



pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAILING DATE: July 1, 2022

[REDACTED]
ARK MANOR LLC
105 SANDRA DRIVE
DELMONT, PA, 15626

RE: ARK MANOR
105 SANDRA DRIVE
DELMONT, PA, 15626
LICENSE/COC#: 44686

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on September 17, 2021, September 20, 2021, September 21, 2021, and September 22, 2021, of the above facility, we have determined that your submitted plan of correction is not implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

A handwritten signature in black ink, appearing to read "Jon Kimberland".

Jon Kimberland
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *ARK MANOR* License #: *44686* License Expiration: *02/19/2022*
Address: *105 SANDRA DRIVE, DELMONT, PA 15626*
County: *WESTMORELAND* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: *7244686200* Email: [REDACTED]

Legal Entity

Name: *ARK MANOR LLC*
Address: *105 SANDRA DRIVE, DELMONT, PA, 15626*
Phone: *7244686200* Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *06/23/2006* Issued By: *L & I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *57* Waking Staff: *43*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint* Exit Conference Date: *09/22/2021*

Inspection Dates and Department Representative

09/17/2021 - Off-Site: [REDACTED]
09/20/2021 - On-Site: [REDACTED]
09/21/2021 - On-Site: [REDACTED]
09/22/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *70* Residents Served: *46*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *13* Are 60 Years of Age or Older: *40*
Diagnosed with Mental Illness: *12* Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *11* Have Physical Disability: *0*

Inspections / Reviews

09/17/2021 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/10/2021*

12/20/2021 - POC Submission

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *12/24/2021*

06/09/2022 - Document Submission

Reviewer: [REDACTED] Follow-Up Type: *Exception* Follow-Up Date:

3c - Post Current License

1. Requirements

2600.

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

Description of Violation

On 9/20/21, at approximately 11:55 a.m., a copy of the most recent licensing inspection summaries dated 10/31/19, 3/10/20, 9/2/20, 1/20/21, 1/28/21, 4/1/21, 4/16/21 and 7/21/21 were not posted in a conspicuous and public place anywhere in the home.

Plan of Correction**Accept**

A copy of all licensing inspection summaries were posted on 9/20/21 with Inspector present. Administration will check monthly that all the proper postings are posted in a conspicuous and public place and have not been removed. It is the responsibility of Administration to keep in compliance with this regulation. Checklist available and kept in recent inspection folder

Completion Date: 09/20/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK
Implemented**Document Submission**

Attachment A

18 - Compliance With Laws

1. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

On 9/20/21, the homes boiler (364319B) that heats the home was not operational and tagged "OUT OF SERVICE" on 9/9/21. On 3/12/21, The Department of Labor and Industry agents had conducted an inspection and deficiencies were cited. On 3/18/21, the home was issued a "Notice of Violation", to correct identified deficiencies. On 4/23/21, an "Order to Show Cause" was issued for failure to correct deficiencies cited on 3/12/21.

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. On 9/21/21, no carbon monoxide detectors were present in the kitchen of the home in accordance with The Care Facility Carbon Monoxide Alarms Standards Act. The home has a gas stove in the kitchen.

Plan of Correction**Accept**

*Boiler was re-inspected on 9-28-21 (invoice available and kept in recent inspection folder)
On 11-5-21 two new high-efficiency boilers were installed in the facility (documentation kept)
Carbon Monoxide detectors were purchased and placed in the kitchen area on 10-6-21.
(receipt available in recent inspection folder). On 12-13-21, Executive Director, Administrator and Administrative Assistant reviewed the regulation as a training and checked the rest of the home for compliance.*

A Weekly walk-through to be sure these items are in compliance will be done and documented by Administration

Completion Date: 12/20/2021 Licensee's Proposed Date for POC Implementation

18 - Compliance With Laws *(continued)*

6/8/22

Implemented**Document Submission***Attachment B*

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

On 9/20/21, the resident home contract for resident #1, dated [REDACTED] 2020, was not signed by the resident. There was no indication the resident was unable to or refused to sign the contract.

Plan of Correction

Resident #1 no longer resides in the facility

Accept

Administration checked all other Resident files for accuracy of signed contracts. A new Checklist including a line for signed contract will be included in all new Resident files. The checklist Will not be put in the file until it is complete. (Documentation available In recent inspection folder)

Completion Date: 11/29/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK

Implemented**Document Submission***Attachment C*

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).

Description of Violation

Direct care staff person A, hired [REDACTED] 2020, did not have a criminal background check completed until, 9/21/21. Direct care staff person A worked unsupervised in the home providing direct care, to include the following dates:

- * 9/5/21 from 2:00 p.m. to 10:00 p.m.*
- * 9/8/21 to 9/10/21 from 6:00 a.m. to 2:00 p.m.*
- * 9/13/21 from 6:30 a.m. to 2:00 p.m.*
- * 9/14/21 from 7:30 a.m. to 2:00 p.m.*
- * 9/15/21 from 6:00 a.m. to 2 00 p.m.*

Plan of Correction

Criminal history check for Staff person A was completed 9/21/21. All other Employee files were reviewed by administration to be sure they had the proper criminal history checks.

A new form to be filled Out at the time of hire was made by Administrator. This form will be kept on Administrator's desk until every item is checked off. At that point it will be put in their file(Documentation of form and criminal history check are Kept in recent inspection file).

Accept

51 - Criminal Background Check (continued)

We disagree with this regulation being cited as a violation. When we received the list of regulations that were on hold, that is all we received, just a list of regulations, no stipulations to follow. I understand and received the stipulations of these regulations, but only after asking for them. There is no way that any of the homes could know about the stipulations, because we never received them from [REDACTED]

Completion Date: 09/21/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK

54a - Direct Care Staff

Not Implimented

1. Requirements

2600.

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

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

On 9/21/21, direct care staff person A, hired [REDACTED] 2020, does not have a high school diploma, a GED or active registration status on the Pennsylvania nurse aide registry. Direct care staff person A worked in the home providing unsupervised direct care, to include the following dates, to include:

* 9/5/21 from 2:00 p.m. to 10:00 p.m.

* 9/8/21 to 9/10/21 from 6:00 a.m. to 2:00 p.m.

* 9/13/21 from 6:30 a.m. to 2:00 p.m.

* 9/14/21 from 7:30 a.m. to 2:00 p.m.

* 9/15/21 from 6:00 a.m. to 2 00 p.m.

Plan of Correction

Accept

Although staff Person A claimed to have a GED it was not obtained and given to the Home.

Staff person A was taken off the schedule for direct care. Staff person A now does only Ancillary work. All other employee files were checked for accuracy by Administration. A new Staff checklist was made by Administration to include GED or Diploma line. This checklist will stay on Administrators desk and will not be put in the file until it is complete. (Documentation of checklist will be kept in the recent inspection folder)

Completion Date: 12/10/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK
Implemented

Document Submission

Attachment D

57c - 2 Hours/Day**1. Requirements**

2600.

57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

The home is required to provide a minimum of 1 hour of personal care services for each mobile resident and 2 hours of personal care services for each resident with mobility needs. On 9/11/21, there were 46 residents residing in the home, 11 residents with mobility needs, including one resident requiring 2-person assistance in transfers requiring a total minimum of 57 direct care hours. On this day, only 54 hours of direct care staffing were provided.

57c - 2 Hours/Day (continued)

On 9/15/21, there were 46 residents residing in the home, including 11 residents with mobility needs, including one resident requiring 2-person assistance in transfers requiring a total minimum of 57 direct care hours. On this day, only 53 hours of direct care staffing were provided.

On 9/18/21, there were 46 residents residing in the home, including 11 residents with mobility needs, including one resident requiring 2-person assistance in transfers requiring a total minimum of 57 direct care hours. On this day, only 52 hours of direct care staffing were provided.

Plan of Correction**Accept**

Administrator immediately on the day of inspection 9-22-21, checked the current schedule for accuracy in staffing. There were enough staff on to cover all shifts. Administrator will review schedules as they are made, and initial the schedules indicating there is enough staffing to cover.

This violation is being disputed due to the following:

For 46 Residents plus one 2 person assist means we needed a total of 47 hours of which 35.25 must be during waking -(6am-10pm), and at least 11.75 on overnight.

9/11/21: two people times eight hours each is 16-4 hours for cooking= 12 + 3 Aides on afternoon x 8 hours each is 24. That ended up as 12 + 24= 40 on day shift and 2 aides x 8 hours each on night shift = 16 hours, both waking a non-waking or over the required time.

9/15/21: 4 people x 8 hours each is 32 hours- 8 hours for a cook is 24+ 2 aids on the afternoon is 16, so it would be 24 + 16 = 40 hours on waking hours and 2 aids x 8 hours each on Night Shift equals 16 hours. Both waking anon waking hours are over the required time.

9/15/21: four people times eight hours each is 32 hours -8 hours for a cook is 24+2 aids on the afternoon is 16, so you have 24+ 16 = 40 hours on waking hours and 2/8x8 hours each on Night Shift equals 16 hours. Both waking anon waking hours are above the required time.

9/15/21: four people times eight hours each is 32 hours -8 hours for a cook is 24+2 aids on the afternoon is 16, so you have 24+ 16 = 40 hours on waking hours and 2/8x8 hours on each Night Shift equals 16 hours. Both waking anon waking hours are about the required time.

9/18/21: Two people times eight hours each is 16 hours +3 aids times eight hours on afternoon is 24. So it would be 16 hours +24 hours equals 40 hours for waking hours and 2 aids x 8 hours each is 16 hours. Both waking a normal working hours are above the required time.

Completion Date: 12/14/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK
Implemented

Document Submission

Attachment E

57d - Waking Hours**1. Requirements**

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

The home is required a minimum of 1 hour of personal care services for each mobile resident and 2 hours of personal care services for each resident with mobility needs.

On 9/11/21, there were 46 residents residing in the home, including 11 residents with mobility needs including one

57d - Waking Hours (continued)

resident requiring 2-person assistance in transfers, requiring a total minimum of 42.75 direct care staffing during waking hours. On this day, only 40 hours of direct care staffing were provided during waking hours.

On 9/15/21, there were 46 residents residing in the home, including 11 residents with mobility needs, including one resident requiring 2-person assistance in transfers requiring a total minimum of 42.75 direct care staffing during waking hours. On this day, only 38 hours of direct care staffing were provided during waking hours.

On 9/18/21, there were 46 residents residing in the home, including 11 residents with mobility needs, including one resident requiring 2-person assistance in transfers requiring a total minimum of 42.75 direct care staffing during waking hours. On this day, only 39 hours of direct care staffing were provided during waking hours.

Plan of Correction**Accept**

Administrator immediately on the day of inspection 9-22-21, checked the current schedule for accuracy in staffing. There were enough staff on to cover all shifts. Administrator will review schedules as they are made, and initial the schedules indicating there is enough staffing to cover.

This violation is being disputed due to the following:

For 46 Residents plus one 2 person assist means we needed a total of 47 hours of which 35.25 must be during waking -(6am-10pm), and at least 11.75 on overnight.

9/11/21: two people times eight hours each is 16-4 hours for cooking= 12 + 3 Aides on afternoon x 8 hours each is 24. That ended up as 12 + 24= 40 on day shift and 2 aides x 8 hours each on night shift = 16 hours, both waking a non-waking or over the required time.

9/15/21: 4 people x 8 hours each is 32 hours- 8 hours for a cook is 24+ 2 aids on the afternoon is 16, so it would be 24 + 16 = 40 hours on waking hours and 2 aids x 8 hours each on Night Shift equals 16 hours. Both waking and non waking hours are over the required time.

9/15/21: four people times eight hours each is 32 hours -8 hours for a cook is 24+2 aids on the afternoon is 16, so you have 24+16 = 40 hours on waking hours and 2/8x8 hours each on Night Shift equals 16 hours. Both waking and non waking hours are above the required time.

9/15/21: four people times eight hours each is 32 hours -8 hours for a cook is 24+2 aids on the afternoon is 16, so you have 24+16 = 40 hours on waking hours and 2/8x8 hours on each Night Shift equals 16 hours. Both waking and non waking hours are about the required time.

9/18/21: Two people times eight hours each is 16 hours +3 aids times eight hours on afternoon is 24. So it would be 16 hours +24 hours equals 40 hours for waking hours and 2 aids x 8 hours each is 16 hours. Both waking and non waking hours are above the required time.

Completion Date: 12/14/2021

Licensee's Proposed Date for POC Implementation

6/8/22 JK

Document Submission**Implemented**

Attachment E

63a - First Aid/CPR Training**1. Requirements**

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 9/20/21 and on 9/21/21, at approximately 12:00 p.m., there were 46 residents in the home, no staff on duty were

63a - First Aid/CPR Training (continued)

able to demonstrate having current training in first aid and certified in obstructed airway techniques and CPR

Plan of Correction**Accept**

CPR class was scheduled immediately and done on 9/21/21 the day of inspection with Inspector present. A second training was done on 12-13-21. The goal is always to have all Employees trained, which is usually done, but due to COVID, hard to get Trainers in. Not that it fixes the situation, but the staff present had been trained, but weren't current. Administrator went through all other files to be sure everyone that could be was trained. Administration will review each schedule, and initial the schedule indicating that there are the adequate amount of CPR trained staff on duty for every shift. (Documentation of class and initialed schedules will be kept in recent inspection file)

Completion Date: 12/20/2021 **Licensee's Proposed Date for POC Implementation**

6/8/22 JK

Not Implimented

85a - Sanitary Conditions**1. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 9/20/2020, the following unsanitary conditions were found in the common bathroom (room 415) in Wing 4 to include:

* The walk-in shower stall on the right was identified as the only shower being used in this bathroom. At approx. 10:00 a.m., there was a large clump of brown hair lying on the shower drain approx. 2" diameter.

* The sink had what appeared to be feces on the right edge and down right side of sink as well as, and inside sink bowl on back left side.

* The exhaust fan in ceiling above toilet has a layer of dust/dirt on slats covering the openings between the slats preventing air flow.

On 9/20/21, at approximately 10:15 a.m., there was a layer of dirt/dust approximately 1/2" thick on the slats and between the slats of the exhaust vent in the ceiling by the window in staff/visitor bathroom #413.

On 9/20/21, at approximately 11:55 a.m., there were three used surgical gloves in the file holder on the left wall by the table in the vending room.

On 9/20/21, there were approximately 11 cigarette butts on the concrete pad and approximately 30 cigarette butts in the grassy area on each side of the pad and a payday candy wrapper with tiny red ants crawling all over it and a Blue Bunny Ice Cream cup lid on the ground of the left side of the concrete pad. The concrete pad is on the exterior side of the emergency exit doors in the hallway between Wing 3 and 4 and identified as the designated smoking area.

On 9/20/21, the interior of the Toshiba Microwave had a heavy concentration of dried food spatter on the inside roof of the microwave in the dining room on the counter.

On 9/20/21, there was a 1/4" layer of dust/dirt in and on slats of the ceiling exhaust fan in the private bathroom in bedroom #403.

On 9/20/21, at approximately 12:55 p.m., there were no paper towels, mechanical air blower, or other sanitary method of hand drying in the shower room/hair salon in Wing #3.

85a - Sanitary Conditions (continued)

On 9/20/21, there was a 2" smear of a brown substance that was dried on wall above the light switches and a large area of brownish spatter or speckles on the wall and the exhaust vent had a heavy concentration of dust/dirt on and in between the slats in the [REDACTED] shared bathroom off bedroom #201.

On 9/20/21, the exhaust fan above the toilet has a heavy concentration of dust/dirt approximately ½" thick with dust hanging down approximately 1" from the vent slats in multiple areas in the Shower room in Wing #2.

On 9/20/21, the following was observed around the exterior of the home in areas that are not identified as a designated smoking area, to include:

- At 11:43 a.m., there was a rusted coffee can with approximately 50 cigarette butts on the walkway next to a tan resin chair. A few feet from the kitchen emergency exit. A freshly extinguished Marlboro cigarette butt was on the walkway between the can and the chair.
- At 1:40 p.m., under the covered patio at the front of the home, there were approximately 25 cigarette butts lying around the rattan furniture on the patio and approximately 25 cigarette butts under the shrubbery just off the patio facing the front of the home.
- At approximately 1:50 p.m., there were 22 cigarette butts and a heavy accumulation of dried leaves around the bench and ground at the front entrance and area around front entrance.

Plan of Correction**Accept**

Immediately on the day of inspection, the staff was made aware of the unsanitary conditions listed above. Administration and all other Staff began cleaning throughout the building. An individual training will be done with each Staff member by 12/31/21 with documentation kept. The training will include the need to report to administration any areas that are in need of attention. There has not been a housekeeper at all times due to staffing. Housekeepers were contracted to come in to do some heavy cleaning. Administration will do walkthroughs of the facility inside and out to ensure all areas of the facility are in good repair and all sanitary conditions are maintained.

A Checklist was made by Administration to check for compliance and be made aware of any new conditions.

Completion Date: 12/31/2021

Licensee's Proposed Date for POC Implementation

6/8/22 JK

Not Implimented

85b - Infestation**1. Requirements**

2600.

85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On 9/20/21, at approximately 11:10 a.m., there was still evidence of live small flying insects identified as "drain flies/fleas flying" in the stairway and basement. The door to the basement is in the back of the dining room, when opened multiple drain flies/fleas flew into the dining room. There was also an ample amount of dead drain flies/fleas along the sides and corners of the steps to the basement and along the basement floor and edges of the walls.

Plan of Correction**Accept**

On 9-16-21, 4 days before inspection a local pest company was called in to access the basement area. The home was aware of the problem Before inspection, and was already taking care of it. The infestation was drain flies in the basement where the boiler is located. No Residents ever go to that area. The Company treated for this problem, but said it may take some time to get rid of them. They are like little gnats that are very hard to get rid of. On 9-17-21

85b - Infestation (continued)

RotoRooter came in and cleaned the sewer pipe to allow for maximum flow. Upon a recent walkthrough, it was found that there are still some remaining. On 12-14-21, A maintenance [REDACTED] started cleaning the basement thoroughly, using a shop vac for the water, and then [REDACTED] will set up a dehumidifier to dry things up. (Dehumidifier and new shop vac were purchased on 12-14-21.)The drain flies like water, so this should deter them. Once the basement is dry it will be rechecked by Administration, and if any further treatment needs done, it will be scheduled. (documentation available in recent inspection folder)

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

Document Submission

Attachment I, J, K, L and M

6/8/22 JK
Implemented

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 9/20/21 at approximately 10:15 a.m., there was no lid on or near the large trash can in the staff/visitor bathroom #413. The trash can was approximately 1/4 full of paper towels.

Plan of Correction

On 9-20-21 the Trash can in staff/visitor bathroom was covered. All other trash cans in the kitchen and bathrooms were checked to be sure they were in compliance. Individual training will be done with Staff by Administration by 12/31/21

Weekly walkthroughs will be done by Administration to ensure all shared bathrooms/public bathrooms/kitchen all have a covered trash can

(Documentation kept in recent inspection folder)

Accept

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

Document Submission

Attachment N and O

6/8/22 JK
Implemented

88a - Surfaces**1. Requirements**

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 9/20/21, approximately 61 inches of the interior right side of the door frame trim has been broken off from the bottom up and is missing in the common bathroom #415 in wing 4.

The interior bottom side of the left emergency exit door in the hallway between wing #3 and #4 is rusting out. There is an area measuring approximately 13" across the bottom where it is rusted and approximately 4" of that area has rusted through leaving a hole in the door.

88a - Surfaces (continued)

Plan of Correction

Accept

The interior right side of door frame was fixed on 9/22/21 by Maintenance [redacted]. Maintenance [redacted] tried to order an exterior door for the exit door between wing #3 & wing #4 through several places. The size is not available. A second Maintenance person was brought in on 12-14-21 and same conclusion. [redacted] did find a way to repair, so when items arrive, the repair will be done. Both maintenance people have agreed to try to find that size door elsewhere. Individual training will be done with all Staff by 12/31/21 to include this regulation.

Administration will do walk throughs weekly with documentation to check that all areas are clean/good repair and free of hazard
(documentation available in inspection folder)

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK

Document Submission

Not Implemented

Attachment P

89a - Water Pressure

1. Requirements

2600.

89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 9/20/21, the sink to the left of the microwave in the dining room does not have any running hot water. When the hot water handle is turned no water comes out of the faucet, only the cold-water handle works.

Plan of Correction

Accept

Faucet in dining room was replaced on 12/7/21 by Maintenance [redacted] (receipt in recent inspection folder). All other faucets were checked by Administration.

Administration will do individual training with all Staff by 12/31/21 on The importance of reporting anything that is broken and needing repair to include hot and cold water pressure. (documentation kept in recent inspection folder)

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK

Document Submission

Implemented

Attachment Q and R

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

On 9/20/21, the hot water temperature at the sink in the private bathroom of bedroom #403, measured 147.4 degrees Fahrenheit at 12:20pm. On 9/21/21, a recheck of the hot water at the private bathroom sink measured 155.1 degrees Fahrenheit at 10:30 a.m.

Plan of Correction

Accept

After trying to regulate temperatures, it was determined that a new hot water tank was needed. A new hot water

89b - Hot Water Temperature (continued)

tank was purchased 10/1/21 and installed on same day. Random checks with documentation of 3 sinks per week for 1 month and then monthly thereafter will be done by Administration (documentation kept)

Completion Date: 12/20/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK

Not Implemented

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

On 9/20/21, at 12:31p.m. there were no emergency phone numbers posted on or near the telephone on the table in phone room off the large living room.

Plan of Correction

Accept

Emergency numbers were posted near the phone off the large living room by Administration on 9/21/21, day of inspection. The emergency number list was found under a book when posting the new one. Administration will re-educate all staff individually by 12/31/21.

Administration will check the emergency numbers monthly with documentation to ensure that all phones with an outside line have the emergency numbers posted (documentation kept)

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK

Document Submission

Implemented

Attachment T and U

100a - Exterior - Free of Hazards**1. Requirements**

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The emergency egress route from the emergency exit in hallway between Wing 3 and Wing 4 is a large grassy area between the two sides of the building. At the far end of the yard is a gate on the left that leads to a concrete walkway. The concrete is in disrepair in several areas posing a trip/fall hazard. The concrete is crumbling and cracked in an area, measuring approximately 34" by 3" and approximately 1" deep and the other measures approximately 5' by 10" and approximately 1/2" deep.

On 9/20/21, there two boards on the wooden deck off the living room, that are loose, the screws are stripped. The boards closest to the door, when stepped on lift at the far end approximately 1/2" to 1", including one board measuring approximately 67" by 5 12" and the one next to it measures 12' by 5 1/2" lifts approximately 1/2".

On 9/20/21 at approximately 1:20p.m., the following furniture was leaning up against the exterior side of the home by the exit door to Wing 1, to include:

- *A twin box spring and mattress with head/foot board under heavy plastic There was dirty water puddled on top of the*

100a - Exterior - Free of Hazards (continued)

plastic and dried leaves all around. Interviews indicated bed had been placed there about a month and a half ago.

- Uncovered green vinyl mattress leaning against another mattress. The mattresses were in poor condition with small holes on the sides.

On 9/20/21, there was an iron framed bench with wooden slats next to the large propane tank in the covered patio area. The bench was in disrepair. A wooden slat was secured to the front seat. The rest of the slats are broken and/or missing. There is an unsecured slat across the back of the seat. There are several broken pieces of wood with sharp splintered edges face up leaning against the bench.

Plan of Correction**Accept**

On 12-14-21, Maintenance [REDACTED] repaired the concrete in disrepair at the emergency exit between wing #3 and wing #4. Cement mix was used to fill it in. All other concrete was checked, and it looks like anything else that might need small repair is not dangerous, so it will be done in better weather. The wooden deck was accessed and it was determined that it needs brackets underneath to brace it up. This will be completed by Maintenance [REDACTED] by 12-31-21

All furniture outside exit door in Wing 1 was removed by Maintenance and Staff and placed in dumpster on 9/27/21. Iron framed bench with wooden slats was removed by Administration on 9/22/21. Administration will do a Weekly walk around the building, to be sure that everything is in good repair and free of hazards. An Individual training will be done by administration with all staff on the importance of this regulation by 12/31/21. (Documentation kept in recent inspection folder)

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK

Document Submission**Implemented**

Attachment P

101j1 - Mattress Fire Retardant**1. Requirements**

2600.

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

1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

On 9/20/21, resident #2's green vinyl mattress is in disrepair. There is a long crack measuring approximately 18" that has pulled apart exposing the white stitching that is holding mattress together. There are 2 small holes in vinyl at bottom outside corner.

On 9/20/21, resident #3's green vinyl mattress is in disrepair. There is a crack across the width of the bed from edge of binding out approximately 13" as well as other smaller cracks in the vinyl. There are several holes to include a 1" ole exposing the spring in bedroom # [REDACTED]

Plan of Correction**Accept**

On 9-21-21 day after inspection the mattresses for Resident #2 and Resident #3 were disposed of and replaced with good ones. All other mattresses were checked by Administration & Staff to be sure they were in good repair. Since all were good, a monthly check by administration or designee will be done with documentation to check all mattresses for compliance with this regulation. Administration will do an individual training with all Staff by

101j1 - Mattress Fire Retardant (continued)*12/31/21.(documentation will be kept in recent inspection folder)***Completion Date: 12/31/2021** Licensee's Proposed Date for POC Implementation6/8/22 JK
Not Implimented**101j3 - Bed/Linens/Pillows/Blankets****1. Requirements**

2600.

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

3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 9/20/21, the blue fitted sheets on the bed of resident #3 had brown stains and brownish coloring from the front side towards middle. The white pillowcase had an odor and appeared dirty with a greyish, brownish coloring on left side of pillowcase in bedroom # [REDACTED] in Wing # [REDACTED]. The resident nor staff interviewed could indicate when the resident sheets were last changed.

Plan of Correction**Accept**

Sheets on bed #3 were changed on 9/21/21. Administration made a schedule for bed changing to be followed by Housekeeping and all staff. All beds will be on a schedule weekly to be changed. A resident checkless will be used to date and initial all bed changes. The list will stay in the med room, and be given to administration weekly. Administration will then check it to be sure that this task is being done. An individual training will be done with all staff by 12/31/21 to go over this regulation and the importance of following. (documentation will be kept in recent inspection folder)

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation6/8/22 JK
Not Implimented**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

On 9/20/21 at approximately 12:15 p.m., resident #2 bedside light was inoperable. There was no source of light that can be turned on/off from the resident's bedside.

On 9/20/21, at approximately 1:22 p.m., resident #3 bedside lamp was not operable. There was no source of light that can be turned on/off from the resident's bedside in bedroom # [REDACTED].

On 9/20/21, there are no lamps or other source of lighting at the bedside of residents #4 and resident #5 in bedroom # [REDACTED]. Neither of the residents have a source of light that can be turned on/off from the resident's bedside.

Plan of Correction**Accept**

On 9/21/21 proper bedside lighting was placed in Resident #2, #3, #4 and #5 bedside. All other rooms were checked by administration and designated staff To be sure that they had the required lighting. Any lighting needed was added.A checklist to include this regulation will be done weekly for one month, then monthly thereafter. Administration will do An individual training by 12/31/21 with all staff. This will include the importance of this

101j7 - Lighting/Operable Lamp (continued)

regulation. (documentation of training and checklist will kept in recent inspection folder)

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK
Not Implimented

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface**1. Requirements**

2600.

102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

On 9/20/20, the grab bar measuring approximately 43" long and was not secure in the common bathroom #415 in wing 4. The bar has movement of approximately 1/2" on the right side when pulled on and the cover over the screws on the right is loose and pulling away from the wall.

Plan of Correction

Accept

On 9-22-21 the Maintenance [REDACTED] fixed the Grab bar in bathroom in wing #4. Administration checked all other toilet and bath areas. Maintenance [REDACTED] walked through and checked all other toilet and bath areas to be sure they had The required items from this regulation and that they were tightened. Administration will do an individual training by 12/31/21 for all staff on this regulation and it's importance. Administration Will do monthly walk-throughs with documentation to stay in compliance. (Documentation kept in recent inspection folder)

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK
Implemented

Document Submission

Attachment P

103g - Storing Food**1. Requirements**

2600.

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

Description of Violation

On 9/21/21 at approximately 9:30 a.m., there was food that was open and unsealed in the kitchen, to include: a bag of eight count Gordon Hamburger Buns on a wooden hutch and three 16 oz. bags of Lays Potato Chips approximately 1/4 full on a wall ledge.

Plan of Correction

Accept

All unsealed food was disposed of on 9/21/21, day of inspection by Administration. Administration will do individual training with each staff by 12/31/21 on the importance of this regulation. Kitchen Staff was instructed to check food storage areas daily. Administration will randomly check areas also.(documentation kept in recent inspection folder)

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK
Not Implimented

104b - Dishes/Glassware/Utensils

1. Requirements

2600.

104.b. Dishes, glassware and utensils shall be provided for eating, drinking, preparing and serving food. These utensils must be clean, and free of chips and cracks. Plastic and paper plates, utensils and cups for meals may not be used on a regular basis.

Description of Violation

On 9/20/21, at approximately 9:00 a.m. and 12:00 p.m., observed the home using Styrofoam bowls, cups, paper plates, and plasticware to serve breakfast and lunch on Interviews indicated that disposable products were also used to serve dinner on 9/20/21. On 9/21/21, at approximately 9:00 a.m., observed the home using Styrofoam bowls, cups, paper plates, and plasticware to serve breakfast on. Per staff person C and administrator, the use of disposable products is a matter of convenience when having to prep and serve a meal, due to not having a full time cook.

Plan of Correction

Accept

Paper Products were not used after 9/21/21, day of inspection.

Paper products will not be used unless we are having a "party", or in an emergency situation. Administration will do individual training with all staff by 12/31/21.(Documentation kept)

We disagree with this regulation being cited as a violation. When we received the list of regulations that were on hold, that is all we received, just a list of regulations, no stipulations to follow. I understand and received the stipulations of these regulations, but only after asking for them. There is no way that any of the homes could know about the stipulations, because we never received them from [REDACTED]

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK Implemented

Document Submission

Attachment X

123b - Emergency Procedures Posted

1. Requirements

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On 9/20/21, The home's emergency procedures are not posted in a conspicuous and public place in the home. Both the home's emergency procedures and Salem Township, Westmoreland County were in the administrators office.

Plan of Correction

Accept

A Copy of Emergency Procedures were posted on 9/22/21 by Administrator.

A Checklist (with documentation) of all required postings will be checked monthly by administration

Completion Date: 09/22/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK Implemented

Document Submission

Attachment A

141b1 - Annual Medical Evaluation

1. Requirements

141b1 - Annual Medical Evaluation (continued)

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

Description of Violation

On 9/21/21, the annual medical evaluation for resident #2, dated [redacted] 21, does not include the weight, pulse rate and temperature. These sections are blank.

Plan of Correction

Accept

Medical Evaluation was completed for resident #2 on 9/27/21 to include weight/pulse and temperature. All other medical evaluations will be checked by Administration for missing data by 2-1-22. Requesting the extra time due to needing a complete audit of all files for multiple items, and Administration also doing shifts at the Home. When new DME's are done, they will be checked by Administrator and one other Designee (documentation will be kept)

Completion Date: 02/01/2022 Licensee's Proposed Date for POC Implementation

6/8/22 JK

Not Implimented

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

On 9/20/21, at approximately 1:10 p.m., the following medications on resident #6's bedside tables were not labeled with the resident's name, to include:

- A bottle of 150 count One A Day Pro Active 65+.
- A bottle of Top Care Ibuprofen Tablets 200mg 50 count caplets, approximately ¼ full.

Plan of Correction

Accept

All medication for Resident #6 was removed from [redacted] room and disposed of due to no order. It was explained to [redacted] that [redacted] was not permitted to have any medication in [redacted] room unless [redacted] is assessed to self administer [redacted] own medications

Individual Training will be done with all Staff on "Proper medication Administration" by 12/31/21. it will be addressed with med techs, but all Staff will have the training also, to be aware to remove any medication and report to Administration if they are left in the room or other place accessible to resident. 2 med observations per week for one month, then monthly for 3 months will be done with all med techs by Administration. Administration will also check 6 random rooms per week for 1 month then monthly thereafter along with walkthroughs of the home

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK
Implemented

Document Submission

Attachment Y and Z

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

On 9/20/21, there was no current weekly activity calendar posted anywhere in the home.

221c - Post Activity Calendar (continued)

Plan of Correction**Accept**

A weekly activity calendar was done on 10/1/21

Administration will complete and post a monthly calendar monthly.

We disagree with this regulation being cited as a violation. When we received the list of regulations that were on hold, that is all we received, just a list of regulations, no stipulations to follow. I understand and received the stipulations of these regulations, but only after asking for them. There is no way that any of the homes could know about the stipulations, because we never received them from [REDACTED]

Completion Date: 10/01/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK
Implemented**Document Submission**

Attachment AA

227c - Support Plan Revision

1. Requirements

2600.

227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

The support plan for resident #7, dated [REDACTED]/21, was not updated to address recent changes, in health decline from [REDACTED] on. The support plan indicates the resident requires cueing and prompting to eat. However, interviews indicate the resident requires to be fed at meals. On 9/20/21, observed resident #7 being fed pieces of a bologna/cheese sandwich by a staff at lunch along with prompting and cueing. Resident #7 is unable to pull clothing up/down for toileting and requires the assistance of staff for all toileting needs and incontinence care and all transfers. The resident no longer ambulates independently, requiring a wheelchair. Currently utilizes a Broda chair that is not addressed in the support plan. The resident's teeth are severely decayed and require dental care or removal. This is not addressed in the resident's support plan.

Plan of Correction**Accept**

Resident #7 no longer resides in the facility

Administration left a new list in the break rooms and med room for DCS to indicate any new needs, decline in health or any other changes in Residents. All Support plans will be reviewed for accuracy by Administration by 2-1-22. The extra Time is needed due to a complete audit being done on all charts. Also administration is also filling in some shifts for staffing and needs the extra time to do the charts accurately. (Documentation kept in recent inspection folder)

Administrator will ensure all Support plans are updated with any new needs of the residents as they are reported

Completion Date: 02/01/2022 Licensee's Proposed Date for POC Implementation

6/8/22 JK
Not Implimented

85e - Trash Outside Home

1. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

85e - Trash Outside Home (continued)

Description of Violation

The home has two dumpsters in the back by a small wooden deck near behind Wing 2 Each dumpster has two lids. On the following dates and times, dumpster lids were open, to include:

- On 9/20/21 at 8:50 a.m., the left lid was open on the dumpster closest to the deck and a recheck at 1:35 p.m., the left lid was open on the dumpster closest to the deck. There was a black garbage bag with Styrofoam plates, bowls, cups and plasticware along with napkins, paper products and food from lunch. And behind the left dumpster in the grassy area that faces the neighbor's fence was several pieces of trash to include a gallon size Ziploc baggie, several paper towels, used surgical gloves (clear and Blue) along with a few other miscellaneous trash scattered about.
- On 9/21/2, at 12:20 p.m., the left lid was open on the dumpster closest to the deck. The dumpster had several black garbage bags full of garbage, a broken grab bar with toilet seat and a twin mattress.

REPEAT VIOLATION 1/20/21

Plan of Correction

Accept

A sign was made by back door for all staff - Dumpster lids must be closed at all times. Administrator will do individual training with all staff by 12/31/21. It will include the need to follow this regulation and keep all trash covered. The training will include the importance of doing this on each shift. Administrator will also do random checks of the outside trash receptacles (documentation kept in recent inspection folder)

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

Document Submission

6/8/22 JK Implemented

Attachment N

92 - Windows

1. Requirements

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 9/20/21, at approximately 10:15 a.m., there was no screen in the window of the visitor/staff bathroom identified as Bathroom 413.

On 9/20/21, there is no screen in the small window on the left emergency exit door in the hallway between Wing #3 and #4.

Repeat Violation 1/20/21

Plan of Correction

Accept

On 9-22-21 the Screen in the window of the visitor/staff bathroom identified as bathroom 413 was replaced by Maintenance [redacted]. The small window on the left emergency door is not an openable window. On 9-21-22 the maintenance [redacted] did a walk around the building to check for any other missing screens. Administration will do individual training with all staff by 12/31/21 on reporting any missing screens to administration. Administration will use a checklist to do a monthly walk-through to check all screens. (Documentation will be kept in the new instruction folder)

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

92 - Windows (continued)

6/8/22 JK

Document Submission

Implemented

Attachment BB

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

On 9/20/2020, the common bathroom #415 in wing 4 is very poorly lit. The common bathroom lighting fixture has long florescent bulbs that when turned on do not function at full wattage and remain very dim. It appears that the florescent tubes are burning out.

On 9/20/21, the grab bar with attached toilet seat in private bathroom in bedroom #403 is in disrepair. The bar under the seat that attaches the handles on each side of the toilet was rusted through. There was a 14" piece of bar still attached on the left side was bent down towards the back of the toilet leaving the very rusted and sharp edge exposed. The broken 6" piece of rusted bar was still across the front of the toilet exposing the sharp rusted broken edge exposed posing a hazard.

On 9/20/21, the faucet on the head washing sink is loose and not secured to the sink in the shower room/hair salon in Wing #3.

On 9/20/21, the toilet grab bar with attached seat has a support bar that should be under the right side of the toilet seat. The support bar is rusted and extends out from the right side of the toilet seat approximately 1" by approximately 7" on the toilet in the shower room/hair salon in Wing #3.

On 9/20/21, the window blind in the shower room/hair salon in Wing #3 is in disrepair. The right side of the window blind has a piece of the slat that measures approximately 7" long broken off the blind.

REPEAT VIOLATION 7/21/21

Plan of Correction

Accept

Common bathroom in wing 4 - lighting was fixed on 9/22/21

Room 403 - toilet seat with grab bar was replaced on 9/22/21

Shower room/hair salon (wing 3) faucet on head washing sink was fixed on 9/22/21

Window blind in shower room/hair salon (wing 3) was replaced on 12/7/21. Administration will do an individual training with all staff on the importance of reporting anything that needs repaired or cleaned. Training to be done by 12/31/21. Checklist will be placed in the break rooms in the med room. Once staff adds any items to the checklist it will be placed in the administrator box for her to review. Administration will also do weekly walk-throughs for one month then monthly thereafter. (Documentation kept in recent inspection folder0

Completion Date: 12/31/2021

Licensee's Proposed Date for POC Implementation

6/8/22 JK

Not Implimented

102i - Soap Dispenser

1. Requirements

2600.

102i - Soap Dispenser (continued)

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

Description of Violation

On 9/20/21, at approximately 12:55 p.m., there was no dispenser of soap to wash hands at or near the sink in the shower room/hair salon in Wing #3.

REPEAT VIOLATION 10/31/19

Plan of Correction

Accept

Soap dispenser was placed in shower room/hair salon (wing 3) on 9/22/21. All other bathrooms were checked for soap for washing hands. Individual trainings will be done with all staff to include the importance of this regulation by 12/31/21. Administration will include checking for soap in the bathrooms with the weekly walkthroughs (documentation kept in recent inspection folder)

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK

Not Implimented

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

On 9/20/21, there was a tan resin chair on exterior side of emergency exit door from the kitchen, that was approximately 3' from the door and obstructing the egress route.

On 9/20/21, the emergency exit door in the back of the dining room cannot be opened without using force to push open.

On 9/20/21 at approximately 1:10p.m., there was a Broda chair blocking the emergency exit door in the hallway across from bedroom #101 in Wing #1.

On 9/20/21, at approximately 1:15 p.m. the emergency exit door across from bedroom #101, could not be easily opened. The administrator demonstrated by pushing in bar while using hip to open the door with force.

REPEAT VIOLATION 1/28/21

Plan of Correction

Accept

Tan resin chair was removed from the exterior side of emergency exit door from kitchen on 9/21/21

On 12/14/21 Maintenance adjusted the 2 doors that were hard to open making them easier to open.

Broda Chair blocking emergency exit door in Wing 1 was moved on 9/20/21

Administration will do individual trainings with all staff by 12/31/21 on the importance of this regulation.

Administration will do weekly walk-throughs for one month, then every two weeks thereafter. Administration will also be aware to look for us at all times when going through the building (documentation kept)

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK

Document Submission

Implemented

Attachment DD

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

On 9/21/21, the initial medical evaluation for resident #3, dated [REDACTED] 21, does not include the height and temperature. These sections were blank.

The initial medical evaluation for resident #6, dated [REDACTED] 21, does not include the temperature or ability to self-administer medication. These sections are blank.

REPEAT VIOLATION 3/10/2020

Plan of Correction**Accept**

Medical evaluations for Resident #3 and Resident #6 were fixed and completed on 9/27/21

All other charts will be completely audited By administration by 2/1/22. The extra time needed for this audit is due to Wanting accuracy in all of the files, and the need for administration to help with some staffing to care for Residents. There was a new checklist created for resident charts by Administration. The checklist will not go into the file until it is complete. It will stay on the Administrators desk until complete. This is to be sure that it has not been forgotten Administrator will ensure all paperwork is complete prior to filing in a chart

We disagree with this regulation being cited as a violation. When we received the list of regulations that were on hold, that is all we received, just a list of regulations, no stipulations to follow. I understand and received the stipulations of these regulations, but only after asking for them. There is no way that any of the homes could know about the stipulations, because we never received them from [REDACTED]

Completion Date: 02/01/2022 Licensee's Proposed Date for POC Implementation

6/8/22 JK

Not Implimented

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 homes designated smoking area is located on the concrete pad on the exterior side of the emergency exit doors off the hallway between Wing #3 and Wing #4. There is a smokestack approximately 2' from the door. The left door has a small window in it that opens into the home. Residents were observed smoking throughout day on 9/20/21, 9/21/21 and 9/22/21. There is no sign identifying this as the designated smoking area.

On 9/20/21 at approximately 1:15 p.m., direct care staff person #B, was smoking against the side of the building identified as Wing 4, in the parking lot, a few feet from the main entrance walkway. This is not a designated smoking area.

REPEAT VIOLATION 7/21/21

Plan of Correction

Accept

A sign was placed in resident smoking area on 9/22/21 identifying resident designated smoking area. Administration Will do individual trainings with staff by 12/31/21 on the importance of this regulation

Staff person B was brought to Administrator office and was instructed on the designated smoking area (documentation kept)

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK
Implemented

Document Submission

Attachment EE

183b - Meds and Syringes Locked

1. Requirements

2600.

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

Description of Violation

On 9/20/21, at approximately 1:10 p.m., the following medications belonging to resident #6 were unlocked, unattended and accessible on a snack tray and bedside table in bedroom # [redacted] to include:

- An Albuterol Inhaler.
- A bottle of 150 count One A Day ProActive 65+.
- A bottle of Top Care Ibuprofen Tablets 200mg 50 count caplets, approximately ¼ full.
- On resident #6's bedside table another Albuterol Inhaler.

Resident #6 is no assessed to be able to self- administer medications

REPEAT VIOLATION 1/20/21

Plan of Correction

Accept

All medication for Resident #6 was removed from [redacted] room and it was explained to [redacted] of not being allowed to have any medication in [redacted] room unless [redacted] is assessed to self administer [redacted] own medications Individual Training will be done with all Staff on "Proper medication Administration" by 12/31/21. it will be addressed with med techs, but all Staff will have the training also, to be aware to remove any medication and

183b - Meds and Syringes Locked (continued)

report to Administration if they are left in the room or other place accessible to resident. 2 med observations per week for one month, then monthly for 3 months will be done with all med techs by Administration. Administration will also check 6 random rooms per week for 1 month then monthly thereafter along with walkthroughs of the home

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK

Not Implimented

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.

Description of Violation

On 9/21/21, resident #1's glucometer was not set to the proper date/time. The glucometer indicated a date/time of 2/26 at 8:15; however, the actual date and time was 9/21/21 at 3:51p.m.

REPEAT VIOLATION 10/31/21

Plan of Correction**Accept**

The staff at the facility or not familiar with calibrating the Glucometers. Executive Director will be doing a training with Administration by 12/31/21. Once the training is finished And understood, all other glucometers will be checked and calibrated. Administration will be mindful that calibration will also need done when daylight savings time occurs. No residents were in any danger, from this violation. No glucometers were cross used and all numbers matched up

Completion Date: 12/31/2021 Licensee's Proposed Date for POC Implementation

6/8/22 JK

Not Implimented

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.

Description of Violation

Resident #1 admitted [REDACTED] 2020; however, the preadmission screening, dated [REDACTED] 2020, does not identify the resident for whom the form is being completed. The document does not include the residents name or date of birth. The sections were blank.

REPEAT VIOLATION 4/1/21

Plan of Correction**Accept**

Resident #1 no longer resides in the facility
All other charts will be completely audited By administration by 2/1/22. The extra time needed for this audit is due to Wanting accuracy in all of the files, and the need for administration to help with some staffing to care for Residents. There was a new checklist created for resident charts by Administration. The checklist will not go into the file until it is complete. It will stay on the Administrators desk until complete. This is to be sure that it has not been forgotten Administrator will ensure all paperwork is complete prior to filing in a chart

Completion Date: 02/01/2022 Licensee's Proposed Date for POC Implementation

224a - Preadmission Screen Form *(continued)*

6/8/22 JK

Document Submission

Implemented

Will be submitted by 2/1/2022