pennsylvania
DEPARTMENT OF HUMAN SERVICES

# CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ALEXANDRIA MANOR OF ALLENTOWN INC**
LEGAL ENTITY

To operate **ALEXANDRIA MANOR II**
NAME OF FACILITY OR AGENCY

Located at **313 S. WALNUT ST., BATH, PA 18014**
(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 **78**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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

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

and shall remain in effect from **May 7, 2021** until **May 7, 2022**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **205260**

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 628 – 01/21

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: May 7, 2021

Mr. Joseph Negrao
President
Alexandria Manor of Allentown, Inc.
7 South New Street
Nazareth, Pennsylvania 18064

RE: Alexandria Manor II
313 South Walnut Street
Bath, Pennsylvania 18014
License #: 205260

Dear Mr. Negrao:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on October 8, 2020, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Jamie L. Buchenauer

Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

# Department of Human Services
# Bureau of Human Service Licensing
# LICENSING INSPECTION SUMMARY

## Facility Information

**Name**: *ALEXANDRIA MANOR II* **License #**: *20526* **License Expiration Date**: *01/10/2021*
**Address**: *313 S. WALNUT ST., BATH, PA 18014*
**County**: *NORTHAMPTON* **Region**: *NORTHEAST*

## Administrator

**Name**: *Jacqueline Burns* **Phone**: *6108373500* **Email**: *jburns@alexandriamanor.com; lindscott@pa.gov; agraziano@pa.gov*

## Legal Entity

**Name**: *ALEXANDRIA MANOR OF ALLENTOWN INC*
**Address**: *7 SOUTH NEW STREET, NAZARETH, PA, 18064*
**Phone**: *6108373500* **Email**: *LHOHL@ALEXANDRIAMANOR.COM*

## Certificate(s) of Occupancy

**Type**: *C-2 LP* **Date**: *05/01/2002* **Issued By**: *L&I*

## Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *48* **Waking Staff**: *36*

## Inspection

**Type**: *Full* **Notice**: *Unannounced* **BHA Docket #**:
**Reason**: *Provisional* **Exit Conference Date**: *10/08/2020*

## Inspection Dates and Department Representative

*10/08/2020 - On-Site: Ryan Yankowy, Amy Deluca*

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *78* **Residents Served**: *41*

### Secured Dementia Care Unit

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

### Hospice

**Current Residents**: *4*

### Number of Residents Who:

**Receive Supplemental Security Income**: *0* **Are 60 Years of Age or Older**: *40*
**Diagnosed with Mental Illness**: *1* **Diagnosed with Intellectual Disability**: *1*
**Have Mobility Need**: *7* **Have Physical Disability**: *1*

## Inspections / Reviews

**10/08/2020 - Full**

**Lead Inspector**: *Ryan Yankowy* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/30/2020*

**12/14/2020 - POC Submission**

**Lead Reviewer**: *Anne Graziano* **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/28/2020*

**5/6/2021 - Document Submission**

**Lead Reviewer**: *Anne Graziano* **Follow-Up Type**: *Not Required*

## 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**

*License Inspection Summary (LIS) reports dated 1/7/20 and 2/20/20 were not posted in the home as required.*
*The homes provisional license was not posted in a public conspicuous area of the home.*

**Plan of Correction** **Directed**

*3c Provisional license was posted same day, along with LIS reports.*
*Moving Forward: Audit sheets will be completed to make sure current license and LIS reports are always in place and up to date. The PCH reviewed the regulations related to 3C.*
*The PCH shall be responsible for assuring all new LIS reports and license are posted upon receipt.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of Correction, the home will submit verification of compliance, such as a digital photo showing a posted POC, which incidentally does NOT contain any protected information such as a Privacy Coding.*
*The PCH will submit a copy of the current Audit sheet that is actually IN USE to demonstrate compliance.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*Please see attached*

**Update - 05/04/2021**

*photo of posting*
*AG, 5-4-21*

## 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**

*The narcotic logs were located on the side of the medication cart upon entering the home. The cart was located in the dining room near the Administrator's office not in a locked area of the home. The narcotic logs contain confidential information of the residents*

## 17 - Record Confidentiality *(continued)*

**Plan of Correction** **Directed**

*Narcotic counts have been moved to QuickMar computer system, we are no longer using narcotic signature books. Education will be provided to all caregivers related to confidentiality and regulation 17- Confidentiality. Audits will be completed monthly x 3 by the PCH to assure all confidential resident information is secured and not accessible.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of correction, the home will submit a copy of the training sign in sheet and a policy or staff instructions related to how confidential material is to be treated going forward.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*verified by RY via technology 5-6-21*

## 65a - FS Orientation 1st Day

**1. 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.

**Description of Violation**

*Direct care staff member A hired [redacted] did not complete the 1st day fire safety orientation until 2/24/20.*

**Plan of Correction** **Directed**

*Moving Forward: Admin will handle new hire paperwork and assistant to admin will follow up and audit paperwork day of hire. Education will be provided to all caregivers related to fire safety and evacuation. Audits will be completed monthly x 3 by the PCH to assure all employees are compliant with fire safety and evacuation regulations.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of Correction, the home will send a copy of the Audit Tool that is actually IN USE. If any new staff have been hired since the date of the renewal inspection, please include a copy of the employee's 1st day of fire safety orientation as well.*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

## 65a - FS Orientation 1st Day *(continued)*

**Update - 05/04/2021**

*documentation provided*
*AG, 5-4-21*

## 82a - Poisonous Materials

1. **Requirements**

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

**Description of Violation**

*An unlabeled jug of detergent was located in the 2nd floor laundry room. The jug did not have the original manufacturer's label on the jug.*

**Plan of Correction** **Directed**

*All staff was educated on importance of this regulation.*
*Moving Forward: Admin and Assistant will audit all laundry rooms and kitchen, to make sure no unlabeled bottles are in cabinets. The unlabeled jug of detergent was removed. The facility was checked for any other unmarked bottles. Staff was educated on this regulation and the need to have all containers with their original labels and stored securely.*

*Directed Plan of Correction:*
*Upon resubmission of this Plan of Correction, the home will include a copy of the sign in sheet used to educate staff on labeling and storage of poisonous materials.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/04/2021**

*documentation on training provided*

*AG, 5-4-21*

## 85a - Sanitary Conditions

1. **Requirements**

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

**Description of Violation**

*Food garbage, wrappers, and a plastic spoon were observed on the floor of the 2nd floor common area and in the stairwell.*

## 85a - Sanitary Conditions *(continued)*

**Plan of Correction** **Directed**

*All staff was educated on importance of this regulation and cleaning up after all meals. Admin and Assistant will oversee that nightshift vacuums the dining rooms. All staff educated on their role to provide sanitary conditions at our home. Audits will be completed weekly x 3 by the PCH to assure a clean sanitary environment.*

*Directed Plan of Correction:*
*Upon resubmission of this Plan of Correction, the home will submit a copy of the sign in sheet used for training purposes of re-educating staff on maintaining a clean environment and a copy of an Audit sheet that is actually IN USE.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*verified via technology by RY 5-6-21*

## 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**

*On the second floor in the memory care section there were trash cans with food garbage found uncovered in both the kitchenette area and just outside the door of the kitchenette area.*

**Plan of Correction** **Directed**

*New trash cans were on the floor with proper fitting lids. Staff will be educated on the need to report any trash receptacles without lids and the importance of this regulation. Audits will be completed monthly x 3 by the PCH to assure all trash is covered.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of Correction, the home will send in receipts for the replacement trach cans with lids as well as a copy of the Audit Tool that is actually IN USE showing verification of compliance.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/04/2021**

*receipts for trash cans provided*

*AG,5-4-21*

## 89b - Hot Water Temperature

**1. Requirements**

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

**Description of Violation**

*The water temperature of the bathroom sink located in the first floor handicapped bathroom measured 133 ° F.*

**Plan of Correction** **Directed**

*Water temp was adjusted day of inspection. Admin will do audit weekly of water temps in random places in the facility. Staff will be educated on this regulation to emphasize water temperatures safety.*

*Directed Plan of Correction:*
*If any item was purchased to correct the water temperature, such as a regulator valve, a copy of the receipt will be included in the resubmission of the Plan of Correction.*
*In addition, a copy of the Weekly Audit Sheets that are actually IN USE will be submitted with the Plan of Correction to demonstrate compliance.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*Water regulators and mixing valves were purchased*
*documentation provided*

*Verified via technology by RY on 5-6-21*

## 101j7 - Lighting/Operable Lamp

**1. Requirements**

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

**Description of Violation**

*The beds in rooms 20 and 21 had no operable bedside lighting.*

## 101j7 - Lighting/Operable Lamp *(continued)*

**Plan of Correction** **Directed**

*Light bulbs were replaced at time of inspection. Audit will be done of rooms weekly to ensure proper bedside lighting. Staff will be educated on this regulation and will be taught to immediately report any lighting concerns to the administrator. Audit will be completed by the PCH*
*weekly x one month and monthly x 3 months.*

*Directed Plan of Correction:*
*Upon resubmission of the Pan of Correction, the home will include a copy of the sign in sheet completed for the training of staff on the need for and importance of bedside lighting. Also to be included will be a copy of a Weekly Audit Sheet that is IN USE an demonstrates compliance in the measuring of compliance with this regulation.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*verified via technology by RY on 5-6-21*

## 102j - Towels/Wash Cloths Access

**1. Requirements**

2600.
102.j. Towels and washcloths shall be in the possession of the resident in the resident's living space unless the resident has access to the home's linen supply.

**Description of Violation**

*The bathroom located on the first floor across from room H2 did not have paper towels or a hand drying mechanism in the bathroom.*

**Plan of Correction** **Directed**

*Corrected day of inspection. Housekeeping was told to keep 2 extra rolls of paper towels under all sinks at all times. Audits will be completed weekly x 4 and monthly x 3.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of Correction, the home will submit verification of training to the Housekeeping staff and also a copy of a Weekly Audit Sheet that is actually IN USE in order to demonstrate verification of compliance.*
*AG, 12-10-2020.*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*receipts provided by home via portal,*
*RY verified back up supply of paper towel via technology 5-6-21*

## 103d - Storing Food Off Floor

**1. Requirements**

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

**Description of Violation**

*In the 1st floor front pantry area there was a box of 2 watermelons and a box of bananas found stored directly on the floor.*

**Plan of Correction** **Directed**

*Kitchen staff working that day were written up. Dietary staff will be educated on the regulation related to storing of food. Audits will be completed weekly x 4 and monthly x 3 by the PCH to assure compliance with this regulation.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of Correction, the home will submit a copy of the Sign In sheet for the training conducted for the Dietary Staff, as well as a copy of a current Weekly Audit Sheet that is actually IN USE to demonstrate evidence of compliance.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*RY verified via technology 5-6-21*

## 103f - Refrigerator/Freezer Temps

**1. Requirements**

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

**Description of Violation**

*On the second floor there were 2 gallon size jugs of milk left out on a table and on the kitchenette window counter, both containing a small amount of milk.*

**Plan of Correction** **Directed**

*Moving Forward: All milk is transported on a cart from the kitchen, it is no longer kept in the 2nd floor new side kitchenette. Staff will be educated on the regulation for food refrigeration and will be aware not to leave any products outside of the refrigerator in any area of the home at any time. Audits will be completed by the PCH monthly x 3 to assure compliance with this regulation.*

*Directed Plan of Correction:*
*Upon Resubmission of the Plan of Correction, the home will send in a copy of the sign In sheet for the training conducted for the Dietary Staff regarding refrigeration/frozen temperatures of food as well as a copy of the Monthly audit Tool that is actually IN USE in order to demonstrate compliance with the regulation.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

## 103f - Refrigerator/Freezer Temps *(continued)*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*RY verified via technology 5-6-21*

## 103g - Storing Food

1. **Requirements**

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

**Description of Violation**

*In the second floor kitchenette area near room 212 there were plastic bags of rice and wheat cereal found in the cupboards that were opened but not sealed.*

*A cup of ice cream that was not covered was located in the freezer located in the kitchenette near room #212.*

**Plan of Correction** **Directed**

*Food items were thrown in the trash day of inspection. Staff will be education on the regulation and the need to store food in closed or sealed containers.*
*Moving Forward: Food will not be kept in 2nd floor new side kitchenette. Audits will be completed by the PCA monthly x 3 to assure compliance with this regulation.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of Correction, the home will submit a copy of the sign in sheet regarding the education provided to the dietary staff and any other staff trained on food storage. The home will also submit a copy of a Monthly Audit Sheet that is actually IN USE to demonstrate compliance with the regulation.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*RY verified via technology 5-6-21*

## 105g - Lint Removal and Duct Cleaning

1. **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.

## 105g - Lint Removal and Duct Cleaning *(continued)*

**Description of Violation**

*A large handful of lint was located in the lint trap of the stackable dryer in the 2nd floor laundry area, posing a possible fire hazard.*

*2 dryers located in the lower level laundry area had a handful of lint located in both traps, posing a possible fire hazard.*

**Plan of Correction** **Directed**

*Lint trap was cleaned the day of inspection. Staff will be educated on the regulation with emphasis on their role of removal of the lint after each use. The Lint in the vent duct and internal and external ductwork of the clothes dryers will be cleaned by maintenance staff weekly. Audits will be completed of the logs and of the actual lint weekly x 3 by the PCH and then monthly x 3. Moving Forward: Lint trap logs have been placed in both laundry room for staff to log initials when lint is removed.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of Correction the home will send in training documentation including sign in sheets for staff that attended the Home's training session, as well as a copy of the logs that staff are initialing upon completion of the cleaning of the dryer(s) lint traps after each use, and the most recent copy of the Monthly Audit Tool of the document actually IN USE in order to demonstrate evidence of compliance.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*RY verified via technology 5-6-21*

## 121a - Unobstructed Egress

1. **Requirements**

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

**Description of Violation**

*The exit labeled #5 was blocked with a medication cart, a chair and a walker, preventing immediate egress in the event of an emergency.*

## 121a - Unobstructed Egress *(continued)*

**Plan of Correction** **Directed**

*All items were removed the day of inspection. Staff was re-educated on the importance of keeping all exits free of items. Audits will be done daily x 2 weeks, weekly x 4 and monthly x 3 by the PCH to assure compliance with unobstructed egress.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of Correction the home will submit evidence of training by sending in the sign in sheets for all staff that were trained, as well as sending in the most recent Audit Tool from the weekly audits that are actually IN USE in order to demonstrate compliance with the regulation.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*RY verified via technology 5-6-21*

## 123c - Evacuation Diagrams

1. **Requirements**

2600.
123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

**Description of Violation**

*The emergency evacuation diagrams located in the lower level do not indicate the location of the pull stations or fire extinguishers.*

**Plan of Correction** **Directed**

*The emergency evacuation diagrams located in the lower level now include the location of pull stations and fire extinguishers. All staff will be educated on the location of the evacuation diagrams and the location of the pull stations and fire extinguishers in the building. Audits will be done monthly to assure the diagrams are in place and to check staff knowledge of the same.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of Correction, the home will submit a digital photo taken of the newly posted diagram showing the updated location of the pull stations and fire extinguishers. A copy of the sign in sheets for all staff that were trained as well as a copy of the Audit Tool actually IN USE to demonstrate compliance will also be submitted.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

## 123c - Evacuation Diagrams *(continued)*

**Update - 05/06/2021**

*RY verified via technology 5-6-21*

## 124 - Notice to Fire Department

**1. Requirements**

2600.

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

**Description of Violation**

*The home did not have a notice to the fire department.*

**Plan of Correction** **Directed**

*Notice was sent to the fire department following inspection.*

*Moving Forward: Admin will send notification; assistant will follow up.*

*Directed Plan of Correction:*

*Upon resubmission of the Plan of Correction, the home will include a copy of the 124 letter to the local fire department along with evidence that it was sent.*

*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*RY verified via technology 5-6-21*

## 131f - Fire Extinguisher Inspection

**1. Requirements**

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

**Description of Violation**

*The fire extinguishers located on the second floor had expired inspection tags. The inspections of the fire extinguishers had expired on 7/20/20.*

## 131f - Fire Extinguisher Inspection *(continued)*

**Plan of Correction** **Directed**

*Call was placed to Simplex to have them come out to inspect fire extinguisher. All fire extinguishers will be inspected. An audit will be completed every 12 months by the PCH to assure ongoing compliance that all fire extinguishers have been inspected annually.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of correction, the home will send in copies of the new tags with current dates.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*RY verified via technology 5-6-21*

## 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**

*Fire drills conducted during sleeping hours took place on 4/22/19 and 11/16/19, more than 6 months apart.*

**Plan of Correction** **Directed**

*Admin is responsible for fire drills, Assistant will audit. An audit will be completed every 6 months by the PCH to assure that fire drills are completed during sleeping hours once every 6 months.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of Correction, the home will submit their current fire drill log, along with a plan, anticipating a post pandemic set of dates to implement fire drills, to include an overnight fire drill that will re-set the calendar onto a six month schedule as quickly as possible.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*The home has a plan to resume fire drills in better weather as long as there is no risk of C-19 and they will run an O N drill when possible.*

*AG, 5-6-21*

## 183b - Meds and Syringes Locked

1. **Requirements**

2600.

## 183b - Meds and Syringes Locked *(continued)*

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 the 1st floor in the newer area of the home there was a med cart found with unlocked medications stored on the side compartment of the cart. The medications found were: Nystop, Betamethasone cream, Clotrimazole cream, and Mupirocin ointment.*
*Resident #1's calmoseptine ointment was unlocked and accessible in the residents room.*

**Plan of Correction** **Directed**

*Med tech on duty was written up, All medication are kept in locked med cart at all times. All staff involved with medications will be educated on this regulation and the expectation to keep medications secured at all times. An Audit will be completed by the PCH every week x 3 weeks and then monthly x 3 to assure compliance.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of Correction, the home will include the sign in sheets for the med techs trained in this topic, as well as a copy of the Audit Tool used to measure compliance for this reg that is actually IN USE for this item.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*RY verified via technology 5-6-21*

## 184a - Labeling OTC/CAM

**1. Requirements**

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

**Description of Violation**

*Resident #2's pharmacy label attached to liquid tylenol does not indicate what the medication is.*

## 184a - Labeling OTC/CAM *(continued)*

**Plan of Correction** **Directed**

*Corrected day of inspection after speaking with pharmacy.*
*Moving Forward: All medication will have proper names of medication listed.*
*All bottles were checked for all residents to assure the medication was noted on the label. Staff will be educated on the need to have all medication labeled and to make PCH aware of any unlabeled medications that does not include the name of the medication. PCH will conduct monthly audits x 3 to assure compliance.*

*Directed Plan of Correction:*
*Upon resubmission of this Plan of Correction, the home will submit the a copy of the Month Audit tool that is most currently IN USE in order to demonstrate compliance. The home should also schedule a regular review of medication that arrives at the home to ensure it is properly labeled prior to storing in the home's medication cart(s).*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*RY verified via technology 5-6-21*

## 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**

*Resident #2's miralax and tylenol do not have the residents name on the bottle.*

**Plan of Correction** **Directed**

*Pharmacy and Med Techs were contacted to regarding this issue and the need to include resident's name on the bottles. This has been corrected for that resident identified. All bottles were checked to assure residents names were included on the bottles. Staff will be educated on the need to have all medications labeled with residents name on the bottle. PCH will conduct monthly audits x 3 to assure compliance with this regulation.*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*RY verified via technology 5-6-21*

## 185a - Implement Storage Procedures

1. **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.

## 185a - Implement Storage Procedures *(continued)*

**Description of Violation**

*Resident #3's narcotic count sheet noted 83 pills when 79 pills were available in the medication card.*

*Resident #1's glucometer was not calibrated to the correct date and time.*

**Plan of Correction** **Directed**

*Staff will be educated on the importance of accurate account of narcotics and the need to Immediately report any discrepancy related to the count of narcotics to the PCA. Glucometers will be calibrated to date and time at initial use when it first arrives from the pharmacy. Audits will be done by nightshift . Audits will be completed of the narcotic sheets to assure no discrepancies. This audit will be completed by the PCH every month x 3 months. Audits will be completed to check the calibration of the glucometer monthly x 3.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of Correction, the home will submit the sign in sheets for the staff that attended trainings related to narcotic counting and discrepancy findings, as well as glucometer calibrations. The home will also submit a copy of a current Monthly Audit tool currently IN USE to verify regulatory compliance.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*RY verified via technology 5-6-21*

## 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:
4. Strength.
6. Dose.

**Description of Violation**

*Resident #4's sliding scale of insulin is not noted on the MAR.*

## 187a - Medication Record *(continued)*

**Plan of Correction** **Directed**

*The sliding scale was placed on the MAR for this resident # 4. All residents with sliding scale orders were checked to assure all had this information on the MAR. Staff will be educated on the need to assure sliding scale in located on the MAR if ordered by the physician. An Audit will be completed monthly x 3 by the PCH for compliance with documentation of physician's orders on the MAR as it pertains to sliding scale for insulin.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of Correction the home will include a copy of the sign in sheet with signatures of staff trained on documentation in the MAR, as well as following DR orders on administering insulin, including dosing and strength. The home will also include a copy of the current Audit Tool sheet currently IN USE to demonstrate compliance with this regulation.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*RY verified via technology 5-6-21*

## 187d - Follow Prescriber's Orders

1. **Requirements**

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

**Description of Violation**

*Resident #1 has an order form metoprolol suc er 50mg 2x daily, hold for systolic blood press less than 100 or heart rate less than 55. On 10/2/20 at 8pm the heart rate was 52 and the medication was administered. On 10/3/20 at 8am the heart rate was 51 and the medication was administered.*

*Resident #1 has an order for 20 units of Novolog 3x daily hold if blood glucose is less than 120. On 10/2/20 at 6am the blood glucose was 94 and on 10/3/20 the blood glucose was 119. The medication was given and should have been held.*

**Plan of Correction** **Directed**

*Moving Forward: Medtechs involved faced disciplinary action for not following prescribed orders. All medtechs were educated on the importance of following directions of the prescriber Audits will be completed weekly x 4 and monthly x 3 to ensure proper compliance.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of Correction the home will include documentation of training provided to med techs regarding how they will follow prescriber orders. The home will also include a copy of the most recent Weekly Audit tool that is actually IN USE to demonstrate compliance. This tool will include any findings included in the audit and any corrective action taken, if necessary.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

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

**Document Submission** **Implemented**

*please see attached*

**Update - 05/06/2021**

*RY verified via technology 5-6-21*

## 227h - Support Plan Refuse Sign

**1. Requirements**

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

**Description of Violation**

*The Resident Assessment and Support Plans for residents #1, #5, and #6 were not signed by the resident nor did the signature pages indicate if the resident refused to sign the plans.*

**Plan of Correction** **Directed**

*The support plans for the residents 1, 5 and 6 were updated. All resident support plans were reviewed for compliance with this regulation. Staff will be educated on this regulation and the need to either have the resident sign the support plan or to mark that the resident refuses or chooses not to sign the support plan. Audits will be completed monthly x 3 by the PCH to assure compliance with this regulation.*

*Directed Plan of Correction:*
*Upon resubmission of the Plan of Correction, the home will submit a copy of each of the signed support plans for Resident #s 1, 5 and 6. Ann annual or new support that has been completed since the renewal inspection will also be included in the resubmitted Plan of Correction to demonstrate evidence of compliance with resident signed support plans. If the resident refused or was unable to sign, there will be documentation indicating that was the case, with staff initials and a date.*
*A monthly Audit Tool sheet that is currently IN USE will also be included as evidence of compliance.*
*AG, 12-10-2020*

**Completion Date:** *12/02/2020*

**Document Submission** **Implemented**

*please see attached*

**Update - 05/04/2021**

*copies of the documents in questions were returned via the portal.*

*AG, 5-4-21*

*RY verified via technology 5-6-21*