pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **PREMIER OAKWOOD TERRACE OPERATING LLC**
LEGAL ENTITY

To operate **OAKWOOD TERRACE**
NAME OF FACILITY OR AGENCY

Located at **400 GLEASON DRIVE, MOOSIC, PA 18507**
(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 **58**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 13**

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 **October 13,** **2023** until **April 13,** **2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **226611**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: [redacted]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: OCTOBER 13, 2023

[redacted]
Premier Oakwood Terrace Operating, LLC
400 Gleason Drive
Moosic, Pennsylvania 18507

RE: Oakwood Terrace
License: 226611

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on May 31, 2023, and August 18, 2023, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 228800) dated May 14, 2023, to May 14, 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. The license dated May 14, 2023, to May 14, 2024, is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to <62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 13, 2023 to April 13, 2024.

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	Census at	Fine Per resident	Calculated Fine	Mandated Correction Date

or 2800 Section:	Violation	Inspection	X Per day	= Per day	(to avoid Fine)
185a	III	48	$3	$144	15 calendar days from mailing date of this letter
187d	III	48	$3	$144	15 calendar days from mailing date of this letter
225c	III	48	$3	$144	15 calendar days from mailing date of this letter

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

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

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

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

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]

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

Facility Information

Name: *OAKWOOD TERRACE* **License #:** *22661* **License Expiration:** *05/14/2023*

Address: *400 GLEASON DRIVE, MOOSIC, PA 18507*

County: *LACKAWANNA* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *PREMIER OAKWOOD TERRACE OPERATING LLC*

Address: *400 GLEASON DRIVE, MOOSIC, PA, 18507*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/02/1998* **Issued By:** *PA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *74* **Waking Staff:** *56*

Inspection Information

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

Reason: *Interim* **Exit Conference Date:** *08/18/2023*

Inspection Dates and Department Representative

08/18/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *58* **Residents Served:** *48*

Secured Dementia Care Unit

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

Hospice

Current Residents: *12*

Number of Residents Who:

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

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

Have Mobility Need: *26* **Have Physical Disability:** *0*

Inspections / Reviews

08/18/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/08/2023*

Inspections / Reviews *(continued)*

10/02/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/07/2023*

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

141a 1-10 Medical Evaluation Information

1. 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. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

The DME for Resident # 1, dated 8/17/23, was not signed by the physician who completed the evaluation.

The DME for Resident # 2, dated 5/17/23, does not indicate whether the resident is able to self-administer medications.

Plan of Correction ***Directed [redacted] - 09/22/2023)***

Resident #1 DME has been corrected and signed by doctor.
Resident #2 DME has been corrected/updated by Wellness Director.
The Admission Director will review all current residents to ensure compliance is met regarding the doctor's signature.
The Administrator will develop a check list/policy procedure for all new admissions to ensure compliance is met. the Administrator will in-service the Wellness Director and Admission director on the policy as well as the tag 141 (a) Admissions Director or designee will be assigned by Administrator to random audit monthly of 10% of all residents' charts to ensure compliance is met and the results will be reported at the QA meeting by the Admission Director.

Within in 30 days of receipt of this directed plan of correction:
The administrator will ensure that physicians perform all of the required actions during medical evaluations. The actions will be documented on form DME. Attachments will be added to form DME as needed to ensure that all actions are documented. The administrator or designees shall audit all current DME's to ensure they are accurate and complete. The home shall maintain documentation of the audit and shall be available to the Department upon request.

Directed Completion Date: *10/31/2023*

184a - Resident's Meds Labeled

2. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #4 is prescribed Lispro Insulin Kwik pen. The medication was not dated to indicate when it was opened or

184a - Resident's Meds Labeled (continued)

initialed by staff who opened it.

Plan of Correction ***Directed (- 09/22/2023)***

Resident #4 pen was discarded and new one was reordered at time of survey.
Wellness Director or designee will review med carts for any other medications without proper labeling and correct them as needed.
All Med Tech staff will be in serviced by Wellness Director on tag 184(a).
a review of proper labeling will be done monthly by admission director or designee to ensure compliance is met and results will be reported at QA meeting.
The home will ensure that all prescription and sample medication containers are labeled with the required information.

Within in 30 days of receipt of this directed plan of correction:
The Administrator or designee will audit all the medications to ensure all medications are properly labeled. Administrator or designee shall audit all medications carts weekly for 3 months. The home shall maintain documentation of the audit and shall be available to the Department upon request.

Directed Completion Date: *10/31/2023*

184b - Labeling OTC/CAM

3. Requirements

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

Description of Violation

A bottle of Calcium Citrate + Vitamin D, prescribed for Resident # Maureen Coren, was noted in the med cart and name labeled with the resident's name.

Plan of Correction ***Directed (- 09/22/2023)***

Medication identified at time of survey was taken from the cart and reviewed with resident's doctor to ensure proper use and directions.
a review all med carts will be done by Wellness Director or designee to identify any other meds without proper labeling and correct them as needed. Administrator or designee will in-service med techs and Wellness Director on Tag 184(b).
A monthly review on medication labeling will be done by the Third shift charge. any non-compliance will be corrected and results of reviews will be presented at QA meetings by Wellness Director.

Within in 30 days of receipt of this directed plan of correction:
The Administrator or designee will audit all the medications to ensure all medications are properly labeled with the resident's name. Administrator or designee shall audit all medications carts weekly for 3 months. The home shall maintain documentation of the audit and shall be available to the Department upon request.

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

Directed Completion Date: *10/31/2023*

185a - Implement Storage Procedures

4. 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

Upon review, Resident # 5 glucometer indicated a blood sugar level (BSL) of 192 on 8/11/23 at 8:05am. A BSL of 193 was documented on the MAR.
Resident # 6 is prescribed Nystatin cream; apply 2x daily; 8am and 8pm. The medication was not available, but the MAR was initialed by staff indicating it was administered from 8/1/23 to 8/18/23.

Plan of Correction ***Directed [redacted] - 09/22/2023)***

resident #5 reading was corrected to ensure reading from glucometer was recorded.
Resident #6 MD was notified of the possible missed of medication/treatment.
medication was reorder and arrived day of survey.
Administrator will in-service Wellness Director and Med Techs on tag 185(a)
Wellness Director or designee will review 20% medication delivery each week to ensure compliance is met, results will be reported at QA meetings by Wellness Director.

Within in 30 days of receipt of this directed plan of correction:
The Administrator or designee will audit all the medications to ensure all medications are on hand for the residents. The Administrator or designee will audit all residents blood glucose readings. Administrator or designee shall audit all medications carts weekly for 3 months. The home shall maintain documentation of the audit and shall be available to the Department upon request.

Directed Completion Date: *10/31/2023*

187d - Follow Prescriber's Orders

5. Requirements

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

Description of Violation

Resident # 6 is prescribed Metformin HCL 500mg. at 8am and 8pm. On 8/2/23 at 8:00pm, the MAR was not initialed by staff to indicate the medication was administered.

Plan of Correction ***Directed [redacted] - 09/22/2023)***

Resident #6 medication identified was counted at time of survey to ensure correct amount meds match the number of days. Med Tech identified will be in serviced by Wellness Director on Tag 187(d). Wellness Director or designee will in service all med techs on tag 187(d).

187d - Follow Prescriber's Orders (continued)

Daily review by Wellness director or designee on Eldermark software to identify any missed meds and follow up immediately as to the reason. The daily review will be reported at QA meeting by Wellness Director or designee to identify compliance in this area.

Within in 30 days of receipt of this directed plan of correction:
The Administrator or designee will audit all residents MARs for missing initials. Administrator or designee shall audit all medications carts weekly for 3 months. The home shall maintain documentation of the audit and shall be available to the Department upon request.

Directed Completion Date: *10/31/2023*

224a - Preadmission Screen Form

6. 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

The Pre-Admission Screening form for Resident #3, dated 3/24/23, does not indicate if the home can meet the resident's needs.

Plan of Correction ***Directed [redacted] - 09/22/2023)***

Resident #3 PASSAR was corrected by Admission Director who did the initial screening.
The Admission Director will review all new resident since last annual survey to ensure compliance is met with this tag.
the Administrator will develop a policy/procedure and check list to ensure compliance is met with each new PASSAR.
The Administrator will in-service Admission Director on Tag 224(a)
the Administrator or designee will review all new admission each month to ensure compliance is met with Tag 224(a) and results will be reported at QA meetings by Administrator.

Within in 30 days of receipt of this directed plan of correction:
The home will ensure that all residents admitted after the date shown have a preadmission screening completed. The administrator will ensure that the preadmission screening is accurate and completed in its entirety, including signing and dating the screening form. If the home determines that the resident's needs cannot be met by the home based on the preadmission screening, the home will refer the resident to the appropriate local assessment agency. The administrator or designees shall audit all current Preadmission Screen Forms to ensure they are accurate and complete. The home shall maintain documentation of the audit and shall be available to the Department upon request.

Directed Completion Date: *10/31/2023*

225a - Assessment 15 Days

7. 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

The initial RASP for Resident #3, admitted [redacted]/23, is not dated to indicate when it was completed.
The initial RASP for Resident # 2, admitted [redacted]23, is not dated to indicate when it was completed.

Plan of Correction ***Directed [redacted] - 09/22/2023)***

Resident #3 RASP was redone and completed correctly, by the Wellness Director.
Resident #2 RASP was redone and completed correctly by the Wellness Director.
Administrator will in-service Wellness Director on tag 225(a).
Administrator or designee will review all new admission using a newly developed checklist, after 14 days to ensure compliance is met. results will be reported at QA, meetings by Administrator.

Within in 30 days of receipt of this directed plan of correction:
Resident's #2 and #3 will have a detailed, comprehensive assessment that identifies all of the resident's personal care needs. The assessments will be documented on the Department's required form. Forms will be filled out in their entirety, including signatures and dates. The administrator will develop a system to ensure that all assessments are done correctly, completely, and within the time frames required by this Chapter. The administrator or designees shall audit all current residents RASPs to ensure they are accurate and complete. The home shall maintain documentation of the audit and shall be available to the Department upon request.

Directed Completion Date: *10/31/2023*

225c - Additional Assessment

8. Requirements

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

Description of Violation

The last annual RASP completed for Resident #1 is dated 5/3/22. An annual RASP has not been completed.
REPEATED VIOLATION: 3-30-23

Plan of Correction ***Directed [redacted] - 09/22/2023)***

Resident #1 will have new updated RASP done by Wellness Director.
Admission Director or designee will review all current residents RASPS to ensure compliance with tag 225(c) and will correct any non-compliance issues.
Administrator will in-service Wellness Director/designee on tag 225(c).
a policy/procedure will be developed by administrator to ensure compliance is met with Tag 225(c).
Audits will be done monthly by Administrator or designee to ensure RASP are completed and in compliance. the results will be reported by Administrator at QA meeting.

Within in 30 days of receipt of this directed plan of correction:
Resident #1 will have a detailed, comprehensive assessment that identifies all of the resident's personal care needs. The assessment will be documented on the Department's required form. Forms will be filled

225c - Additional Assessment (continued)

out in their entirety, including signatures and dates. The administrator will develop a system to ensure that all assessments are done correctly, completely, and within the time frames required by this Chapter. The administrator or designees shall audit all annual resident RASPs to ensure they are accurate and complete. The home shall maintain documentation of the audit and shall be available to the Department upon request.

Directed Completion Date: *10/31/2023*

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

Facility Information

Name: *OAKWOOD TERRACE* **License #:** *22661* **License Expiration:** *05/14/2023*

Address: *400 GLEASON DRIVE, MOOSIC, PA 18507*

County: *LACKAWANNA* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *PREMIER OAKWOOD TERRACE OPERATING LLC*

Address: *400 GLEASON DRIVE, MOOSIC, PA, 18507*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/02/1998* **Issued By:** *PA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *87* **Waking Staff:** *65*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date:** *05/31/2023*

Inspection Dates and Department Representative

05/31/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *58* **Residents Served:** *44*

Secured Dementia Care Unit

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

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *43*

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

Have Mobility Need: *43* **Have Physical Disability:** *0*

Inspections / Reviews

05/31/2023 - Full

Lead [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/23/2023*

Inspections / Reviews *(continued)*

09/28/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/28/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/29/2023*

10/02/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *09/28/2023*

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

The most recent LIS's dated 11/3/22, 1/18/23, 5/14/23, and 8/23/23 were not posted in a conspicuous and public place in the home.
The home did not post a copy of the Department of Human Services Chapter 2600 Personal Care Homes regulation book in a conspicuous and public place in the home.

Plan of Correction ***Accepted ([redacted] - 09/29/2023)***

Corrected at time of survey.
LIS was secured to wall. all previous survey were copied and placed in it. compliance rounds done by department heads, will include to identify LIS current and present. administrator will Inservice department heads on tag 3 (c). Administrator will conduct monthly checks on LIS's posted.

Licensee's Proposed Overall Completion Date: 08/11/2023

Not Implemented [redacted] - 09/29/2023)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 4/13/23 staff noted a "used narcotic page" from the Narcotic Log on the desk in the Wellness Room. The medication listed on the sheet was Hydrocodone/acetaminophen 5-325mg; 1 tablet to be given 2x daily and PRN every 4 hours if needed for pain for Resident #1.
The home determined that Staff Person B failed to initial the MAR or the narcotic sheet to indicate the medication was administered to resident #1. Based on the information provided by the home's administrator, Staff Person B did not follow proper procedures when administering the narcotic to Resident #1. The home did not report the incident to the Department until 5/22/23.
REPEATED VIOLATION: 3-20-2023

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Staff identified was terminated, report to proper agencies were complete by the administrator. all med technicians will be educated by administrator or QA RN regarding the proper way of documenting for narcotics, tag 16 (c) as well as develop a new policy by the wellness director & QA RN, which all med techs will be in-service done by 8/11/23 by the QA RN/designee. Directed: The administrator will review the incidents required to be reported by 2600.16a with all staff. All future incidents will be reported as required.

Licensee's Proposed Overall Completion Date: 08/11/2023

Implemented [redacted] - 09/29/2023)

26a - Quality Management Plan

3. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home did not have documentation that that an annual quality management plan review had taken place with the past 12 months.

Plan of Correction ***Accepted [redacted] 09/29/2023)***

QA was not able to be located, the QA book will now be located in the administrator's office. a new QA policy and procedure will be developed by the administrator/ QARN and implemented following the guideline of Tag 26 (a). an in-service will be done by the Administrator or QA. RN/designee for all staff. The QA plan will now be located in the "survey ready" book. Directed: The home will establish and implement a quality management plan that contains all of the elements required by 2600.26b. At a minimum, the plan will include:
(1) The date the administrator and executive staff will review the effectiveness of the reportable incident and condition reporting procedures developed as required by 2600.16b, and a plan to correct any errors or inefficiencies identified during a review or all incidents reported within the past year.
(2) The date the administrator and executive staff will review all of the complaints received from residents within the past year, a plan to reduce future complaints, and a review of how the home addressed each complaint in accordance with the requirements of these regulations. (3) A plan to review all training provided to direct care staff within the past year, addressing which trainings were
effective, which were not effective, and what additional training courses would be helpful. (4) A review of all of the violation reports received within the past year, and a complete self-inspection using the Department's licensing measurement instrument. (5) The development and maintenance of a resident council.

Licensee's Proposed Overall Completion Date: 08/11/2023

Not Implemented [redacted] - 09/29/2023)

42b - Abuse

4. 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 4/25/23 @ approximately 6:45am, staff heard Resident #2 calling for help and found [redacted] on the hallway floor. Staff reviewed the video recording of the hallway where resident #2 was found and determined that [redacted] was pushed by resident #3. Resident #2 was taken to GCMC for evaluation. Results of an x-ray confirmed they sustained a fractured left hip because of the fall which occurred when resident #3 pushed them.

Plan of Correction ***Directed [redacted] - 09/29/2023)***

Resident # 2 was transferred to hospital and skilled rehabilitation for PT/OT. both residents RASPs were updated by wellness director. all Staff will be in-serviced on tag 42 (b) by administrator/designee. a review of all incidents will be done by the QA RN or designee, as part of the QA process.
Within in 30 days of receipt of this directed plan of correction:
Resident's who are with diagnosis dementia will have their Resident Assessment and Support Plan reviewed and updated. Each direct care staff person working with residents with dementia shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65. 2 hours of the required 6 hours annual training will be completed by 11/5/2023. Resident #3 shall have their RASP reviewed and accessed for behaviors.

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

[redacted] - 09/29/2023)

42s - Privacy

5. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

Based on an interview with Staff Person A, it was determined that there are cameras that video record the common hallways and entrances of the home. There are no signs posted to inform the residents or visitors that images are being recorded. In addition, the residents were not informed upon admission that the areas mentioned are subject to a video recording.

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Postings added /corrected at time of survey. As part of the new admission process the admission director will now add a notice developed by the Administrator/designee, that video recordings do take place in certain identified areas. Postings will now be added to compliance rounds done by department heads/designee staff. In addition, all RPs will receive a letter from the Administrator that identifies recording devices in the community. administrator will in-service all staff on tag 42 (s).

Licensee's Proposed Overall Completion Date: 08/11/2023

Implemented [redacted] - 09/29/2023)

54a - Direct Care Staff

6. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:

Description of Violation

The home had no documentation that direct care staff person C (hired [redacted]-23) was in possession of a high school diploma, GED, or active registry status on the PA nurse's aide registry. Staff was retained beyond the 30-day provisional hiring period pending receipt of the education document required by the regulation.

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

The staff member was put on leave until documentation was provided.
the HR director will review all new hires to identify any other staff member without the documentation, of diploma/GED. A QA new employee checklist will be developed, by administrator and QA RN, to ensure that tag (54 (a) is in compliance. The checklist will be reviewed by administrator/designee for each new hire.

Licensee's Proposed Overall Completion Date: 08/11/2023

Not Implemented [redacted] - 09/29/2023)

65b - Rights/Abuse 40 Hours

7. 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:

Description of Violation

There was no documentation that staff person C received the required training that is to take place the first 40 working hours.

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

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Staff member (c) identified has been scheduled by wellness director, for the re training and documentation along with it. The HR director is no longer with the company to be educated. The new HR director will be in-service by the Administrator on tag 65 (b). the QA RN/administrator will develop a new employee checklist to include this tag and ensure its compliance. A review will be done for each new employee by administrator/designee to ensure compliance is met, results will be reviewed at QA meetings.

Licensee's Proposed Overall Completion Date: 08/11/2023

Not Implemented [redacted] 09/29/2023)

65d - Initial Direct Care Training

8. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

Description of Violation

The personnel file of staff person C did not contain documentation that staff person C has completed (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, mental retardation 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 (bed sores), incontinence, malnutrition and dehydration, if applicable to the residents served in the home

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Staff member (c) has been scheduled for the training by wellness director for missed topics, for July 10. A new employee checklist for compliance will be developed by the QA RN/administrator to identify all necessary components of new hire training is met. Review of new employees will be done by a designated department head to identify and ensure compliance is met with this tag. results will be reviewed monthly with the HR director by the administrator/designee.

Licensee's Proposed Overall Completion Date: 08/11/2023

Not Implemented [redacted] 09/29/2023)

65e - 12 Hours Annual Training

9. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person F did not receive the required 12 hours of annual training related to their job duties in 2022.

65e - 12 Hours Annual Training *(continued)*

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Employee (f) has been scheduled by wellness director/administrator to complete the necessary hours of training by July 10. A review of all employee files will be done by administrator. Designee to identify any others that need training and
will be scheduled appropriately. QA will be developed to have HR director to review all staff one month prior to their anniversary date to ensure all requirements of tag 65 (e) are met. In-service will be done with new HR director on tag 65 (e) by administrator.

Licensee's Proposed Overall Completion Date: 08/11/2023

Not Implemented [redacted] - 09/29/2023)

65f - Training Topics

10. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

Direct care staff persons E & F did not receive the following required annual training topic for the 2022 training year:
**Medication self-administration training*
**Instructions on meeting the needs of the residents as described in the preadmission screening, medical evaluation and resident assessments support plan*
**Care for residents with dementia and cognitive impairments*
**Infection control*
**Personal care service needs of the resident*
**Safe management techniques*
**Care with residents with intellectual disabilities*

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Employee E & F has been scheduled for the missing identified topics of training. the training will be done by the HR director/designee. this will be done by July 25th. a new 2023-24 employee training schedule will be developed and implemented by the HR director & administrator; this will ensure all topics are met for the year. Each month the HR director will develop along with the appropriate departments an in-service schedule and be posted each month. In-service completion and given will be reviewed at the QA meeting by the QA RN/designee.

Licensee's Proposed Overall Completion Date: 08/11/2023

Not Implemented ([redacted] - 09/29/2023)

65g - Annual Training Content

11. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

Description of Violation

Staff persons D, E & F did not attend Fire Safety, Emergency Preparedness, Resident Rights, and the Older Adult Protective Services trainings for the year 2022.

65g - Annual Training Content *(continued)*

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Staff D, E & F will be scheduled for the identified topics of training by July 25th, given by the administrator/designee. A new training scheduled will be developed by administrator and HR director to ensure all training is complete with in the time allotted. An in-service calendar will be posted a monthly by the HR director for staff to prepare to attend.

Licensee's Proposed Overall Completion Date: 08/11/2023

Not Implemented [redacted] - 09/29/2023)

103g - Storing Food

13. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

A box of frozen chicken breast was found in an unsealed box located in the home's walk-in freezer.

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Chicken identified was discarded at the time of survey. Dietary director checked the freezer for any other items out of compliance. Dietary director will in-service all dietary staff on tag 103 (g), by July 11. food storage will be added to the monthly compliance rounds and will results will be discussed at QA meeting.

Licensee's Proposed Overall Completion Date: 08/11/2023

Implemented [redacted] - 09/29/2023)

124 - Notice to Fire Department

14. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The most recent letter submitted to the local fire department is dated 12/30/22 and does not indicate the home's licensed capacity. The letter does indicate there are 40 residents in the home and 19 are immobile. On the day of the inspection, there were 44 residents in the home and 43 are determined to be immobile due to the need for constant verbal queuing when evacuating in an emergency.

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Letter identified will be adjust to the recommended wording. this will be done by July 5th by the administrator. The home's administrator will be responsible for compliance when residents' mobility change.

Licensee's Proposed Overall Completion Date: 08/11/2023

Implemented [redacted] - 09/29/2023)

141a - Medical Evaluation

15. Requirements

2600.

141a - Medical Evaluation *(continued)*

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 #4, admitted [redacted]/23, did not have a Medical Evaluation completed 60 prior or 30 days after admission.

Plan of Correction ***Accepted[redacted] - 09/29/2023)***

Resident #4 identified DME was completed by acting wellness director.
Wellness director /designee will review all new resident admitted form January 1, 2023, to present to ensure DME is completed. A new resident checklist will be developed by administrator/ admission and wellness director to ensure compliance is met with tag 141 (a). a monthly review by the administrator or designees will be done to ensure all necessary paperwork is in compliance for new residents. reports will be reviewed at QA meeting.

Licensee's Proposed Overall Completion Date: 08/11/2023

Implemented[redacted] - 09/29/2023)

141a 1-10 Medical Evaluation Information

16. 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. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

The Initial DME dated 1/27/23 for Resident #3. does not list their immunization history or if the resident able to self-administer medications. The DME also indicates Resident # requires a Secured Dementia Care Unit.

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Resident #3 was corrected by acting wellness director June 15th. A complete review of all residents will be done by admission director to ensure compliance with tag 141 (a) is met. Training will be done on tag 141 (a)by administrator/designee for the wellness director and admission director.

Licensee's Proposed Overall Completion Date: 08/11/2023

Not Implemented [redacted] - 09/29/2023)

141b1 - Annual Medical Evaluation

17. Requirements

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

141b1 - Annual Medical Evaluation *(continued)*

Description of Violation

The Annual DME competed for Resident #2 is dated 12/2/21. An Annual DME was not completed in 2022.

The Annual DME competed for Resident #5 is dated 12/31/21. An Annual DME was not completed in 2022.
REPEATED VIOLATION: 3-30-2023

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Resident #2 and #5 DME was sent to physician to be completed by July 8th.
A review of all residents DMEs will be done by wellness director and admission director to identify any other resident that may be out of compliance on this tag and correct any that is needed. d new policy will be developed by administrator and QA RN to ensure annual DME are completed on time and a QA developed to identify the results of the review.

Licensee's Proposed Overall Completion Date: 08/11/2023

Implemented ([redacted] - 09/29/2023)

162c - Menus Posted

18. Requirements

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

Description of Violation

The home did not have the current weeks and following weeks menu posted at time of inspection.

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Menu corrected at the time of survey. Postings will now be listed for entire month. As part of compliance rounds menu posting will be added to the rounds. any non-compliance will be corrected immediately. A review of the tag 162 (c) will be done with the entire dietary staff by the administrator/designee.

Licensee's Proposed Overall Completion Date: 08/11/2023

Implemented ([redacted] - 09/29/2023)

183d - Prescription Current

19. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident #5 is prescribed Albuterol HFA 90mg inhaler. The manufacturer directions indicate the Advair is to be used within 30 days of the package being opened. The home did not have documentation when the inhaler was opened. Resident #6 had a prescription of Entresto 97mg that was discontinued on 5/30/23 but was left in the home's medication cart.
REPEATED VIOLATION: 8-23-2022

Plan of Correction ***Accepted ([redacted] 09/29/2023)***

Medications identified were discarded and resident #5 received a new medication. A new policy will be written and educated regarding the reviewing and checking for outdated medications. This policy will be given by the wellness

183d - Prescription Current (continued)

director to all med tech, in addition we have added additional med cart audits by our pharmacy. weekly abbreviated med cart audit will be added weekly to the third shift to complete and correct any noncompliance issues identified, and results will be discussed at the QA meeting.

Licensee's Proposed Overall Completion Date: 08/11/2023

Implemented [redacted] - 09/29/2023)

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

Upon investigation, the home determined that Staff Person B failed to initial the MAR or the narcotic sheet to indicate Hydrocodone/acetaminophen 5-325mg was administered to resident #1 on 4/13/23. Staff Person B did not follow proper procedures when administering the narcotic to Resident #1.

Resident #3 is prescribed PRN Tylenol Arthritis ER 650mg. The medication was not on hand.
Resident #6's PRN Vicks Vapor Rub Ointment was not on hand.
Resident # 6's glucometer reading on 5/29/23 was 137; 132 was documented as on the MAR.
On 5/25/23 @ 4:04pm, the reading was 168; 143 was documented on the MAR.
On 5/25/23 @12:09pm, the reading was 94; 92 was documented on the MAR.
On 5/25/23 @v 9:08am, the reading was 401; 400 was documented on the MAR.

REPEATED VIOLATION: 8-23-2022

Plan of Correction ***Accepted ([redacted] - 09/29/2023)***

Resident # 3 was received from pharmacy on day of survey. Resident # 6 was received from pharmacy on day of survey. Resident #6 MD was contacted regarding the readings. by acting wellness director meters were checked for any error. new meters were order by wellness director. Staff will be in-serviced by wellness director on the accuracy of reading and recording regarding tag 185 (a).
wellness director or designees will randomly check meter readings against documented one.

Licensee's Proposed Overall Completion Date: 08/11/2023

Not Implemented [redacted] - 09/29/2023)

187a - Medication Record

21. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

The Medication Administration Record for resident #3 did not indicate a diagnosis or purpose for Glimepiride 1mg and Loratadine 10mg.
The Medication Administration Record for resident #6 did not indicate a diagnosis or purpose for Entresto 97mg,

187a - Medication Record (continued)

Fluticasone 50 mg spray and Loratadine 10mg.
The Medication Administration Record for resident #5 did not indicate a diagnosis or purpose for Eliquis 5mg, and Meloxicam 15mg.

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Resident identified #3, #6, and #5 MARs have been updated by wellness director with DX for the identified medications. A review by the wellness director and admission director for all current residents MAR will take place by July 15th to
ensure DX is associated with each medication and correct any found out on non-compliance with this tag. An education will be done by the wellness director/designee regarding Tag 187 (a) for all med techs. random reviews when cart audits are done will include DX for meds.

Licensee's Proposed Overall Completion Date: 08/11/2023

Implemented [redacted] - 09/29/2023)

187d - Follow Prescriber's Orders

22. Requirements

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

Description of Violation

Resident #3 is prescribed a straight order of Nystatin 100.000-unit cream. The medication was not on hand.
REPEATED VIOLATION: 8-23-2022

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Resident #3 had medication ordered at time of survey and was delivered that night. A weekly review of medication carts will be conducted by 3rd shift to ensure compliance is met with medications on hand, in addition, a new part will be added to the daily report to identify meds needed to be ordered. this will be reviewed each day by wellness director or designee.

Licensee's Proposed Overall Completion Date: 08/11/2023

Not Implemented [redacted] - 09/29/2023)

190b - Insulin Injections

23. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

Staff Person F, hired [redacted]/23, did not receive Diabetic Training through a Department -approved diabetes education program.

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Staff member F will be scheduled for diabetic training in July. The HR director will now be responsible to ensure compliance is met with all training. HR director will be in-service by administrator on tag 190 (b). A new checklist will be developed by HR and the Administrator to ensure training is met with all tags, regarding in-services and

190b - Insulin Injections (continued)

training. the training will be reviewed each month at QA.

Licensee's Proposed Overall Completion Date: 08/11/2023

Implemented [redacted] - 09/29/2023)

224a - Preadmission Screen Form

24. 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

The Pre-Screen form for Resident #1, admitted [redacted]/23 does not indicate the name of the admitting Personal Care Home.

Plan of Correction ***Accepted [redacted] - 09/29/2023)***

Resident #1 was corrected time of survey. A review of all residents admitted from 2022-2023 will be reviewed by admission director and ensure compliance is met with this tag... education will be provided by administrator to wellness director and admission director on this tag.

Licensee's Proposed Overall Completion Date: 08/11/2023

Not Implemented [redacted]/29/2023)

225a - Assessment 15 Days

25. 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, admitted [redacted]/23, did not have an Initial Resident Assessment completed within 15 days of admission. The Initial RASP for Resident #3, admitted [redacted]4/23, was not completed until 5/3/23.

Plan of Correction ***Accepted [redacted]29/2023)***

all resident admitted from 2022-2023 will be reviewed by wellness director& admission director to ensure compliance was met for RASPs. Education to the new wellness direct will be given by administrator on tag 225 (a). Admission director will be assigned to audit by day 25 all new admissions RASPs to be completed in the appropriate amount of time and follow up with wellness by day 29.

Licensee's Proposed Overall Completion Date: 08/11/2023

Not Implemented [redacted] - 09/29/2023)

225c - Additional Assessment

26. Requirements

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

225c - Additional Assessment *(continued)*

Description of Violation

Resident #5, admitted [redacted]21, did not have an annual RASP completed until 1/10/23.
REPEATED VIOLATION: 8-23-2022

Plan of Correction ***Accepted[redacted] 09/29/2023)***

All residents RASPs will be audited by July 18th by administrator, wellness director and admission director to ensure and identify any non-compliance of RASPs and correct them immediately. A yearly check list will be developed and implemented to ensure RASPs are started and completed before they anniversary date, wellness director will be educated on tag 225 (c) by administrator.

Licensee's Proposed Overall Completion Date: 08/11/2023

Not Implemented[redacted] - 09/29/2023)