pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **2618 E MARKET STREET OPERATING COMPANY LLC**
LEGAL ENTITY

To operate **AUTUMN HOUSE EAST**
NAME OF FACILITY OR AGENCY

Located at **2618 EAST MARKET STREET, YORK, PA 17402**
(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 **150**
(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 32**

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 **April 11,** **2025** until **October 11,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **338233**

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

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: APRIL 11, 2025

[redacted], Executive Vice President
2618 E Market Street Operating Company LLC
[redacted]

RE: Autumn House East
2618 East Market Street
York, Pennsylvania 17402
License #: 33823

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on December 11, 2024, December 12, 2024 and December 19, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summaries (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a THIRD PROVISIONAL license to operate the above facility. A THIRD 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) and 55 Pa. Code §20.71(a)(1);(4);(5) (relating to conditions for denial, nonrenewal or revocation). Your THIRD PROVISIONAL license is enclosed.

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

55 Pa. Code Chapter 2600:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
2600.42(b)	II	108	$5	$540	5 calendar days from mailing date of this letter
2600.102(i)	III	108	$3	$324	15 calendar days from mailing date of this letter
2600.132(c)	III	108	$3	$324	15 calendar days from mailing date of this letter
2600.144(c)1	III	108	$3	$324	15 calendar days from mailing date of this letter
2600.184(a)	III	108	$3	$324	15 calendar days from mailing date of this letter
2600.185(a)	II	108	$5	$540	5 calendar days from mailing date of this letter
2600.187(d)	II	108	$5	$540	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 THIRD 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. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you

decide to appeal, 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
[redacted]

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

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summaries

cc: [redacted]

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

Facility Information

Name: *AUTUMN HOUSE EAST* **License #:** *33823* **License Expiration:** *03/06/2025*

Address: *2618 EAST MARKET STREET, YORK, PA 17402*

County: *YORK* **Region:** *CENTRAL*

Administrator

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

Legal Entity

Name: *2618 E MARKET STREET OPERATING COMPANY LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *04/27/2004* **Issued By:** *Labor and Industry*

Type: *I-1* **Date:** *08/11/2020* **Issued By:** *Springettsbury Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *160* **Waking Staff:** *120*

Inspection Information

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

Reason: *Renewal, Provisional, Incident* **Exit Conference Date:** *12/19/2024*

Inspection Dates and Department Representative

12/11/2024 - On-Site: [redacted]

12/12/2024 - On-Site: [redacted]

12/19/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served:** *108*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Laural Court* **Capacity:** *32* **Residents Served:** *26*

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *108*

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

Have Mobility Need: *52* **Have Physical Disability:** *2*

Inspections / Reviews

12/11/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/16/2025*

01/17/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/14/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/23/2025*

01/24/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/14/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/17/2025*

02/19/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *02/14/2025*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 12/11/24, at 10:42AM, the exterior part of Resident #14's bedroom door displayed an eye-catching, bright orange sign, visible to anyone walking by the door that indicated Resident #2's level of care needed and how often the resident received bathroom checks.

Plan of Correction ***Accept (- 01/24/2025)***

Sign was removed from Resident 14's door on 12/11/24. Education was provided to the family about the importance of privacy and HIPPA by the administrator on 12/12/24. Family of Resident 14 understood and voiced compliance. Weekly audits of the facility to make sure that no private resident information is displayed openly to be conducted by the Administrator beginning the week of 1/20/25. Education will be provided to the staff on residents' right to privacy and HIPPA at the meeting being held on 1/15/25 by the administrator.

Licensee's Proposed Overall Completion Date: *01/20/2025*

Not Implemented (- 02/19/2025)

20b3 - Written Receipts

2. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
3. The home shall obtain a written receipt from the resident for cash disbursements at the time of disbursement.

Description of Violation

The home provides financial management services for Residents #1, #5, and #7. However, per the Administrator, the home does not obtain written receipts from these residents for cash disbursements at the time of disbursement.

Plan of Correction ***Accept (- 01/16/2025)***

Education was provided to Receptionists, Business Office Manager, and Director of Wellness on obtaining written receipts from residents and families for cash disbursement on 12/16/24. Audit of petty cash accounts to be performed by the Business Office Manager weekly beginning on 1/10/25 to ensure receipts are being obtained. Education on proper documentation and handling of residents' petty cash accounts to be held at the staff meeting on 1/15/25 by the Administrator.

Licensee's Proposed Overall Completion Date: *01/15/2025*

Not Implemented (- 02/19/2025)

20b8 - Quarterly Account

3. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

The home provides financial management services for Residents #1, #5, and #7. However, per the Administrator, the home does not give residents and their designated persons an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Plan of Correction ***Accept (- 01/24/2025)***

Itemized accounts will be sent to all residents with the monthly bills on 1/24/25 and then will be sent on a monthly basis going forward. Education was provided to the Business Office Manager on adding an itemized list of transactions to the quarterly statement sent to responsible parties on 12/16/24 by the Administrator. Administrator to audit all billing cycles to ensure that itemized accounts are being sent on a regular basis beginning with the bills being sent on 1/24/25. Education on proper documentation and handling of residents' petty cash accounts to be held at the staff meeting on 1/15/25 by the Administrator.

Licensee's Proposed Overall Completion Date: *01/24/2025*

Not Implemented (- 02/19/2025)

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 11/3/24 Resident #13 threw Resident #1 out of their wheelchair and onto the floor. Resident #1 hit a nearby wall during the fall, causing a hole in the wall. Resident #1 , immediately started vomiting, and was sent to the emergency room for evaluation. The resident was evaluated for head injury. An X-ray of the resident's shoulder and chest was completed as well as a CT scan of their head and spine. Resident #1 was discharged with instructions to monitor for potential symptoms over the next few days.

From October 2024 to December 2024, the home failed to assist Resident #1 communicate their medical concerns and symptoms with medical professionals timely and accurately, delayed medical treatments, and in this time frame the resident was complaining of pain, unable to eat and sleep regularly, having unexplained bruises, and unable to bear weight when walking. The following was discovered during the 12/11/24 inspection:

- *On 10/26/24, the home was aware the resident was not taking their MiraLAX every other day as prescribed and obtained a new order for senna/docusate, as needed for constipation. On 10/26/24, senna/docusate was*

42b - Abuse (continued)

administered to Resident #1 but did not monitor if it was effective at resolving the resident's constipation.

- *On 10/28/24, Resident #1 was ordered senna/docusate 8.6mg-50mg, take 1 tablet by mouth once daily. The home did not initiate daily administrations of senna/docusate until 11/5/24.*
- *On 11/3/24 Resident #13 threw Resident #1 out of their wheelchair and onto the floor, and Resident #1 hit a nearby wall in the fall, causing a hole in the wall. The resident was discharged from the hospital with instructions to monitor for potential [redacted] symptoms over the next few days. The home has no records of monitoring for [redacted] symptoms.*
- *Resident #1 received ibuprofen for pain twice on 11/11, and once on 11/12, 11/13, and 11/14.*
- *On 11/19/24, Resident #1's physician was notified due to the resident's increase in [redacted] pain and was prescribed Tylenol 1000mg by mouth twice daily for 2 weeks and to follow up.*
- *Again on 11/20/24, the resident's physician was notified due to resident's [redacted] pain, able to bear weight, and the resident was grimacing and stated it hurts.*
- *On 11/20/24, Staff Member M noticed bruising on resident's [redacted], was not sure when it occurred, and noted that the resident was expressing discomfort when the area is touched. The home did not seek medical advice or treatment until 11/29/24, when increased [redacted] bruising was noticed. The home has no records of monitoring the bruise.*
- *On 11/20/24, at 5:23PM lorazepam was administered for anxiety and morphine was administered for pain.*
- *On 11/21/24, staff noted the resident was very lethargic all day and did not eat much, but hospice evaluated the resident's vitals.*
- *On 11/22/24, hospice and Staff Member L noticed Resident #1's hands are bruised and swollen, were not sure what happened, and would monitor. However, the home doesn't have records of monitoring this concern or consulting medical professions for advice and treatment.*
- *On 11/23/24, at 5:56am, Staff Member N noted the resident was very sweaty overnight, continues to "ouch" excessively, and believed the resident may be constipated. However, the home doesn't have records of monitoring this concern or consulting medical professionals for advice and treatment.*
- *On 11/23/24, at 5:26pm, Staff Member L noted the resident has been in bed and sleeping since earlier this afternoon, refused dinner and did not want their ensure supplement.*
- *On 11/29/24, the home requested a mobile X-ray due to the increased [redacted] bruising witnessed on Resident #1. On 11/29, the resident's physician ordered the X-ray.*
- *Resident #1 was administered morphine for pain on 11/29/24 and 12/1/24.*
- *The home did not attempt to schedule Resident #1's [redacted] X-ray until 12/2/24.*
- *On 12/2/24, [redacted] exam results reveal narrowing in the bony relationship particularly in the [redacted] regions in weight bearing portions [redacted], some areas of mild marginal spurring present, large amount of [redacted] material throughout [redacted], no acute fracture nor dislocation is evident however if symptomatology persists a short-term follow-up series or comparison is recommended. Marked distal constipation is apparent.*
- *During the 12/11/24 inspection, Staff Member E reports the home was not and is not tracking the resident's bowel movements, despite Resident #1 being prescribed medication as needed for constipation, daily for constipation, and orders to hold medications for loose stools. At the time of the inspection, Resident #1's last bowel movement is unknown.*

On 9/15/24, Resident #9 shoved Resident #15 to the ground, causing Resident #15 to suffer [redacted]

42b - Abuse (continued)

Repeated Violation - 3/19/24, et al.

Plan of Correction ***Accept (- 01/24/2025)***

Incorrect resident was incorrectly identified in the incident dated 11/3/24. Should be Resident 14, not 13. Residents 14 and 15 had been moved out of the facility prior to the inspection dates due to the inciting incidents that occurred. Resident 14 was sent out to the hospital on and did not return to prevent any further incidents with Resident 15 was removed from the facility on after proper placement elsewhere was found. Resident 9 was seen by a new physician, and outside psych doctor to evaluate behaviors. New medication was ordered, and other med adjustments were made. Education on proper communication with hospice and physicians regarding resident's physical/medical needs and communicating in a timely manner with physicians, proper documenting of PRN medications, and follow-up of physician orders was provided to Resident Care Coordinator, Director of Wellness, Memory Care Coordinator and Dementia Care Programmer by the Administrator on 12/19/24. This education will be provided to the rest of the staff by the Administrator and Director of Wellness at the meeting being held on 1/15/25. Additional abuse prevention training will be done by certified dementia trainers on 2/19/25.

Licensee's Proposed Overall Completion Date: *01/24/2025*

Not Implemented (- 02/19/2025)

65a - FS Orientation 1st Day

5. 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 Member A, whose first day of work was did not receive orientation on the following topics until :

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.

65a - FS Orientation 1st Day (continued)

5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Plan of Correction ***Accept (- 01/16/2025)***

Education on requirements of first day training provided to Business Office Manager and Regional Human Resources Manager on 12/19/24 by the Administrator. All first day training topics to be covered at all orientations at Autumn House East beginning with the orientation on 1/8/25. Administrator to audit all orientation topics to ensure they are being covered after each orientation beginning on 1/8/25. Education on required training procedures to be given by the Administrator and Business Office Manager at the staff meeting being held on 1/15/25.

Licensee's Proposed Overall Completion Date: *01/15/2025*

Not Implemented (- 02/19/2025)

65b - Rights/Abuse 40 Hours

6. 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 Member A completed 40th scheduled work hour by 2024. However, this staff person did not complete training in the following topics until :

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.

Plan of Correction ***Accept (- 01/24/2025)***

Education was provided to Human Resources Manager and Business Office Manager on all required training topics for first day, and 40 hours by the Administrator on 12/19/24. New orientation and training schedules to be made by Administrator and Human Resource Manager to ensure all training requirements are met by 2/3/25. Administrator to have monthly staff meetings to implement the training schedule beginning with the meeting on 1/15/25. Education to be provided to all staff regarding required materials to be done by the administrator at the staff meeting being held on 1/15/24.

Licensee's Proposed Overall Completion Date: *02/03/2025*

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

Not Implemented ([redacted] - 02/19/2025)

85a - Sanitary Conditions

10. Requirements

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

Description of Violation

On 12/19/2024, Staff Member F informed an agent of the Department that Resident #3's blood glucose testing on 12/11/2024 at 19:00 had been completed using another resident's glucometer.

Plan of Correction ***Directed ([redacted] - 01/24/2025)***

Letter regarding the possibility of shared glucometer use and the risks involved will be sent to all residents, and designated person with on the regular billing cycle on 1/23/25. Physicians were notified of the same by the DOW on 1/21/25. Director of Wellness and Resident Care Coordinator completed an audit of all glucometers in the building to ensure they are labelled correctly. Audits of glucometers to be done weekly be DOW and RCC to ensure labels are still in place and are correct beginning on 1/1/25. Certified diabetic training was held for all Certified Medical Technicians on 1/13/25. Education to be provided to staff on importance of not using residents' personal items for other residents by the Administrator at the staff meeting being held on 1/15/25.

(Directed)
In addition to the above plan of correction, beginning no later than 2/3/2025, the Administrator or designated contact will audit the actual readings on a resident's glucometer as compared with the documented readings on the resident's Medication Administration Record. This shall be done on a weekly basis (on at least a 10% sample of) for the residents who receive blood glucose testing for a minimum of 3 months.

Directed Completion Date: *02/03/2025*

Not Implemented ([redacted] - 02/19/2025)

89b - Hot Water Temperature

11. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 12/12/2024 at 2:52 PM, the water temperature in the kitchenette sink at the end of the G-Hall measured 122.4 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

Water temperature was adjusted by the Maintenance Director on 12/12/24. Weekly audits of water temperatures to be done by Maintenance Director or Maintenance Assistant to ensure proper temperatures beginning on 1/10/24. Education to be provided to staff regarding proper water temperatures and who to report any water issues to by the Administrator at the staff meeting being held on 1/15/25.

89b - Hot Water Temperature (continued)

Licensee's Proposed Overall Completion Date: *01/15/2025*

Not Implemented (- 02/19/2025)

101j3 - Bed/Linens/Pillows/Blankets

12. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

The fitted bedsheet for Resident #3 contained 3 streaks of feces approximately the size of fingers, near the head of the bed.

Plan of Correction ***Accept (- 01/24/2025)***

Resident 3s' bedsheet with streaks of lipstick were removed from the bed and properly laundered by housekeeping staff on 12/11/24. Education was provided to the resident on importance of reporting any messes to the housekeeping staff when they occur. All linens to be checked daily by Housekeeping Director and/or housekeeper on duty beginning on 1/13/25. Education to be provided to staff on importance of cleaning up any linens in a timely manner by the administrator at the staff meeting on 1/15/24.

Licensee's Proposed Overall Completion Date: *01/22/2025*

Not Implemented (- 02/19/2025)

102i - Soap Dispenser

13. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 12/11/24, at 10:17AM, there was an unlabeled used bar of soap in a Styrofoam cup in the shared shower and an unlabeled used bar of soap in the cabinet in the shared A-Hall tub room.

On 12/11/2024 at 10:39AM, there was an unlabeled green bar of soap in the H-hall tub room. The shower room is used by multiple residents.

On 12/12/2024 at 2:50PM, there was an unlabeled yellow bar of soap in the H-hall shower room. The shower room is used by multiple residents.

Repeated Violation - 5/16/24.

102i - Soap Dispenser *(continued)*

Plan of Correction ***Accept (- 01/24/2025)***

Unlabeled bars of soap were disposed of on 12/12/24. Audits of shower rooms and residents' personal hygiene items will be performed weekly by the Resident Care Coordinator to ensure that all items are properly stored and labeled to begin on 1/20/25. Education on proper labeling and storage of residents' personal care items to be given by Administrator at the staff meeting on 1/15/24.

Licensee's Proposed Overall Completion Date: *01/20/2025*

Not Implemented (- 02/19/2025)

103d - Storing Food Off Floor

14. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 12/19/2024, at approximately 3:10PM, various food items including 3 oranges, 1 green pepper, and a bag of what appeared to be shredded white and orange cheese was observed on the floor of the kitchen's walk-in refrigerator.

Plan of Correction ***Accept (- 01/16/2025)***

Items found on the floor of the walk-in refrigerator were disposed of on 12/19/24. Daily audits of the walk-in refrigerator to be performed by Dietary Director or cook on duty to ensure that no items are on the floor of any part of the kitchen beginning on 1/10/25. Education to be provided to the staff on proper storage and cleaning of the kitchen to be provided by the Administrator at the staff meeting being held on 1/15/25.

Licensee's Proposed Overall Completion Date: *01/15/2025*

Not Implemented (- 02/19/2025)

105g - Lint Removal and Duct Cleaning

15. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 12/11/24, at approximately 10:36AM, there was approximately a baseball-sized accumulation of lint in the lint trap of the dryer in the B-Hall activities room. There were no clothes in the dryer at the time.

Plan of Correction ***Directed (- 01/24/2025)***

Lint was removed from the dryer by the inspector at time of incident. Daily audits of lint traps to ensure no lint build up to be done weekly by the Housekeeping Director beginning on 1/10/25. Education on proper maintenance of appliances to be provided by the Administrator at the staff meeting being held on 1/15/25.

105g - Lint Removal and Duct Cleaning (continued)

(Directed)
In addition to the above plan of correction, daily audits of the lint traps will be completed by housekeeping staff beginning 1/10/2025. The Housekeeping Director will complete weekly audits beginning 1/10/2025. Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: *01/20/2025*

Not Implemented ([redacted] - 02/19/2025)

107d - Procedure Emergency Management Agency Submission

16. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

At the time of the 12/11/24 inspection, the home submitted their written emergency procedures to the local emergency management agency on 7/20/23 and not again until 11/8/24.

Plan of Correction ***Accept ([redacted] - 01/24/2025)***

Education was provided to all management staff on compliance with regulation 107d provided by the Administrator on 12/19/24. Administrator to ensure that emergency procedures will be sent in a timely manner and on time. Procedures will be sent on 7/20/25.

Licensee's Proposed Overall Completion Date: *01/22/2025*

Not Implemented ([redacted] - 02/19/2025)

132c - Fire Drill Records

17. 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 records for the drills conducted on 11/29/24, 10/31/24, 8/30/24, 7/31/24, do not include the number of residents in the home at the time of the drill or the number of residents that participated in the drill.

Repeated Violation - 3/19/24, et al.

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

Education was provided to the Maintenance Director on proper documentation of residents participating and in the home at time of drill by the Administrator on 12/19/24. Fire drill was held on 12/31/24 and Administrator confirmed proper documentation of residents with Maintenance Director at time of drill. All future drills to be

132c - Fire Drill Records (continued)

audited by Administrator at time of drill beginning with the 1/25 drill. Education to be provided to all staff on proper documentation during a fire drill by the Administrator at the staff meeting being held on 1/15/24.

Licensee's Proposed Overall Completion Date: *01/15/2025*

Not Implemented (- 02/19/2025)

141b1 - Annual Medical Evaluation

18. Requirements

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

Description of Violation

Resident #3's annual medical evaluation (dme), completed on , does not include the medications the resident can self-administer, if any. The resident's dme reads, the resident can self-administer some medications, but not others, "see med addendum". However, the medication list attached does not identify any medications Resident #3 can self-administer.

At the time of the 12/11/24 inspection, Resident #7 had a medical evaluation on and not again until

As of 12/19/24, Resident #9's most recent medical evaluation was completed on

Plan of Correction ***Accept (- 01/24/2025)***

Order received from the physician on 1/23/25 stating that resident 3 can not self-administer any medications. Support plan for resident 3 updated to reflect those changes on the same date. New DME was obtained for resident 9 on1/9/25. Physician order updating Resident 3s self-administer order was obtained on Education was provided to the Director of Wellness, Dementia Care Programmer, and Memory Care Coordinator and the importance and necessity of having DMEs completed in full and in a timely manner. This education was provided by the Administrator on 12/19/24. Audits of all DMEs will be done by the Administrator weekly beginning on 1/10/25 to ensure they are being completed on time. Education to all staff to be provided by the Administrator at the staff meeting being held on 1/15/24.

Licensee's Proposed Overall Completion Date: *01/23/2025*

Not Implemented (- 02/19/2025)

144c1 - Smoking Area Guidelines

19. Requirements

144c1 - Smoking Area Guidelines *(continued)*

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home does not permit smoking on the porch of the Market Street entrance to the home, nor are there proper smoking disposal receptacles at this location. However, on 12/11/24 at 10:20AM, Resident #4 was actively smoking a cigarette while sitting on a bench on the porch of the Market Street entrance of the home. Per resident report, when they are finished with their cigarette, they will dispose of the cigarette butt in the Styrofoam cup next to them, then throw the cup away in the small plastic trashcan, lined with a plastic bag, on the porch.

On 12/11/24, at 12PM, kitchen employees were smoking on the parking lot side/main entrance to the home, where a no smoking sign was posted. The home does not permit smoking in this area.

Repeated Violation - 5/16/24, 3/19/24, et al.

Plan of Correction ***Accept ([redacted] - 01/24/2025)***

Resident and family were educated on the smoking policy and the location of the resident smoking areas for Autumn House East by the Administrator on 12/11/24. Resident and family expressed understanding that next violation of the smoking policies will result in a 30 day eviction notice being issued to them. Audits of the non-smoking areas to be completed daily by the Administrator and or Maintenance Director to ensure all residents are in compliance with smoking policy to begin on 1/20/25. Education on the Autumn House East smoking policy to be given to all staff at the meeting being held on 1/15/25.

Licensee's Proposed Overall Completion Date: *01/21/2025*

Not Implemented ([redacted] - 02/19/2025)

182b - Prescription Medication

20. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 12/6/24 at 8AM, Staff Member D administered Trulicity injection to Resident #3. Staff Member D is not a licensed medical professional and the home does not have a waiver for a non-licensed staff member to administer this medication.

182b - Prescription Medication *(continued)*

Plan of Correction ***Accept ([redacted] - 01/24/2025)***

All injection medication to be provided by licensed staff beginning the week of 1/20/25. Education was provided to staff member D on guidelines for administering injection medications by the Director of Wellness on 12/19/24. Audits of injection medication administration to be done weekly by the Director of Wellness and Resident Care Coordinator starting on 1/10/25. Education on injection medication administration guideline to be provided by the Administrator at the staff meeting being held on 1/15/25.

Licensee's Proposed Overall Completion Date: *01/20/2025*

Not Implemented ([redacted] - 02/19/2025)

183b - Meds and Syringes Locked

21. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 12/11/24, at 10:25AM, ibuprofen 200mg soft gels, Stopain roll on medication, elderberry gummies and cough drops were unlocked, unattended, and accessible in Resident #3's bedroom. At the time of the inspection, Resident #3 was not present in their bedroom, and is not assessed to self-administer medications.

Repeated Violation - 5/16/24.

Plan of Correction ***Accept ([redacted] - 01/24/2025)***

Medications were removed from Resident 3's room on 12/11/24 by the resident. They were given to the Certified Medication Technician for disposal. Education on how residents may not have medications in private rooms without doctor orders was provided to the resident and family by the Administrator on 12/12/24. Same education given to Director of Wellness and Resident Care Coordinator on the same date. Weekly audits of resident rooms to be completed by Resident Care Coordinator to ensure that no medications are in rooms without a doctors order to begin on 1/20/25. Same education to be provided to staff at the staff meeting by the Administrator on 1/15/25.

Licensee's Proposed Overall Completion Date: *01/20/2025*

Not Implemented ([redacted] - 02/19/2025)

183e - Storing Medications

22. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 12/19/2024, at12:08PM, Lactaid tablets prescribed for Resident #11 were in the home's medication cart; however, the medication expired in June 2024.

183e - Storing Medications (continued)

On 12/19/2024 at 12:52PM, Timolol drops prescribed for Resident #12, were in the home's medication cart; however, the medication expired in April 2023.

Repeated Violation - 5/16/24.

Plan of Correction ***Accept (- 01/16/2025)***

Expired medications were disposed of by the Director of Wellness on 12/19/24. Audits of med carts will be performed weekly by Resident Care Coordinator and Director of Wellness to ensure no expired medications are present in the med carts beginning on 1/10/25. Education to be provided to the staff on ordering medications in a timely manner and disposing of expired medications by the Administrator at the staff meeting being held on 1/15/25.

Licensee's Proposed Overall Completion Date: *01/15/2025*

Not Implemented (- 02/19/2025)

184a - Resident's Meds Labeled

23. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #3 is prescribed Lidocaine pain relief patch, apply 1 patch topically to lower back for pain, on for 12 hours off for 12 hours. However, one of the pharmacy labels for Resident #3's Lidocaine pain relief patches reads, 1 application topically every 12 hours.

Resident #13 is prescribed Insulin Lispro, inject per sliding scale subcutaneously four times a day (with sliding scale included). However, the pharmacy label reads, inject 5 units under skin 3 times a day before meals and per sliding scale.

Repeated Violation - 5/16/24, 3/19/24, et al.

Plan of Correction ***Accept (- 01/24/2025)***

Change of direction orders were placed on the medications for Resident 3 and Resident 13 by the DOW on 12/19/24. Audit of all current medications to ensure pharmacy labels match physician orders to be done by the Resident Care Coordinator on 1/22/25. Monthly audits to ensure the same to be completed by RCC and DOW beginning 2/1/25. Education on proper labeling of medications was given to Director of Wellness and Resident Care Coordinator on 12/19/24 by the Administrator. Education on proper labeling of medications to be given to all staff by the Administrator and Director of Wellness at the all-staff meeting being held on 1/15/25.

Licensee's Proposed Overall Completion Date: *02/01/2025*

Not Implemented (- 02/19/2025)

185a - Implement Storage Procedures

24. Requirements

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

Description of Violation

Resident #13 is ordered blood glucose monitoring 4 times a day, before meals and at bedtime, and to notify MWR hospice if the reading is above 400. According to the resident's glucometer, their blood glucose level was 266 at 12pm on 12/5/24; however, the resident's blood glucose level was never recorded on the resident's medication administration record (mar).

Resident #13's blood glucose level is recorded as 299 and 502 on 12/3/24 at 9PM, on two separate locations on their mar. Only one of these levels, 299, is recorded in the resident's back-up glucometer.

According to Resident #13's progress notes, staff documented on 12/4/24 at 9PM, "late entry, resident blood sugar was over 400- reached out to hospice." However, the only blood glucose levels recorded on the resident's mars on 12/4/24 are: 86, 271, 267, and 336.

According to Resident #13's 12/7/24 mar, at 9PM their blood glucose level was 550. However, staff recorded on progress notes at 8PM on 12/7/24, that the home was unable to obtain any blood glucose levels for Resident #13, and didn't check the resident's blood glucose level until 9:33PM which was 451.

Repeated Violation - 5/16/24. 3/19/24, et al.

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

Education was provided to the Director of Wellness and Resident Care Coordinator on proper documenting of blood glucose levels by the Administrator on 12/19/24. Weekly audits of all glucometers and EMARs to ensure that all documentation is being done correctly and that glucometers match EMARs to be done by the DOW and RCC beginning the week of 1/13/25. Education on proper blood glucose monitoring to be done by the Administrator at the staff meeting being held on 1/15/25.

Licensee's Proposed Overall Completion Date: *01/15/2025*

Not Implemented ([redacted] - 02/19/2025)

187a - Medication Record

25. Requirements

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

Description of Violation

Resident #3 is prescribed Lidocaine pain relief patch, apply 1 patch topically to lower back for pain, on for 12 hours off for 12 hours. However, Resident #3's December 2024 medication administration record (mar) reads, apply to lower back topically two times a day for pain.

187a - Medication Record (continued)

Resident #7 is prescribed gabapentin and centrum silver. However, the resident's December 2024 mar does not include the reason for prescribing gabapentin and centrum silver. Their mar reads, "indications for use, resident care."

Repeated Violation - 5/16/24.

Plan of Correction ***Accept ([redacted] - 01/24/2025)***

EMAR for Resident 7 was updated to include reason for prescription on 12/19/24 by Director of Wellness. EMAR for Resident 3 was updated to include reason for prescription on 12/19/24 by Director of Wellness. Weekly EMAR audits to be completed by Director of Wellness and/or Resident Care Coordinator to ensure all medications have a proper order and indication for use beginning on 1/10/25. Education on importance of indication use for medications and the proper order for medications to be given by the Administrator and Director of Wellness at the staff meeting being held on 1/15/24.

Licensee's Proposed Overall Completion Date: *01/22/2025*

Not Implemented ([redacted] - 02/19/2025)

187d - Follow Prescriber's Orders

26. Requirements

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

Description of Violation

Resident #1 was prescribed senna/docusate 8.6mg-50mg, take 1 tablet by mouth once daily, and was administered this medication at 7AM on 12/6/24. On 12/6/24, their order changed to senexon-s 8.6mg-50mg, take 2 tablets by mouth twice daily. Staff administered two tablets at 8:30AM and 8:30PM on 12/6/24, thus administering the medication 3 times on 12/6/24.

On 10/28/24, Resident #1 was ordered senna/docusate 8.6mg-50mg, take 1 tablet by mouth once daily. The home did not initiate daily administrations of senna/docusate until 11/5/24.

Resident #3's December 2024 medication administration record (mar) reads, they are to use their blood glucose monitoring strips twice daily for blood glucose monitoring. However, staff are only monitoring the resident's blood glucose twice daily, every other day in December 2024.

Resident #13 is prescribed verapamil, take 120mg by mouth daily at bedtime, hold for systolic blood pressure less than 100. On 12/5/24 at 9PM, the resident's blood pressure reading was 143/100 and the home did not administer the resident their verapamil.

Resident #13 has the following orders: monitor their blood glucose 4 times a day, before meals and at bedtime, and to notify MWR hospice if the reading is above 400 and administer 12 units of insulin lispro if their blood glucose level is

187d - Follow Prescriber's Orders (continued)

between 401-450, contact hospice for further instructions if the 12 units does not drop blood glucose below 400. The resident's blood glucose level was above 400 on the following days, and the home did not implement the physician's orders as indicated:

- 502 at 9PM on 12/3, the home contacted hospice, but additional monitoring of blood glucose was not completed.
- 412 at 9PM on 12/5, never contacted hospice and no additional monitoring of blood glucose completed.
- 448 at 5PM on 12/6, the home contacted hospice, but additional monitoring of blood glucose was not completed.
- 550 at 9PM on 12/7, however, at 8PM hospice was contacted due to the home not being able to obtain a blood glucose level. Hospice advised home to administer 12 units of insulin lispro and if the resident's blood glucose didn't drop below 400 in 20 minutes, to contact them again. The home did not administer 12 units of insulin lispro and did not recheck the resident's blood glucose level until 9:33PM, which was 451, then again at 10:33PM which was 132.
- 421 at 9PM on 12/10, the home contacted hospice, but additional monitoring of blood glucose was not completed.
- 461 at 9PM on 12/12, per hospice, give 12 units of insulin lispro, monitor blood glucose, and notify again if it does not decrease. The home did not administer 12 units of insulin lispro or monitor the resident's blood glucose until 12/13 at 4:03am

Resident #13 is ordered to have their blood glucose level measured before meals and at bedtime and is prescribed a sliding scale administration of insulin lispro to be administered at that time according to their blood glucose level. The resident's blood glucose levels were monitored at 8AM, 12PM, 5PM, and 9PM. However, the resident's insulin lispro was administered after mealtimes on the following occasions:

- 12/13, Staff Member K didn't administer the 5PM dose of insulin lispro until 7:21PM.
- 12/16, Staff Member K didn't administer the 12PM dose of insulin lispro until 1:47PM.
- 12/16, Staff Member K didn't administer the 5PM dose of insulin lispro until 7:34 PM.
- 12/17, Staff Member K didn't administer the 8AM dose of insulin lispro until 9:39AM.
- 12/18, Staff Member K didn't administer the 8AM dose of insulin lispro until 9:45AM.

Repeated Violation - 5/16/24, 3/19/24, et al.

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

Education on following prescribers' orders and administering medication in a timely manner was provided to the Director of Wellness and Resident Care Coordinator by the Administrator in 12/19/24. EMAR audits to be performed weekly to ensure orders are being followed and medications are given at the appropriate times to be done by the RCC and DOW beginning the week of 1/12/25. Education on proper medication administration, time frames for administration, and following prescribers' orders to be done by the Administrator and Director of Wellness at the staff meeting being held on 1/15/25.

Licensee's Proposed Overall Completion Date: 01/15/2025

Not Implemented ([redacted] - 02/19/2025)

190a - Completion Medication Course

27. 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 Member G reports being qualified to administer medications as of [redacted], through the completion of the Department's annual medication administration training course. However, as of 2/8/24, Staff Member G failed to be requalified to administer medications, evidenced by only completing two of the four annual requirements by 2/8/24. Staff Member H administered the following medications to Resident #13 in December 2024:

- *12/2-5, 12/7-9, 12/11 at 10AM, brimonidine/timol eye drops.*
- *12/2-5, 12/7-9, 12/11 at 9AM, Lantus Solostar insulin injection.*
- *12/2-5, 12/7-9, 12/11 at 10AM, olanzapine.*
- *12/7 at 9PM, verapamil.*

Staff Member I was certified to administer medications on [redacted], by passing the Department's initial medication administration training course. However, since then, Staff Member I has failed to receive all medication administration training course requirements annually; evidenced by only receiving 2 out of the 4 requirements in 2023 and no record of a date of requalification from a medication administration trainer in 2023 and never retaking the initial medication administration training course due to the length of time passed after failing to requalify annually. Additionally, there's no record of a date of requalification from a medication administration trainer in 2024 on any forms produced during the inspection. Staff Member I administered the following medications to Resident #9 in December 2024:

- *On 12/2 and 12/5 at 7PM, buspirone, donepezil, ecitalopram, nemantine, and quetiapine.*
- *On 12/2 at 7:13PM, lorazepam gel.*

Staff Member K was certified to administer medications on [redacted], by passing the Department's initial medication administration training course. However, since then, Staff Member K has failed to receive all medication administration training course requirements annually; evidenced by only receiving 2 out of the 4 requirements in 2023 and no record of a date of requalification from a medication administration trainer in 2023 and never retaking the initial medication administration training course due to the length of time passed after failing to requalify annual. Staff Member K administered the following medication to Resident #10 in December 2024:

- *On 12/3, 12/7, and 12/10 at 2100, divalproex sodium ER, melatonin, risperidone, preparation H external cream.*
- *On 12/3 and 12/7 at 2200, docusate sodium.*

Plan of Correction ***Accept ([redacted] - 01/17/2025)***

Education on the importance of having all of the Certified Medical Technicians are trained with the proper courses and in a timely manner was given to the Dementia Care Programmer and Director of Wellness by the Administrator on 12/19/24. Director of Wellness to have all Certified Medical Technicians receive the proper training by 1/31/25. Audits of all CMT trainings and recertifications to be performed by the Administrator monthly to ensure completion beginning on 2/1/25. Education on importance of the CMTs training and recertifications being done in a timely manner to be presented by the Administrator and Director of Wellness at the staff meeting being held on 1/15/25.

Licensee's Proposed Overall Completion Date: *02/01/2025*

190a - Completion Medication Course *(continued)*

Not Implemented (- 02/19/2025)

190b - Insulin Injections

28. 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

On 12/2/24 at 8AM, Staff Member G, who has not completed a Department-approved diabetes patient education program within the past 12 months, administered insulin to Resident#13.

On 12/1/24 at 5PM, Staff Member J, who has not completed a Department-approved diabetes patient education program within the past 12 months, administered insulin to Resident#13.

On 12/2/24 at 5PM, Staff Member K, who has not completed a Department-approved diabetes patient education program within the past 12 months, administered insulin to Resident#13.

Plan of Correction ***Directed (- 01/24/2025)***

Education was provided to the Director of Wellness and Resident Care Coordinator on regulation 190b and the importance of completing the proper education in a timely manner. Diabetic certification classes are being held on 1/13/25 for all CMTs. Director of Wellness to audit all CMT trainings quarterly to ensure all CMTs are certified in a timely manner beginning January 2025. Education to be provided to all staff regarding importance of regulation 190b by the Administrator and the Director of Wellness at the staff meeting on 1/15/24.

(Directed)
In addition to the above plan of correction, the Director of Wellness will audit all CMT trainings quarterly to ensure all CMTs are certified in a timely manner beginning no later than 1/31/2025.

Directed Completion Date: *01/31/2025*

Not Implemented (- 02/19/2025)

225a - Assessment 15 Days

29. 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 bed was affixed with an enabler bar. The resident's assessment, dated , does not include the specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, or identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

225a - Assessment 15 Days (continued)

The home manages personal spending money, "petty cash" for Resident #1. However, Resident #1's [redacted] support plan reads, their Power of Attorney (POA) will have complete control over all finances.

Resident #5's assessment, dated [redacted], reads, they require some assistance with managing finances with the support plan reading, the resident's POA will have complete control over all the resident's finances. However, the home is currently managing personal spending money, "petty cash," for the resident. This is not identified within the resident's assessment and support plan.

Resident #6's bed was affixed with an enabler bar. The resident's [redacted] assessment and support plan does not include the specific need for the device, the intended use and any risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, or identification of the specific device to be used and whether a cover is required to meet FDA guidelines.

Resident #7's bed was affixed with an enabler bar. The resident's [redacted] assessment and support plan doesn't include identification of the specific device to be used, or the risks associated with the use.

Resident #7 is prescribed escitalopram for a diagnosis of depression. Their [redacted] assessment and support plan does not include this diagnosis or a support plan in this area.

Plan of Correction ***Accept ([redacted] - 01/24/2025)***

The enabler bar for Resident 1 was removed by the Dementia Care Programmer on 12/19/24. Identification of the devices and the risks associated by their use for Residents 6 and 7 was added to their respective support plans by the Director of Wellness on 1/13/25. Director of Wellness contacted physician to get an order for a depression diagnosis for Resident 7 on 1/13/25. Support plan will be changed as soon we get the order from the physician. Support plans for Residents 5 and 1 was updated to state that the home manages [redacted] petty cash account by the Director of Wellness on 1/13/25. Initial audit of all RASPs to be completed by the Administrator and Director of Wellness to ensure all needs and supports are documented properly by 2/1/25. Continuing audits to be done monthly by Director of Wellness to ensure the same starting 3/1/25. Education to be provided to the staff regarding full completion of assessments and support plans by the Administrator and Director of Wellness at the staff meeting being held on 1/15/25.

Licensee's Proposed Overall Completion Date: *02/01/2025*

Not Implemented ([redacted] - 02/19/2025)

225c - Additional Assessment

30. 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.

225c - Additional Assessment *(continued)*

Description of Violation

On 4/12/24, Resident #1's physician changed the resident's dietary orders from a regular diet to a mechanical soft diet. At the time of the 12/11/24, Resident #1's assessment, dated [redacted] indicates Resident #1 receives a regular diet.

At the time of the 12/11/24 inspection, Resident #7 had an assessment and support plan completed on [redacted] and not again until [redacted]

On 11/27/24, Resident #7's physician ordered the resident to follow a mechanical soft diet after the resident choked on food on [redacted] At the time of the 12/12/24 inspection, Resident #7's [redacted] assessment and support plan was never updated to include this dietary change.

According to Resident #10's December 2024 medication administration record, as of 10/11/24 they were ordered all medications to be crushed and put in applesauce due to diagnosis of dysphagia, and liquids are to be honey/moderately thick consistency. However, the resident's [redacted] assessment and support plan reads, the resident is to follow a regular diet and does not include any modifications needed, or a diagnosis of dysphagia.

Plan of Correction ***Accept ([redacted] - 01/24/2025)***

Support Plans for residents 1,7, and 10 were updated by the Director of Wellness on 1/21/25. Education was provided to the Director of Wellness and Dementia Care Programmer on obtaining support plans on an annual basis and on updating them after a significant change by the Administrator on 12/19/24. Audits of support plans to ensure they are done annually and changes are being made when necessary to be done monthly by the Administrator starting on 1/13/25. Education on proper maintaining of support plans to be done by the Administrator and Director of Wellness at the staff meeting being held on 1/15/25.

Licensee's Proposed Overall Completion Date: *01/21/2025*

Not Implemented ([redacted] - 02/19/2025)

227e - Self Administer Medication

31. Requirements

2600.
227.e. The resident's support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident #7's [redacted] assessment reads, the resident can self-administer medications when offered assistance with medications at prescribed times. However, the resident is prescribed 16 daily and as needed medications, and their physician only indicated the resident can self-administer 3 of these medications: voltaren gel, Systane sol eye drops, and Eucerin eczm cream. The home stores, prepares, and administers all medications with the exception of voltaren gel, Systane sol eye drops, and Eucerin eczm cream.

Plan of Correction ***Accept ([redacted] - 01/24/2025)***

Support plan for resident 7 was updated on 1/14/25 to reflect the ability to self-administer certain medications by the Director of Wellness on Education was provided to Dementia Care Programmer and Director of Wellness on regulation 227.e and the importance of support plan matching the physician's assessment by the Administrator on

227e - Self Administer Medication (continued)

12/19/24. Director of Wellness and Dementia Care Programmer to audit all support plans monthly to ensure they match physician's assessments beginning on 1/12/25. Education on support plans and assessments to be provided to the staff by the Administrator and Director of Wellness at the staff meeting being held on 1/15/25.

Licensee's Proposed Overall Completion Date: *01/20/2025*

Not Implemented (- 02/19/2025)

227g -Support Plan Signatures

32. 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 #10's assessment and support plan was not signed or dated by the assessor or the resident.

Repeated Violation - 3/19/24, et al.

Plan of Correction ***Accept (- 01/17/2025)***

Resident 10's assessment and support plan were reviewed and signed by the assessor on 12/12/24. Audits of support plans to be done monthly by Administrator beginning on 1/10/25 to ensure all signatures are accounted for. Education on proper record keeping and support plans to be given by the Administrator at the staff meeting being held on 1/15/25.

Licensee's Proposed Overall Completion Date: *01/15/2025*

Not Implemented (- 02/19/2025)

251a - Record for Each Resident

34. Requirements

2600.
251.a. A separate record shall be kept for each resident.

Description of Violation

On 12/11/24, Resident #8's fall and incident record was included in Resident #1's record.

Plan of Correction ***Accept (- 01/17/2025)***

Resident 8's fall and incident record were removed from the record of Resident 1 on 12/11/24 by the Dementia Care Programmer. Audits of all resident records to be performed by the Director of Wellness and DCP monthly to ensure all records are separate beginning on 1/10/25. Education on proper filing and importance of resident records being separate to be given by the Administrator at the staff meeting being held on 1/15/25.

251a - Record for Each Resident *(continued)*

Licensee's Proposed Overall Completion Date: *01/15/2025*

Not Implemented (- 02/19/2025)

251b - Record Entries Legible

35. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction tape was used on Resident's #9's preadmission screening document. Correction tape was used to cover up and alter the following items on the document:

- *cover up the date the form was faxed to the home (2/6/24 at 8:24AM).*
- *altered the date the physician signed Part IV: cognitive screening (changed*
- *altered sensory needs section from not seeing with a device, to sees with glasses.*

Repeated Violation - 3/19/24, et al.

Plan of Correction ***Accept (- 01/17/2025)***

New DME was obtained for Resident 9 on 1/9/25 by the Dementia Care Programmer. Education was provided to Director of Wellness and Dementia Care Programmer on regulation 251.b and how correction is not to be used by the facility or any office that may send any part of the resident record by the Administrator on 12/19/24. All new DMEs to be audited by the Administrator beginning on 1/12/25. Education on resident records being legible with no corrections to be done by the Administrator at the staff meeting being held on 1/15/25.

Licensee's Proposed Overall Completion Date: *01/15/2025*

Not Implemented (- 02/19/2025)