



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 **May 9, 2023** until **November 9, 2023**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **452691**

[Signature]
ISSUING OFFICER

[Signature]
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



CERTIFIED MAIL – RETURN RECEIPT
REQUESTED MAILING DATE: MAY 9, 2023

[REDACTED]
Sterling Home LLC
[REDACTED]
[REDACTED]

RE: Sterling Home
1318 Arch Street
McKeesport, Pennsylvania 15132
License/COC #: 452691

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on August 23, 2022, August 24, 2022, August 25, 2022, October 19, 2022, October 20, 2022, and October 21, 2022, 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), failure to submit an acceptable plan to correct noncompliance items, failure to comply with the acceptable plan to correct noncompliance items, and mistreatment or abuse of residents being cared for in the facility, the Department hereby REVOKES your certificate of compliance (license number 452690) dated December 6, 2022 – December 6, 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. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from May 9, 2023 to November 9, 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 Chapter 2600	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
<u>Section:</u>					
23(a)	II	22	\$5	\$110	5 calendar days from mailing date of this letter
85(a)	II	22	\$5	\$110	5 calendar days from mailing date of this letter
95	II	22	\$5	\$110	5 calendar days from mailing date of this letter
101(j)(2)	III	22	\$3	\$66	15 calendar days from mailing date of this letter
101(o)	II	22	\$5	\$110	5 calendar days from mailing date of this letter
121(a)	II	22	\$5	\$110	5 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
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

[REDACTED]
[REDACTED]
[REDACTED]

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

Facility Information

Name: *STERLING HOME* License #: *45269* License Expiration: *12/06/2022*
Address: *1318 ARCH STREET, MCKEESPORT, PA 15132*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] 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: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *24* Waking Staff: *18*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint* Exit Conference Date: *08/25/2022*

Inspection Dates and Department Representative

08/23/2022 - On-Site: [REDACTED]

09/24/2022 - On-Site: [REDACTED]

08/25/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *42*

Residents Served: *23*

Secured Dementia Care Unit

In Home: *No*

Area:

Capacity:

Residents Served:

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *13*

Are 60 Years of Age or Older: *7*

Diagnosed with Mental Illness: *11*

Diagnosed with Intellectual Disability: *4*

Have Mobility Need: *1*

Have Physical Disability: *0*

Inspections / Reviews

08/23/2022 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/25/2022*

10/04/2022 - POC Submission

Submitted By: [REDACTED] Date Submitted: *12/29/2022*
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *10/07/2022*

11/04/2022 - POC Submission

Submitted By: [REDACTED] Date Submitted: *12/29/2022*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *11/14/2022*

04/11/2023 - Document Submission

Submitted By: [REDACTED] Date Submitted: *12/29/2022*
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

On 8/23/22, at approximately 4:00 p.m. there were unsecured, unattended, and accessible binders on the desk shelf at front lobby entrance, to include:

- Shower binder indicating names of residents who showered, and assistance provided, to include all residents in the home.
- Binder labeled "Resident to Resident, Resident to Staff, Complaints" that included complaints from residents, to include complaint forms from staff dated 1/11/22 and 2/7/22 regarding resident #1,
- Binder labeled "Resident #1's Daily meal Intake".
- A Pestco Pest Siting Log containing a document dated 8/6/22 at 6:30p.m. indicating resident #2 Bedbugs, in bedroom walls way too many on wall they are all over the walls.

POC Submission

Accept [REDACTED] 10/04/2022)

1. Binders were removed on site and placed in administrative office

2. Employee meeting held on 8/29/2022 explaining HIPPA laws, and proper placement of records. Monthly site inspection document has been implemented on 8/29/2022 for administrator and assistant administrator to check front area for any records and place them back in administrative office. documentation will be filed in administrative office.

3. Administrator or assistant administrator will do daily walk-thru to make sure binders are in the proper place. Monthly physical site check will be completed by administrator or assistant administrator, documentation will be on file in administrative office,

Licensee's Plan Completion Date: 09/30/2022

Not Implemented [REDACTED] - 04/11/2023)

23a - Activities of Daily Living Assistance

2. Requirements

2600.

- 23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #3's assessment and support plan, dated [REDACTED] indicate the resident is diagnosed with [REDACTED] The resident is assessed to be able to self- administer some medications and not others with staff assistance.

The residents support plan indicates the resident receives 2 liters of oxygen. Staff to administer medications/O2 including inhalers or nebulizer treatments per MD order. Staff to report to MD any complaints of symptoms of SOB, wheezing or hypoxia for further instructions/evaluations/treatment. Currently ordered 2L of oxygen via NC PRN. Staff

23a - Activities of Daily Living Assistance (continued)

to maintenance concentrators/tanks. However, a physician's order, dated 9/17/2020, indicates resident #3 is prescribed 3Liters of oxygen for outings and oxygen concentrator of 3Liters continuously daily.

On 8/17/22, resident #3 arrived via ACCESS at the Mon Yough Outpatient Clinic approximately 9:40 a.m., for an appointment scheduled at 10:40 a.m. with an empty oxygen tank.

The nurse and the resident indicated the resident requires the use of 7Liters of oxygen and that the tank was too small and would only last an hour or hour and a half for the amount of oxygen required for this resident. The nurse stated that [REDACTED] called the home and spoke to an unidentified staff person, informing them they sent the resident to the appointment with an empty oxygen tank and asked if someone could transport the resident to the home. The staff person indicated they knew the tank was empty. The resident was transported to the hospital emergency room via ambulance provided oxygen and then transported back to the home.

The assessment and support plan, dated 10/22/21, for resident #4 indicate the resident is diagnosed with [REDACTED] [REDACTED] The resident's support plan indicates the resident requires total assistance by staff and case manager for managing health care and minimal assistance with personal hygiene. The resident needs assistance when managing health care and medications to ensure compliance. Staff to assist with making appointments/transportation arrangements to suit the resident's needs.

On 7/19/22, staff person A and RN, completed a physical assessment of resident #4, noting the residents' toenails were long and needed cut. Staff person A and RN requested resident #4 be put on the podiatrist list to be seen. Staff person A instructed the staff to put resident #4 on the podiatrist list to be seen. However, the resident was not seen.

Interviews of staff, indicated resident #4's toenails were "ingrown." On 7/26/22. the podiatrist on-site inquired if the home had bedbugs, which was confirmed by the administrator. The podiatrist indicated cannot provide any service due to bedbugs and left. On 7/26/22, upon arrival at the Senior Programs staff noted the resident's gait was off. The resident had recently gotten new tennis shoes. The staff at the program had resident #4 remove their shoes to check for blisters and found the residents feet had a horrible odor from toenail fungus/infection. Resident #4's toenails were not ingrown; however, were grossly overgrown. The toenail on the right big toe was growing into the second toe cutting into the skin. The second toe was discolored and infected. The staff at the program contacted the home, spoke with direct care staff person B asking if anyone available to transport the resident to the emergency room. Direct care staff person B indicated unable to transport and suggested they call an ambulance to transport. The resident was transported to the hospital emergency room by a staff person at the program who stayed with resident. The resident's toenails were cut and treated.

REPEAT VIOLATION 1/10/22**POC Submission**

Accept [REDACTED] 11/04/2022)

1. Both support plans have been updated to reflect resident #3 and #4.

2. DRC assessed all residents beginning 8/29/2022. System in place for DRC to complete all resident monthly assessments, as needed and once returning from hospital and update resident RASP at time of assessment as needed. DRC to follow up with any recommendations and note in resident chart once completed. DRC reviewed all current resident support plans on 9/1/2022 and updated files accordingly. All staff meeting held on 8/29/2022 to review violation, reviewed and discussed how to read/document in resident charts and RASP. All DCS were

23a - Activities of Daily Living Assistance (continued)

reeducated on different types of oxygen tanks and proper ways to fill them. All DCS had to demonstrate how to refill all current resident oxygen during meeting. All newly hired DCS will be trained on oxygen and demonstrate during orientation how to properly fill tanks. Document placed on Resident #4's concentrator for DCS to sign off every time O2 tank has been filled.

3. DRC will complete assessments monthly, as needed and once after resident returns from hospital. DRC will keep documentation in resident chart. Administrator will review resident records monthly to ensure DRC has completed notes, DCS are following through with recommendations and make changes as needed. Administrator or DRC will select random DCS members monthly to demonstrate how to properly fill oxygen tanks. Administrator will ensure all new hired DCS are educated on types of O2 and how to properly fill them. Administrator, assistant administrator or DRC will check document daily during rounds to ensure DCS is signing off on document and O2 tanks are being filled as needed and before resident leaves facility.

Licensee's Plan Completion Date: 10/11/2022

Not Implemented [REDACTED] - 04/11/2023)

42s - Privacy**3. Requirements**

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The home was being treated for a bedbug infestation that was first identified in April 2022. The extermination company informed the home for the treatment to be effective the resident rooms needed cleaned out of personal belongings prior to treating on 8/3/22. On or around 7/30/22, most of the resident's belongings were bagged, labeled, and placed on the side porch while the home was treated. The residents were provided a change of clothing to keep and was told they could not bring in anything from the bags unless staff washed and checked it for bedbugs. The residents have minimal access to much of their belongings during the process and was not given a time frame when their belongings would be returned to their rooms. As of 8/25/22, the residents' belongings are still bagged on the side porch from approximately 7/30/22. On 8/25/22, the home indicated the residents will need to go through their belongings and determine what will be kept and what will have to be thrown out prior to bringing back into their room; however, the residents are unaware of this.

POC Submission

Accept [REDACTED] 0/04/2022)

1. Residents were told on 7/26/2022 by Administrator during resident council regarding the steps that needed to take place before treatment can begin. Residents were aware that clothes needed to be cleaned prior to returning back to rooms and going forward rooms needed to be free and clear of any hazards to prevent another infestation of any kind. All clothes have since been washed at local laundry mat, possessions have been returned to residents on as of 9/16/2022. There are no signs of bed bugs in resident rooms.

2. Resident council meeting was held again on 8/30/2022 regarding personal belongings and prevention of further infestation. Residents were made aware of the amount of square footage that needed to be equal for shared rooms. Daily housekeeping has continued to be implemented. Daily resident room checklist has been implemented on

42s - Privacy (continued)

8/29/2022 for Administrator and Assistant Administrator to check all resident bedrooms' to ensure they continue to stay clean. Monthly checklist has been implemented for Administrator or Assistant Administrator to check all resident rooms to ensure clothes are placed inside wardrobes, possessions are placed in an area that is safe for residents to enter and exit freely without hazard.

3. Resident clothing continues to be washed at least once weekly on shower days, daily housekeeping of resident rooms continues to be implemented. Administrator or assistant administrator will do daily resident room checks to ensure clothing and possessions are with residents. Monthly resident room checklist will be completed by Administrator or assistant administrator. Documentation will be placed in administrative office.

Licensee's Plan Completion Date: 09/30/2022

Not Implemented [REDACTED] - 04/11/2023)

54a - Direct Care Staff**4. Requirements**

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 person C started working in the home on [REDACTED] Direct care staff person C does not have a high school diploma, GED diploma or active registration status on the Pennsylvania nurse aide registry. Direct care staff person C performed unsupervised direct care to the residents in the home on the following dates and times, to include: 8/9/22, 8/11/22, 8/14/22, 8/15/22, 8/16/22, 8/21/22 and 8/23/22 from 11:00 p.m. to 7:00 a.m. and on 8/12/22 and 8/13/22 from 7:00 p.m. to 7:00 a.m.

POC Submission

Accepted [REDACTED] - 11/04/2022)

1. Direct care person C no longer is employed

2. New hire checklist implemented on 8/29/2022 to be completed on date of hire. Document will be signed off by Administrator or assistant administrator prior to employee's first day of work to ensure all documentation is filed in employee record. Administrator checked all current employee files with new checklist on 9/1/2022 to ensure all current employee's have necessary documentation placed in their file.

3. Administrator or assistant administrator will complete all new employee hire paperwork. Document will be signed by Administrator once completed. A copy of document will be placed inside employee file once completed. Administrator will check all employee files quarterly to ensure all documentation is file is completed and new checklist is signed

Licensee's Plan Completion Date: 10/11/2022

Not Implemented [REDACTED] - 04/11/2023)

57a - Designee Present/Age**5. Requirements**

2600.

57a - Designee Present/Age (continued)

57.a. At all times one or more residents are present in the home a direct care staff person who is 21 years of age or older and who serves as the designee, shall be present in the home. The direct care staff person may be the administrator if the administrator provides direct care services.

Description of Violation

On 8/18/22, the home serviced 22 residents, there was no direct care staff person in the home from 11:08 p.m. to 11:34 p.m. The only staff person present in the home was ancillary staff person D.

POC Submission

Directed [REDACTED] 11/04/2022)

1. Staff person D completed DCS training on 8/29/2022.

2. New policy implemented on 8/25/2022 that all new employees rather DCS or ancillary complete DCS training prior to first day of work. New employee checklist created and implemented 8/29/2022 for administrator to complete new hire employee checklist to ensure all paperwork is completed and placed inside file. prior to filing away. Administrator checked all current employee files on 9/1/2022 using new checklist and signed off that all employee's have necessary paperwork.

3. Administrator will review all new hire paperwork prior to first day of work and complete new form. Documentation will be placed in employee file. Administrator will conduct quarterly audit of all employees to ensure all documentation is complete and checklist is in employee file.

DIRECTED

Within 5 calendar days of the accepted Plan of Correction: The administrator shall audit the upcoming schedule to ensure the requirements of Regulation 2600.57(a) are met. The administrator shall audit all completed schedules weekly to ensure the requirements of Regulation 2600.57(a) are met. 11/4/22 [REDACTED]

Directed Completion Date: 10/11/2022

Not Implemented [REDACTED] 04/11/2023)

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 served 23 residents on the following dates. However, there were no staff working in the home certified in first aid/CPR, to include:

- * 8/16/22 from 12:00 a.m. to 7:15 a.m.
- * 8/18/22 from 11:08 p.m. to 12:26 a.m.
- * 8/19/22 from 7:00 p.m. to 11:00 p.m.

POC Submission

Accept [REDACTED] 10/04/2022)

1. CPR training was held on 9/14/2022.

2. Weekly meeting in place for Administrator and Assistant Administrator to go over employee schedule before posting to ensure there is at least one staff member on each shift who is CPR certified

3. Administrator and assistant administrator will meet weekly to create schedule. Administrator or assistant

63a - First Aid/CPR Training (continued)

administrator will sign weekly schedule confirming one staff member is scheduled for each shift

Licensee's Plan Completion Date: 09/30/2022

Not Implemented [REDACTED] - 04/11/2023)

65c - Ancillary Staff Orientation**7. Requirements**

2600.

65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Ancillary staff person E, hired [REDACTED] did not have a general orientation to their specific job function as a cook, prior to or on the first day of working in the capacity as a cook.

POC Submission

Accept (JK - 11/04/2022)

1. Staff person E completed employee training on 8/24/2022.

2. A new orientation worksheet was implemented for all staff on 8/24/2022 to be included in all new hire paperwork. All new staff members will complete orientation prior to first day, on first day and within the first 40 hours of work week, Administrator checked all current employee files on 9/1/2022 using new worksheet to ensure all current employees have all new hire paperwork and filed away accordingly.

3. Administrator will sign off on all new employee orientation paperwork and documentation will be kept in employee record. Administrator will check all employee paperwork quarterly to ensure all paperwork is filed according to state regulations and checklist is filed in all employee files

Licensee's Plan Completion Date: 10/11/2022

Not Implemented [REDACTED] - 04/11/2023)

65d - Initial Direct Care Training**8. 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 person C started working in the home on 8/4/22. Direct care staff person C did not complete the Department- approved direct care training course and passing of the competency test until 8/25/22. However, direct care staff person C provided unsupervised personal care to the residents of the home on the following dates and time, to include: 8/9/22, 8/11/22, 8/14/22, 8/15/22, 8/16/22, 8/21/22 and 8/23/22 from 11:00 p.m. to 7:00 a.m. and on 8/12/22 and 8/13/22 from 7:00 p.m. to 7:00 a.m.

POC Submission

Accept ([REDACTED] 11/04/2022)

1. Staff person C completed DCS training on 8/24/2022. Documentation was given to inspector on site.

65d - Initial Direct Care Training (continued)

2. New employee checklist was implemented on 8/29/2022 for all new employees to complete all proper documentation prior to first day of work, documentation will be placed in employee file. Administrator checked all current employee files with new hire checklist implemented on 8/29/2022 to ensure all current and new employees have necessary paperwork according to regulations.

3. Prior to filing paperwork, administrator or assistant administrator will sign off on all new hire documentation to ensure all paperwork is completed before first day. Administrator will sign off on all new hire paperwork before filing. Administrator will check all employee paperwork quarterly to ensure all proper documentation is filed in employee chart

Licensee's Plan Completion Date: 10/11/2022

Not Implemented [REDACTED] 04/11/2023)

82b - Poisonous Material Storage**9. Requirements**

2600.

82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation

On 8/23/22, there were seven bottles of yellow mustard on the bottom of the shelving unit in the pantry. On the floor next to the mustard was a one-gallon container of Roberts 3095 Carpet Adhesive and a one-quart can of Minwax Wood Finish stain.

POC Submission

Accept [REDACTED] 10/04/2022)

1. Mustard was placed on shelf, carpet adhesive and minwax were removed and placed in storage area on site.

2. Physical site checklist implemented on 8/29/2022 to check entire physical site monthly. documentation to be kept in administrative office

3. Administrator will complete monthly physical site checklist, sign off on documentation and place in administrative office for reference.

Licensee's Plan Completion Date: 09/30/2022

Not Implemented [REDACTED] 04/11/2023)

85a - Sanitary Conditions**10. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 8/23/22, at approximately 9:47 a.m., the following unsanitary conditions were noted in the common bathroom across from the dining room by hallway of bedroom #1, #2 and #3, to include:

- There were no paper towels, mechanical air blower, or other sanitary method of hand drying in the common bathroom.
- There was a brown smear of what appeared to be feces, measuring approximately 3" on the back of the toilet seat.

85a - Sanitary Conditions (continued)

- There were crumbled used paper towels on the right side of the sink vanity and on the floor next to the right side of the sink.

On 8/23/22, at approximately 10:01a.m., the following unsanitary conditions were noted in the common bathroom at the end of the hall next to bedroom #11, to include:

- There was a very foul pungent odor that permeated from the common bathroom into the hallway near the bathroom that did not dissipate throughout the day.
- The front exterior side of the toilet bowl had brown speckles that appeared to be feces over the toilet bowl.

On 8/23/22 at approximately 10:09 a.m., the following unsanitary conditions were noted in the common bathroom by bedrooms #3, #5 and #9, to include:

- There was a very foul pungent odor that permeated from the common bathroom into the hallway near the bathroom that did not dissipate throughout the day.
- There were no paper towels, mechanical air blower, or other sanitary method of hand drying in the common bathroom.
- There was a heavy concentration of a blackish substance, that appeared to be mold, measuring approximately 2" wide over the grout on the tile floor by the toilet. Heaviest concentration is on the left side of the toilet.

On 8/23/22, 8/24/22 and 8/25/22, the raised planter area on the right side of the deck and designated smoking area is filled with overgrown weeds and contains multiple cigarette butts with a count of 8 or more butts in the planter area.

On 8/23/22, at approximately 10:21 a.m., the refrigerator section of the little refrigerator/freezer had a blackish/brownish liquid that had dried and covered the bottom of the refrigerator.

REPEAT VIOLATION 4/6/21**POC Submission****Accept** [REDACTED] **11/04/2022)**

1. Paper towels were thrown away in trash can, paper towels were replaced on site. All toilets' were cleaned on site. Bathroom tile was cleaned on site, overgrown weeds were cleaned by Caley services on 8/29/2022, cigarette butts were removed on site, Small refrigerator was cleaned on site.

2. Daily housekeeping tool was implemented on 8/29/2022. Employees were re-educated and trained on proper sanitary conditions on 8/29/2022. Daily rounds for Administrator and assistant administrator are in place to check all common bathrooms to ensure sanitary conditions are within standards. Monthly physical site checklist implemented on 8/29/2022 for Administrator and assistant administrator to check all entire facility and outside grounds, Documentation to be kept in administrative office. Hourly bathroom checklist created and implemented on 9/1/2022 for housekeeping to sign off on bathroom cleanings. Weekly refrigerator checklist created and implemented to clean refrigerators prior to weekly delivery to ensure it's clean and safe to store food. Daily rounds will be completed to monitor home for any hazards or sanitary conditions. Documentation will be placed in administrative office

3. Daily rounds will be conducted by Administrative or assistant administrator. Monthly physical site checklist will be completed by Administrator or assistant administrator. Administrator or assistant administrator will monitor bathrooms and bathroom checklist daily and refrigerator checklist weekly to ensure they are being completed and followed thru. documentation will be placed on file in administrative office

85a - Sanitary Conditions (continued)

Licensee's Plan Completion Date: 10/12/2022

Not Implemented [REDACTED] - 04/11/2023)

85b - Infestation

11. Requirements

2600.

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

Description of Violation

On 8/23/22, at approximately 12:30 p.m., there was a heavy concentration of dead bedbugs in bedroom # [REDACTED]. They were on the walls, ceiling, carpet, behind the wall light fixtures and along the base boards. However, there was one live bedbug observed moving on the ceiling.

On 8/23/22, 8/24/22 and 8/25/22, the agent of the Department observed multiple gnats and flies present throughout the home.

POC Submission

Accept [REDACTED] - 11/04/2022)

1. Resident #5's room was deep cleaned on 8/26/2022. dead bed bugs were removed, light fixture was removed and cleaned no signs of bed bugs, base boards, walls and ceiling were cleaned

2. Daily housekeeping checklist was created and implemented on 8/29/2022. All staff were re-educated on sanitary conditions and signs of infestation and educated on checklist on 8/29/2022. Administrator or assistant administrator will check resident rooms daily during rounds to ensure cleanliness and housekeeping is performing tasks. Monthly resident room checklist implemented on 8/29 for Administrator or assistant administrator to check all resident rooms to ensure cleanings and deep cleanings are being completed and they are free of hazards or infestations. Contract was signed with pest control on 7/22/2022 to come out once monthly for normal pest control or as needed. Documentation of all services will be placed in a binder located in Administrative office. Staff were educated during meeting on 8/29/2022 to keep doors closed at all times. During monthly pest control spraying technician will replace Nat traps avoid any infestation.

3. Administrator will continue to monitor pest control treatments and ensure all treatments have been completed for infestation. Administrator will clarify all on going monthly pest control is completed and documentation will be kept. Administrator will investigate all resident rooms monthly to check for any signs of insects and notify pest control immediately. Administrator or assistant Administrator will complete monthly room checklist's to ensure rooms are being deep cleaned. Administrator or assistant administrator will continue to complete daily rounds of facility to clarify there are no signs of infestation and doors are closed

85b - Infestation (continued)

3. Daily rounds will be conducted by Administrator or assistant administrator, Monthly resident room checks will be completed and documented. Documentation will be held in administrative office

Licensee's Plan Completion Date: 10/12/2022

Not Implemented [REDACTED] 04/11/2023)

88a - Surfaces**12. Requirements**

2600.

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

Description of Violation

On 8/23/22, the hallway carpet to the small TV room is in disrepair. There is black tape running horizontally and vertically over the multiple areas where the carpet is torn and frayed.

On 8/23/22, the emergency exit door from the TV room to the small deck and designated smoking area is in disrepair. The insert measuring approximately 23" by 65" by 2" was missing and replaced with sheet metal on the interior and exterior side of the door and held in with duct tape. However, the metal insert on the interior side is missing leaving the opening of the insert exposed. There are several screws along the sides exposed and the insulation is exposed.

On 8/23/22, the right wall just inside the small TV room has a pipe sticking out approximately 6" posing a hazard from where the water fountain was removed. The wall above the pipe has several strips of black duct tape covering an area in disrepair.

POC Submission

Accept [REDACTED] 11/04/2022)

1. Hallway carpet has been removed and replaced with tile on 9/21/2022. Door was repaired on 8/26/2022. Wall was repaired on 9/08/2022

2. Daily rounds will be conducted by Administrator or assistant administrator to ensure there are no safety hazards present. Monthly physical site checklist implemented on 8/29/2022 for Administrator or assistant administrator to check entire physical site of facility and sign off all sections are in good repair. documentation will be kept. Maintenance sheet implemented on 8/29/2022 for staff members, residents or family members to complete for any repair's needed. Binder located at front desk. Staff members were educated on hazard prevention during meeting on 8/29/2022 to look and document any signs of hazards that need to be fixed and document them in maintenance folder. Resident council meeting held 9/6/2022 to educate residents on signs of hazards and to notify Administrator or assistant administrator should it need to be fixed.

3. Daily rounds of facility and outside grounds and monthly checklist will be completed by Administrator or assistant administrator to ensure all areas are in good repair and documentation will be kept on file. Administrator or assistant administrator will check maintenance binder daily for any requests, maintenance to sign off when task completed. documentation will be filed in administrative office

Licensee's Plan Completion Date: 10/12/2022

88a - Surfaces (continued)

Not Implemented [REDACTED] - 04/11/2023)

89b - Hot Water Temperature

13. Requirements

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 8/23/22, at 10:04 a.m., the water temperature at the sink in the common bathroom next to bedroom [REDACTED] measured 122.9 degrees Fahrenheit.

On 8/23/22, at 10:09 a.m., the water temperature at the sink in the common bathroom next to bedrooms [REDACTED] and [REDACTED] measured 126.7 degrees Fahrenheit.

POC Submission

Accept [REDACTED] - 11/04/2022)

1. Water temperature was turned down on site on 8/23/2022 by maintenance.

2. New document created and implemented on 8/29/2022 to check common bathroom sinks and showers water temperatures weekly to ensure water is at regulation standards to avoid injury prior to shower or sink usage. Staff meeting held on 8/29/2022, resident council meeting held on 9/6/2022 educating staff members and residents that water temperatures cannot exceed 120 degrees and reasoning behind regulation. All documentation will be filed in administrative office

3. Administrator, assistant administrator or maintenance director will check all common bathrooms weekly record numbers, adjust water heater as needed. All documentation will be kept in administrative office

Licensee's Plan Completion Date: 10/12/2022

Not Implemented [REDACTED] 04/11/2023)

95 - Furniture and Equipment

14. Requirements

2600.

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

Description of Violation

On 8/23/22, at 10:01 a.m., the florescent ceiling light in the middle of the bathroom requires two long florescent tubes. However, the one fluorescent tube was missing and the other one was burnt out in the common bathroom by bedroom [REDACTED]

On 8/23/22, at 10:09 a.m., the cover to the long florescent ceiling light in the common bathroom by bedrooms [REDACTED] and [REDACTED] was hanging open on the right side. The light was missing one of the long florescent tubes and the other one was burnt out.

On 8/23/22, at 10:09 a.m., the shower handle that turns on/off the water on the right side of the shower stall in the common bathroom by bedroom [REDACTED] is broken. A back piece of the neck that connects to the handle is broken off. The water does not shut off all the way. When the handle is turned to on position the water sprays out from the

95 - Furniture and Equipment (continued)

broken piece spraying water everywhere.

REPEAT VIOLATION 4/6/21

POC Submission

Accept [REDACTED] - 11/04/2022)

1. Lights were changed on 8/23/2022. Cover was secured on 8/23/2022. Shower handle was repaired by Sullivan plumbing on 8/25/2022.

2. Monthly physical site checklist was created and implemented on 8/25/2022 to check entire facility to ensure all equipment is in good working condition. Daily rounds to be completed to check facility for any hazards. Maintenance sheet created for any repair needs, located at front counter. Hourly bathroom checklist created for common bathrooms. Staff meeting held on 8/29/2022 to implement forms and educate members of signs to look for when on shift. Resident council meeting held on 9/6/2022 educating residents on new maintenance form and to let a member of management know if something needs fixed. Checklists and forms will be placed in a binder located in administrative office.

3. Administrator, assistant administrator or maintenance will complete physical site document once a month to ensure compliance. Daily rounds will be completed by administrator or assistant administrator to check facility and checklists to ensure completion. repairs will be completed in a timely manner. Documentation will be placed on file in administrative office --

Licensee's Plan Completion Date: 10/13/2022

Not Implemented ([REDACTED] - 04/11/2023)

100a - Exterior - Free of Hazards**15. 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 Violation

On 8/23//22, 8/24/22 and 8/25/22, the landscaping on the exterior of the home is overgrown with weeds and brush. The shrubs and bushes by the front porch and sidewalk are overgrown onto the porch and sidewalk with overgrown weeds throughout. The area off the back porch and steps identified as an emergency egress route is overgrown with weeds and brush. The residents are unable to access the back walkway of the home as it is overgrown with weeds and brush.

On 8/23/22, 8/24/22 and 8/25/22, the large area with a raised planter on the right side of the wooden deck off the TV room and designated smoking area is full of overgrown weeds that have been there for more than several months.

REPEAT VIOLATION 4/6/21

POC Submission

Accept [REDACTED] - 11/04/2022)

1. Administrator contacted landscaping company on 7/30/2022. Contract signed with Caley Services LLC. Start date was 8/29/2022.

100a - Exterior - Free of Hazards (continued)

2. Caley Services removed all overgrown weeds, cut down trees blocking access to walk ways and replace mulch. Administrator will check all outside grounds once monthly during spring and summer season to make sure all weeds are removed. Maintenance

Director will spray weeds monthly and remove as needed. Caley Services will come annually and as needed for service.

3. Administrator will check grounds monthly. Maintenance Director to spray and remove weeds monthly. Landscaping to come annually and as needed for service. Administrator will check grounds monthly to ensure outside egress are clear easily assessable. Documentation will be kept on file in Administrative office.

Licensee's Plan Completion Date: 10/13/2022

Implemented [REDACTED] - 04/11/2023)

100b - Removal Snow/Obstructions**16. Requirements**

2600.

100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On 8/23//22, 8/24/22 and 8/25/22, approximately 80% of the back/side porch off the back lounge area is piled up with resident belongings and construction materials, that are obstructing the use of the back porch and obstructing the egress route from the porch, to include:

- Multiple black trash bags full of clothing and personal items belonging to the residents of the home. Some bags are torn open with the contents strewn over the porch floor.
- Large framed pictures, plastic bins full of shoes, musical instruments, and other personal resident belongings.
- Stacked cardboard boxes.
- An old toilet and a bathroom sink vanity, several boxes containing ceramic tiles.
- A large stack of old construction materials and tools against the house on the right side of the door that have been there for several months from the remodel of the wing and back lounge, to include: a bag of sackrete, multiple drywall and spackling and tools, handles for paint rollers, paint brushes, dry wall tape and spackling materials that were used to complete the remodel of the back sitting area and hall several months ago.

POC Submission

Accept [REDACTED] 11/04/2022)

1. Administrator contracted Big's Dumpster rental on 8/17/2022. Dumpster was delivered on 9/1/2022. All garbage has been removed from back patio clearing access to patio and emergency egress. All resident personal property has been returned to their bedrooms.

2 A 30 yard dumpster was placed on the sidewalk of home for removal of all garbage on 9.14.2022 for one week. All trash and hazardous materials were removed from patio. Monthly physical site checklist created and implemented on 9/29/2022 to check all outside grounds monthly. Daily rounds will be conducted to check entire facility outside grounds to ensure garbage is removed, exits are cleared and residents can access patio.

3. Administrator or assistant administrator will conduct daily rounds of patios and outside grounds. Administrator, assistant administrator or maintenance director will complete monthly physical site checklist of entire facility and all outside grounds. Documentation will be kept on file in Administrative office.

100b - Removal Snow/Obstructions (continued)**Licensee's Plan Completion Date:** 10/13/2022**Not Implemented** [REDACTED] - 04/11/2023)**101j2 - Bedroom Chairs****17. Requirements**

2600.

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

2. A chair for each resident that meets the resident's needs.

Description of Violation

On 8/23/22, there are two residents residing in bedroom #13; however, there were no chairs available in the bedroom.

On 8/23/22, there are two residents residing in bedroom #12; however, there was only one chair.

REPEAT VIOLATION 4/6/21**POC Submission****Accept** [REDACTED] - 11/04/2022)

1. Chairs were placed in resident room on 8/24/2022.

2. Bi-weekly resident room checklist created and implemented on 8/29/2022 for Administrator or assistant administrator to check all resident rooms to ensure all residents are equipped with necessary furniture documentation to be kept on file. During daily rounds Administrator or assistant administrator will check resident rooms. All staff meeting was held on 8/29/2022 to discuss inspection and regulations. Staff were educated on needed equipment for each resident and to monitor rooms daily during DC rounds to ensure residents have necessary equipment and notify administration if equipment needs added or replaced.

3. Administrator or assistant administrator will complete bi-weekly room checklist documentation will be on file in administration office. Administrator or assistant administrator will complete daily rounds of resident rooms to ensure all furniture is present. DCS will monitor rooms daily during DC rounds and notify management of any missing furniture or needed repairs.

Licensee's Plan Completion Date: 10/13/2022**Not Implemented** [REDACTED] - 04/11/2023)**101o - Walls, Floors, Ceilings****18. Requirements**

2600.

101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

On 8/23/22, bedroom [REDACTED] was identified as the host room for the bedbugs. The walls and ceiling had this

101o - Walls, Floors, Ceilings (continued)

brownish/reddish smears over them that was reported from killing the bedbugs. The carpet in the room has two large prominent stains over more than half of the area in the room.

REPEAT VIOLATION 4/6/21

POC Submission

Accept () 11/04/2022)

1. Walls were cleaned on 8/26/2022. Carpet has been removed and replaced with flooring on 9/16/2022.

2. Bi-weekly resident room checklist created and implemented on 8/29/2022 to check all resident rooms to ensure daily housekeeping is being completed. Daily housekeeping checklist was created and implemented on 8/29/2022. Bi-weekly deep clean room checklist was created and implemented on 8/29/2022 All staff meeting held on 8/29/2022 to discuss inspection and violations. Staff members were educated on on new checklist tools, expectations of room cleaning and to ensure all resident rooms stay clean, free from hazards and clutter and unsanitary conditions

3. Administrator or assistant administrator will complete bi-weekly room checklist. Documentation will be on file in administrative office. Monthly deep cleaning checklist will be completed and filed. Daily resident room cleaning will be completed and verified by Administrator or assistant administrator during daily rounds. repairs to bedrooms will be completed as needed.

Licensee's Plan Completion Date: 10/13/2022

Not Implemented () 04/11/2023)

102k - No Common Towel**19. Requirements**

2600.

102.k. Use of a common towel is prohibited.

Description of Violation

On 8/23/22, at approximately 10:09 a.m., there was an unlabeled used brown washcloth in the shower stall of the common bathroom by bedrooms #3, #5, and #9.

POC Submission

Accept () 11/04/2022)

1. washcloth was removed on site 8/23/2022.

2. Hourly bathroom checklist has been created and implemented on 8/29/2022 for housekeeping or DCS to sign off on document hourly to ensure bathroom is clean and all sanitary conditions are signed off on . Staff meeting held on 8/29/2022 to educate staff members on common bathrooms and sanitary conditions once residents are done with showering before signing off on shower schedule they must first check bathroom for anything left behind to clean up and record. Daily routine rounds will continue to take place for administrator or assistant administrator to check all common bathrooms and checklist to ensure bathrooms are being cleaned hourly. Monthly physical site checklist created and implemented on 8/29/2022 for Administrator, or assistant administrator to check entire facility and all common bathrooms, documentation to be stored in administrative office.

102k - No Common Towel (continued)

3. Housekeeping to sign off on hourly cleaning , DCS to sign off before and after showers, Administrator or assistant administrator to conduct daily rounds of all common bathrooms to ensure documentation is being completed and followed thru. Monthly physical site checklist to be completed by administrator or assistant administrator. All documentation will be kept in administrative office

Licensee's Plan Completion Date: 10/14/2022

Not Implemented [REDACTED] 04/11/2023)

103f - Refrigerator/Freezer Temps**20. 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

On 8/23/22 at approximately 10:22 a.m., the temperature of the refrigerator section of the little refrigerator/freezer had two thermometers. The long thermometer measured a temperature of 48 degrees Fahrenheit, and the round thermometer measured a temperature of 54 degrees Fahrenheit. A recheck of the freezer section on 8/24/22 at 9:55 a.m., the long thermometer measured a temperature of 48 degrees Fahrenheit and the round thermometer measured 55 degrees Fahrenheit.

On 8/23/22, at 12:55 p.m., the temperature of the large stainless-steel double door refrigerator in the kitchen measured 41 degrees Fahrenheit on the exterior door. However, a thermometer on the inside of the refrigerator measured 50 degrees Fahrenheit. A recheck of the refrigerator temperature on 8/24/22 at 9:34 a.m., measured 41.1 degrees Fahrenheit on the exterior side of the refrigerator door and the thermometer on the inside measured 50 degrees Fahrenheit.

POC Submission

Accept [REDACTED] 11/04/2022)

1. Refrigerator was checked for three days throughout the day. on 8/25/2022 reading was 36, 8/27/2022 reading was 34, 8/28/2022 reading was 36. reading has been steady at 35 degrees for one week.

2. Daily refrigerator and freezer document was created and implemented on 8/29/2022. Employees were educated on acceptable temperatures for both refrigerator and freezer 8/29/2022 and to log temperatures of both twice daily. Account set up with Allegheny Refrigeration to come and service as needed. Telephone number posted and employees were shown where and when to call

3. Administrator or assistant administrator will check log daily to ensure readings are being logged and notify refrigeration company with any issues. documentation will be on file in administrative office

Licensee's Plan Completion Date: 10/15/2022

Not Implemented [REDACTED] 04/11/2023)

107c - Food/Water 3 Day Supply

21. Requirements

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 8/23/22, the home currently serves 23 residents requiring 69 gallons of drinking water for a 3-day emergency supply. However, there was only 35 gallons of emergency drinking water on-site. The home's most current contractual agreement with Turner's Dairy is, dated 1/27/21 and valid until March 31, 2022.

POC Submission

Accept [REDACTED] 0/04/2022)

1. Additional water equaling 75 gallons arrived at the home on 8/24/2022. inspector was shown. Turner dairy letter was updated

2. Monthly physical site checklist created and implemented on 9/29/2022 to check emergency water amount and order as needed to ensure a three day supply is available in the home for all residents

3. Administrator, assistant administrator or maintenance will complete monthly document, documentation will be held in administrative office

Licensee's Plan Completion Date: 10/03/2022

Not Implemented [REDACTED] 04/11/2023)

121a - Unobstructed Egress

22. 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

On 8/23/22, 8/24/22 and 8/25/22, there were multiple black trash bags with resident clothing and other belongings, that were stacked on top of each other on the side porch. The bags were obstructing the emergency egress route from the side porch to the steps.

REPEAT VIOLATION 4/6/21

POC Submission

Accept [REDACTED] 11/04/2022)

1. belongings were given back to residents once final treatment was performed and no infestation present. dumpster was ordered on 9/10/2022 all trash was removed making exit route assessable to everyone.

2. Monthly physical site checklist created and implemented on 9/29/2022 to check exit routes and ensure there is an easy egress out of facility. Staff were educated on 8/29/2022 on ensuring all exit routes need to be assessable for everyone. Daily rounds in place for Administrator or assistant administrator to complete daily rounds to ensure exit routes are clear and assessable.

3. Administrator, assistant administrator will complete daily rounds to ensure all exit routes are assessable. Monthly physical site checklist will be completed by administrator or assistant administrator. documentation will be kept on

121a - Unobstructed Egress (continued)*file on administrative office***Licensee's Plan Completion Date:** 10/15/2022**Not Implemented** (██████ 04/11/2023)**144c2 - Smoking Area Distance****23. 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

On 8/23/22, at approximately 9:00 a.m., the agent of the Department observed a male staff person smoking a cigarette on the left side of the front porch under the sign "Nonsmoking Area" on left side of the front door. The designated smoking area is to the right of the front door of the front entrance.

POC Submission**Accept** (██████ 10/04/2022)*1. Employee was educated on where designated smoking section is**2. all chairs and ash tray have been removed from front area and placed in designated smoking area**3. Administrator or assistant administrator will conduct daily rounds to ensure all chairs and ashtrays are located in designated smoking area***Licensee's Plan Completion Date:** 10/03/2022**Not Implemented** (██████ 04/11/2023)**162e - Menu Changes****24. 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).

Description of Violation

On 8/25/22, at 12:20 p.m., Nacho's w/cheese and meat, Spanish rice, and yogurt were listed on the menu for lunch. However, meatballs w/sauce, mashed potatoes were served. No notice was provided to the residents in advance of the meal.

POC Submission**Accept** (██████ 10/04/2022)*1. Kitchen staff were educated on 8/25/2022 on change of menu**2. poster board has been bought and placed in dining hall to inform residents of change in menu**3. Administrator or assistant administrator will check menu daily and ensure menu change is posted should there be one*

162e - Menu Changes (continued)

Licensee's Plan Completion Date: 10/03/2022

Not Implemented [REDACTED] 04/11/2023)

183b - Meds and Syringes Locked

25. 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

On 8/24/22 at approximately 9:35 a.m., there was a box of Nystatin Topical Powder prescribed for resident [REDACTED] with a label indicating apply topically daily, that was unlocked, unattended, and accessible on top of the med cart in the hallway by the dining room.

POC Submission

Accept [REDACTED] 10/04/2022)

1. medication was placed inside med cart

2. medication techs were re-educated on 8/29/2022 to place all medications in medication carts

3. Daily rounds will be completed by administrator or assistant administrator to ensure all meds are stored properly

Licensee's Plan Completion Date: 10/03/2022

Not Implemented [REDACTED] 04/11/2023)

183e - Storing Medications

26. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 8/24/22, resident [REDACTED] was prescribed Albuterol 0.083% 2.5mg/3ML Sol - use 1 vial via nebulizer twice daily as needed for [REDACTED]. However, the manufacture box indicated an expiration date of April 2022, and the medication was still stored in the med cart.

Resident [REDACTED] prescribed Novolog Flexpen Syringe had two dates written on the pen 5/3/22 and 5/31/22. The staff could not determine which was the actual open date.

POC Submission

Accept [REDACTED] - 11/04/2022)

1. Medication was removed from medication cart

2. Monthly medication cart audit has been implemented on 8/29/2022 for DRC to check all medications currently in cart and order or dispose as needed. DRC checked all current resident medications to ensure medications are stored and D/C medications have been removed and discarded. Documentation on file in administration office. Staff meeting held on 8/29/2022 to re-educate medication technicians on ensuring current medications are stored in medication cart and discontinued medications are removed from medication cart, discarded, recorded and placed

183e - Storing Medications (continued)

inside resident chart.

3. DRC will complete monthly cart audit for all residents and place documentation in file. Administrator will ensure paperwork is completed, all documentation will be on file in administrative office

Licensee's Plan Completion Date: 10/15/2022

Not Implemented (████ - 04/11/2023)

184a - Resident's Meds Labeled**27. Requirements**

2600.

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

Description of Violation

Resident █████'s August 2022 Medication Administration Record (MAR) indicates the resident is prescribed Lantus Solostar 100u/ML pen- inject subcutaneously 30 units at bedtime. However, there is not pharmacy label or instruction on the pen or bag.

Resident #████ August 2022 MAR indicates the resident is prescribed Novolog Flex pen Syringe SS inject subcutaneously per sliding scale before meals: (8:00 a.m., 12:00 p.m., 4:00 p.m.) SS: 150-200=2u; 201-250=4u; 251-300=6u; 301-350=8u; 351-400=10u; >400=12u& call MD. However, there is no label on the pen or instructions and the medication was not in package or container with a label.

POC Submission

Accepted (████ 11/04/2022)

1. labels were placed on medications on 8/25/2022.

2. Monthly cart audits are in place for DRC to complete. DRC completed cart audit of all current residents to ensure all resident medications have proper labels on all medications. Staff meeting held on 8/29/2022 for medication technicians to check labels during med pass to ensure they are correct before passing medications and notify supervisor immediately if labels are different or missing. documentation will be on file in administrative office

3. DRC will complete cart audits. Medication techs will monitor medication labels daily during medication administration. Staff aware to notify supervisor and pharmacy should there be an issue. Administrator will monitor documentation and cart audits to ensure system in place in being completed

Licensee's Plan Completion Date: 10/15/2022

Not Implemented (████ 04/11/2023)

185a - Implement Storage Procedures**28. Requirements**

2600.

185a - Implement Storage Procedures (continued)

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 # [REDACTED] prescribed blood glucose readings twice a day before meals (8:00 a.m. and 5:00 p.m.) On 8/19/22, at 8:00 a.m., resident # [REDACTED] glucometer indicated a blood glucose level of 135; however, 130 was documented in the resident August 2022 Medication Administration Record (MAR).

POC Submission**Accept [REDACTED] - 10/04/2022)**

1. Medication aide was re-educated on 8/29/2022 to make sure numbers match
2. Monthly glucometer checklist has been implemented and medication techs were educated on 8/29/2022
3. DRC will check glucometers monthly to ensure numbers match for EMAR, Administrator will check to ensure documentation is completed. Documentation will be filed in administrative office

Licensee's Plan Completion Date: 10/03/2022

Not Implemented [REDACTED] - 04/11/2023)**186a - Authorized Prescriber****29. Requirements**

2600.

186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

On 8/17/22, resident # [REDACTED] and the nurse at the clinic indicated the resident receives 7L of oxygen. The residents support plan dated 9/22/21 indicates the resident is ordered 2L's oxygen via NC as needed. However, a physician orders, dated 9/17/2020, indicated that the resident is prescribed oxygen tanks at 3L for outings and an order, dated 9/17/2020, for a concentrator oxygen 3L in nasal cannula continuous daily for COPD. On 8/24/22, the home was not able to produce a current prescription for the actual amount of oxygen.

POC Submission**Accept [REDACTED] - 11/04/2022)**

1. order was obtained for oxygen, 2 liters per physician.
2. DRC completed an audit on all current resident physician orders on 9/1/2022. Medication techs were re-educated on 8/29/2022 on physician orders and to notify DRC with any changes in resident orders. Monthly cart audits in place for DRC to complete for all current residents and ensure all orders are filed in resident charts
3. DRC to complete monthly med cart audits, med techs educated to notify DRC on MD changes to physician orders. Administrator to monitor monthly med cart audits to ensure all orders are present and placed on resident chart.

Licensee's Plan Completion Date: 10/15/2022

Not Implemented [REDACTED] 04/11/2023)

187d - Follow Prescriber's Orders

30. Requirements

2600.

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

Description of Violation

On 8/24/22, resident # [REDACTED] is prescribed Levothyroxine - 50mcg tablet take one tablet once daily (7:00 a.m.). On 8/9/22, at 7:00 a.m., the August 2022 MAR was not signed off by staff as being administered. Per direct care staff person B, the medication was not administered as prescribed.

POC Submission

Accept ([REDACTED] - 11/04/2022)

1. Staff member B was re-educated on medication administration on 8/29/2022. reportable was sent to DHS on 9/26/2022 reporting error

2. all staff meeting held on 8/29/2022 regarding medication administration. All medication techs are aware they must sign off on medications once giving medications to residents at time of administration and to record ant issues upon administration. Policy on place for all medications techs to record any issues during medication pass and notify supervisor or MD as needed

3. Monthly review of resident medications and documentation will be completed by DRC, Administrator will monitor notes monthly to ensure all documentation is in resident chart and sent off to DHS as needed.

Licensee's Plan Completion Date: 10/15/2022

Not Implemented ([REDACTED] 04/11/2023)

225c - Additional Assessment

31. Requirements

2600.

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

2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident [REDACTED]'s assessment dated 9/22/21, was not updated to include a current physician order, dated 6/21/22, to discontinue self-administration of the following medications, to include:

- * Brimonidine 0.2% eye drops
- * Deep sea 0.65% nose spray
- * Fluticasone Prop 50mcg Spray 120
- * Lumigan 0.01% eye drop
- * Symbicort 160-4.8 mcg Inhaler (20)

POC Submission

Accept ([REDACTED] 11/04/2022)

1. Resident number 3's support plan has been updated to include medications

2. All staff meeting held on 8/29/2022 to review assessments , documentation and what to record in resident chart. DRC completed a review of all current resident RASP and updated accordingly. Monthly review or as needed assessments with be completed and updated in resident assessment

225c - Additional Assessment (continued)

3. DRC will complete monthly audits, Administrator will ensure documentation is completed and placed in resident file. documentation of audit will be placed in administrative office

Licensee's Plan Completion Date: 10/15/2022

Not Implemented [REDACTED] 04/11/2023)

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

Facility Information

Name: *STERLING HOME* License #: *45269* License Expiration: *12/06/2023*
Address: *1318 ARCH STREET, MCKEESPORT, PA 15132*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] 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*
Type: *C-2 LP* Date: *08/22/2001* Issued By: *L & I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *23* Waking Staff: *17*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *12/09/2022*

Inspection Dates and Department Representative

10/19/2022 - On-Site: [REDACTED]

10/20/2022 - On-Site: [REDACTED]

10/21/2022 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *42* Residents Served: *22*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *12*

Are 60 Years of Age or Older: *15*

Diagnosed with Mental Illness: *9*

Diagnosed with Intellectual Disability: *3*

Have Mobility Need: *1*

Have Physical Disability: *0*

Inspections / Reviews

10/19/2022 - Partial

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *12/31/2022*

01/06/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *01/16/2023*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *01/09/2023*

04/11/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *01/16/2023*

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

5a1 - DHS Access

1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

1. Agents of the Department.

Description of Violation

On 10/19/2022 at 10:30 am, an agent of the Department requested access to the closed record of resident #1, date of admission 8/9/2022. Staff person A, the assistant administrator, indicated she did not have access to this record.

Plan of Correction

Accept [REDACTED] - 01/06/2023)

1. Extra keys were made for all DCS to have access to records. Additional keys were labeled and placed in Administrative office for future access

2. Staff meeting held on 10/26/2022 and 11/30/2022 with new DCS staff members educating them on policy and procedures, current VR report's and where to access keys to locked resident files.

3. Administrator and assistant administrator will continue to review lock box monthly using facility physical site checklist to ensure keys are present and employees are aware of how to access them should they need to

Licensee's Proposed Overall Completion Date: 01/02/2023

Not Implemented [REDACTED] 04/11/2023)

23a - Activities of Daily Living Assistance

2. Requirements

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated 10/22/2021 for resident [REDACTED] indicate the resident wears pull ups and sometimes needs assistance with bathroom use and per care, and is usually able to manage own bowels, but will request assistance if needed. On 8/26/2022, the resident did not receive this assistance when she had an incident of bowel incontinence right before leaving for her senior day program. Staff person C refused to assist in cleaning [REDACTED] and changing her pull up.

REPEAT VIOLATION 1/10/22

Plan of Correction

Accept [REDACTED] 01/06/2023)

1. Staff person C was interviewed during the time of incident "resident did get a shower prior to leaving for [REDACTED] day program". Staff person C indicated that resident left [REDACTED] day program shortly after that. Staff person C indicated to Administrator that day program called the home and explained [REDACTED] had an accident under their care and [REDACTED] returning early. Program coordinator wanted resident to be showered immediately upon return, staff person C indicated [REDACTED] would but she would have to wait until she was done serving lunch. Staff persons indicated to Administrator that resident refused to get back in shower but agreed to wash hands. Administrator instructed to staff members to try and calm resident down and encourage to get cleaned up. Resident was very worked up, staff members monitored [REDACTED]

2. Staff meeting was held with all DCS members 10/26/2022 and 11/30/2022 reviewing care plans and resident

23a - Activities of Daily Living Assistance (continued)

rights. DCS members were instructed to ensure that all residents are to receive care as it pertains to the RASP and when requested. DCS reviewed ways to calm residents with mental health issues and how to redirect them. DCS was instructed to notify supervisor of any changes in resident care needs to update it on support plan. Administrator and DRC contacted day program to coordinate a schedule and meeting on how to accommodate needs of residents they provide care for. Day program never responded back to Administrator. Resident is no longer at Sterling home

3. Administrator, Assistant administrator and DRC will complete resident RASP audits monthly to ensure all proper documentation is completed and all DCS is aware of any changes to residents and their care needs. documentation will be placed on administrative office

Licensee's Proposed Overall Completion Date: 01/02/2023

Not Implemented [REDACTED] - 04/11/2023)

42b - Abuse**3. Requirements**

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 8/26/2022, staff from an unaffiliated agency called the home to inquire if resident #2 was coming to the day program. The staff at Sterling home answered the phone yelled for resident #2 to get on the phone. Resident #2 asked who was calling and the staff person stated "Don't who me, just get on the phone." Staff stated she was too busy to call for a ride for resident #2 that morning.

Staff from the unaffiliated agency came to the home to pick up resident #2 and noticed a smell of feces on resident #2 and saw "feces under [REDACTED] nails and caked on [REDACTED] hands." The agency staff accompanied resident #2 back into the home and asked 2 staff persons for assistance with a shower for resident #2. Staff at the home refused to assist, yelling that they gave [REDACTED] a shower just an hour before. At this time, resident #2 was getting anxious from the yelling of the staff. The unaffiliated agency staff assisted resident #2 with washing [REDACTED] hands in the bathroom. After returning to the van, resident #2 was crying and said [REDACTED] did not want to go back to Sterling Home. At the day program, the resident's soiled brief was changed and soiled clothes washed.

Resident #2 was returned to Sterling Home later in the day to collect [REDACTED] belongings as [REDACTED] was moving to another location. The Sterling Home staff attempted to take resident #2 out of the van and told her to come inside to eat dinner. A verbal and physical altercation occurred between the agency staff and staff person C which resident #2 also witnessed and police were called to the home.

Plan of Correction

Accept [REDACTED] 01/06/2023)

1. Staff person C notified Administrator immediately upon altercation. Administrator was on the phone the entire time during altercation. Staff person C admitted [REDACTED] stepped on the bus next to resident to assist [REDACTED] to come back

42b - Abuse (continued)

but never once touched resident the program employee held [REDACTED] arm, resident was scared. Administrator heard the verbal altercation with staff person C and member of program both were screaming at each other. Administrator then spoke with Resident she indicated she was scared and didn't know what to do. Administrator asked resident what [REDACTED] wanted to do she stated "I want to go back". Administrator then spoke with McKeesport police officer who was present on scene along with program director. Administrator told staff person C to remove [REDACTED] from bus, at that time [REDACTED] did. Police officer confirmed she was back inside. Administrator approved program director to remove all her personal belongings and medications from the facility and a form was signed for release. Program director stated resident will go to a shelter. Family was notified, phone calls were never returned. Resident is no longer there. State reportable was filed on 8/26/2022 by Administrator.

2. Staff meeting was held with all DCS members 10/26/2022 and 11/30/2022 reviewing care plans and resident rights. DCS members were instructed to ensure that all residents are to receive care as it pertains to the RASP and when requested. DCS reviewed ways to calm residents with mental health issues and how to redirect them. DCS was instructed to notify supervisor of any changes in resident care needs to update it on support plan. All resident care plans were reviewed on 8/28/2022 by Administrator and DRC, monthly staff meetings are still in effect to train and re-educate DCS on proper ways to handle residents with mental health needs. Documentation will be placed in Administrative file. Administrator still tries to contact Mon Yough, nothing has yet to be resolved. Staff person C is no longer employed at Sterling Home

3. Administrator, assistant administrator and DRC will continue to review all resident care plans, medications, and training to ensure DCS has all the necessary tools available to assist them with the care needs of all residents. DCS continues to be encouraged to notify supervisor of any changes to resident physical or mental health needs. All documentation will be updated, reviewed and stored in resident file.

Licensee's Proposed Overall Completion Date: 01/02/2023

Not Implemented ([REDACTED] 04/11/2023)

127a - Portable Space Heaters**4. Requirements**

2600.

127.a. Portable space heaters are prohibited.

Description of Violation

On 11/19/2022 at 10:50 am, there was a portable space heater in use next to the chair in resident #3's room.

Plan of Correction

Accept [REDACTED] 01/06/2023)

1. Space heater was removed during inspection

2. Resident was educated [REDACTED] is not permitted to have a space heater in [REDACTED] room at any time, Staff was re-educated on 10/26/2022 regarding regulation and to notify management if they witness any heaters present in home for them to remove it.

3. Administrator or assistant administrator will continue to complete daily morning rounds of all resident rooms to ensure all rooms are free and safe of any hazards to resident or facility and notify family if applicable to remove equipment from home.

127a - Portable Space Heaters (continued)

Licensee's Proposed Overall Completion Date: 01/02/2023

Not Implemented [REDACTED] - 04/11/2023)

226b - Mobility Requirements

5. Requirements

2600.

226.b. If a resident is determined to have mobility needs as part of the initial or annual assessment, specific requirements relating to the care, health and safety of the resident shall be met immediately.

Description of Violation

Resident #1's assessment, dated [REDACTED] indicates the resident is physically mobile but "can be unsteady at times." However, according to staff interviews, resident #1 was unable to bear weight on legs and was using a wheelchair to ambulate. Resident #1 was admitted to the hospital on 9/11/2022 and diagnosed with a fracture of the left leg distal fibula.

Plan of Correction

Accept [REDACTED] - 01/06/2023)

1. Resident #1 walked into home on day of admission. [REDACTED] asked for a wheelchair a few days following, one was given to [REDACTED]. Case manager was present in the home at time of admission no mention of pain at that time. Resident complained of ankle pain on 9/11/2022, [REDACTED] was sent out to hospital. Hospital confirmed to DRC LP that fracture was old and there was no new fractures at present time. DRC spoke with case manager, [REDACTED] agreed it was an old fracture and DRC requested more documentation from previous home and hospital findings. DRC reviewed admission notes nothing stated "resident couldn't walk". Administrator, DRC, case manager all reviewed resident discharge documents, nothing stated "resident was unable to walk"

2. DRC LP and Administrator reviewed resident charts along with all other resident updates to ensure all updates were added to care plan. DRC and Administrator will continue to check resident RASP to confirm updates are being added. Monthly DCS meetings are implemented to go over all resident care plans and updates to ensure everyone is aware of any changes. Monthly DME/RASP reviews are in effect as of 10/26/2022 for Administrator and DRC to review and clarify all updates are documented and DCS are notified of any changes to resident care needs

3. Administrator and DRC will continue to review care plans monthly and as needed. Monthly DCS meetings are in place to review all resident charts and review any changes in resident status. Documentation will be completed and placed in resident file for review

Licensee's Proposed Overall Completion Date: 01/02/2023

Not Implemented [REDACTED] - 04/11/2023)

[REDACTED]

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