pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **TLC HEALTHCARE LLC**
LEGAL ENTITY

To operate **DUNLEVY MANOR**
NAME OF FACILITY OR AGENCY

Located at **2218 ROUTE 88, DUNLEVY, PA 15432**
(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 **24**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **February 25, 2021** until **August 25, 2021**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **447542**

ISSUING OFFICER

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 – 01/21

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: February 25, 2021

Ms. Leah Laffey
Owner
TLC Healthcare, LLC
801 Elm Spring Road
Pittsburgh, Pennsylvania 15243

RE: Dunlevy Manor
2218 Route 88
Dunlevy, Pennsylvania 15432
License #: 447542

Dear Ms. Laffey:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on November 3, 2020 and December 23, 2020, 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 (447541) dated August 18, 2020 to February 18, 2021 and issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), failure to submit an acceptable plan to correct noncompliance items, and failure to comply with the acceptable plan to correct noncompliance items. This decision is pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from February 25, 2021 to August 25, 2021.

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 or § 2800 (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 or 2800 Section:	Class of Violation	Census at Inspection	X	Fine Per resident Per day	=	Calculated Fine Per day	Mandated Correction Date (to avoid Fine)
25b	III	15		$3		$45	15 calendar days from mailing date of this letter
187d	II	15		$5		$75	5 calendar days from mailing date of this letter
191	III	15		$3		$45	15 calendar days from mailing date of this letter
225a	III	15		$3		$45	15 calendar days from mailing date of this letter
227a	III	15		$3		$45	15 calendar days from mailing date of this letter

A fine was assessed for 2600.51 but has been removed due to a temporary suspension of these regulations as of March 29, 2020.

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:

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

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

Sincerely,

Jamie L. Buchenauer
Deputy Secretary
Office of Long-Term Living

Enclosure
License
Licensing Inspection Summary

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

Facility Information

Name: *DUNLEVY MANOR* **License #**: *44754* **License Expiration Date**: *02/18/2021*
Address: *2218 ROUTE 88, DUNLEVY, PA 15432*
County: *WASHINGTON* **Region**: *WESTERN*

Administrator

Name: *Leah Laffey* **Phone**: *7243265611* **Email**: *llaffey@gmail.com; dunlevygardenspch@gmail.com*

Legal Entity

Name: *TLC HEALTHCARE LLC*
Address: *801 ELM SPRING ROAD, PITTSBURGH, PA, 15243*
Phone: *7243265611* **Email**: *LLAFFEY@GMAIL.COM*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/20/1996* **Issued By**: *Dept L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *16* **Waking Staff**: *12*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal,Provisional* **Exit Conference Date**: *11/03/2020*

Inspection Dates and Department Representative

11/03/2020 - On-Site: Amy Duncan, Josh Hoover

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* **Residents Served**: *13*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *13*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *3* **Have Physical Disability**: *0*

Inspections / Reviews

11/03/2020 - Full

Lead Inspector: *Amy Duncan* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/18/2020*

11/30/2020 - POC Submission

Lead Reviewer: *Larry Mazza* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/04/2020*

12/4/2020 - POC Submission

Lead Reviewer: *Larry Mazza* **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/04/2020*

1/29/2021 - Document Submission

Lead Reviewer: *Larry Mazza* **Follow-Up Type**: *Exception*

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 home's current licensing inspection summaries, dated 5/18/20, et. al., 1/13/20, et. al., and 12/3/19 are not posted in a conspicuous and public place in the home.

Plan of Correction **Accept**

The administrator and designee did not know where they had it was considered a non conspicuous place. After the inspection and the inspect gave direction The binder was moved to the entry way table. Moving forward every time a plan of correction is submitted and approved they will be put in the binder in the entry way so anyone can see it. The administrator or designee will check month to ensure it is where it is suppose to be.

Completion Date: *11/04/2020* Licensee's Proposed Date for POC Implementation  1/29/21

Document Submission Not Implemented

16b - Incident Policies

1. Requirements

2600.

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

Description of Violation

The home's reportable incident policy does not address the prevention, notification, investigation and management of reportable incidents and conditions.

Plan of Correction **Accept**

The policy that the inspector saw was written was from 06/13/2016. The policy was revised on 2/1/2017. That was not in both binders so the inspector only saw the one on 6/13/2016. (attached is the 2017 updated one) The binder for policies and procedures will be audited by 12-5-2020 to ensure all the updated polices are in both binder. The administrator or designee will check month to make sure the policies are visible and accessible. And as new polices are written staff will sign off on a sign in sheet to ensure they received the latest polices and procedures. The administrator or designee will check monthly to make sure the polices and procedures are accessible. And twice a year the polices will be audited for correction.

Completion Date: *11/18/2020* Licensee's Proposed Date for POC Implementation  1/29/21

Document Submission **Implemented**

The policy is attached to show that it was there all the time just not available for the inspector.

25b - Contract Signatures

1. Requirements

2600.

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

Description of Violation

Resident #1's resident-home contract, dated 6/25/19, is not signed by the resident.

REPEAT VIOLATION: 1/13/2020, et. al.; 9/5/2019, et. al.

25b - Contract Signatures *(continued)*

Plan of Correction **Accept**

The one page of the contract was signed by the resident on 11-4-2020. (attached). The old administrator was here during this contract and the new administrator and designee did not realize they could have the resident sign it after the fact so it was never signed. The files will be audited by 12-4-2020 and anything blank will be signed even if it is late. Moving forward two people will sign off on the initial paper work DME, RASP and contracts to make sure all lines are filled out. And the files will be audited twice a year moving forward. (attached)

1/29/21

Completion Date: *11/04/2020* Licensee's Proposed Date for POC Implementation

Document Submission Not Implemented

25c11 - List of Rates

1. Requirements

2600.

25.c. At a minimum, the contract must specify the following:

11. A list of personal care services to be provided to the resident based on the outcome of the resident's support plan, a list of the actual rates that the resident will be periodically charged for food, shelter and services and how, when and by whom payment is to be made.

Description of Violation

Resident #1's resident-home contract, dated 6/25/19, does not indicate the actual rates that the resident will be periodically charged for food, shelter, and services. This section of the contract is blank.

Plan of Correction **Accept**

-The contact was fixed that day 11/3/2020, and moving forward the designee will have a second person sign on a check list that all initial paperwork was completed and all blanks are filled in correctly within 30days of intake. The designee missed this in her audits. An audit will be done of all contracts by 12-04-20 to ensure all contracts blanks are filled out and moving forward there will be a second person who will check contracts, DME' and RASP's within 30 days of a new intake to make sure all paperwork is completed and will sign off on a check list called resident admission.(attached) Then the administrator or designee will continue to check monthly to make paperwork is all in files and complete and this will be checked off on a monthly checklist (attached).

1/29/21

Completion Date: *11/04/2020* Licensee's Proposed Date for POC Implementation

Document Submission Not Implemented

51 - Criminal Background Check

1. Requirements

2600.

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

51 - Criminal Background Check *(continued)*

Description of Violation

A Pennsylvania criminal history background check was not completed for the following staff persons:

- *Direct care staff person A, hired 9/8/20, who worked unsupervised in the home on numerous occasions, to include from 7:00 am - 3:00 pm on 10/26/20 through 10/30/20.*
- *Direct care staff person B, hired 8/28/20, who worked unsupervised in the home on numerous occasions, to include from 7:00 am-3:00 pm on 10/30/20 through 11/2/20.*

REPEAT VIOLATION: 9/5/2019, et. al.

Plan of Correction **Accept**

The designee tried to get background checks on 9/12/2020 and it said pending but it did not have the results. She went on again on 11/4/2020 and it still said pending. On 11/18/2020 they were available. Administrator and designee does know that a criminal background checks have to be within a month of hire. Moving forward if they are not available in the time frame they will take a picture and make a copy of what the website says to show proof it was completed in the time frame and see if they can reach the department criminal background checks are completed. Also an audit of all personal file will happen by 12/4/2020 to make sure nothing else is missing from any files. And the files will be checked by a second person within the first month of a new staff to ensure all paperwork is completed. The administrator will check monthly to make sure anything missing in new hire files.

Completion Date: *11/18/2020* Licensee's Proposed Date for POC Implementation

1/29/21

Document Submission Not Implemented

56 - Admin 20 Hours/Week

1. Requirements

2600.

56. Administrator Staffing - The administrator shall be present in the home an average of 20 hours or more per week, in each calendar month.

Description of Violation

Staff and resident interviews indicate that staff person C, the home's administrator, is not present in the home an average of 20 hours per week.

Plan of Correction **Accept**

The administrator does not work normal 8 hr shifts therefore it may not always seem like she is in the building as much as she is. Moving forward the administrator will document her time in the building and make sure she is visible for staff and residents to see. She is also looking to hire a new administrator who is in the building more than a few hrs at a time. This has been posted. She will begin writing her hours starting 11/22/2020. And will check in monthly to make sure she is meeting the 20 hrs a week.

Completion Date: *11/22/2020* Licensee's Proposed Date for POC Implementation

1/29/21

Document Submission Not Implemented

64c - Annual Training

1. Requirements

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

64c - Annual Training *(continued)*

Description of Violation

Staff person C, the home's administrator, only completed 8 hours of Department-approved training during the 2019 training year.

REPEAT VIOLATION: 1/13/2020, et. al.

Plan of Correction **Directed**

The administrator had no idea that her CEU credits would not be able to used since they are training that are given to Registered Nurses. My designee was told by Amy Duncan that 7 of the credits will be counted (attached) The administrator completed 24 hours on line for 2020. 15 are attached and 9 have not been sent to the administrator from the state as of yet. Two of them are on 10-22-20 State Guidance on re-opening and inspections and 11-02-2020 called Pharmacy partnership for long-term care for covid-19 vaccines. This will give 24 hours. There is no way to make up for trainings for 2019 other than to use current trainings. If we use the 7 for 2019 and 17 from 2020 that gives 24hrs and still will leave 7 hrs done for 2020 and at this time 2020 has been suspended. The administrator will continue to do training through 2020 but also knows that when the suspension is over she has 90 days to get the rest of the 24 hours completed. Moving forward the administrator will contact the state and fill out the paperwork on line to get approval for any trainings not on the approval list from the state to ensure each training she attends are accepted as credits for the administrator. To ensure she has her 24 hours of training. Moving forward I get the approval before hand and not after the fact.

Upon receipt of the plan of correction: The administrator shall keep a record of all completed and upcoming trainings, which shall be reviewed during each of the home's quality management meetings. 12/2/20 LM

Completion Date: *12/09/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

credits for 2020 were attached to be used for 2019 and moving forward all outside credits will get approval first.

65f - Training Topics

1. **Requirements**

2600.

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

6. Safe management techniques.

Description of Violation

Direct care staff person D, hired 1/23/15, and direct care staff person E, hired 2/28/18, did not receive training in safe management techniques during the 2019 training year.

65f - Training Topics *(continued)*

Plan of Correction **Accept**

The administrator thought that the first 40 hr training safe management techniques was the safe management techniques training that was being talked about. (attached) she did not know there was also an additional training. She was able to get a safe management training and completed it with Staff D, and E and all other staff on 11/20/20. (attached). Moving forward the Administrator looked in the 2600 to make sure all the required training are on the mandatory page and they will be talked about in the quality management meeting to make sure all staff have required training. And the administrator will check month to make sure all training are completed.

Completion Date: *11/20/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

training was completed with staff that were missing training.

66a - Staff Training Plan

1. **Requirements**

2600.

66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have a staff training plan for the 2020 training year.

Plan of Correction **Accept**

11 training have been completed there was just not the one page mandator training guide filled out. (attached) But all 11 trainings were completed and the sign in sheets were available. Moving forward at the beginning of the year the one page Mandatory training sheet will be created so each time a training is completed the date can be written on it to make it easier for the Administrator to know what is done and what is not done and they will be discussed at each of the Quality Management training.

Completion Date: *11/10/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission Not Implemented

84 - Heat Sources

1. **Requirements**

2600.

84. Heat Sources - Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120° F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from comin in contact with the heat source.

Description of Violation

At 9:32 am, the temperature of the portable electric fireplace in the TV room was 172.8 degrees Fahrenheit. There were no protective guards in place to prevent residents from coming in contact with the front grate.

84 - Heat Sources *(continued)*

Plan of Correction **Accept**

The fireplace was there as a decoration and as a entertainment center. The administrator did not even know it was in working condition is was bought to hold all the homes DVD and as decor. One of the residents was plugging in her pencil sharper and must have plugged in the fireplace and staff did not know because it was not lit up because they did not know it was in working order. The fire place was removed that day because the staff all know portable space heaters are not allowed in. All staff were talked to and everyone knew space heaters are not allowed in the building and moving forward nothing that is in working condition that is a space heater or heating source that is not approved will be in the home. The administrator or designee will check monthly to ensure the are no space heaters in the building.

Completion Date: *11/04/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

heating source was removed immediately.

85d - Trash Receptacles

1. Requirements

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 9:40 am, there was an uncovered trash can, which was approximately 1/2 full of trash, located in the shared bathroom off the lobby's living room.

Plan of Correction **Accept**

The lid was broke on the trash can so it was replaced on 11/10/20. Moving forward the administrator or designee will check the trash cans month to ensure all trash can are in working order and all have a lid on it.

Completion Date: *11/10/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

Trash can lids were all attached

91 - Telephone Numbers

1. Requirements

2600.

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

Description of Violation

There are no emergency telephone numbers on or by the two cordless telephones in the kitchen.

Plan of Correction **Accept**

The emergency contact list was up and must have fallen down. New lists were put up next to every phone. Moving forward the administrator or designee will check monthly to make sure they are always up and available.

Completion Date: *11/05/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

telephone lists were all put up by phones.

93a - Handrails

1. Requirements

2600.

93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

No handrail is present at the approximate 7" step outside the emergency exit door off the home's pantry area.

Plan of Correction **Accept**

The facility was inspected for licensing and no one ever said a handrail needed to be placed on the pantry door exit. There have been 4 other inspections that no one has ever brought this to the attention that it needed to be on there. The maintenance man was called and a hand rail will be added. it will be added by 12-4-2020. It is difficult to know how this could have been avoided because it was not flagged during initial inspections from the building inspector or any previous audits. The premises is always checked by maintenance and it will continued to be checked a minimum of once a month to make sure anything broken is fixed.

Completion Date: *12/04/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

handrail was put up by maintain man.

95 - Furniture and Equipment

1. Requirements

2600.

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

Description of Violation

At approximately 9:25 am, there was a red, sticky liquid spilled on the bottom right shelf of the refrigerator on the right in the kitchen.

Plan of Correction **Accept**

The kitchen staff did not see the spill while she was cooking breakfast. The spill was cleaned up immediately. Moving forward the will be a cleaning list for the kitchen staff and the refrigerator will wiped down at the end of each shift. The administrator or designee will check weekly to make sure the cleaning list is being completed.

Completion Date: *11/03/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

cleaned up at inspection. Training completed with staff.

96a - First Aid Kit

1. Requirements

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

There is no first aid kit present in the home.

96a - First Aid Kit *(continued)*

Plan of Correction **Accept**

The designee did not show the inspector the correct first aid kit that is accessible to move. She showed her one in the med room that is on the wall. We have a first aid kit that was not shown to the inspector but is in our kitchen. This was there all the time but not shown. All the correct supplies are in it it was checked and signed off on 11-4-2020. All the staff were shown where the first aid kit is on 12-1-2020 during a staff Quality Management training to ensure everyone knows where it is so it can be utilized. Every worker knows where the first aid kit is stored now and the designee will check the first aid kit and sign off on a check list monthly to ensure all the proper equipment is in it. (attached). All new staff will be shown on the first 40 hrs of on the job training as well as part of orientation. The administrator or designee will also sign off on it monthly on the monthly checklist (attached).

Completion Date: *11/04/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission Not Implemented

103c - Food Protected

1. **Requirements**

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

At 9:24 am, there was a 64 oz. tub of margarine, labeled 'keep refrigerated', stored on the kitchen counter next to the sink.

Plan of Correction **Accept**

Breakfast was ending and the staff did not put the margarine away yet. The margarine should have been put away immediately. It was put away immediately at the inspection. There was a training on 11-23-2020 about kitchen duties to ensure this doesn't happen again. The administrator and designee will check daily to ensure food is being put away when it is not being used. This will be done until there is confidence that the kitchen staff know when food should be put away.

Completion Date: *11/03/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

It was put away immediately and training was completed

103d - Storing Food Off Floor

1. **Requirements**

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

Description of Violation

Seven 5-gallon jugs of emergency water were stored on the floor in the storage room next to the furnace room.

103d - Storing Food Off Floor *(continued)*

Plan of Correction **Accept**

A shelf will be put up in the storage room on 11-24-2020 and and all the water will be stored on the shelf to ensure it is not on the floor. There is not a lot storage space in the facility and the water was just delivered and put in the storage room. The kitchen staff who unload the water were all talked to about where the water needs to be stored and how no water can be on the floor. Moving forward all the water will be stored on the shelf and the administrator or designee will check weekly to make sure all the water is off the floor.

Completion Date: *11/24/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

a shelf was put in for the water to be put on to get off the floor.

103e - Left Overs

1. Requirements

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

The following foods were unlabeled and undated in the kitchen refrigerator on the right:

- *A plastic container of breakfast casserole*
- *An ear of cob of corn in a zippered bag*
- *A bag of cheese cubes, pepperoni, and crackers*

Plan of Correction **Accept**

The three items were thrown away and moving forward all food even if it is a staff members will have a label and date on it. All the staff were talked to about labeling and dating their food and the kitchen staff. A staff training was done on 11-23-2020 (attached). The kitchen staff will also be responsible and added to their check list to check food in the refrigerator three times a week to make sure all food is properly labeled and dated. The administrator or designee will check weekly to ensure it is getting done.

Completion Date: *11/03/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

Items were thrown away and a training was completed.

103g - Storing Food

1. Requirements

2600.

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

Description of Violation

The following open and unsealed foods were stored in the kitchen refrigerator on the right:

- *A bag of cheese cubes, pepperoni and crackers*
- *(2) 11.8 oz. bags of kosher dill pickles*

103g - Storing Food *(continued)*

Plan of Correction **Accept**

The two items were thrown away and moving forward all food even if it is a staff members will stored in a sealed container. All the staff were talked to about storing food and the kitchen staff. This was done on 11-23-2020 (attached) during a staff meeting. The kitchen staff will also be responsible and added to their check list to check food in the refrigerator three times a week to make sure all food is properly stored and sealed. The administrator or designee will check weekly to ensure it is getting done.

Completion Date: *11/03/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

Items were thrown away and a training was completed.

103i - Outdated Food

1. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

At approximately 9:25 am, a bag of Little Salad Bar garden salad, which indicated, "use by 10/3/20", was stored in the kitchen refrigerator on the right.

Plan of Correction **Accept**

The salad was thrown away and moving forward all food even if it is a staff members will thrown away when it expires. All the staff were talked to about making sure they throw away their food when it expires. . This was done during a staff meeting on 11-23-2020 (attached). The kitchen staff will also be responsible and added to their check list to check food in the refrigerator three times a week to make sure nothing is expired and they will discard anything that is expired. The administrator or designee will check weekly to ensure it is getting done.

Completion Date: *11/03/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

Food was thrown away and a training was completed.

109b - Rabies Vaccination

1. Requirements

2600.
109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

There is no record of a current rabies vaccination for the home's dog, Branch.

109b - Rabies Vaccination *(continued)*

Plan of Correction **Accept**

Attached is Branches rabies shots it was in another folder the designee did not look in. Moving forward there will be a yearly appt scheduled and it will be scheduled at the appointment to make sure it is not missed and they send out a reminder. An appt has been scheduled for 9/15/2021 to ensure we stay in compliance. And it will be checked monthly to make sure we always have all updated vaccines for the animals. And there will be a folder created for Branch to make sure the designee knows where all the vaccinations are kept.

Completion Date: *12/15/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission Not Implemented

127a - Portable Space Heaters

1. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

At 9:32 am, the portable electric fireplace in the TV room was on and in use.

REPEAT VIOLATION: 1/13/2020, et. al.

Plan of Correction **Accept**

The fireplace was there as a decoration and as a entertainment center. The administrator did not even know it was in working condition is was bought to hold all the homes DVD and as decor. One of the residents was plugging in her pencil sharper and must have plugged in the fireplace and staff did not know because it was not lit up because they did not know it was in working order. The fire place was removed that day because the staff all know portable space heaters are not allowed in. All staff were talked to and everyone knew space heaters are not allowed in the building and moving forward nothing that is in working condition that is a space heater or heating source that is not approved will be in the home. The administrator or designee will check monthly to ensure the are no space heaters in the building.

Completion Date: *11/04/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

Space heater was removed immediately.

132c - Fire Drill Records

1. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record does not indicate if the fire drill conducted on 1/25/20 at 7:38 was conducted in the am or pm.

REPEAT VIOLATION: 1/13/2020, et. al.

132c - Fire Drill Records *(continued)*

Plan of Correction **Accept**

The fire drill was completed on 7:38pm and it was fixed on the form on 11-4-2020. (attached). That was missed when filling out the form. Moving forward the fire drill log will be checked monthly and a form will be signed off on by the Administrator or designee to ensure All dates and times are accurate and that the correct amount of fire drills are completed. (attached) The fire drills will also be talked about at the quarterly Quality management meeting with staff to ensure every understands the importance of the fire drills how they are done and when they have to be done. On 12-1-2020 (attached) a Quality Management meeting was held and fire drills was a main topic of conversation. The will continue to be talked about and check at each quarterly meeting as well. The Administrator or designee will be responsible for signing off monthly that the fire drill form is filled out properly and the correct fire drills were completed. (form attached). A safety training was conducted on 8-14-2020 by the chief fire Marshall. This was the first training the designee who runs the fire drills took part in. She was able to get an understand of fire drills and the importance of everything being done right because of how serious the issues is.

Completion Date: *11/04/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

the time was added and a training was completed on fire safety.

132e - Fire Drill Sleeping Hours

1. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The home has not conducted a fire drill during sleeping hours from September 2019 through March 2020.

Plan of Correction **Accept**

The administrator took over in September did not realize she had to do one every 6 months she thought it was twice a year. 11/11/2020 a midnight fire drill was conducted. Moving forward the fire drill log will be check monthly to ensure all dates and times are accurate and that the correct amount of fire drills are completed. a monthly check list was created and it will be signed off on. (attached) The administrator and designee will check to make sure one fire drill a month is completed during different times throughout the day and once every 6 months a midnight fire drill is completed. The fire drills were talked about at the quarterly Quality management meeting on 12-1-2020 (attached). They will continue to be talked about fire drills at each quarterly meeting moving forward as well. A midnight fire drill was completed on 11/11/2020 at 6:10am. (attached). Another midnight drill will be done in December and moving forward one will be done every 6 months with it checked off on the monthly checklist. (attached). The next midnight fire drill will happen before May 2021. A safety training was conducted on 8-14-2020 by the chief fire Marshall. This was the first training the designee who runs the fire drills took part in. She was able to get an understand of fire drills and the importance of everything being done right because of how serious the issues is especially midnight fire drills. Monthly documentation of fire drill will be done monthly. (attached)

Completion Date: *11/11/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

midnight fire drill was completed. and a training was completed.

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

Resident #2's initial medical evaluation, dated 8/25/20, indicates, "see medication list" under the medications section; however, no list of medications are attached.

Resident #3's initial medical evaluation, dated 8/10/19, indicates, "see attached list" under the medications section; however, no list of medications are attached.

REPEAT VIOLATION: 1/13/2020, et. al.; 12/3/2019;

Plan of Correction **Directed**

A copy of the med list was printed out and the Doctor signed off on it on 11/12/2020. (attached) and it was placed in file with the DME. An audit will be done by 12-4-2020 of all DME's to make sure a MAR is attached to all DME's. The pharmacy was just changed to health direct and now the MAR comes up on the tabula pro to copy on to the DME. Moving forward all medications will now be on the DME before it is printed up. The administrator or designee will make sure before a DME is printed up the med list is on the computer and the second person (2 people assigned) checking off the initial month forms will check to make sure the med list is attached and sign off on the check list. (attached) The administrator or designee will check monthly to make sure all meds are on the med list and sign off on the monthly checklist. (attached).
DIRECTED: Documentation of the monthly checklist shall be kept. LM 12/2/20

Within 24 hours upon receipt: A designated staff person shall develop and implement a checklist to ensure all newly-admitted residents have a medical evaluation, completed in its entirety, within 60 days prior to admission or within 30 days after admission. Documentation of the checklist shall be kept. LM 12/2/20

Completion Date: *11/12/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission Not Implemented

144c2 - Smoking Area Distance

1. Requirements

2600.

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

144c2 - Smoking Area Distance *(continued)*

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

Description of Violation

The home's smoking policy does not indicate the location of the designated smoking area.

Plan of Correction **Accept**

The smoking plan that is implemented was created on 06/30/16 and has never been cited or questioned. It will be attached. We did add the the exact locations of the smoking area on the policy on 11/12/2020. (attached) Moving forward we will look through the polices by 12-4-2020 and ensure we have all the polices needed and everything that needs to be on them corrected this will be done by 12/04/20. We will use the 2600 regulations for guidance. We had a Quality Management meeting on 12-1-2020 (attached) and the smoking policy was addressed with the addition added. Policies will be updated as regulations chance. New staff are always given the smoking policy on the first day. The Administrator or designee will check the policies monthly to make sure any changes are needed and sign the check list that it was completed. (attached)

1/29/21

Completion Date: *11/12/2020* Licensee's Proposed Date for POC Implementation

Document Submission **Implemented**

The designated smoking area was identified on the smoking policy

187a - Medication Record

1. Requirements

2600.

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

187a - Medication Record *(continued)*

Description of Violation

On 9/18/20, resident #2 was prescribed Bactrim DS-Take 1 tablet by mouth twice a day for 5 days; however, the medication is still present on the resident's October 2020 and November 2020 medication administration records (MARs).

On 10/5/20, resident #2 was prescribed Cephalexin 500 mg capsule-Take by mouth 3 times a day for 7 days; however, the medication is still present on the resident's November 2020 MAR.

On 9/24/20, Resident #3 began taking Cefuroxime Axetil 500 mg tablet-Take 1 tablet by mouth twice daily for 10 days; however, the medication is still present on the resident's November 2020 MAR.

REPEAT VIOLATION: 1/13/2020, et. al.

Plan of Correction **Accept**

All the medications were taken off the MAR's on 11/3/2020 by the pharmacy. The home was in the process of changing pharmacies. We used one pharmacy and we changed over in October to a new pharmacy so we were still in our learning curve of the New MAR. . A med refresher training was also completed on 11-23-2020 (attached) with designee who learned how to use the MAR system to ensure all staff know how to use the Quick MAR system, until the pharmacist could come out on 12-1-2020. The pharmacist was out again on Dec 1,2020 (attached) to do a cart audit and to do a training to make sure all question about the MAR was answered. Cart audits will continue to happen weekly and documented when completed. (attached). to ensure the MAR and the medications match correctly. Meds will be talked about at quarterly Management meetings as well. 12-1-2020 after the training from the pharmacist a quality management meeting was held and talked about one more time. (attached). The administrator or designee will schedule the audits weekly and document the days on the weekly check list.

Completion Date: *11/03/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission Not Implemented

187b - Date/Time of Medication Admin.

1. **Requirements**

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

187b - Date/Time of Medication Admin. *(continued)*

Description of Violation

On 9/18/20, resident #2 was prescribed Bactrim DS-Take 1 tablet by mouth twice a day for 5 days; however, the resident's October 2020 and November 2020 MARs indicate the medication was still being administered through 11/3/20.

On 10/5/20, resident #2 was prescribed Cephalexin 500 mg capsule-Take by mouth 3 times a day for 7 days; however, the resident's October 2020 and November 2020 MARs indicate the medication was administered 3 times a day from 10/5/20 through 11/2/20 and once on 11/3/20.

On 9/24/20, Resident #3 began taking Cefuroxime Axetil 500 mg tablet-Take 1 tablet by mouth twice daily for 10 days; however, the resident's October 2020 and November 2020 MARs indicate the medication was still being administered through 11/3/20.

REPEAT VIOLATION: 1/13/2020, et. al.; 9/5/2019, et. al.

Plan of Correction **Accept**

All the medications were taken off the MAR's on 11/3/2020 by the pharmacy. The home was in the process of changing pharmacies. We used one pharmacy and we changed over in October to a new pharmacy so we were still in our learning curve of the New MAR. . A med refresher training was also completed on 11-23-2020 (attached) with designee who learned how to use the MAR system to ensure all staff know how to use the Quick MAR system, until the pharmacist could come out on 12-1-2020. During this training with the designee on 11-23-2020 it was addressed how people were clicking off on Meds that were no longer in the building to be given. Med Tech were taught how to use the new scanner and how to recheck your meds. Med Techs all understand the next time this occurs their will be disciplinary action. The pharmacist was out again on Dec 1,2020 (attached) to do a cart audit and to do a training to make sure all question about the MAR was answered. Cart audits will continue to happen weekly and documented when completed. (attached). to ensure the MAR and the medications match correctly and that no meds are on the MAR that are not being given and that no one is clicking off on meds that are not being given. The administrator or designee will schedule the audits weekly. The audit will be done by the designee or the Med tech supervisor and the designee or Administrator will document the days on the weekly check list)attached) and deal with staff individually for any med cart issues.

1/29/21

Completion Date: *11/03/2020* Licensee's Proposed Date for POC Implementation

Document Submission Not Implemented

187d - Follow Prescriber's Orders

1. **Requirements**

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

187d - Follow Prescriber's Orders *(continued)*

Description of Violation

Resident #3 is prescribed Travoprost 0.004%, 5ml drops-Instill 1 drop into each eye at bedtime. However, this medication was not administered to the resident since 10/23/20 at 9:00 pm, because the medication was not available in the home.

REPEAT VIOLATION: 1/13/2020, et. al.; 9/5/2019, et. al.

Plan of Correction **Accept**

The medication was order, the pharmacy was waiting on an order from the DR and the DR did not sent the order over in a timely manor. The eye drops were back in the building on 11/5/2020. Moving forward the med tech will write down all medications that need ordered 5 days before they are out so that there is enough time to get the Doctor to send a script and to ensure it is in the building on time . A med refresher training was completed on 11-23-2020 (attached) with designee who learned how to use the MAR system to ensure all staff know how to use the Quick MAR system and to talk about meds not being in the building. The pharmacist was out again on Dec 1,2020 (attached) to do a cart audit and to do a training to make sure all question about the MAR was answered. (attached) The issue of not having orders filled in a timely manor was addressed with the pharmacist and how this pharmacy will reach out to the doctors to get the order. This was not happening with the other pharmacy. The Doctor was called on 11/22/2020 to talk about ways to get orders in a timely manor and the Doctor will start calling the pharmacy weekly to make sure all meds have scripts to be filled. Cart audits will continue to happen weekly and documented when completed. (attached). This will be another opportunity to catch any meds that need ordered to ensure the MAR and the medications match correctly and all medications are in the building. The administrator or designee will schedule the audits weekly and document the days on the weekly check list. The administrator will also follow up with the Doctor and pharmacy monthly to ensure all issues are addressed and document the date on the monthly checklist. (attached).

Completion Date: *11/05/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission Not Implemented

221c - Post Activity Calendar

1. **Requirements**

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

Description of Violation

The home's activity calendar posted between the dining area and the TV area is undated.

Plan of Correction **Accept**

The designee had the calendar filled out the Month and year was not on it. The rest of the calendar was dated correctly and filled out. Moving forward someone will be assigned to ensure that the month and date are on the calendar. This will be checked on the first day of every month to make sure there is always correct dates and months. The administrator will check monthly to make sure it is happening.

Completion Date: *11/03/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission **Implemented**

The Month was added.

225a - Assessment 15 Days

1. 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 #2 was admitted to the home on 8/25/20; however, an assessment was not completed.

REPEAT VIOLATION: 12/3/2019

Plan of Correction **Accept**

The residents support plan was not in her file but it was completed. After the inspector left the designee was able to located it in a pile of paperwork that was taken out because hospice was looking at it. (attached). The support plan was put back in her file on 11/5/2020. There will be an audit of all assessments completed by 12-4-2020 and any assessment not in the file will be put in the file, and moving forward the Administrator or designee will check weekly to make sure all paper work is filed and put in the correct files to ensure it is always available. (attached weekly checklist). And month the assessment will be check in each file to make sure all paperwork is completed and in the file. This will be documented on the month check list (attached). And there is a residents admission checklist that is to be done in the first 30 days that will be signed off by a designated staff to make sure all paperwork is in files in the specified time. (attached). DIRECTED: The admission checklist shall be completed for each newly-admitted resident to ensure a resident assessment is completed for each resident within 15 days of admission. Documentation of the checklist shall be kept in each resident's record. LM 12/3/20

1/29/21

Completion Date: *11/05/2020* Licensee's Proposed Date for POC Implementation

Document Submission Not Implemented

227a - Support Plan 30 Days

1. Requirements

2600.

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

Description of Violation

Resident #2 was admitted to the home on 8/25/20; however, a support plan was not completed.

REPEAT VIOLATION: 5/18/2020, et. al.; 12/3/2019

227a - Support Plan 30 Days *(continued)*

Plan of Correction **Accept**

The residents support plan was not in her file but it was completed. After the inspector left the designee was able to located it in a pile of paperwork that was taken out because hospice was looking at it. (attached). The support plan was put back in her file on 11/5/2020. There will be an audit of all assessments completed by 12-4-2020 and any assessment not in the file will be put in the file, and moving forward the Administrator or designee will check weekly to make sure all paper work is filed and put in the correct files to ensure it is always available. (attached weekly checklist). And month the assessment will be check in each file to make sure all paperwork is completed and in the file. This will be documented on the month check list (attached). And there is a residents admission checklist that is to be done in the first 30 days that will be signed off by a designated staff to make sure all paperwork is in files in the specified time. (attached). DIRECTED: The admission checklist shall be completed for each newly-admitted resident to ensure a resident support plan is completed for each resident within 30 days of admission. Documentation of the checklist shall be kept in each resident's record. LM 12/3/20

Completion Date: *11/05/2020* Licensee's Proposed Date for POC Implementation 1/29/21

Document Submission Not Implemented

227d - Support Plan Medical/Dental

1. Requirements

2600.

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

Description of Violation

Resident #1 began receiving hospice services on 7/10/20; however, the resident's support plan, dated 7/10/20, does not indicate the care and services or frequency of services that are being provided by hospice.

Resident #4's initial support plan, dated 11/22/19, indicates, "a PNA (personal needs account) will be made at the facility. Documentation will be kept", under the managing finances section; however, the home does not assist the resident with finances. Also, the resident's support plan indicates to, "follow dr's orders" for the diagnoses of a hernia surgery and depression; however, the resident's support plan does not specifically address how the home will meet the resident's needs relating to these diagnoses.

227d - Support Plan Medical/Dental *(continued)*

Plan of Correction **Accept**

The update and changes was changed to include the care and frequency of the hospice workers. this was done on 11/5/2020. (attached). Moving forward it will be identified in the updates to give details of care and frequency. An file audit of all assessments and support plans will be completed by 12-4-2020 and all updates will be check to make sure there is details with any care given to a resident to reflect the kind of care being given and the frequency.
The updates and changes will be checked weekly to ensure any changes are documented within 5 days of a change. It will be documented ion the weekly check list. (attached).
Resident # 4 where is says PNA we added if needed and changed the language on 11-5-2020. (attached). Moving forward we will write moving forward we will change the language to ensure it is understood that we do not currently have one but if one is requested or needed we can set it up and document it. The diagnoses for hernia surgery more dialog was added on 11-5-2020 (Attached). Same with depression more dialog was added to explain what will take place if the medication is not working. Moving forward we will make sure more information is added to explain how DCS will monitor the behavior in the building and what follow doctors orders look like. The files will be audit by 12-4-2020 and detail will be added to all charts. The administrator or designee will check updates and changes weekly to make sure updates are made within the required time. (weekly checklist attached). The files will be check monthly as well to make sure all files are completed correctly and all information is in the file. (checklist attached)


1/29/21

Completion Date: *11/05/2020* Licensee's Proposed Date for POC Implementation

Document Submission Not Implemented

251b - Record Entries Legible

1. 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 fluid was used on the following areas of resident #2's resident-home contract, dated 8/25/20,:

- *The month the contract was generated*
- *The area for the bed hold charge*

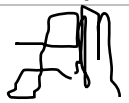
Plan of Correction **Accept**

The administrator knows that white out cannot be used. A new page was created to show it does not have white out we will keep the old one for future inspections. Moving forward the designee was taught that under no circumstances can white out be use that we cross out with one line and date and initial it. The administrator will audit all files by 12-4-2020 to ensure all files are filled out correctly and all staff will be talked to about not using white out on any documents to make sure everyone know corrective fluid cannot be used. Files will be checked monthly.

Completion Date: *11/05/2020* Licensee's Proposed Date for POC Implementation

Document Submission **Implemented**

new page without white out was created and a training was completed


1/29/21

252 - Record Content

1. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident #2's record does not include a photograph of the resident that is no more than 2 years old.

REPEAT VIOLATION: 12/3/2019

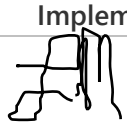
Plan of Correction **Accept**

Resident number # 2 came on 8/25/2020 did not have a picture in her file it was on tabula pro but not in their file. All residents had a new pic taken 11/12/2020 and it was placed in everyone's file. The pics are good for 2 years but we will take pics yearly so we do not miss anyone. It was scheduled on tabula pro to take all residents files on 11/12/2021. And all new residents will have pics taken on there first day and uploaded to the computer. This was added to residents admissions checklist. The administrator or designee will check monthly to make sure all pics are taken. (document on month checklist attached) The second person checking monthly files will also check to make sure the pic is in the file and document it on the residents admission checklist.

Completion Date: *11/12/2020* Licensee's Proposed Date for POC Implementation

Document Submission **Implemented**

All people got new pictures



1/29/21

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

Facility Information

Name: *DUNLEVY MANOR* **License #**: *44754* **License Expiration Date**: *02/18/2021*
Address: *2218 ROUTE 88, DUNLEVY, PA 15432*
County: *WASHINGTON* **Region**: *WESTERN*

Administrator

Name: *Leah Laffey* **Phone**: *7243265611* **Email**: *llaffey@gmail.com; dunlevygardenspch@gmail.com*

Legal Entity

Name: *TLC HEALTHCARE LLC*
Address: *801 ELM SPRING ROAD, PITTSBURGH, PA, 15243*
Phone: *7243265611* **Email**: *LLAFFEY@GMAIL.COM*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/20/1996* **Issued By**: *Dept of L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *18* **Waking Staff**: *14*

Inspection

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Complaint,Provisional,Interim* **Exit Conference Date**: *12/24/2020*

Inspection Dates and Department Representative

12/23/2020 - On-Site: Amy Duncan

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* **Residents Served**: *15*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *15*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *3* **Have Physical Disability**: *0*

Inspections / Reviews

12/23/2020 - Partial

Lead Inspector: *Amy Duncan* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/13/2021*

1/22/2021 - POC Submission

Lead Reviewer: *Larry Mazza* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/20/2021*

1/25/2021 - POC Submission

Lead Reviewer: *Larry Mazza* **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/31/2021*

1/29/2021 - Document Submission

Lead Reviewer: *Larry Mazza* **Follow-Up Type**: *Exception*

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

At approximately 9:20 am, the privacy coding documents were attached to the following license inspection summaries and posted in a red binder near the home's front door:

** The license inspection summary, dated 12/3/19, which included the names of residents #1 and #2*

** The license inspection summary, dated 1/3/20, which included the names of residents #3 and #4*

Plan of Correction **Accept**

The privacy coding documents that were attached were immediately removed. The administrator and designee did not realized they were not allowed in the folder they thought that all pages of the plan of correction needed to be in the binder. All the POC's in the binder were checked to make sure there was nothing in the file with a name on it. Moving forward when a POC is put in the binder it will be checked by two people to make sure that no pages that have someone name on it are in the binder. This will then be checked monthly to make sure nothing confidential is in the binder. The building is checked daily to make sure all files are locked up and no confidential residents papers are out for anyone to see.

Document Submission Not Implemented

Completion Date: *12/23/2020* Licensee's Proposed Date for POC Implementation 1/29/21

25c6 - Refunds

1. Requirements

2600.

25.c. At a minimum, the contract must specify the following:

6. The conditions under which refunds will be made, including the refund of admission fees and refunds upon a resident's death.

Description of Violation

The resident-home contracts for resident #5, dated 9/1/20, and resident #7, dated 3/20/20, do not specify the conditions under which refunds will be made, including the refund of admissions fees and refunds upon the resident's death. The resident-home contracts indicate that refunds are at the owner's discretion.

25c6 - Refunds *(continued)*

Plan of Correction **Directed**

The contract for the residents #5 and # 7 were fixed on to state that everything is prorated as long as they are current on rent. This was completed with these two contracts on 1 -3-2021, other contracts will be fixed by 1-28-21 and signed off by residents to ensure all the contract state the same thing. The language needed to have more details to explain what happened in a refund..

Moving forward a generic blank contract was used to fill in all the blanks and it will be used with all new residents to make sure that every line is filled in properly. The only thing that will need to be filled in will be personal information and price. (attached).

An admission check list was created on 11/5/2020 and will be used with any new residents to make sure moving forward all forms are double checked. this has not been used yet since we have not had a new resident. (attached). two staff have been trained and identified to check the files. a training was done on 1/6/21 with them. (attached). Administrator and or designee will check monthly to make sure everything is filled out properly and in files.

Lastly, a new contract was created for each resident with all the new information and they will all be signed by 1/31/21. (DIRECTED: All residents shall receive a copy of the updated resident-home contract in accordance with 2600.25g. LM 1/25/21). They will be placed in the folder behind the original contract. Also a Letter will be sent out to the family about the three areas that need to be fixed in the contract. Refunds is one of them. This will be mailed out next week with the invoices. (attached is the letter explaining the changes). A copy will also be kept in their files.

Document Submission Not Implemented

Completion Date: *01/03/2021* Licensee's Proposed Date for POC Implementation 1/29/21

109a - Pets

1. Requirements

2600.

109.a. The home rules shall specify whether the home permits pets on the premises.

Description of Violation

The home rules included in the resident-home contracts for resident #5, dated 9/1/20, resident #6, dated 11/6/20 and resident #7, dated 3/20/20, do not specify whether the home permits pets.

109a - Pets *(continued)*

Plan of Correction **Directed**

The contract for the residents #5 and # 7 were fixed on 1/3/21. It was fixed to state "Pet therapy with house Dogs that are vaccinated only. No outside pets. All the other contracts will be fixed by 1-28-21 to ensure they all state the same thing. The Administrator needed to be more accurate and descriptive. (contracts attached for 5 and 7 resident 6 passed away.)
Moving forward a generic blank contract was used to fill in all the blanks and it will be used with all new residents to make sure that every line is filled in properly. The only thing that will need to be filled in will be personal information and price.
(attached) An admission check list was created on 11/5/2020 and will be used with any new residents to make sure moving forward all forms are double checked. this has not been used yet since we have not had a new resident. (attached). Two staff have been identified and trained to check them. (attached)

Administrator and or designee will check monthly to make sure everything is filled out properly and in the files. Lastly, a new contract was created for each resident with all the new information and they will all be signed by 1/31/21. (DIRECTED: All residents shall receive a copy of the updated resident-home contract in accordance with 2600.25g. LM 1/25/21). They will be placed in the folder behind the original contract. Also a Letter will be sent out to the family about the three areas that need to be fixed in the contract. Pets are one of them. This will be mailed out next week with the invoices. (attached is the letter explaining the changes). A copy will also be kept in their files.

Document Submission Not Implemented

Completion Date: *01/03/2021* Licensee's Proposed Date for POC Implementation 1/29/21

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

Resident #6's initial medical evaluation, dated 11/5/20, indicates "see attached" in the medications section; however, no list of medications is attached.

Resident #7's initial medical evaluation, dated 3/19/20, indicates "see attached" in the medications section; however, no list of medications is attached.

REPEAT VIOLATION: 1/13/2020, et. al. ; 12/3/2019; 9/5/2019, et. al.

141a 1-10 Medical Evaluation Information *(continued)*

Plan of Correction **Accept**

Attached is Resident number 7 medication list. resident # 6 is not attached because she passed away. We printed off each resident's medication list and had the doctor sign off on every residents sheet. All 16 residents have a signed medication list signed by the Doctor. The medication lists were in the files they were just not signed by a doctor. This was done on 1/8/21.

Moving forward the Administrator and Designee were both given a training on tabula pro the software system(by the tabula pro techs) they taught us how to covert the medication lists to the Medical Evaluation. Moving forward all new residents will now have the initial DME with the Medical Evaluation attached and if medications change all orders with Doctor signatures will be in the file to ensure all orders match the MAR. We have not had any new residents at this time to show. There was also a admission checklist that another staff will go over all forms to make sure everything is in the file on time and completed. This is also part of the new checklist that the administrator and designee fill out weekly and monthly that was created in December (attached). Two staff have been identified and trained on1-6-21. (attached).

Document Submission Not Implemented

Completion Date: *01/08/2021* Licensee's Proposed Date for POC Implementation  1/29/21

184b - Resident's Meds Labeled

1. 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 0.5 oz. tube of Ayr saline nasal gel belonging to resident #6 was located in the medication cart, and was not labeled with the resident's name.

Plan of Correction **Accept**

This medication was just brought in from the family and the staff did not write her name on it. That staff was disciplined from the designee due to a training taking placed a few weeks prior. The name was added to the medication.
A check list was created for staff in the interim of audits to make sure when something new is brought in it is labeled. They will check it daily to make sure all medications are labeled as soon as they are brought in.
The new pharmacist from the new pharmacy came on 12-4-2020. to do a cart audit
and to do a training to make sure all question about the MAR was answered. Cart audits will continue to happen weekly and documented when completed. (attached).
The administrator or designee will schedule the audits weekly. The audit will be done by the designee or the head med tech and they will check the checklist daily to make sure new medications are labeled.
Med tech supervisor and the designee or Administrator will document the days on the weekly check list they administrator and designee have to do.

Completion Date: *12/23/2020* Licensee's Proposed Date for POC Implementation

Document Submission **Implemented**

The medication was immediately labeled and training and forms are all included.

 1/29/21

187a - Medication Record

1. Requirements

2600.

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

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

According to staff interviews, resident #6 is administered Ayr saline nasal gel on a daily basis; however, this medication is not included on the resident's December 2020 medication administration record (MAR).

REPEAT VIOLATION: 1/13/2020 et. al.

Plan of Correction **Accept**

The medication was added to the MAR on 12/23/2020.
This medication was brought in by the family after 12-4-2020 when the pharmacist did a med audit. Dunlevy was still trying to learn the process of the new pharmacy because of how different the MAR is. The designee should have added the medication to the MAR but did not catch that. The pharmacist is going to come out on 1-25-21 to do another cart audit and the designee is going to teach another MED TECH to add the medications on the MAR to ensure there are no more breakdowns. A check list was created on 1/11/21 for MED TECH to start checking off daily to ensure everything is matching.
The new pharmacist from the new pharmacy came on 12-1-2020. to do a cart audit
and to do a training to make sure all question about the MAR was answered. Cart audits will continue to happen weekly and documented when completed. (attached).
The administrator or designee will schedule the audits weekly. The audit will be done by the designee or the head med tech and they will check the new checklist daily(attached) to make sure new medications are all added to the MAR.
Med tech supervisor and the designee or Administrator will document the days on the weekly check list). And check the check list 5 days a week.
Because this error happened another med training will happen on 1-25-21 when the pharmacist comes out to do any other audit. It the interim each med tech had a one on one training with the designee to ensure they understand how to add and take off meds if the pharmacy does not do it. It is our best practice to have the pharmacy add and delete any medications but in the event they are closed and cannot be contacted staff were taught how to add and remove mediations. The pharmacies will go into better detail on his audit on 1-25-2021.

Document Submission Not Implemented

Completion Date: *12/23/2020* Licensee's Proposed Date for POC Implementation 1/29/21

191 - Resident Right to Refuse

1. Requirements

2600.

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

Description of Violation

There is no documentation that resident #5, admitted to the home on 9/1/20, was educated on the resident's right to refuse medication if the resident believes that there may be a medication error.

REPEAT VIOLATION: 1/13/2020, et. al.

Plan of Correction **Directed**

The resident # 5 was fixed on 1-3-21 and all the flies will be fixed by 1-28-21. The resident rights are in the contract the contract was fixed to add Z. Z states that any resident has a right to refuse medication if they feel a medication error has occurred. All the other contracts will be fixed if needed by 1-28-21 to ensure they all state the same thing. The Administrator needed to be more accurate and descriptive.
(contracts attached for 5.)
Moving forward a generic blank contract was used to fill in all the blanks and it will be used with all new residents to make sure that every line is filled in properly. The only thing that will need to be filled in will be personal information and price.
(attached) An admission check list was created on 11/5/2020 and will be used with any new residents to make sure moving forward all forms are double checked. this has not been used yet since we have not had a new resident. (attached).
Administrator and or designee will check monthly to make sure everything is filled out properly.
Lastly, a new contract was created for each resident with all the new information and they will all be signed by 1/31/21. (DIRECTED: All residents shall receive a copy of the updated resident-home contract in accordance with 2600.25g. LM 1/25/21). They will be placed in the folder behind the original contract. Also a Letter will be sent out to the family about the three areas that need to be fixed in the contract. Resident rights Z was added. This will be mailed out next week with the invoices. (attached is the letter explaining the changes). A copy will also be kept in their files. Document Submission Not Implemented

Completion Date: *01/03/2021* Licensee's Proposed Date for POC Implementation 1/29/21

224a - Preadmission Screen Form

1. Requirements

2600.

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

224a - Preadmission Screen Form *(continued)*

Description of Violation

The preadmission screening for resident #6, dated 10/7/20, is incomplete and blank in numerous sections, to include the resident's level of supervision, mobility needs or ability to self-administer medications. Also, the preadmission screening does not include a determination that the home can meet the resident's needs. This section of the form is also blank.

REPEAT VIOLATION: 12/3/2019

Plan of Correction **Accept**

Resident # 6 has passed away. I placed a copy of resident # 7 completed on 12/26/20 to show that all the pre screening are being check for accuracy. (attached). An audit took place and was finished on 1/15/21 and all Pre screen were checked to make sure everyone has one and all the proper blanks are fixed. Moving forward Administrator or designee will make sure all the blanks are filled it to reflect the needs of the resident to ensure they can be managed at the home. A admission check list was created on 11-5-20 that will be used with all new residents and will be checked off by a second person to ensure all the blanks are filled out. Two staff have been identified and have been trained to know how to properly fill out forms and what to look for to make sure they are filled out. It was added to the 11-3-20 Weekly check list created for the original inspection(attached). The administrator will check the files monthly to make sure everything is attached.

1/29/21

Completion Date: *12/26/2020* Licensee's Proposed Date for POC Implementation

Document Submission Not Implemented

225a - Assessment 15 Days

1. 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 #6 was admitted to the home on 11/6/20; however, an assessment was not completed.

REPEAT VIOLATION: 12/3/2019

Plan of Correction **Accept**

Resident # 6 has passed away since the audit. The administrator and designee have been working on all the residents files since the inspection on 12/23/2020 Unfortunately she and one other person were two that the audit was not complete on due to timing. The audit on the other resident that was not completed is now complete and in the file. Completed on 1/6/2021. There was nothing cited on this inspection for the other resident so even though it was no audited there was nothing missing. We did have a copy of what was done so far on Tabula Pro for resident #6 but the auditor did not want us to print up since in was not in the file. All files are now audited. Moving forward all files will be updated in a timely manor and any new resident will have all paperwork in the files in on the day it is due. The new admissions check list will be utilized for all new residents and it will be checked off by a second person to ensure everything is in there filled out correctly (attached). Two staff have been trained and identified (attached). The administrator and or designee will check monthly and sign off on monthly checklist that everything is in file and completed. (attached.)

Document Submission Not Implemented

Completion Date: *01/06/2021* Licensee's Proposed Date for POC Implementation

1/29/21

227a - Support Plan 30 Days

1. Requirements

2600.

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

Description of Violation

Resident #6 was admitted to the home on 11/6/20; however, a support plan was not completed.

REPEAT VIOLATION: 5/18/2020 et. al.; 12/3/2019

Plan of Correction **Accept**

Resident # 6 has passed away since the audit. The administrator and designee have been working on all the residents files since the inspection on 12/23/2020 Unfortunately she and one other person were two that the audit was not complete on due to timing. The audit on the other resident that was not completed is now complete and in the file. Completed on 1/6/2021. There was nothing cited on this inspection for the other resident so even though it was no audited there was nothing missing. We did have a copy of what was done so far on Tabula Pro for resident #6 but the auditor did not want us to print up since in was not in the file. All files are now audited. Moving forward all files will be updated in a timely manor and any new resident will have all paperwork in the files in on the day it is due. The new admissions check list will be utilized for all new residents and it will be checked off by a second person to ensure everything is in there filled out correctly (attached). The administrator and or designee will check monthly and sign off on monthly checklist that everything is in file and completed. (attached.)

Completion Date: *01/06/2021* Licensee's Proposed Date for POC Implementation

Document Submission Not Implemented

 1/29/21