



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to WEST HAVEN MANOR LP

LEGAL ENTITY

To operate QUALITY LIFE SERVICES - APOLLO

NAME OF FACILITY OR AGENCY

Located at 153 GOODVIEW DRIVE, APOLLO, PA 15613

(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

80

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 June 23, 2023 until December 23, 2023 ,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **442381**


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



CERTIFIED MAIL – RETURN RECEIPT
REQUESTED MAILING DATE: JUNE 23, 2023

[REDACTED]
West Haven Manor LP
153 Goodview Drive
Apollo, Pennsylvania 15613

RE: Quality Life Services Apollo
153 Goodview Drive
Apollo, Pennsylvania 15613
License/COC #: 442381

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on October 18, 2022, October 19, 2022, November 1, 2022, November 2, 2022, November 3, 2022, January 24, 2023, January 25, 2023, and March 7, 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), 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 442380) dated May 19, 2023 – February 27, 2024, 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 June 23, 2023 to December 23, 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 X	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
<u>Section:</u>					
15(b)	II	30	\$5	\$150	5 calendar days from mailing date of this letter
25(b)	II	30	\$5	\$150	5 calendar days from mailing date of this letter
42(b)	II	30	\$5	\$150	5 calendar days from mailing date of this letter
60(a)	II	30	\$5	\$150	5 calendar days from mailing date of this letter
132(c)	II	30	\$5	\$150	5 calendar days from mailing date of this letter
132(d)	II	30	\$5	\$150	5 calendar days from mailing date of this letter
184(a)	II	30	\$5	\$150	5 calendar days from mailing date of this letter
191	II	30	\$5	\$150	5 calendar days from mailing date of this letter
224(a)	II	30	\$5	\$150	5 calendar days from mailing date of this letter
225(a)	II	30	\$5	\$150	5 calendar days from mailing date of this letter
225(c)	II	30	\$5	\$150	5 calendar days from mailing date of this letter
227(d)	II	30	\$5	\$150	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]
[REDACTED]

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

Facility Information

Name: *QUALITY LIFE SERVICES - APOLLO* License #: *44238* License Expiration: *02/27/2023*
Address: *153 GOODVIEW DRIVE, APOLLO, PA 15613*
County: *WESTMORELAND* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *WEST HAVEN MANOR LP*
Address: *153 GOODVIEW DRIVE, ATTN SANDRA MOTCHAR, APOLLO, PA, 15613*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *08/13/2001* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *47* Waking Staff: *35*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint* Exit Conference Date: *11/03/2022*

Inspection Dates and Department Representative

10/18/2022 - On-Site: [REDACTED]
10/19/2022 - On-Site: [REDACTED]
11/01/2022 - On-Site: [REDACTED]
11/02/2022 - On-Site: [REDACTED]
11/03/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* Residents Served: *26*

Secured Dementia Care Unit

In Home: *Yes* Area: *SDCU* Capacity: *36* Residents Served: *0*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *26*
Diagnosed with Mental Illness: *3* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *21* Have Physical Disability: *0*

Inspections / Reviews

10/18/2022 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *12/09/2022*

12/15/2022 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *01/30/2023*

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *12/21/2022*

12/29/2022 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *01/30/2023*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *02/01/2023*

06/14/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *01/30/2023*

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

3c - Post Current License

1. Requirements

2600.

- 3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 10/18/22, the following license inspection summaries were not posted in a conspicuous and public place in the home:

- *The license inspection summary, dated 6/30/21, et. al,*
- *The license inspection summary, dated 9/9/21*
- *The license inspection summary, dated 1/14/22*
- *The license inspection summary, dated 1/20/22*

Plan of Correction

Accept ([REDACTED]) - 12/20/2022)

1. *The license inspection summary date 6/30/21, 9/9/21, 1/14/22 and 1/20/22 were placed in the binder by the PC Administrator on 10/18/22.*
2. *Education to PC administrator on the importance of posting each inspection summary given on 12/5/22 by clinical director. Documentation of education will be kept.*
3. *NHA or designee will audit monthly x's 3 months to ensure any new inspection summary is placed in the binder. The monthly audits will also insure other items indicated in 2600.3c are also posted in the home to include a copy of the home's current license and a copy of the Chapter 2600 regulation or "pink book" Audits to start December 2022 and end with February 2023 Documentation of audits will be kept.*
4. *Results of these audits will be recorded and reviewed at the monthly QAPI meeting.*

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

Implemented ([REDACTED]) - 06/14/2023)

25b - Contract Signatures

2. Requirements

2600.

- 25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #1's resident-home contract, dated 4/24/21, is not signed by the resident.

REPEAT VIOLATION: 6/30/2021, et. al.

Plan of Correction

Directed ([REDACTED]) - 12/20/2022)

1. *Contract for Resident 1 was signed by the resident on 11/25/2022.*
2. *Contracts for all other residents will be reviewed by the PC admin or designee to ensure they are signed by the resident and administrator. This Audit will be completed no later than 12/16/2022*
3. *NHA and wellness director will be educated by the clinical director on the importance of the resident signing each contract on admission and readmission. Education will be completed by 12/16/22. Documentation of education will be kept.*

25b - Contract Signatures (continued)

4. A new admission checklist will be implemented including contracts being signed timely by all parties. Education on this new checklist will be given to the staff by the PC Administrator or designee. Education will be completed by December 30th 2022 Implementation of the new checklist will start January 1 2023 Documentation of the education will be kept.
5. PC admin or designee will audit all new admissions and readmissions within 72 hours of admission or readmission for the next 3 months to ensure compliance. The 3 month audit will start January 2023 with the first admission or readmission and end with March 2023 with the last admission or readmission for the month of March 2023 Documentation of audits will be kept. (DIRECTED: The administrator audits shall begin on 1/2/23. [REDACTED] 12/20/22).
6. Results of these audits will be recorded and reviewed at the monthly QAOP meeting.

Directed Completion Date: 01/02/2023

Not Implemented [REDACTED] 06/14/2023)

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 [REDACTED], resident #3 was admitted to the home's secured dementia care unit (SDCU). On 10/12/22, resident #3 was moved from the home's SDCU and placed on the 2nd floor of the personal care home, which is not part of the SDCU. From 10/12/22 through 11/1/22, multiple staff persons indicated resident #3 was attempting to exit the personal care home on an almost daily basis, to include on 10/25/22, when resident #3 exited the home unattended from the front door and walked down the sidewalk to the parking lot before a staff person re-directed resident #3 back into the personal care home.

On 11/1/22 at approximately 4:30 pm, resident #3 exited the home and was seen on video surveillance walking by the front entrance of the personal care home onto Goodview Drive. Resident #3 walked down Goodview Drive unattended for approximately 0.2 miles, until a neighbor observed resident #3 walking alone and contacted the home. Staff persons C and D went to the neighbor's house to bring resident #3 back to the personal care home. Staff person E, the home's administrator, indicated on numerous occasions [REDACTED] has witnessed staff persons disarming the door alarm on the "drink area" exit door, which leads to the home's skilled nursing facility. Multiple staff persons indicated that on 11/1/22 at 4:30 pm when resident #3 exited the home, no alarm was heard in the building notifying staff persons that the door was opened.

REPEAT VIOLATION: 6/30/2021, et. al.

Plan of Correction

Directed [REDACTED] - 12/20/2022)

1. Resident 3 was assessed by the Nurse Practitioner with a new medical assessment form completed and returned to the SDC unit on 11/3/22 as the assessment states meets [REDACTED] needs. All other residents were assessed by a Registered Nurse and none found to be displaying exit seeking behavior. Assessments completed by 12/16/22. Initial interviews conducted by Clinical Director with staff conducted on 12/14/22 revealed no exit seeking behaviors by any residents. All exit doors are alarmed for resident safety. .

42b - Abuse (continued)

2. Staff will be reeducated by the PC Admin or designee on the alarm process for the door and the importance of maintaining for resident safety. Education to be completed by 12/16/2022 Documentation of education will be kept.
3. An audit of the doors will be conducted by the PC Administrator or designee weekly for 4 weeks to ensure the door alarms are set as instructed. The audits will begin the week of December 19th 2022 and conclude January 9th 2023. Documentation of the audits will be kept. (DIRECTED: Within 72 hours of receipt of the plan of correction: A supervisor shall check all door alarms daily to ensure all door alarms are present and operable. ■ 12/20/22)
4. Results of the audits will be reviewed and recorded in the monthly QAPI meeting.

On 11/15/22, the Department received written notice from the administrator of the home's intent to close the secure dementia care unit effective 12/19/22. ■ 12/29/22

DIRECTED: Within 7 calendar days of receipt of the plan of correction: The administrator shall develop and implement policies and procedures to ensure resident safety. The policies and procedures shall include a system for staff persons to report exit-seeking behaviors of residents to the administrator within 24 hours. Upon receipt of a report of a resident displaying exit-seeking behaviors, the administrator shall review the resident's assessment and support plan and implement changes to ensure residents are safe within the home and do not leave the home unattended. The procedures shall also include a quarterly review of all resident assessments and support plans with members of the administrative staff, including the administrator, to ensure resident assessments and support plans are accurate and proper supervision plans are in place for all residents. The quarterly review of resident assessments and support plans shall begin on 1/9/23. If the home determines a resident's functional level has advanced or declined that the resident's needs can no longer be met by the services provided by the home, a written 30-day notice shall be provided to the resident and the resident's designated person in accordance with 2600.228b. The home shall immediately implement a supervision plan to ensure resident safety during the duration of the 30-day period. Documentation of the policies and procedures shall be kept, as well as documentation of the quarterly reviews shall be kept. All direct care staff persons shall be educated on the new policies and procedures by 1/5/23. Documentation of the education shall be kept.

Directed Completion Date: 01/10/2023

Not Implemented ■ - 06/14/2023)

42I - Personal Clothing**4. Requirements**

2600.

42.I. A resident has the right to furnish his room and purchase, receive, use and retain personal clothing and possessions.

Description of Violation

Resident #8's resident-home contract, dated 10/25/22, indicates the use of "nanny cam" cameras is prohibited in resident's private bedrooms.

Plan of Correction

Directed (LM - 12/20/2022)

1. The contract for resident #8 was reviewed and the addendum to the contract of the policy stating the restriction of "nanny cam" was removed from the contract. The section regarding nanny cams was removed from the contract for all future admissions by the PC Administrator on 12/14/2022
2. An audit of all other resident's contracts was performed on 12/13/2022 to ensure the restriction of "nanny cams"

42l - Personal Clothing (continued)

is not included. Any found will be re written, reviewed and resigned by the resident and Pc Administrator before 12/16/2022. Documentation of audits will be kept.

3. A weekly audit for 3 months of all new admission or readmission conducted by the PC Administrator or designee will begin in January of 2023 with the first admission or admission and conclude March of 2023 with the last admission or readmission of March 2023 to ensure the section regarding nanny cams is not included in the contract. (DIRECTED: The administrator audits shall begin on 1/2/23).

3. Education provided to the Pc Administrator by the Clinical Director on the regulation 2600.42.l stating a resident has the right to furnish his room and purchase, receive, use and retain personal clothing and possessions. Education completed on 12/13/2022. Documentation of education will be kept.

4. An audit of all new admission and readmission with in the first 72 hours of admission for 3 months will be conducted by the PC Administrator or designee to ensure the deficient practice has been corrected. Audits will begin January 1 2023 and conclude March 31st 2023 Documentation of the audit will be kept

5. The results of the audits will be reviewed and recorded in the monthly QAPI meetings.

Directed Completion Date: 01/02/2023

Not Implemented (LM - 06/14/2023)

42x - Safeguard

5. Requirements

2600.

42.x. A resident has the right to a system to safeguard a resident's money and property.

Description of Violation

Resident #8's resident-home contract, dated 10/25/22, indicates the use of "nanny cam" cameras is prohibited in resident's private bedrooms.

Plan of Correction

Directed [REDACTED] - 12/20/2022)

1. The contract for resident #8 was reviewed and the addendum to the contract of the policy stating the restriction of "nanny cam" was removed from the contract by the PC Administrator on 12/14/2022The section regarding nanny cams was removed from the contract for all future admissions by the PC Administrator on 12/14/2022

2. An audit of all other resident's contracts was performed on 12/13/2022 to ensure the restriction of "nanny cams" is not included. Any found will be re written, reviewed and resigned by the resident and Pc Administrator before 12/16/2022. A weekly audit for 3 months of all new admission or readmission conducted by the PC Administrator or designee will begin in January of 2023 with the first admission or admission and conclude March of 2023 with the last admission or readmission of March 2023 to ensure the section regarding nanny cams is not included in the contract. Documentation of the audits will be kept. (DIRECTED: The administrator audits shall begin on 1/2/23).

3. Education provided to the Pc Administrator by the Clinical Director on the regulation 2600.42.l stating a resident has the right to furnish his room and purchase, receive, use and retain personal clothing and possessions. Education completed on 12/13/2022. Documentation of the education will be kept.

4. An audit of all new admission and readmission will be conducted within 72 hours of admission for 3 months will be conducted by the PC Administrator or designee to ensure the deficient practice has been corrected. Audits will begin January 1 2023 and conclude March 31st 2023 Documentation of the audits will be kept.

5. The results of the audits will be reviewed and recorded in the monthly QAPI meetings.

42x - Safeguard (continued)

Directed Completion Date: 01/02/2023

Not Implemented [REDACTED] - 06/14/2023)

60a - Staff/Support Plan

6. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 10/15/22 and 10/16/22, the home served 24 residents, including 21 residents with mobility needs. Of the 21 residents with mobility needs, 1 resident requires the physical assistance of 3 staff persons to transfer in/out of bed/chair, and 5 residents require the physical assistance of 2 staff persons to transfer in/out of bed/chair. At times, only 2 staff persons were present in the home, to include the following dates and times, which is not adequate to evacuate all residents in an emergency:

- On 10/10/22, 10/15/22, 10/16/22 and 10/17/22 from 11:00 pm through 7:00 am
- On 10/16/22 from 3:00 pm through 11:00 pm

REPEAT VIOLATION: 6/10/2022; 6/30/2021, et. al.

Plan of Correction

Directed [REDACTED] - 12/20/2022)

1. At present there are no residents greater than an assist of two. The resident who was an assist of 3 was transferred to a skilled facility. The staffing pattern is a minimum of 3 staff on duty at all times. The homes description of services was updated to state we do not care for resident over assist of 3 staff persons. An announced fire drill was conducted on 11/18/2022 with only 3 staff members who participated in the drill. All residents were evacuated within the 8 minute time allotment.
2. Education will be given to the PC administrator and the new designated scheduler on the number of required staff according to their level of assistance. Documentation of the education will be kept. (DIRECTED: The education shall be completed by 1/2/23. [REDACTED] 12/20/22).
3. The NHA or designee will review daily staffing to ensure compliance indefinitely. The reviews will begin the week of December 19th 2022.
4. Results of these audits will be recorded and reviewed at the monthly QAPI meeting for 3 months. The review will begin with January 2023 QAPI meeting and conclude with March 2023 QAPI meeting.

DIRECTED: Within 48 hours of receipt of the plan of correction: The administrator or Director of Nursing shall review the home's direct care staff schedule daily to ensure adequate staffing is present in the home in accordance with 2600.57a, 2600.57b, 2600.57c, 2600.57d and 2600.60a. Documentation of the daily staffing needs and daily reviews shall be kept. LM 12/20/22

DIRECTED: Within 72 hours of receipt of the plan of correction: The administrator or Director of Nursing shall develop and implement procedures for substitute personnel in accordance with 2600.61, which shall include implementing a contract with a staffing agency to ensure adequate staffing is present in the home in accordance

60a - Staff/Support Plan (continued)

with 2600.57a, 2600.57b, 2600.57c, 2600.57d and 2600.60a. Documentation of the procedures shall be kept. 12/20/22

Directed Completion Date: 01/01/2023

Not Implemented - 06/14/2023)

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

Description of Violation

Staff person A, hired on [REDACTED], did not receive orientation on the following topics:

- Evacuation procedures
- Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable
- The designated meeting place outside the building or within the fire-safe area in the event of an actual fire
- Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable
- The location and use of fire extinguishers

Agency staff person B, hired on [REDACTED], did not receive orientation on any of the topics specified in 2600.65a.

Plan of Correction

Accept - 12/20/2022)

1. Employee A was educated by Maintenance Director on 12/13/2022 on Evacuation procedures, Staff duties and responsibilities during fire drills as well as during emergency evacuation, transportation and at an emergency location if applicable. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire. Smoking safety procedures, the homes smoking policy and location of smoking areas if applicable and the location and use of fire extinguishers. Documentation of the education will be kept
2. Employee B was oriented by the Maintenance Director on 12/14/2022 and received education on the topics specified in 2600.65.a. Documentation of the education will be kept
3. An audit of all current staff will be completed by PC Administrator or designee to determine if the mandatory education is complete. This audit will be completed by 12/16/2022 Documentation of the education will be kept.
4. Education will be provided to the PC administrator and the scheduler by the Clinical Director on the educational

65a - FS Orientation 1st Day (continued)

requirements of a PC employee. This education will be completed by 12/16/2022 Documentation of the education will be kept

5. A new hire checklist will be created to ensure trainings are completed timely at time of hire. Education of the new checklist will be provided to the PC Administrator by the Clinical director. This checklist and education will be completed by December 30th 2022. The checklist will be implemented January 1, 2023. Documentation of the education will be kept.

6. PC administrator will audit all new hires, rehires, agency, ancillary, substitute personnel and volunteers for the next 3 months to ensure compliance. The 3 monthly audit will begin January 1 2023 and conclude with March 31st 2023. Documentation of the audit will be kept

7. Results of these audits will be recorded and reviewed at the monthly QAPI meeting.

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

Not Implemented [REDACTED] - 06/14/2023)

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

Staff person A, hired on [REDACTED] did not receive orientation on the following topics:

- Emergency medical plan
- Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101-10225.5102)
- Reporting of reportable incidents and conditions

Agency staff person B, hired on [REDACTED] did not receive orientation on any of the topics specified in 2600.65b.

Plan of Correction

Directed [REDACTED] - 12/20/2022)

1. Employee A was educated by the PC Administrator or designee on 12/13/2022 on Resident rights, Emergency medical plan, Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act 35 P.S. 10225.1011-225.5102) Documentation of the Education was kept

2. Employee B was education by the PC Administrator or designee on all topics of 2600. 65.b. on *****. Documentation of the education was kept. (DIRECTED: Staff person B shall be educated on all topics specified in 2600.65b within 72 hours of receipt of the plan of correction. Documentation of the education shall be kept. [REDACTED] 12/20/22).

3. An audit of all current staff will be completed by the PC Administrator or designee to determine if the mandatory education is complete. Audit to be completed by 12/16/2022. Documentation of the audits will be kept

4. Education will be given to the PC administrator by the Clinical Director on the educational requirements of a PC employee and the importance of the education being completed within the allotted time frame as set by the

65b - Rights/Abuse 40 Hours (continued)

Department. Documentation of the education will be kept (DIRECTED: The education shall be completed within 72 hours of receipt of the plan of correction. [REDACTED] 12/20/22).

5. A new hire checklist will be created to ensure trainings are completed timely at time of hire. Education of the new hire checklist will be provided to the PC Administrator by the Clinical director. This checklist and education will be completed by December 30th 2022. The checklist will be implemented January 1, 2023. Documentation of the education will be kept.

6. PC administrator will audit all new hires for the next 90 days to ensure compliance. Audits to begin on January 12023 and conclude with March 31st2023.

7. Results of these audits will be recorded and reviewed at the monthly QAPI meeting.

Directed Completion Date: 01/02/2023

Not Implemented ([REDACTED] - 06/14/2023)

81b - Resident Personal Equipment**9. Requirements**

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 11/1/22, resident #5's bed enabler, which was attached to resident #5's bed; was uncovered and had an approximate 1 foot x 1 foot, 3 inch opening in the enabler, posing an entrapment risk.

Plan of Correction

Accept ([REDACTED] - 12/20/2022)

1. The enabler bar on Resident 5's bed was removed by maintenance on 11/1/2022 by maintenance.

2. A new enabler bar meeting the FDA requirements was installed to the resident's bed on 11/1/2022 by maintenance.

3. All other residents' beds will be audited by the Clinical Director to ensure compliance. This audit was completed on 11/1/2022

4. Education provided to staff by the PC Administrator or designee on the FDA requirements of the size of the opening of the enabler bar. This education will be completed by 12/16/2022. Documentation of the education will be kept

5. An audit of all residents' beds will be conducted by the PC Administrator or designee monthly for 3 months to ensure any new enabler bar meets the FDA requirements. Monthly audits will begin with January 10th 2022 and end with March 14th 2023. Audits will be conducted on the second Tuesday of each month. Documentation of the audits will be kept

6. Results of these audits will be recorded and reviewed at the monthly QAPI meeting

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

Not Implemented (LM - 06/14/2023)

88a - Surfaces

10. 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 10/18/22, the bottom of the exit door next to bedroom #8 is in disrepair and cannot be shut without excessive force.

Plan of Correction

Directed (LM - 12/20/2022)

1. A new door has been ordered by the Maintenance Director to replace the door next to room 8. The door was ordered on 11/11/2022. The door is currently on back order with an estimated delivery of 8-12 weeks from order date. The door will be installed within 72 hours of delivery to the home by maintenance or designee.
2. Education will be provided to the maintenance department as well as the PC administrator by Nursing Home Administrator on maintaining proper repair of the doors. Education provided on 12/5/2022 Documentation of the education will be kept
3. An audit will be completed by maintenance or designee of all doors in the personal care to ensure compliance. Audit completed on 10/18/2022 Documentation of the audits will be kept
4. Monthly audit of all doors, walls, ceiling, windows and other surfaces will be conducted to ensure surfaces are clean, in good repair and free of hazards by the maintenance or designee. Documentation of the audits will be kept. (DIRECTED: The monthly audits shall begin within 72 hours of receipt of the plan of correction. ■ 12/20/22).
5. Results of these audits will be recorded and reviewed at the monthly QAPI meeting

Directed Completion Date: 02/01/2023

Not Implemented ■ - 06/14/2023)

101j7 - Lighting/Operable Lamp

11. Requirements

2600.

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

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 11/1/22, resident #3's bedside lamp was approximately 3 feet from the resident's bedside and could not be turned on/off from bedside.

On 11/1/22, resident #5's bedside lamp was approximately 2 feet from the resident's bedside and could not be turned on/off from bedside.

Plan of Correction

Accept (■ - 12/20/2022)

1. Resident 3 and 5 lamps were placed within reach of 11/1/22 by the maintenance department.
2. Education will be given to staff by Pc Administrator by the Clinical Director on the regulation of lights to be able to be turned on at bedside. Education completed on 12/13/2022. Documentation of the education will be kept.
3. An audit will be completed by the PC administrator or designee of all residents to ensure compliance. Audit completed by 12/16/2022 Documentation of the audit will be kept
4. An audit of all resident's light source will be conducted by the PC Administrator or designee weekly for 4 weeks to ensure the light can be turned on from bed side. Audit to begin the week of December 19th 2022 and conclude with the week of January 9th 2023. A monthly audit will then be conducted by the PC Administrator or designee to

101j7 - Lighting/Operable Lamp (continued)

ensure light sources are able to be turned on from the resident's bedside. Documentation of the audit will be kept 5. A Results of these audits will be recorded and reviewed at the monthly QAPI meeting weekly audit times 4 weeks will be completed by the PC administrator to ensure compliance.

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

Implemented (LM - 06/14/2023)

103f - Refrigerator/Freezer Temps**12. 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 10/18/22 at 10:31 am, there was no thermometer in the home's Frigidaire Freezer.

Plan of Correction

Accept (LM - 12/20/2022)

1. Thermometer was placed in refrigerator freezer on 10/18/22 by Certified Dietary Manager.
2. Education will be given to the dietary department by PC Administrator or designee on the regulation of the thermometer. Completed on 10/18/2022 Documentation of education will be kept.
3. An audit will be completed by the PC administrator or designee weekly times 4 weeks to ensure compliance. Audit to begin on 11/9/22 and conclude with week of 12/1/2022. A monthly audit will then be conducted by the PC Administrator or designee to ensure the thermometer is in place Documentation of the audit will be kept
4. Results of these audits will be recorded and reviewed at the monthly QAPI meeting

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

Implemented [REDACTED] - 06/14/2023)

121a - Unobstructed Egress**13. 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 10/18/22 at approximately 10:30 am, a mesh guard with a sign stating, "STOP", was blocking the emergency exit door next to bedroom #35, preventing egress through the door.

On 10/18/22 at approximately 10:30 am, a mesh guard was blocking the emergency exit door next to bedroom #19, preventing egress through the door.

On 10/18/22 at approximately 10:30 am, the following exit doors were locked with a keypad, which are not located in the home's SDCU:

- The exit door next to bedroom 1#6
- Front main exit doors, located next to the medication room
- The exit door in the home's "drink area"

121a - Unobstructed Egress (continued)

The gate leading from the SDCU courtyard to Goodview Drive does not securely latch. On 10/18/22, a large rock was holding the gate closed, blocking the egress route.

Plan of Correction**Accept** [REDACTED] - 12/20/2022)

- 1. The stop signs were removed on 10/18/2022 from the exit door next to bedroom #35 and the exit door next to bedroom #19 by the PC Administrator. On 10/18/2022 the doors were all unlocked by the PC Administrator. The rock was removed from the gate 11/8/2022 by the maintenance department. The gate was repaired by maintenance on 11/4/2022*
- 2. Education will be provided to Personal Care Staff by the Nursing Home Administrator or designee on regulation 2600 212.a egress. Completed by 12/16/2022 Documentation of the education will be kept.*
- 3. An audit will be completed by PC Administrator or designee of all exits to ensure compliance. Audit completed on 12/13/2022. Documentation of the audit will be kept*
- 4. An audit will be completed weekly by the Pc Administrator or designee times 4 weeks to ensure compliance. Weekly audits to begin the week of 12/19/22 and completed with the week of January 9th, 2023. A monthly audit will then be conducted by the PC Administrator or designee of all exits to ensure compliance with regulation 2600.121.a Documentation of the audit will be kept*
- 5. Results of these audits will be recorded and reviewed at the monthly QAPI meeting*

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

Not Implemented [REDACTED] - 06/14/2023)**132c - Fire Drill Records****14. Requirements**

2600.

- 132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the fire drill conducted on 9/14/22 at 2:20 am does not include the number of residents in the home at the time of the drill.

REPEAT VIOLATION: 6/10/2022

Plan of Correction**Directed** [REDACTED] - 12/20/2022)

- 1. Number was corrected on the fire drill on 10/18/22 by the PC Administrator.*
- 2. Education will be provided to the PC administrator by the Clinical Director on regulation 2600132.c Education completed on 12/12/22 Documentation of the education will be kept*

132c - Fire Drill Records (continued)

(UNACCEPTABLE PORTION OF PLAN OF CORRECTION. [REDACTED] 12/20/22). The PC Administrator will continue to monitor the monthly fire drill documentation for completion and compliance in accordance to the regulation of 2600.132.c (DIRECTED: Beginning on 1/1/23: The administrator shall audit all fire drill records monthly to ensure all items indicated in 2600.132c are present on the fire drill records. [REDACTED] 12/20/22). Documentation of the audit will be kept

4. Results of these audits will be recorded and reviewed at the monthly QAPI meeting.

Directed Completion Date: 01/01/2023

Not Implemented [REDACTED] 06/14/2023)

132d - Evacuation**15. Requirements**

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The most recent documentation from the fire safety expert, dated 6/28/22, indicates the maximum evacuation time to the home's fire-safe areas is 4 minutes, 5 seconds; however, the home exceeded the maximum evacuation time during the following fire drills:

- 8/29/22 at 7:33 pm-Evacuation time of 4 minutes, 7 seconds
- 9/14/22 at 2:20 am-Evacuation time of 5 minutes, 8 seconds

REPEAT VIOLATION: 6/10/2022

Plan of Correction

Accept [REDACTED] - 12/20/2022)

1. The fire company reassessed the evacuation plan and evacuation timing on 11/18/22. The timing was changed to 8.0 minutes. Documentation of this assessment will be kept. If evacuation of all residents to a safety zone during a drill is unattained an ad hoc quality assurance meeting will be held to find the root cause which will then be addressed as needed.

2. Education will be provided to staff by the PC Administrator to ensure compliance. Education to be completed by 12/16/2023 Documentation of the education will be kept.

3. NHA or PC administrator will monitor the next 3 fire drills to ensure compliance. Monthly audits will begin with January 1 2023 and end with March 31st 2023 Documentation of the audits will be kept. On going monthly monitoring will be conducted by the PC Administrator for compliance regulation 2600. 132.d indefinitely.

4. Results of these audits will be recorded and reviewed at the monthly QAPI meeting

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

Not Implemented [REDACTED] - 06/14/2023)

141b1 - Annual Medical Evaluation**16. Requirements**

141b1 - Annual Medical Evaluation (continued)

2600.

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

Description of Violation

Resident #1's most recent medical evaluation was completed on 10/11/22; however, resident #1's previous medical evaluation was completed on 4/19/21.

Resident #2's most recent medical evaluation was completed on 10/3/22; however, resident #2's previous medical evaluation was completed on 5/8/21.

Resident #3's most recent medical evaluation was completed on 10/12/22; however, resident #3's previous medical evaluation was completed on 9/13/21.

Plan of Correction**Directed** [REDACTED] - 12/20/2022)

1. All current residents' records will be audited to ensure compliance by the PC Administrator. Audit to be completed by 12/6/2022.
2. Education will be provided to wellness nurse and the PC administrator by the Clinical Director on this regulation and importance of timely completion of paperwork specifically DMEs Education completed on 12/12/2022
3. The PC administrator or designee will audit all new admission for the next 3 months to ensure compliance. Audits to start January 2023 and be completed with March 2023. Documentation of the audits will be kept (DIRECTED: The administrator audits shall begin on 1/2/23. [REDACTED] 12/20/22).
4. Results of these audits will be recorded and reviewed at the monthly QAPI meeting

DIRECTED: Within 7 calendar days of receipt of the plan of correction: The administrator shall develop and implement a tracking system to ensure medical evaluations are completed for each resident at least annually. Documentation of the tracking system shall be kept. All staff persons responsible for the completion of medical evaluations shall be educated on the new system within 10 calendar days of receipt of the plan of correction. Beginning on 1/1/23, the tracking system shall be reviewed by the administrator/wellness nurse monthly. [REDACTED] 12/20/22

Directed Completion Date: 01/06/2023**Not Implemented** [REDACTED] 06/14/2023)**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

On 10/18/22, the only menus posted in the home were dated 9/25/2 through 10/1/22 and 10/16/22 through 10/22/22.

162c - Menus Posted (continued)

REPEAT VIOLATION: 6/30/2021, et. al.

Plan of Correction

Directed [REDACTED] - 12/20/2022)

1. Menus for the following week was posted on 10/18/22 by the Certified Dietary Manager.
2. Education provided to the dietary department by the PC Administrator on this regulation and the importance of posting current week and next week of menus. Education completed on 12/13/2022 Documentation of the education will be kept
3. Audits will be completed by the PC administrator or designee [REDACTED]
[REDACTED] --(DIRECTED: UNACCEPTABLE PORTION OF PLAN OF CORRECTION. [REDACTED] 12/22/22). The PC Administrator or designee will do continued weekly monitoring to ensure the current week's menu as well as a menu one week in advance is posted. Documentation of the audits will be kept (DIRECTED: Within 72 hours of receipt of the plan of correction: A designated staff person shall inspect the home weekly to ensure the current menu, as well as a menu one week in advance, is posted in a conspicuous and public place in the home. [REDACTED] 12/22/22).
4. Results of these audits will be recorded and reviewed at the monthly QAPI meeting

Directed Completion Date: 01/02/2023

Implemented [REDACTED] - 06/14/2023)

183e - Storing Medications

18. 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

Resident #3 is prescribed Lorazepam 0.5 mg-Take 1/2 tablet (0.25 mg) by mouth 2 times a day at 3:00 pm and at bedtime. On 11/1/22, a puncture hole for dose #11 was present in the back of resident #3's Lorazepam medication card, with the pill still present in dose #11.

Plan of Correction

Accept [REDACTED] - 12/15/2022)

1. Resident 3's Lorazepam was wasted on 11/1/2022 by the Clinical Director.
2. Education to be provided to staff by the PERSONAL CARE Administrator or designee on proper disposal of contaminated or compromised medications. Education will be completed by 12/16/2022
3. An audit will be completed by PERSONAL CARE Administrator or designee on all current narcotics to ensure compliance. Audit completed on 12/5/2022 by the Clinical Director.
4. An audit will be completed by PERSONAL CARE Administrator or designee weekly times 4 weeks to ensure compliance. Weekly audits will begin the week of December 19th 2022 and conclude the week of January 9th, 2023.
5. Results of these audits will be recorded and reviewed at the monthly QAPI meeting

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

183e - Storing Medications (*continued*)

Implemented [REDACTED] - 06/14/2023)

184a - Resident's Meds Labeled

19. Requirements

2600.

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

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #2 is prescribed Humalog Kwikpen 100u/ml-Inject 8 units subcutaneously 3 times daily and inject 3 times daily with meals per sliding scale 70-140=0 units; 141-180=2 units; 181-220=4 units; 221-260=6 units; 261-300=8 units; 301-340=10 units; 341+=12 units and call MD; however, resident #2's Humalog pharmacy label does not include the sliding scale coverage.

REPEAT VIOLATION: 6/30/2021, et. al.

Plan of Correction

Accept [REDACTED] - 12/20/2022)

1. Resident 2 sliding scale was added to the storage label on 11/1/2022
2. Education to be provided to staff by PC Administrator on sliding scales to be included with insulin pens. Education will be completed by 12/16/2022. Documentation of the education will be kept.
3. Audit of all insulin pens to be completed by the PC Administrator or designee to ensure compliance. Audit completed by 11/1/2022. Documentation of the audit will be kept
4. An audit of all insulin pens will be completed by the PC Administrator or designee weekly times 4 weeks to ensure compliance. Weekly audits will begin the week of December 19th 2022 and be completed the week of January 9th 2023. On going monthly audits will then be conducted to ensure compliance of regulation 2600.184.a by the Wellness Director or designee. Documentation of the audits will be kept

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

Not Implemented [REDACTED] - 06/14/2023)

185a - Implement Storage Procedures

20. 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

On 11/1/22, resident #2's Prodigy glucometer was not set to the current date and time.

185a - Implement Storage Procedures (continued)

Plan of Correction

Directed [REDACTED] - 12/20/2022)

1. Resident 2,s glucometer was reset for accurate date and time by the Wellness Director on 12/1/2022 All other current resident's glucometers were checked on 12/1/2022 by the Clinical Director to ensure they all had the correct date and time. No others found out of compliance.
2. Education to be provided to staff by the PC Administrator or designee on the importance of ensuring each residents glucometer date and time is accurate. Education will be completed by 12/16/2022 Documentation of the education will be kept.
3. An audit will be completed weekly by the PC Administrator or designee times 4 weeks to ensure compliance of current resident's glucometers showing the correct date and time Weekly audits will begin the week of December 19, 2022 and be completed the week of January 9th 2023. Documentation of the audit will be kept (DIRECTED: Beginning on 1/9/23: The administrator shall conduct monthly audits of all resident glucometers to ensure they are set to the current date and time. [REDACTED] 12/20/22).
4. Results of these audits will be recorded and reviewed at the monthly QAPI meeting

Directed Completion Date: 01/09/2023

Implemented [REDACTED] - 06/14/2023)

191 - Resident Right to Refuse

21. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

There is no documentation present in resident #1's record indicating resident #1 has been educated on her right to question or refuse medication if the resident believes that there may be a medication error.

REPEAT VIOLATION: 6/30/2021, et. al.

Plan of Correction

Accept [REDACTED] 12/20/2022)

1. Education was provided in writing to resident 1 by the PC Administrator on 12/13/2022 on [REDACTED] right to refuse medication
2. Education will be provided to the wellness nurse and PC administrator by the Clinical Director on ensuring the education to refuse medications is provided to the resident on admission and readmission. Education will be completed by 12/13/2022 Documentation of the education will be kept
3. Audit of current resident's records will be completed by the PC Administrator or designee to ensure compliance. This audit will be completed by 12/16/2022 Documentation of the audit will be kept
4. All new admission will be audited by the PC administrator or designee for the next 3 months. Monthly audits will start January 1 2023 and end with March 31st 2023. Audits will be completed within 72 hours of the admission to ensure the right to refuse medication notice was reviewed with the resident and or family and signed by all parties. The home will use a new admission checklist to ensure the Right to refuse or question a medication document was reviewed and signed. The staff will be educated on this new checklist by the PC Administrator or designee Education will be completed by December 31st and the new checklist will be in use starting January 1, 2023. Documentation

191 - Resident Right to Refuse (continued)

of the audit will be kept

5. Results of these audits will be recorded and reviewed at the monthly QAPI meeting

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

Not Implemented () - 06/14/2023)

223a - Description of Service**22. Requirements**

2600.

223.a. The home shall have a current written description of services and activities that the home provides including the following:

1. The scope and general description of the services and activities that the home provides.
2. The criteria for admission and discharge.
3. Specific services that the home does not provide, but will arrange or coordinate.

Description of Violation

The home has no current description of services.

Plan of Correction

Accept () - 12/20/2022)

1. A new description of services has been written by the Cooperate Office The new description of services includes the scope and general description of the services and activates that the home provides, the criteria for admission and discharge and specific services that the home does not provide, but will make arrange or coordinate. The new description of services addresses the fact that the home does not accept residents who need the assistance of 3 staff members.

The new Description of Services will be completed by 12/16/2022

The new description of services along with a 30 days notice to the effective date of February 1, 2023 will be given to and reviewed with all current residents by the Pc Administrator or designee by December 31st 2022.

2. Education on the new description of services will be provided to the PC Administrator and staff by the Clinical Director. Education will be completed by 12/16/2022. Documentation of education will be kept

3. A 30 day notice and a copy of the new description of services will be provided to all current residents and their responsible parties when applicable. This will be completed by 12/16/2022

4. An audit of all new admissions/readmission will be conducted for 3 months by the Pc Administrator to ensure compliance. The monthly audits will begin with January 2023 and conclude with March 2023.

5. A review of audits will be reviewed and recorded in monthly QSPI meeting.

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

Not Implemented () - 06/14/2023)

224a - Preadmission Screen Form**23. 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.

224a - Preadmission Screen Form (continued)

Description of Violation

Resident #5 was admitted to the home on [REDACTED] however, resident #5's preadmission screening was completed on 3/11/21, which exceeds 30 days prior to admission.

REPEAT VIOLATION: 6/30/2021, et. al.

Plan of Correction

Directed ([REDACTED] - 12/20/2022)

1. R5's pre screener was completed on 11/4/2022 by the PC Administrator.
2. Education will be provided to the PC Administrator by the Clinical Director on importance of pre screener being done [REDACTED] (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. [REDACTED] 12/22/22). (DIRECTED: Preadmission screenings for all newly admitted residents shall be completed within 30 days prior to admission. [REDACTED] 12/20/22) Education will be completed by 12/16/2022 Documentation of the education will be kept.
3. Current resident's prescreens will be audited by the PC Administrator or designee to ensure compliance. Audit completed on 12/6/2022. Results of the audits will be kept
4. All new admissions and re admissions will be audited for 3 months by the PC Administrator or designee to ensure compliance with pre screener being completed timely. Audits will begin January 1 2023 and conclude with March 31st 2023.
5. A new admission checklist will be implemented including contracts being signed timely by all parties. (DIRECTED: Within 72 hours of receipt of the plan of correction: The preadmission screening shall be added to the home's new admission checklist to ensure a preadmission screening is completed for each newly-admitted resident within 30 days prior to admission. [REDACTED] 12/20/22). Education on this new checklist will be given to the staff by the PC Administrator or designee. Education will be completed by December 30th 2022 Implementation of the new checklist will start January 1 2023 Documentation of the education will be kept.
6. Results of the audits will be recorded and reviewed in monthly QAPI meeting

Directed Completion Date: 01/01/2023

Not Implemented [REDACTED] - 06/14/2023)

225a - Assessment 15 Days

24. 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 #4's assessment, dated 9/16/22, indicates resident #4 requires some physical assistance transferring in/out of bed/chair; however, resident #4 requires the full physical assistance of 2 staff persons to transfer in/out of bed/chair.

Resident #5 was admitted to the home on [REDACTED]; however, resident #5's assessment is dated 2/4/22.

225a - Assessment 15 Days (continued)

REPEAT VIOLATION: 6/30/2021, et. al.

Plan of Correction

Directed () - 12/20/2022)

1. R4's assessment was updated to match the physical requirements on 11/25/2022 by the Wellness Director via an addendum. All other residents' records were reviewed by the PC Administrator to ensure accurate assessment was completed. This review will be completed by December 16, 2022.
2. R5's assessment was updated and signed on 11/30/2022 by the resident and the Wellness Director.
3. Education will be provided to the Pc Administrator by the Clinical Director on the importance and regulation of the assessments being done timely and accurately. Education completed by 12/13/2022 Documentation of the education will be kept
4. A new admission checklist will be implemented including contracts being signed timely by all parties. (DIRECTED: Within 72 hours of receipt of the plan of correction: The assessment shall be added to the home's new admission checklist to ensure an assessment is completed for each newly-admitted resident within 15 days of admission. () 12/20/22). Education on this new checklist will be given to the staff by the PC Administrator or designee. Education will be completed by December 30th 2022 Implementation of the new checklist will start January 1 2023 Documentation of the education will be kept.
5. An audit of new admission or readmission will be done within 72 hours of admission by PC Administrator or designee for 3 months to ensure compliance. Audits to start January 1 2023 and conclude with March 31st 2023
6. The results of the audits will be reviewed and recorded in monthly QAPI

Directed Completion Date: 01/02/2023

Not Implemented () - 06/14/2023)

225c - Additional Assessment

25. Requirements

2600.

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

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #2 was moved out of the home's SDCU to regular personal care on 10/4/22; however, resident #2's most recent assessment, dated () indicates the resident is still being served in the SDCU.

On (), resident #3 was admitted to the home's SDCU. On 10/12/22, resident #3 was moved from the home's SDCU and placed on the 2nd floor of the personal care home, which is not part of the SDCU. From 10/12/22 through 11/1/22, resident #3 attempted to exit the home on an almost daily basis, to include on 10/25/22, when resident #3 was found walking in the parking lot unattended. Also, on 11/1/22 at approximately 4:30 pm, resident #3 exited the home unattended and walked approximately 0.2 miles down the road before being found by a neighbor. However, resident #3's assessment, dated 3/24/22, indicates resident #3 only requires moderate supervision and still indicates the resident is being served in the home's SDCU.

225c - Additional Assessment (continued)

Resident #6's most recent assessment, dated 2/25/22, indicates resident #6 requires some physical assistance transferring in/out of bed/chair; however, resident #6 requires the full physical assistance of 2-3 staff persons to transfer in/out of bed/chair.

Resident #7's most recent assessment was completed on 8/3/21.

REPEAT VIOLATION: 1/14/2022; 9/9/2021; 6/30/2021, et. al.

Plan of Correction**Directed [REDACTED] - 12/20/2022)**

1. Resident #2 had a new assessment completed by the CRNP stating his level of care no longer met the requirements of the secured dementia unit.
Resident #3 had an updated RASP on 11/3/22 and based on that determination the resident was placed back on SDCU on 11/3/2022.
Resident #6 recent annual assessment can't be completed due to transfer to skilled nursing on 10/29/2022 and return to Personal Care has not occurred and not expected.
Resident #7 recent annual assessment can't be completed due to transfer to hospital on 11/07/2022 and return to Personal Care has not occurred and not expected.
2. Education will be provided to the Personal Care Administrator and Wellness Director by the Clinical Director on the importance and regulation of the assessments being done timely and accurately. Education completed will be by 12/16/2022. Documentation of education will be kept.
3. Currently the Assessments and support plans are in electronic format in Point Click Care software which triggers 15 days prior to the next due date for assessment. PC Administrator will use tracking system that documents Prior RASP, Next RASP due, Last DME completed and next DME due. (DIRECTED: Within 72 hours of receipt of the plan of correction: The administrator shall review the Point Click Care system weekly to ensure an assessment is completed for each resident as least annually. [REDACTED] 12/20/22). PC Administrator or designee will review the process for completion on RASP and DME documents.
5. If the resident care needs change in the facility PC Administrator or Wellness Director will assess resident to determine the new level of care to provide on RASP. PC Director or Wellness Director will be responsible for document completion. (DIRECTED: Within 72 hours of receipt of the plan of correction: The administrator or Wellness Director shall update resident assessments and support plans within 5 calendar days of the change to ensure all resident assessments and support plans are kept current and accurate. If it is determined a significant change has occurred, a new assessment and support plan shall be completed within 5 calendar days. [REDACTED] 12/20/22).
6. An audit of assessments will be done by PERSONAL CARE Administrator or designee for 3 months to ensure compliance. Audits to start January 1, 2023 and conclude with March 31, 2023
7. The results of the audits will be reviewed and recorded in monthly QAPI

On 11/15/22, the Department received written notice from the administrator of the home's intent to close the secure dementia care unit effective 12/19/22. [REDACTED] 12/29/22

DIRECTED: Within 30 calendar days of receipt of the plan of correction: The Wellness Director shall review all current resident assessments to ensure accuracy and completeness, and to ensure an assessment is completed for each resident at least annually. [REDACTED] 12/20/22

225c - Additional Assessment (*continued*)

Directed Completion Date: 01/28/2023

Not Implemented [REDACTED] - 06/14/2023)

226a - Mobility Assessment

26. Requirements

2600.

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

Description of Violation

Resident #1's assessment, dated [REDACTED], indicates the resident is independent with mobility; however, resident #1 requires oral assistance to evacuate in an emergency.

Resident #4's assessment, dated [REDACTED], indicates the resident is independent with mobility; however, resident #4 requires the physical assistance of 1-2 staff persons to transfer in/out of bed/chair.

Plan of Correction

Directed [REDACTED] - 12/20/2022)

1. Resident 1's assessment was updated on 11/25/2022 to reflect [REDACTED] correct mobility showing verbal cueing for emergency evacuation. All other resident's assessments reviewed by the PC Administrator to ensure accuracy of mobility needs. The review will be completed by 12/16/22.
2. Resident 4's assessment was updated on 11/25/2022 by an addendum showing the need for physical assistance for transferring in/out of bed/chair.
3. Education will be provided to the PC Administrator by the Clinical Director on the importance of the resident's assessments accurately reflecting the information from the medical assessment form. This education will be completed by 12/16/2022.
4. An audit of all new admissions for 3 months will be conducted by the PC Administrator or designee. Monthly audits to begin January 2023 and conclude March 2023 (DIRECTED: The administrator audits shall begin on 1/2/23. [REDACTED] 12/20/22).
5. The Wellness Director will be responsible for the homes process of updating mobility changes on the RASP when needed. The Wellness Director will be educated to the new process by the PC Administrator. The education will be conducted by December 31st 2022. The new process will go into effect January 1, 2023. The documentation of the education will be kept.
6. Results of the audits will be reviewed and recorded in the monthly QAPI meeting.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: The administrator shall develop and implement procedures to ensure resident assessments are updated as resident care needs change within 5 calendar days of the change, to include a change in mobility status. The Wellness Director shall be educated on the new system within 10 calendar days of receipt of the plan of correction. [REDACTED] 12/20/22

DIRECTED: Within 30 calendar days of receipt of the plan of correction: The Wellness Director shall review all current resident assessments to ensure accuracy and completeness, which includes an accurate assessment of the residents' mobility needs. [REDACTED] 12/20/22

Directed Completion Date: 01/28/2023

Not Implemented [REDACTED] - 06/14/2023)

226a - Mobility Assessment (continued)

227a - Support Plan 30 Days

27. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #5 was admitted to the home on [REDACTED]; however, resident #5's support plan is dated 2/4/22.

Plan of Correction**Directed [REDACTED] - 12/20/2022)**

1. Resident 5's support plan was updated on 11/30/2022 by the Wellness Director. All other residents were reviewed by the PC Administrator to ensure an accurate support plan was completed.
2. An audit of all current readmitted residents for the past 3 months will be performed by the PC Administrator or designee to ensure a support plan was re done on readmission. This audit will be completed by 12/16/2022.
3. Education to the PC Administrator and Wellness Director will be provided by the Clinical Director on the importance of support plans being completed within 30 days of admission to the home. Documentation of education will be kept
4. An audit of all admission and readmission for the next 3 months will be completed by the PC Administrator or designee within 72 hours to ensure compliance of support plans being completed within 30 days of admission. Audit to begin January 1 2023 and conclude with March 31st 2023. Documentation of the audits will be kept.
5. A new admission checklist will be implemented including contracts being signed timely by all parties. (DIRECTED: Within 72 hours of receipt of the plan of correction: The support plan shall be added to the home's new admission checklist to ensure a support plan is completed for each newly-admitted resident within 30 days of admission. [REDACTED] 12/20/22). Education on this new checklist will be given to the staff by the PC Administrator or designee. Education will be completed by December 30th 2022 Implementation of the new checklist will start January 1 2023 Documentation of the education will be kept.

Directed Completion Date: 01/01/2023

Not Implemented [REDACTED] - 06/14/2023)

227d - Support Plan Medical/Dental

28. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #4 requires the physical assistance of 2 staff persons to transfer in/out of bed/chair; however, this is not indicated in resident #4's support plan, dated 9/16/22.

Resident #6 requires the physical assistance of 2-3 staff persons to transfer in/out of bed/chair; however, this is not

227d - Support Plan Medical/Dental (continued)

indicated in resident #6's support plan, dated 2/25/22.

REPEAT VIOLATION: 6/30/2021, et. al.

Plan of Correction**Directed (████ - 12/20/2022)**

1. Resident 4's support plan was updated by The Wellness Director on 11/25/22 by an addendum to reflect the resident's need for physical assistance to transfer in/out of bed/chair.
2. Resident 6's support plan was updated by The Wellness Director via an addendum to reflect the resident's need for physical assistance of 2-3 staff persons to transfer in/out of bed/chair
3. Education will be provided to the PC Administrator and Wellness Director by the Clinical Director on the importance of the resident's support plan showing the correct transfer needs of the resident as indicated on the medical assessment form. Documentation of the education will be kept. (DIRECTED: The education shall be completed within 7 calendar days of receipt of the plan of correction. █████ 12/20/22).
4. An audit of all current residents will be completed by the PC Administrator or designee to ensure the current support plans match the physical assistance need as indicated on the medical assessment form. Audit will be completed by December 1st 2022. Documentation of the education will be kept.
5. An audit of all new admissions or re admissions will be conducted for 3 months by the PC Administrator or designee to ensure the support plan matches the medical assessment form for the physical assistance for transferring. Monthly audits will begin January 1, 2023 and conclude March 31st, 2023
The Wellness Director will be responsible for the homes process of updating mobility changes on the RASP when needed. The Wellness Director will be educated to the new process by the PC Administrator. The education will be conducted by December 31st 2022. The new process will go into effect January 1, 2023. The documentation of the education will be kept.
6. The results of the audits will be reviewed and recorded in monthly QAPI meeting.

DIRECTED: Within 5 calendar days of receipt of the plan of correction: The administrator shall develop and implement procedures to ensure resident support plans are updated as resident care needs change within 5 calendar days of the change. The Wellness Director shall be educated on the new system within 10 calendar days of receipt of the plan of correction. █████ 12/20/22

Directed Completion Date: 02/01/2023

Not Implemented (████ - 06/14/2023)**228b - Discharge or Transfer****29. Requirements**

2600.

- 228.b. If the home initiates a discharge or transfer of a resident, or if the legal entity chooses to close the home, the home shall provide a 30-day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. This shall be stipulated in the resident-home contract. A 30-day advance written notice is not required if a delay in discharge or transfer would jeopardize the health, safety or well-being of the resident or others in the home, as certified by a physician or the Department. This may occur when the resident needs psychiatric or long-term care or is abused in the home, or the Department initiates closure of the home.

228b - Discharge or Transfer (continued)

Description of Violation

On [REDACTED] resident #6 was discharged from the home; however, a 30-day advance written notice was not provided to resident #6 or resident #6's designated person.

Plan of Correction

Directed [REDACTED] - 12/20/2022)

1. Education to the PC Administrator will be provided by the Clinical Director on regulation 2600.228.b and the importance of issuing a 30 day notice when services cannot be met as indicated in our Description of Services. Education completed on 12/13/2022. Residents and designee will be provided a 30 day advanced written notice. Documentation of the education will be kept.
2. An audit of all discharges planned for the next 3 months will be conducted by the PC Administrator or designee to ensure a 30 day notice is provided when indicated. Audits to begin January 2023 and conclude with March 2023. Documentation of the audit will be kept. (DIRECTED: The administrator audits of all 30-day written notices shall begin on 1/2/23 and shall also ensure the discharge meets one of the criteria specified in 2600.228h. Copies of all written 30-day notices shall be kept in each resident's record. [REDACTED] 12/20/22).
3. The PC Administrator will continue to monitor all future discharge notices to ensure they are compliant with regulation 2600.228.b. Education to the PC Administer on this process will be conducted by the Clinical Director by December 31st 2022. The process will begin January 1, 2023. Documentation of the education will be kept
4. Audits of the results will be reviewed and recorded in the monthly QAPI meeting.

Directed Completion Date: 01/02/2023

Not Implemented [REDACTED] - 06/14/2023)

228h - Grounds Discharge/Transfer

30. Requirements

2600.

228.h. The only grounds for discharge or transfer of a resident from a home are for the following conditions:

1. If a resident is a danger to himself or others.
2. If the legal entity chooses to voluntarily close the home, or a portion of the home.
3. If a home determines that a resident's functional level has advanced or declined so that the resident's needs cannot be met in the home. If a resident or the resident's designated person disagrees with the home's decision to discharge or transfer, consultation with an appropriate assessment agency or the resident's physician shall be made to determine if the resident needs a higher level of care. A plan for other placement shall be made as soon as possible by the administrator in conjunction with the resident and the resident's designated person, if any. If assistance with relocation is needed, the administrator shall contact appropriate local agencies, such as the area agency on aging, county mental health/intellectual disability program or drug and alcohol program, for assistance. The administrator shall also contact the Department's personal care home regional office.
4. If meeting the resident's needs would require a fundamental alteration in the home's program or building site, or would create an undue financial or programmatic burden on the home.
5. If the resident has failed to pay after reasonable documented efforts by the home to obtain payment.
6. If closure of the home is initiated by the Department.
7. Documented, repeated violation of the home rules.

Description of Violation

On [REDACTED], resident #6 was discharged from the home; however, the discharge did not meet any of the criteria indicated in 2600.228h.

228h - Grounds Discharge/Transfer (continued)

Plan of Correction

Directed [REDACTED] - 12/20/2022)

1. Education will be provided to the PC Administrator on regulation 2600.228.h. outlining the reasons for a discharge or transfer of a resident. Education completed on 12/13/2022.
2. All discharge notices for the next 3 months will be reviewed by the PC Administrator, The Nursing Home Administrator and the Clinical Director to ensure the discharge meets the requirements of the regulation. (DIRECTED: The administrator audits of all 30-day written notices shall begin on 1/2/23 and shall also ensure the discharge meets one of the criteria specified in 2600.228h. Copies of all written 30-day notices shall be kept in each resident's record. [REDACTED] 12/20/22).
3. The PC Administrator will continue to monitor all future discharge notices to ensure they are complaint with regulation 2600.228.b. Education to the PC Administer on this process will be conducted by the Clinical Director by December 31st 2022. The process will begin January 1, 2023. Documentation of the education will be kept
4. Results of the audits will be reviewed and recorded in the monthly QAPI meeting.

Directed Completion Date: 01/02/2023

Not Implemented [REDACTED] - 06/14/2023)

233c - Key-Locking Devices

31. Requirements

2600.

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

Description of Violation

On 10/18/22, the 2 codes posted at the exit door in the dining room of the home's SDCU were both incorrect codes and would not unlock the door.

On 10/18/22, the code posted at the exit door next to bedroom #53 of the home's SDCU was the incorrect code and would not unlock the door.

On 10/18/22, the code posted at the exit door next to bedroom #36 of the home's SDCU was the incorrect code would not unlock the door.

REPEAT VIOLATION: 6/30/2021, et. al.

Plan of Correction

Accept [REDACTED] - 12/20/2022)

1. Correct codes were posted on 10/18/22at the exit door in the dining room of the SDCU, the exit door next to bedroom #53 of the SDCU and the exit door next to bedroom #36 of the SDCU by the maintenance department. All other doors were checked by the maintenance o 10/18/22 to ensure the proper codes were posted.
2. Education will be provided to the PC staff on regulation 2600.233.c. the importance of posting the correct code to allow immediate egress when needed. Documentation of the education will be kept.
3. A weekly audit for 4 weeks will be conducted by the PC Administrator or designee starting December 19th 2022 concluding on January 9th 2023 to ensure the codes posted are correct. A monthly audit will be conducted by the maintenance to ensure all correct codes are posted. Monthly audit to begin January 1, 2023. Results of the audits

233c - Key-Locking Devices (continued)

will be kept.

4. The results of the audits will be reviewed and recorded in monthly QAPI meeting.

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

Implemented (████) - 06/14/2023)

233d - Electronic/Magnetic System**32. Requirements**

2600.

- 233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

On 11/2/22, the 1st floor exit door from the SDCU, which leads to the unlocked courtyard next to Goodview Drive, does not securely latch into the door frame when opened and does not engage the door's locking mechanism.

Plan of Correction

Directed (████) - 12/20/2022)

1. The 1st floor exit door from SDCU leading to the unlocked courtyard next to Goodview Drive was repaired so it latches properly by the maintenance department. All other doors in the SDCU were checked on 10/18/22 by maintenance.
2. A new door was ordered to replace the 1st floor door from SDCU to the unlocked courtyard. The door will be replaced when the new door arrives. This door was replaced on *****by the maintenance or designee. (DIRECTED: The 1st floor exit door from the SDCU, which leads to the unlocked courtyard next to Goodview Drive, shall be replaced by 1/30/23. (████) 12/20/22).
3. An audit of the door will be conducted weekly by the PC Administrator or designee for 4 weeks to ensure proper functioning. Audits will begin the week of December 19th 2022 and conclude the week of January 9th 2023. A monthly audit will be conducted by maintenance starting January 1, 2023 to ensure proper functioning of all doors. Results of the audits will be kept.
Education will be provided to the staff by the PC Administrator on the regulation of 2600.233.d. and the importance of reporting any problems found or noticed to the PC Administrator. This education will be completed by December 31st and will be kept
4. Results of the audits will be reviewed and recorded in monthly QAPI meeting.

Directed Completion Date: 02/01/2023

Implemented (████) - 06/14/2023)

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

Facility Information

Name: *QUALITY LIFE SERVICES - APOLLO* License #: *44238* License Expiration: *02/27/2023*
Address: *153 GOODVIEW DRIVE, APOLLO, PA 15613*
County: *WESTMORELAND* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *WEST HAVEN MANOR LP*
Address: *153 GOODVIEW DRIVE, ATTN SANDRA MOTCHAR, APOLLO, PA, 15613*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *08/13/2001* Issued By: *Dept L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *41* Waking Staff: *31*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Incident* Exit Conference Date: *01/25/2023*

Inspection Dates and Department Representative

01/24/2023 - On-Site: [REDACTED]
01/25/2023 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* Residents Served: *28*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *1* Are 60 Years of Age or Older: *28*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *13* Have Physical Disability: *0*

Inspections / Reviews

01/24/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *02/05/2023*

02/06/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/05/2023

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 02/13/2023

02/13/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/13/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission

Follow-Up Date: 02/20/2023

06/15/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/21/2023

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

15b - Supervisor Plan

2. Requirements

2600.

15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On 1/8/23, at approximately 6:00 p.m., staff person A stated [REDACTED] observed resident #1 crying and screaming as staff person B was towel-drying [REDACTED] hair in a rough manner and saying, I will wrap this towel around your head. Quit being an [REDACTED]. However, staff person B continued to work [REDACTED] scheduled shift until approximately 11:00 p.m.

REPEAT VIOLATION: 1/20/2022

Plan of Correction

Directed [REDACTED] - 02/13/2023)

On 1/25/23, PCHA received clarification of the infraction relevant to the lapse in time reporting the alleged abuse with Staff Person A's observation of Staff Person B. On this same day, PCHA addressed verbally with Staff Person A was verbally explained the specifics of needing to report immediately any abuses observed the minute they are observed to the staff supervisor or to call the PCHA, Wellness Director and RN supervisor on call so that the alleged perpetrator can be removed from direct patient care immediately. On 1/9/23, Staff Person B was removed from the facility and placed under suspension pending internal and external investigations, upon making the allegation aware to the prior interim PCHA. On 1/25/23, PCHA with NHA approval has implemented an updated "Abuse Reporting" policy within the PCH and all employees have acknowledged this change as of 1/27/23. The updated "Abuse Reporting" policy was implemented in practice and placed in all internal external versions of the Policies and Procedures manual. Additionally, on 1/25/23 to 1/27/23 all employees were subject to reeducation of updated reporting policy and abuse education by the PCHA and Wellness Director. As of 1/27/23, it was agreed between Wellness Director and PCHA with oversight from NHA, that abuse education and continued Abuse Reporting policy education is to be provided on a quarterly basis as of 1/27/23 for submission to NHA for continued effectiveness and clarity into the Abuse Reporting policy, as well as varied written education materials and verbal teachings on Abuse Reporting and Education by PCHA and Wellness Director.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit any allegations of abuse to ensure any staff person alleged of abuse is immediately suspended or placed on a plan of supervision approved by the Department. 2/13/23 [REDACTED]

Directed Completion Date: 02/13/2023

Not Implemented [REDACTED] - 06/14/2023)

16b - Incident Policies

3. Requirements

2600.

16.b. The home shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

Description of Violation

The home's written abuse reporting policy located in the policy and procedures manual indicates, "Staff at Quality Life Services shall immediately report suspected abuse of a resident served at Quality Life Services in accordance with the Older Adult Protective Services Act and comply with the requirements regarding restrictions on staff persons. All reports of suspected abuse of a resident shall also be reported to the administrator as an incident."

However, on 1/8/23, at approximately 6:00 p.m., staff person A stated [REDACTED] observed resident #1 crying and screaming

16b - Incident Policies (continued)

as staff person B was towel-drying [REDACTED] hair in a rough manner and saying, I will wrap this towel around your head. Quit being an asshole. However, this allegation of abuse was not reported to the Department until 1/9/23 at approximately 10:00 a.m., and staff person B continued working her scheduled shift until approximately 11:00 p.m.

Plan of Correction**Directed [REDACTED] - 02/13/2023)**

On 1/25/23, PCHA was alerted to the technicality of reporting the abuse as occurred 1/8/23, and not reported until 1/9/23. Staff Person A was educated to the specificity of requiring immediately a report in occurrence, as well as to alert shift supervisor, Wellness Director, PCHA, NHA, and/or any other presiding employee entity that the occurrence of suspected resident abuse occurred and to immediately remove the alleged offender from all aspects of direct resident care. Staff Person A confirmed verbal understanding and was provided remediation in the form of formal in-service, written materials to review and discuss, and verbal clarification from PCHA. Following this review on 1/25/23, PCHA and NHA conducted a thorough review of the current policy and procedure for abuse reporting within the company handbook, and refined verbiage was determined to be necessary. As of 1/27/23, Abuse Reporting updated policy and procedure was implemented across all public and internal versions of the company handbook. Additionally, this updated Abuse Reporting policy was provided to all ancillary services held within the PCH as of 1/27/23. As of 1/27/23, abuse reporting education and associated company policies will be subject to quarterly reeducation to all staff in the PCH by Wellness Director and PCHA with oversight by NHA on an ongoing basis.

DIRECTED

Within one calendar day of receipt of the accepted plan of correction: The administrator shall audit all reportable incidents and conditions to ensure reporting compliance with Regulation 2600.16(c). 2/13/23 [REDACTED]

Directed Completion Date: 02/13/2023**Not Implemented [REDACTED] - 06/14/2023)****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 person B was hired on [REDACTED]; however, the home did not request a criminal history background check until 9/2/22.

Plan of Correction**Accepted [REDACTED] - 02/06/2023)**

On 1/25/23, PCHA began to research Staff Person A's background check in conjunction with two associated staffing agencies, as well as in-house Human Resources Representatives. PCHA and HR determined that Staff Person B was employed by a competing staffing agency prior to the Background Check as presented 1/25/23. Human Resources representatives were able to provide and confirm background checks dated 8/20/21, and 9/2/22, coinciding within 30 days of initial hire date of 7/11/22 with first staffing agency, and placement with the second staffing agency 8/30/22. PCHA has implemented a form titled "Personal Care Home Employee Checklist" (inclusive of 1st day and 40 hour trainings) to get ensure all requisite forms are secured for every existing and new hires from the date of 1/25/23 onward. PCHA completed an initial audit of all employee files occurred 1/25/23, and quarterly audit is scheduled to occur from this date to ensure completeness

51 - Criminal Background Check (*continued*)

Licensee's Proposed Overall Completion Date: 02/17/2023

Not Implemented () 06/14/2023)

141a - Medical Evaluation

7. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

A medical evaluation was not completed for resident #1, admitted on ().

Plan of Correction

Accept () - 02/13/2023)

On 1/25/23, PCHA attempted to find the DME form for surveyor for Resident #1, and this was subsequently unable to be located. Given this, on the same date, following a review of Resident #1's chart it was determined that Resident #1 was seen on 1/6/23, and an updated DME form was completed and signed by CRNP on 1/27/23. PCHA conducted a review of Resident #1's chart on 1/25/23, and determined that all other requisite forms were compiled appropriately, as evidenced by this chart review guided by forms "Audit for 227a", "141b" and "New Admission Checklist". As of 1/9/23, PCHA compiled "RASP and DME Audit" form, to outline dates of necessary forms for all residents, inclusive of Resident #1. From the date of 1/27/23, and on an ongoing monthly and quarterly cumulative review, these forms will be continuously audited for completeness and accuracy. For compounded oversight, an ongoing monthly audit for violation 224a, is also implemented as of 1/27/23, to ensure extra oversight.

Licensee's Proposed Overall Completion Date: 02/13/2023

Not Implemented () - 06/14/2023)

190a - Completion Medication Course

8. Requirements

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person B, who has not successfully completed the Department-approved medications administration course since 9/26/21, administered numerous medications to multiple residents at various dates and times, to include the following medications administered to resident #1 at bedtime on 1/1/23, 1/6/23, 1/7/23, and 1/8/23:

- mirtazapine 7.5mg
- requip 0.5mg
- trimetroprim 100mg
- Tylenol PM extra strength 500-25mg

Plan of Correction

Accept () - 02/06/2023)

On 1/24/22, PCHA and NHA conducted parallel investigations regarding Staff Person A's background check and certifications as supplied through two competing staffing agencies. It was outlined from these agencies, that Staff Person A was in compliance with initial orientation training for both medication technician position as well as an

190a - Completion Medication Course (continued)

"Initial Personal Care Aide Training" that complies with all skills and knowledge as would be required for direct patient care in a personal care home setting. Following this presentation of certificates, it was also uncovered that Staff Person A, did in fact achieve an orientation to the position of Personal Care Aide. Due to this not having occurred within the first 40 hours of work, a comprehensive audit form of the "Personal Care Aide Orientation" occurred initially between 12/2/22 and 12/14/22, with planned quarterly audits from this date to ensure completeness of orientation and necessary skills to patient care.

Licensee's Proposed Overall Completion Date: 02/17/2023

Implemented [REDACTED] - 06/14/2023)

224a - Preadmission Screen Form**9. 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 #1's preadmission screening form, dated 10/3/22, does not include a determination that the needs of the resident can be met by the services provided by the home.

REPEAT VIOLATION: 6/30/2021, et. al.

Plan of Correction

Accept [REDACTED] - 02/13/2023)

On 1/24/23, PCHA was alerted to an omission on form "Preadmission Screen Form" was incomplete with regard to a determination of facility to confirm ability to meet resident needs for Resident #1. As of 1/27/23, this form has been reviewed in conjunction with all electronic medical records to confirm the date of admission, as well as a review of capacity for facility to meet current care needs. On 1/27/23, following this review and care conference with PCHA and Wellness Director and CRNP, it was determined that facility and staff can meet needs, and this determination was amended to show on the original form as previously omitted. On 1/27/23, PCHA and Wellness Director completed an audit of Resident #1's chart as guided by form "New Admission Checklist". Additionally, on 1/9/23 PCHA compiled a "RASP and DME" audit form to reflect an included date of Preadmission Screen Forms and audit evaluation. As of 1/27/23, and on a monthly and ongoing quarterly cumulative review basis (from 1/27/23), an audit inclusive of Preadmission Screen Forms, will be conducted to ensure compliance.

Licensee's Proposed Overall Completion Date: 02/13/2023

Not Implemented [REDACTED] - 06/14/2023)

225a - Assessment 15 Days**10. 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's initial assessment, dated [REDACTED], indicates the resident has no problem with aggression; however,

225a - Assessment 15 Days (continued)

multiple staff interviews indicate the resident becomes aggressive and combative during showering.

REPEAT VIOLATION: 6/30/2021, et. al.

Plan of Correction

Accept [REDACTED] - 02/06/2023)

On 1/24/23, PCHA conducted a review of internal clinical and psychosocial documentation with regard to Resident #1. On 1/24/23, PCHA also conducted informal interviews with patient care aides, medication technicians and Wellness Director to clarify instances of aggression with Resident #1. In collaboration, on 1/25/23, it was determined that Resident #1 requires an updated assessment to promote a clearly defined outline to ensure that Resident #1 is receiving proper physical hygiene. From the date of 1/25/23, a complete audit of all resident files occurred to reflect input of direct care workers and the Wellness Director's knowledge of patient's on site, as well as to form the basis of monthly and cumulative quarterly audits from the date onward of 1/25/23 to ensure completeness.

Licensee's Proposed Overall Completion Date: 02/17/2023

Not Implemented [REDACTED] - 06/14/2023)

227g -Support Plan Signatures**11. Requirements**

2600.

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

Description of Violation

Resident #1's initial support plan, dated 10/11/22, was not signed by the resident and the assessor until 12/7/22.

Plan of Correction

Accept [REDACTED] - 02/13/2023)

On 1/24/23, PCHA and Wellness Director conducted a review of Resident #1's support plan to reveal initial completeness from the date of 10/11/22, but this support plan was not signed by Resident #1 until 12/7/22. However, on 1/24/23, PCHA and Wellness Director, in conjunction with medication technicians and personal care attendants, that Resident #1's support plan did require revision. As of 1/26/23, Resident #1's support plan has been amended by PCHA to reflect associated care changes along with verbal input from Son/Designated Support Person. PCHA has implemented a working document as of 1/9/23 "Rasp and DME Audit" to be amended by PCHA and Wellness Director month over month, as well as to be compounded by quarterly review of all associated documentation changes from the date of 1/27/23.

Licensee's Proposed Overall Completion Date: 02/13/2023

Not Implemented [REDACTED] - 06/14/2023)

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

Facility Information

Name: *QUALITY LIFE SERVICES - APOLLO* License #: *44238* License Expiration: *02/27/2023*
Address: *153 GOODVIEW DRIVE, APOLLO, PA 15613*
County: *WESTMORELAND* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *WEST HAVEN MANOR LP*
Address: *153 GOODVIEW DRIVE, ATTN SANDRA MOTCHAR, APOLLO, PA, 15613*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *08/13/2001* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *51* Waking Staff: *38*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Monitoring* Exit Conference Date: *03/07/2023*

Inspection Dates and Department Representative

03/07/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* Residents Served: *30*

Secured Dementia Care Unit

In Home: *Yes* Area: *SDCU* Capacity: *36* Residents Served: *0*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *30*
Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *21* Have Physical Disability: *0*

Inspections / Reviews

03/07/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/24/2023*

Inspections / Reviews (*continued*)

03/30/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/25/2023

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 04/05/2023

06/14/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/05/2023

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

25a - Written Contract and Review

1. Requirements

2600.

- 25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #6 was admitted to the home on [REDACTED] however, there is no resident-home contract present for resident #6. The resident-home contract present in resident #6 record, dated 3/5/23, was completed for resident #6's designated person, who is not a current resident of the home.

Plan of Correction

Directed ([REDACTED] - 06/14/2023)

On 3/8/2023, PCHA and Wellness Director conferred with Resident #6 to achieve successful completion of admissions documents and contract. As of 3/8/2023, this document has been completed with Resident #6 signature and placed in resident's file. As of 3/8/23, PCHA and Wellness Director have begun to audit thoroughly all resident contracts to include Preadmissions Screening, DME and RASP forms with an initial audit intended to occur over 60 days to ensure a resident-home contract is completed within 24 hours of admission, and occur monthly thereafter from the date of 5/8/2023 ongoing without end, and as of this same day, a form entitled "New Admission Checklist" has begun to drive the audit process for all existing and onboarding employees. (DIRECTED: By 5/8/23: The administrator shall review all current resident records to ensure each resident has a completed resident-home contract. Copies of resident-home contracts shall be kept in each resident's record. [REDACTED] 4/6/23). (DIRECTED: By 4/17/23: The administrator shall implement the new admission checklist to ensure a resident-home contract is completed within 24 hours for each newly-admitted resident. Copies of the completed checklists and completed resident-home contracts shall be kept in each resident's record. All staff persons involved in the admission process shall be educated on the new checklist by 4/17/23. Documentation of the education shall be kept. [REDACTED] 4/6/23). On 3/9/23, NHA provided education to PCHA and Wellness Director as to necessary points of compliance within regulation 2600.25a. Record of education for all current employees has been provided as of 3/9/23 to ensure requirements for hire are transparent and understood along side the PA 2600.25a regulation and will kept alongside monthly audits of resident contracts. Results of initial and ongoing monthly audits to be reviewed and recorded in the monthly QAPI meeting and will be kept for reference. (DIRECTED: By 5/1/23: The home shall conduct a quality management meeting. Documentation of the quality management meeting minutes shall be kept. [REDACTED] 4/6/23).

Directed Completion Date: 05/08/2023

Not Implemented 6/14/23 [REDACTED]

54a - Direct Care Staff

2. Requirements

2600.

- 54.a. Direct care staff persons shall have the following qualifications:
1. Be 18 years of age or older, except as permitted in subsection (b).
 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
 3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

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

54a - Direct Care Staff (continued)

Plan of Correction

Directed [REDACTED] - 04/06/2023)

On 3/7/2023, PCHA obtained Employee B's high school diploma was immediately placed in Employee B's file. As of 3/8/2023, PCHA and Wellness Director completed an audit of all current employee files to ensure compliance. From the date of 3/8/2023, audits will be maintained on all employee files by PCHA, Wellness Director or appointed designee, as driven by form "New Hire Checklist" implemented on 3/8/2023. (DIRECTED: Copies of the completed new hire checklists, as well as copies of the qualifications specified in 2600.54a, shall be kept in each newly-hired direct care staff person's [REDACTED] 4/6/23). On 3/8/2023, education was completed with PCHA and Wellness Director by NHA (both/all relevant parties responsible for hiring process in the home) on the importance of regulation 2600.54.a. Documentation of education will be maintained. As of 3/8/2023, PCHA, Wellness Director or appointed designee will complete an audit of all new hires for 60 days, and results of these audits will be reviewed and recorded in the monthly QAPI meeting and will be kept for reference. (DIRECTED: BY 5/1/23: The home shall conduct a quality management meeting. Documentation of the quality management meeting minutes shall be kept. LM 4/6/23).

Directed Completion Date: 05/01/2023

Not Implemented 6/14/23 [REDACTED]

65a - FS Orientation 1st Day

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

Description of Violation

Direct care staff person A, hired on [REDACTED], did not receive orientation on any of the topics specified in 2600.65a.

Direct care staff person B was hired on [REDACTED]; however, staff person B did not receive orientation on the topics specified in 2600.65a until 12/7/22.

Plan of Correction

Directed [REDACTED] - 04/06/2023)

On 3/8/2023, PCHA conducted orientations for both Employees A and B inclusive of all relevant listed topics contained within 2600.65a. (DIRECTED: Documentation of the completed trainings specified in 2600.65a shall be kept in staff persons A and B's records. [REDACTED] 4/6/23). As of 3/8/2023, all other current employee charts were audited by PCHA to ensure compliance, and to be completed for all new hires within 60 days of 3/8/2023. As of 3/8/23, a form titled "New Hire Checklist" was implemented to drive all current and future audits. (DIRECTED: Copies of the completed new hire checklists, as well as documentation of the completed trainings specified in 2600.65a, shall be kept in each newly-hired staff person's record. [REDACTED] 4/6/23). Education to be provided (on 3/9/23) to PCHA and

65a - FS Orientation 1st Day (continued)

Wellness Director by NHA (all relevant parties responsible for hiring process within the home) on the importance of regulations 2600.65a. Documentation of all education will be kept. The PCHA or Wellness Director will audit all new hires for 60 days starting 3/8/2023 to ensure compliance and proper training on the areas outlined in 2600.65a. The results of these audits will be reviewed and recorded in upcoming QAPI monthly meetings and will be kept for reference. (DIRECTED: BY 5/1/23: The home shall conduct a quality management meeting. Documentation of the quality management meeting minutes shall be kept. [REDACTED] 4/6/23).

Directed Completion Date: 05/01/2023

Not Implemented 6/14/23 [REDACTED]

65b - Rights/Abuse 40 Hours**4. 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 person A, hired on [REDACTED], did not receive orientation on resident rights and the emergency medical plan.

Plan of Correction

Directed [REDACTED] - 04/06/2023)

On 11/14/22, Staff Person A acknowledged both statements of understanding in Personal Care Home Resident's Rights, as well as the knowledge of a standing emergency medical plan. (DIRECTED: Documentation of the completed trainings specified in 2600.65b shall be kept in staff person A's record. [REDACTED] 4/6/23). On 3/7/23, PCHA, per audit notes, these items remained outstanding in employee file. On 3/8/23, Staff Person A was oriented to all topics included under PA Regulation 2600.65b and as of 3/9/23 a form titled "New Hire Checklist" was implemented to drive all current and future hired employees. (DIRECTED: Copies of the completed new hire checklists, as well as documentation of the completed trainings specified in 2600.65b, shall be kept in each newly-hired staff person's record. [REDACTED] 4/6/23). As of 1/9/23, PCHA conducted an initial audit of employee files to notice deficiencies and to locate needed items. Monthly audits occurred on 1/27/23 and 2/24/23 and will remain occurring on a monthly basis until files complete, then to transition to semiannual from date of completion for all current employees and to remain ongoing on a monthly basis with each new employee hired from the date of 1/27/2023. On 3/8/23, following DOH visit to facility, PCHA encountered both Staff Person A's Resident Rights and Emergency Medical Plan acknowledgements dated 11/14/22 and these items were placed immediately in Staff Person A's employee record. On 3/8/2023, QLS HR Director and NHA provided education to PCHA and Wellness Director as to requisite items for employee file completion. Documentation of education to be maintained with monthly audit records. Also, on 3/9/2023, all current staff were provided education as to hiring requirements to promote transparency and understanding. Monthly audits of employee records will be reviewed and recorded in the monthly QAPI meeting and will be kept for reference. (DIRECTED: BY 5/1/23: The home shall conduct a quality management meeting. Documentation of the quality management meeting minutes shall be kept. [REDACTED] 4/6/23).

Directed Completion Date: 05/08/2023

Not Implemented 6/14/23 [REDACTED]

65d - Initial Direct Care Training

5. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
 - i. Safe management techniques.
 - ii. ADLs and IADLs
 - iii. Personal hygiene.
 - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
 - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
 - vi. Implementation of the initial assessment, annual assessment and support plan.
 - vii. Nutrition, food handling and sanitation.
 - viii. Recreation, socialization, community resources, social services and activities in the community.
 - ix. Gerontology.
 - x. Staff person supervision, if applicable.
 - xi. Care and needs of residents with special emphasis on the residents being served in the home.
 - xii. Safety management and hazard prevention.
 - xiii. Universal precautions.
 - xiv. The requirements of this chapter.
 - xv. Infection control.
 - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, hired on [REDACTED], did not receive training on any of the topics specified in 2600.65d, including the successful completion and passing of the Department-approved direct care training course and passing of the competency test.

Direct care staff person C, hired on [REDACTED], did not receive training on any of the topics specified in 2600.65d, including the successful completion and passing of the Department-approved direct care training course and passing of the competency test.

Plan of Correction

Directed [REDACTED] - 04/06/2023)

On 1/9/23, PCHA conducted a full audit of PCH employee files, with monthly audits occurring on 1/27/23 and 2/24/23 yielding further refinement and completion of employee files. On 3/8/23, PCHA, following survey visit continued to gather more documents, and outline items needed for employee files and sent an email to QLS HR Directors to apprise them of outstanding needs to include Direct Care Certifications for Staff Persons A and C. On 3/9/23, PCHA personally handed Staff Persons A and C outlined instructions to complete this certification in all haste. As of 3/8/23, PCHA and QLS HR Directors have been in contact to remedy all deficient employee files to include Staff Persons A and C. As of this same date 3/8/23, monthly employee file audits remain occurring on a monthly basis with transition to semiannual auditing once all employee files are complete. (DIRECTED: By 5/1/23: The administrator shall audit all current direct care staff person records to ensure each direct care staff person has successfully completed all trainings specified in 2600.65d, including the successful completion and passing of the

65d - Initial Direct Care Training (continued)

Department-approved direct care competency course. Documentation of the education shall be kept in each staff person's record. [REDACTED] 4/6/23). And on 3/9/23, NHA provided PCHA and Wellness Director education (all parties responsible for hiring and onboarding employees) as to the importance of Pa regulation 2600.65d. On 3/23/2023, Both Staff Persons A and C have completed the requisite Department approved direct care training course and passing of the competency test and were immediately placed in respective employee files. As of 3/8/2023, PCHA, Wellness Director or appointed designee will complete an audit of all new hires for 60 days, and results of these audits will be reviewed and recorded in the monthly QAPI meeting and will be kept for reference. (DIRECTED: BY 5/1/23: The home shall conduct a quality management meeting. Documentation of the quality management meeting minutes shall be kept. [REDACTED] 4/6/23).

DIRECTED: By 4/17/23: The administrator shall implement the new hire checklist to ensure all newly-hired direct care staff persons receive training on all topics specified in 2600.65d, including the successful completion and passing of the Department-approved direct care competency course, before providing unsupervised ADL services to residents. Copies of the completed checklists and documentation of the trainings shall be kept in each newly-hire direct care staff person's record. All staff persons involved in the admission process shall be educated on the new checklist by 4/17/23. Documentation of the education shall be kept. [REDACTED] 4/6/23

Directed Completion Date: 05/01/2023

Not Implemented 6/14/23 [REDACTED]

81b - Resident Personal Equipment**6. Requirements**

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #1's bed enabler, which was attached to resident #1's bed, was uncovered and had an approximate 11.5 inch x 5 inch opening in the enabler, posing an entrapment risk.

Plan of Correction

Directed ([REDACTED]) - 04/06/2023)

On 3/7/23, it was brought to attention of PCHA that Resident #1's family had installed a bed rail without asking PCH for approval. On 3/8/23, PCHA conferred verbally with Central Supply to order a bed rail cover for the mentioned uncovered bed rail to prevent entrapment and Central Supply confirmed the bed rail cover would be ordered to satisfy the regulation. On 3/9/23, all current direct care staff in the PCH have received education on maintenance, cleanliness, and appropriate function of wheelchairs, walkers, prosthetic devices (if applicable), and other present apparatus used by residents within the home. All records of education will be kept for reference and recording. On 3/8/23, PCHA spoke to Resident #1 and Resident #1's family to alert them as to having to have items such as this inspected prior to installation, and to the need for cover. As of 3/8/23, Resident #1, Resident #1's family and PCHA are in agreement that the bed rail would not be in use until a cover was procured and applied. As of 3/20/23, per Central Supply, this bed rail cover is still on order. Additionally, PCHA has conducted monthly audits for bed rails have been occurring as of 1/2/23 and has been notated accordingly for the current month. As of 1/2/23, PCHA will maintain these ongoing bed rail audits as ongoing without end. Additionally, respective items to include any equipment relevant to residents (wheelchairs, walkers, enabler bars, etc.) are to be included

81b - Resident Personal Equipment (continued)

and reported in monthly QAPI meetings and documentation will be kept for reference and review. (DIRECTED: BY 5/1/23: The home shall conduct a quality management meeting. Documentation of the quality management meeting minutes shall be kept. [REDACTED] 4/6/23).

Directed Completion Date: 05/01/2023

Not Implemented 6/14/23 [REDACTED]

132c - Fire Drill Records**7. Requirements**

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the fire drill conducted in December, 2022 only indicates "12" as the date, and does not include the date the fire drill was held. Also, the fire drill record does not include the number of residents present in the home at the time of the fire drill.

The fire drill record for the fire drill conducted in January, 2023 only indicates "1" as the date, and does not include the date the fire drill was held. Also, the fire drill record does not include the number of residents present in the home at the time of the fire drill.

The fire drill record for the fire drill conducted on 2/26/23 at 10:57 does not indicate if the fire drill was conducted in the AM or PM. Also, the fire drill record does not indicate the number of residents present in the home at the time of the fire drill, and indicates the evacuation time as "11102:10510sec."

REPEAT VIOLATION: 6/10/2022

Plan of Correction

Directed [REDACTED] - 04/06/2023)

On 3/8/23, Wellness Director, Maintenance Director, PCHA and NHA held conference to complete appropriately all fire drills as internally recorded from the months of December 2022 to March 2023 with Maintenance Director providing missing and to transcribe these fire drills onto the current version of the state form "Personal Care Home Fire Drill Record- 55 Pa.Code 2600.132c".

Further, on 3/8/2023, Wellness Director, Maintenance Director and PCHA were provided education as to proper process and procedure of fire drills, importance of complete documentation of monthly fire drills, provided outlined copies of regulation 2600.132c for reference and record. (DIRECTED: Documentation of the education shall be kept. [REDACTED] 4/6/23). On this same day, it was determined that PCHA, Wellness Director and Maintenance Director would complete fire drills collaboratively for the next 90 days (three months), to ensure accurate completion with review and signature from NHA. Per directive, PCHA will ultimately maintain responsibility and accountability for all monthly fire drills kept within the home. Additionally, at the direction of the NHA, monthly fire drills as of 3/8/2023 are to be completed on state form "Personal Care Home Fire Drill Record-55 Pa.Code 2600.132c." rather than company provided forms as prior. 90 days from 3/8/2023, upon successful completion of fire drills as intended to refine process under initial audit, Maintenance Director with alternating collaboration from Wellness Director and PCHA will complete monthly fire drills and NHA will confirm accurate completion of forms on an ongoing monthly basis. (DIRECTED: The monthly reviews of the home's fire drill records conducted by the NHA shall begin within 72

132c - Fire Drill Records (continued)

hours of receipt of the plan of correction and continue monthly thereafter, to ensure all items specified in 2600.132c are present on the monthly fire drill records. ■ 4/6/23). As of 3/8/23 with new understanding, audits will be maintained and to occur ongoing without end. Results of these audits will be reviewed and recorded in monthly QAPI meetings and will be kept for reference. (DIRECTED: BY 5/1/23: The home shall conduct a quality management meeting. Documentation of the quality management meeting minutes shall be kept. ■ 4/6/23).

Directed Completion Date: 05/01/2023

Not Implemented 6/14/23 ■

132g - Fire Drills Days/Times**8. Requirements**

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely schedules 2 staff persons in the home from approximately 11:00pm through 7:30am, to include on 2/18/23 and 2/19/23; however, the home has not conducted a fire drill with only 2 staff persons within the last year.

Plan of Correction

Directed ■ - 04/06/2023)

On 3/8/23, Wellness Director, Maintenance Director, PCHA and NHA held conference to complete appropriately all fire drills as internally recorded from the months of December 2022 to March 2023 with Maintenance Director providing missing information and to transcribe these fire drills onto the current version of the state form "Personal Care Home Fire Drill Record- 55 Pa.Code 2600.132c". This same date accommodated education from NHA to PCHA, Wellness Director, and Maintenance Director as to proper completion of fire drill and education pertinent to regulation 2600.132g. (DIRECTED: Documentation of the education shall be kept. ■ 4/6/23). PCHA and Maintenance Director under the guidance of the NHA, completed a monthly calendar for fire drills for the remainder of 2023, ensuring that all shifts are covered, to include those shifts where minimal (2-3) staff members may be present. Document of education pertinent to fire drills in the personal care home setting to be kept alongside the monthly fire drill documentation, as well as a copy of QLS Personal Care Fire Drill internal policy and PA Regulatory Compliance Guide Fire Safety components. A fire drill will be conducted on Wednesday March 12, 2023 with 2 staff members on a shift. (DIRECTED: Documentation of the fire drill conducted on 3/12/23 shall be kept in accordance with 2600.132c. ■ /6/23). Per directive, PCHA will ultimately maintain responsibility and accountability for all monthly fire drills kept within the home. Audits will start April 1, 2023. All personal care employees as of 3/8/2023 have been provided and educated as to the process and procedure of fire drills to occur within the home with accompanying signatures of acknowledgement. All records of education are to be kept. Results of monthly audited fire drills for 90 days from the date of 3/8/2023 with oversight and signature from NHA to ensure proper completion to be reviewed and recorded at monthly QAPI meeting and will be kept for reference. (DIRECTED: BY 5/1/23: The home shall conduct a quality management meeting. Documentation of the quality management meeting minutes shall be kept. ■ 4/6/23).

Directed Completion Date: 05/01/2023

Not Implemented 6/14/23 ■

141a - Medical Evaluation

9. Requirements

2600.

- 141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #5's medical evaluation, which was completed and signed by the medical professional on 2/20/23, indicates "see attached" under the medical diagnoses section; however, the attachment is dated 2/27/23, which was after the medical evaluation was completed. Also, the medication addendum section of resident #5's medical evaluation is blank. The attachment to resident #5's medical evaluation includes a list of medications; however, the attachment is dated 2/27/23, which is after the medical evaluation was completed.

Resident #6's medical evaluation indicates the in-person evaluation occurred on 1/23/23 and that the medical evaluation was completed and signed by the medical professional on 2/23/23. Resident #6's medical evaluation indicates "see attached" under the medical diagnoses section; however, the attachment is dated 2/27/23, which was after the medical evaluation was completed. Also, the medication addendum section of resident #6's medical evaluation is blank. The attachment to resident #6's medical evaluation includes a list of medications; however, the attachment is dated 2/27/23, which is after the medical evaluation was completed.

Plan of Correction

Directed (████ 04/06/2023)

On 3/7/23, PCHA was made aware of changes necessary to DME forms for Residents #5 and #6 were improperly completed. On 3/8/23, PCHA contacted CRNP for amendment and signature to include diagnoses and medications as written on the DME forms, rather than as an attachment. On 3/8/23, PCHA received corrected DME forms for Residents #5 and #6 and these were appropriately filed as hard copies within their respective charts. Additionally, as of 1/9/23, monthly DME form audits were established in conjunction with associated admissions forms to track and forecast upcoming remediation. Additionally, as of 2/10/23, PCHA uses a working resident tracking document is updated with every admission to track DME forms to maintain accountability and compliance with regulation 2600.141a. Alternatingly, as of 3/8/23, PCHA and Wellness Director will be completing monthly DME audits to ensure details are not missed in review, as present remains minor differences, though differences are in process of being identified and remediated. On 3/9/23, PCHA and Wellness Director (all persons involved in the completion of resident DME) were provided education from NHA on process and importance of PA regulation 2600.141a. (DIRECTED: Documentation of the education shall be kept. █████ 4/1/23). Results of DME audits and relevant issues will be reported to QAPI committee and results will be kept for reference and review. (DIRECTED: BY 5/1/23: The home shall conduct a quality management meeting. Documentation of the quality management meeting minutes shall be kept. █████ 4/6/23).

Directed Completion Date: 05/01/2023

Not Implemented 6/14/23 █████

184a - Resident's Meds Labeled

10. Requirements

2600.

- 184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
 2. The name of the medication.
 3. The date the prescription was issued.
 4. The prescribed dosage and instructions for administration.

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

5. The name and title of the prescriber.

Description of Violation

Resident #2 is prescribed Lidocaine 4% patch-Apply 1 patch to left hip once a day; however, the pharmacy label indicates Lidocaine 4% patch-Apply 1 patch to right rib for 14 days.

Resident #3 is prescribed Acetaminophen 500/25 mg-Take 2 tablets by mouth at bedtime; however, resident #3's pharmacy label does not include the prescribed dosage for this medication.

Resident #4 is prescribed Acetaminophen 500/25 mg-Take 2 tablets by mouth at bedtime; however, resident #4's pharmacy label does not include the prescribed dosage for this medication.

REPEAT VIOLATION: 6/30/2021, *et. al.*

Plan of Correction

Directed (████ - 04/06/2023)

On 3/8/23, PCHA received corrected DME forms for Residents #5 and #6 and these were appropriately filed as hard copies within their respective charts. Additionally, as of 1/9/23, monthly DME form audits were established in conjunction with associated admissions forms to track and forecast upcoming remediation. Additionally, as of 2/10/23, PCHA uses a working resident tracking document is updated with every admission to track DME forms to maintain accountability and compliance with regulation 2600.141a. Alternatingly, as of 3/8/23, PCHA and Wellness Director will be completing monthly DME audits to ensure details are not missed in review, as present remains minor differences, though differences are in process of being identified and remediated. On 3/9/23, PCHA and Wellness Director (all persons involved in the completion of resident DME) were provided education from NHA on process and importance of PA regulation 2600.141a. Results of DME audits and relevant issues will be reported to QAPI committee and results will be kept for reference and review.

184a:

*On 3/7/2023, Orders for Resident #2 were clarified to show "apply one patch to left topically one time a day for OSTEOARTHRITIS OF HIP and remove per schedule *REMOVE AFTER 8 HOURS*, so both pharmacy label and eMar display the same order.*

On 3/7/2023, Orders for Resident #3 were clarified to show "Tylenol PM Extra Strength Tablet 500-25 MG Give 2 tablets by mouth at bedtime for pain mild", so both pharmacy label and eMar display the same order.

On 3/7/2023, Orders for Resident #4 were clarified to show "ACETAMINOPHEN PM CAPLET Give 2 tablets (1000-50) by mouth at bedtime for bilateral hip pain", so both pharmacy label and eMar display the same order.

On 3/8/2023, PCHA and Wellness Director established more thorough Medication Cart and Pharmacy Label Audits to be conducted on a weekly basis for the next 60 days (from 3/8/2023) in collaboration with Quality Pharmacy Consultants. DON and NHA conducted education on 3/8/2023 to standardize pharmacy processes, provide education on best practices relative to Medication Cart maintenance and the importance of regulation 2600.184a as it applies to medication administration in personal care homes. Record of this education is to be kept for reference with ongoing oversight of audit process from DON and NHA for the prescribed 60 days ending 5/8/2023, and to occur biweekly thereafter on an ongoing basis without end. Results of cart audits will be reviewed and recorded in the monthly QAPI meeting and will be kept for reference. (DIRECTED: BY 5/1/23: The home shall conduct a quality management meeting. Documentation of the quality management meeting minutes shall be kept. █████ 4/6/23).

184a - Resident's Meds Labeled (continued)

Directed Completion Date: 05/01/2023

Not Implemented 6/14/23

191 - Resident Right to Refuse

11. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

There is no documentation present in resident #6's record indicating resident #6 has been educated on his right to question or refuse medication if the resident believes that there may be a medication error. Resident #6 was admitted to the home on [REDACTED]

REPEAT VIOLATION: 6/30/2021, et. al.

Plan of Correction

Directed [REDACTED] - 04/06/2023)

On 2/27/23, PCHA educated both Resident #6 and Resident #6's Family that resident has the right to refuse and/or question medications, and resident confirmed verbal understanding. On 3/5/23 Resident #6's Family returned admission packet with POA signing on resident's behalf. On 2/27/23, Resident #6's family specifically requested that Resident #6 not be overwhelmed by paperwork due to an emotionally fragile state having recently lost a spouse. On 3/7/23, PCHA found out that this is not acceptable, and remedied by providing Resident Education to outline the right to refuse and/or question any medications provided and acquired resident signature following education of resident right to refuse medication and was immediately placed in the resident's hard chart. On 3/8/23 a form titled "New Admission Checklist" was implemented for all current and oncoming residents to the home. (DIRECTED: Copies of the completed new admission checklists, as well as copies of the acknowledgements that residents have been educated on their right to refuse or question a medication if they believe it to be an error, shall be kept in each newly-admitted resident's record. [REDACTED] 4/6/23).

Additionally, PCHA on 3/8/23, completed an audit of all "Right to Refuse" medication addenda contained within the admissions packets to ensure total completeness and appropriate signatures. As of 3/8/22, PCHA will maintain this as a monthly audit to be included with all new admissions as they occur, with monthly review and record in QAPI meetings and will be kept for reference. (DIRECTED: BY 5/1/23: The home shall conduct a quality management meeting. Documentation of the quality management meeting minutes shall be kept. [REDACTED] 4/6/23).

Directed Completion Date: 05/01/2023

Not Implemented 6/14/23

224a - Preadmission Screen Form

12. 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.

224a - Preadmission Screen Form (continued)

Description of Violation

Resident #6 was admitted to the home on [REDACTED] however, resident #6's preadmission screening was completed on 2/28/23.

Resident #7's preadmission screening, dated 2/15/23, indicates "see attached" under the medical, psychological, and behavioral section; however, nothing is attached. Also, resident #7's preadmission screening does not include an assessment of resident #7's ability to safely use and avoid poisonous materials. This section of the preadmission screening is blank.

REPEAT VIOLATION: 6/30/2021, et. al.

Plan of Correction

Directed [REDACTED] - 04/06/2023)

On 3/8/23, PCHA reviewed Residents #6 and #7 for completeness. On 3/8/23, PCHA amended Resident #6's Prescreen to reflect an initial evaluation date of 2/20/23 when Resident #6 came to the PCH to evaluate rooms best suited and to meet staff. As of 3/20/23, there has been no notable change in condition with Resident #6, and PCHA has not changed anything from the initial prescreen documentation.

On 3/8/23, PCHA reviewed Resident #7's Prescreen. On 3/8/23, Resident #7's Prescreen was amended to reflect associated medical, physical and psychological diagnoses as were present at time of admission to PCH on 2/20/23, as well as the confirmation that Resident #7's ability to safely use and avoid poisonous materials.

On 3/8/23, PCHA conducted an initial Prescreen audit to ensure completeness of all necessary items contained within the form. Following this initial audit on 2/27/23, Prescreen completion is tracked alongside all other admissions documents, to include highlighting mobility and supervision. As of 2/27/23, PCHA will track month over month as admissions occur and will be reviewed on the last Friday of each month. Additionally, education and remediation was provided to PCHA and Wellness Director on the necessity and importance of regulation 2600.224a on 3/10/2023. On 3/8/23, a form "New Admission Checklist" was established to drive all current residents and future admissions as implemented by Wellness Director and PCHA. (DIRECTED: Copies of the completed new admission checklists, as well as copies of the completed preadmission screenings, shall be kept in each newly-admitted resident's record. [REDACTED] 4/6/23). Documentation of all education will be kept. Results of the abovementioned audits will be reviewed and recorded at monthly QAPI meetings and will be kept for future reference. (DIRECTED: BY 5/1/23: The home shall conduct a quality management meeting. Documentation of the quality management meeting minutes shall be kept. [REDACTED] 6/23).

Directed Completion Date: 05/01/2023

Not Implemented 6/14/23 [REDACTED]

226a - Mobility Assessment

13. Requirements

2600.

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

Description of Violation

Resident #2's most recent assessment, dated 1 [REDACTED] indicates the resident is independent with mobility; however, resident #2 requires oral assistance to evacuate in an emergency.

226a - Mobility Assessment (continued)

Plan of Correction**Directed () - 04/06/2023)**

On 2/27/23, PCHA began to compile and complete an electronic tracking mechanism to compile mobility and supervision designations across all DME, Prescreen and RASP documents. On 3/20/23, PCHA, Wellness Director and CRNP in IDT meeting confirmed that resident would need verbal supervision in the event of an emergent situation. On 3/24/23, PCHA and Wellness Director conferred to amend Resident #2's DME form to indicate "minimal" supervision is required and PCHA documented this change on a DME form. Additionally, on 3/20/23, upon completion of consolidation on an electronic tracking document, a monthly audit is intended to occur, coinciding with an original tracking mechanism implemented upon 1/9/23 by PCHA upon hire, to maintain more consistent accuracy and current understanding of resident status. PCHA will conduct these monthly mobility and supervision audits from the date of 3/20/23, and will confer with Wellness Director and Head Aide monthly to ensure accuracy in reporting. On 3/8/23, PCHA and Wellness Director were provided education by NHA to clarify and assist in maintaining compliance with regulation 2600.226a. Record of education to be kept with monthly audit instance. Results of audits will be reviewed and recorded in the monthly QAPI meeting. (DIRECTED: BY 5/1/23: The home shall conduct a quality management meeting. Documentation of the quality management meeting minutes shall be kept.) 4/6/23).

DIRECTED: Within 72 hours of receipt of the plan of correction: The administrator shall update resident #2's assessment to accurately reflect resident #2's current mobility needs. A copy of the updated assessment shall be kept in resident #2's record. LM 4/6/23)

Directed Completion Date: 05/01/2023**Not Implemented 6/14/23**

227d - Support Plan Medical/Dental

14. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #1's uses a bed enabler for positioning and transferring; however, this is not indicated on resident #1's support plan, dated 2/17/23.

REPEAT VIOLATION: 6/30/2021, et. al.

Plan of Correction**Directed () 04/06/2023)**

On 3/8/2023, PCHA and Wellness Director conducted review and updated completion of Resident #1's use of bed enabler for positioning and transfer- to include explanation and education for Resident #1 of the dangers of entrapment present when bed enabler is uncovered. In this same meeting, Resident #1 confirmed verbal understanding of these risks, and complied with safety measures to include removal of bed enabler bar until an appropriate cover arrives to facility. On 3/8/23, the inclusion of use of bed enabler bar for positioning and transfer is included within Resident #1's RASP to more accurately reflect continued use. As of 3/9/23, all resident RASPs were documented on an electronic tracking mechanism (excel file) to highlight any and all needs and amendment

227d - Support Plan Medical/Dental (continued)

process was begun. From the date of 3/8/23, weekly visual surveys of use of bed enabler bars will be conducted by PCHA and Wellness Director. On 3/10/2023, NHA provided education to PCHA and Wellness Director as to the importance of proper use and record of bed enabler bars and the liability of use without covering. An audit of all rooms and bed enabler bars for 60 days from 3/8/23 is set to occur and will be recorded alongside education as provided per NHA. Following the initial 60-day audit, on 5/8/2023, the Wellness Director and PCHA will continue to conduct weekly audits on an ongoing basis without end. Results of these audits will be reviewed and recorded in the monthly QAPI meeting and will be kept for future reference. (DIRECTED: BY 5/1/23: The home shall conduct a quality management meeting. Documentation of the quality management meeting minutes shall be kept. LM 4/6/23).

DIRECTED: By 5/1/23: The home shall develop and implement policies and procedures for updating resident assessments and support plans as resident care needs change. All staff persons involved in the completion of resident assessments and support plans shall be educated on the new procedures by 5/1/23. Documentation of the education shall be kept. ■ 4/6/23

Directed Completion Date: 05/01/2023

Not Implemented 6/14/23 ■