responsible for proper ongoing compliance.

Within 30 days of receipt of this directed plan of correction:
The administrator will complete new assessments for all residents on the Department's required form. The assessments will be detailed, comprehensive, and filled out in their entirety, including signatures and dates. Thereafter, the administrator or designee shall monitor monthly for ongoing compliance. ([redacted] 5/1/23)

Directed Completion Date: *06/03/2023*

252 - Record Content

18. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
16. The resident's medical insurance information.

252 - Record Content *(continued)*

Description of Violation

Resident #1's record did not include the residents social security number, race, color of hair, color of eyes, identifying marks, picture of the resident, emergency contact information, the residents doctor, and medical insurance information.

Resident #9's record did not include identifying marks.

Repeat violation: 6/8/22 & 10/25/21

Plan of Correction ***Directed [redacted] - 05/01/2023)***

Moving Forward:
Computerized factsheet's were changed to add a section for identifying marks. Charts were audited to make sure all new factsheet's are available.

As the administrator I am responsible for proper ongoing compliance.

Within 20 days of receipt of this directed plan of correction:
The administrator will review and audit all resident records to ensure that all the information required by this regulation is present. Missing information will be added immediately. Ongoing, the administrator shall monitor resident records and ensure ongoing compliance with this regulation. Records shall be audited biannually. [redacted] 5/1/23)

Directed Completion Date: *05/24/2023*