pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: August 5, 2022

[redacted]
TLC Healthcare, LLC
[redacted]

RE: Dunlevy Manor
2218 Route 88
Dunlevy, Pennsylvania 15432
License/COC #: 447544

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on February 8, 2022, February 9, 2022, February 10, 2022, February 11, 2022, and May 16, 2022, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a FOURTH PROVISIONAL license to operate the above facility. A FOURTH PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4); (relating to conditions for denial, nonrenewal or revocation). Your FOURTH PROVISIONAL license is enclosed and is valid from August 5, 2022 to February 5, 2023.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
141(a)	II	16	$5	$80	5 calendar days from mailing date of this letter
187(b)	II	16	$5	$80	5 calendar days from mailing date of this letter
187(d)	II	16	$5	$80	5 calendar days from mailing date of this letter
225(a)	II	16	$5	$80	5 calendar days from mailing date of this letter
225(c)	II	16	$5	$80	5 calendar days from mailing date of this letter
227(a)	II	16	$5	$80	5 calendar days from mailing date of this letter

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

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

Your facility's FOURTH PROVISIONAL license will expire on 2/5/2023. Pursuant to 55 Pa. Code § 20.54, a maximum of four consecutive provisional certificates of compliance may be issued to the legal entity for each specific facility or agency (1 Pa. Code. Part II).

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide

to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Jeanne Parisi, Bureau Director
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

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

Sincerely,

Jamie L. Buchenauer

Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *DUNLEVY MANOR* **License #:** *44754* **License Expiration:** *05/23/2022*

Address: *2218 ROUTE 88, DUNLEVY, PA 15432*

County: *WASHINGTON* **Region:** *WESTERN*

Administrator

Name: [redacted] **Phone:** *7243265611* **Email:** [redacted]

Legal Entity

Name: *TLC HEALTHCARE LLC*

Address: [redacted]

Phone: *7243265611* **Email:** [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/20/1996* **Issued By:** *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *21* **Waking Staff:** *16*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional, Incident* **Exit Conference Date:** *02/10/2022*

Inspection Dates and Department Representative

02/08/2022 - On-Site: [redacted]
02/09/2022 - On-Site:
02/10/2022 - On-Site:
02/11/2022 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* **Residents Served:** *17*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *16*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *4* **Have Physical Disability:** *0*

Inspections / Reviews

02/08/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/07/2022*

04/15/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/18/2022*

07/07/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** **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 2/8/22, the home's current license, dated 11/23/21 to 5/23/22, was not posted in the home.

Plan of Correction ***Accept***

The owner thought [redacted] had the correct license posted. This was fixed the day of the inspection the new license was placed on the wall.
There is a new Administrator at the facility and [redacted] know the regulations.
Moving forward the license will be checked monthly by the administrator or designee, and every time there is a new inspection emails will be checked daily for new information to ensure if there is a license change or new license it will always be up to date with the newest license. The inspector now has the new Administrators email to ensure they also get a copy of all DPW information including licenses.

Completion Date: *02/10/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Implemented

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On 2/10/22 at 3:55 p.m., an agent of the Department requested financial records for residents #1, #2, and #3 from staff person A, [redacted] The records were never provided to the Department.

Plan of Correction ***Directed***

There is a binder that has a copy of every check received by each resident and anyone [redacted] owe money to and anyone who owes [redacted] money. (attached).
All the residents that are gone and are owed a refund will have a check by May 1st, 2022.(will be attached).
A binder was created and all refund checks will be copied and placed in the binder.
A training was done on 5/15/2022 with all supervisors and administrators about financials and refund checks.
The New administrator is aware that all refunds need to be send within 30 days of the residents last day in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107. The administrator will check weekly and document anytime a resident leaves and will make a copy of the refund check and place it in the binder to ensure all residents owed a refund check receive it within 30 days of their last day.
there will also be a quarterly audit on all financials to ensure all documentations is in place.

DIRECTED
Within 15 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons to provide agents of Dept. immediate access to home, residents, and records. Documentation of education shall be kept. 6/29/22 JK

Within 15 calendar days of receipt of the accepted plan of correction: As part of the home's quality management review the administrator shall address all of the requirements of 26(b)(1) – (5) and 26(c) in addition to specific

5a1 - DHS Access (continued)

measures for improving immediate record accessibility to agents of the Dept. 6/29/22 JK

Completion Date: *05/01/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Not Implemented

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

On 2/8/22, there were the following unlocked, unattended, and accessible documents at the staff desk in a small nook off the living room, to include:

• On the top of desk was a notebook "Dunlevy Communication Log", with information pertaining to the current residents on each shift regarding skin break down, toileting, etc.

• Activity in Daily Living sheets for each resident, to include resident #4, #5, and #6 in the middle drawer of the desk.

• On a shelf above the desk is a binder labeled, "Dr. [redacted]". Contains doctor notes on previous and current residents to include resident #4, #7, #8, and #9.

Plan of Correction ***Accept***

This was removed and placed behind a lock the day of the inspections.

A training took place on 4/3/22 and confidentiality was addressed and every one was educated about how with resident information is to be locked up at all times when not in use.

Moving forward the building will be checked 3 times a day by Administrator or designees to ensure nothing is out that is confidential. (attached).

Completion Date: *04/04/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Implemented

28e - Death of a Resident

1. Requirements

2600.

28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

The homes contracts indicate the homes refund policy, including refunds of admission fees and refunds resulting from resident's death indicating a nonrefundable admission fee and the monthly rent is prorated as long as current on bill (rent). Documents show residents #1, #2, and #3 were current on their bill. Interviews consistently indicated in the case of a resident death, the home only charges up until the date the resident vacates the room, not until it is cleared of possessions. The home has not refunded the resident's family monies due, as follows:

Resident #1, [redacted] passed away on the resident's date of death. The resident's contract indicates a rent fee of $2,300.00 per month. The prorated fee for [redacted] 2021 is $74.19 per day ([redacted] days). Documents show the home received two payments in [redacted] and were cashed on [redacted]/21, as follows:

28e - Death of a Resident (continued)

• Check # [redacted], dated [redacted]/21 for $2,300.00.
• Check # [redacted], dated [redacted]/21 for $2,300.00
A refund is due at the prorated fee per day of $74.19 for [redacted]/21 and the [redacted] payment made by family in the amount of $2,300.00. The total refund due family is $2,374.19 The home did not refund the resident's previously paid rent to the resident's estate within 30 days in accordance with the Elder Care Payment Restitution Act (35 P.S. § 10226.101 – 10226.107).

Resident #2, [redacted], passed away on the resident's date of death. The resident's contract indicates a rent fee of $2,300.00 per month or a prorated fee of $74.19 for [redacted] per day ([redacted] days). The resident was in the home 16 days at a cost of $1,187.04. Documents show the home received payments, as follows:
• [redacted]/21 check# 2983 for $500.00 (nonrefundable admin fee)
• [redacted]21 check # 2987 for $2250.00
The refund due the family is $1,062.96. [redacted] payment $2250.00 - $1187.04 = $1,062.96). The home did not refund the resident's previously paid rent to the residents estate within 30 days in accordance with the Elder Care Payment Restitution Act ((35 P.S. § 10226.101 – 10226.107).

Resident #3, who is over [redacted] old, admission passed away on the resident's date of death. The resident's contract indicates a rent fee of $2,300.00 per month rent with a prorated fee of $82.14 per day for [redacted] ([redacted] days). Documents show the home received payments in [redacted] as follows:
• Check # [redacted] dated [redacted]/21 for $575.00 (prorated from [redacted]/21)
• Check # [redacted] dated [redacted]/21 for $2,800.00 ([redacted]rent $2,300 plus $500.00 nonrefundable admin fee)
The refund due the family is $2,300.00, for [redacted] 2021 rent. The home did not refund the resident's previously paid rent to the residents' estate within 30 days in accordance with the Elder Care Payment Restitution Act (35 P.S. § 10226.101 – 10226.107).

Plan of Correction ***Accept***

All the residents that have left or passed and are owed a refund will have a check by May 1st, 2022.(will be attached). Resident # 1,2, and 3.
A binder was created and all refund checks will be copied and placed in the binder.
The New administrator is aware that all refunds need to be send within 30 days of the residents last day in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107.[redacted] will check weekly and document anytime a resident leaves and will make a copy of the refund check and place it in the binder.

Completion Date: *05/01/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Not Implemented

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

The home is required to have at least one staff person for every 50 residents trained in first aid and certified in obstructed airway techniques and CPR present in the home. On the following dates/times, there were two working; however, none of the staff present in the home were trained in first aid and certified in obstructed airway techniques and CPR, as follows:
• 1/24/22 7:00 a.m. to 3:00 p.m.
• 1/27/22 7:00 a.m. to 3:00 p.m.

63a - First Aid/CPR Training (continued)

- *1/28/22 7:00 a.m. to 7:00 p.m.*
- *1/29/22 7:00 a.m. to 7:00 p.m.*
- *1/30/22 7:00 a.m. to 3:00 p.m.*
- *1/31/22 7:00 a.m. to 3:00 p.m.*
- *2/03/22 7:00 a.m. to 3:00 p.m.*
- *2/04/22 7:00 a.m. to 7:00 p.m.*

Plan of Correction ***Directed***

We have been trying for months to get a first aid training and finding someone to do it has been a challenge. We were able to find someone and all staff members in the building were trained on 2/22/02022 (attached).
Moving forward we will have someone schedule two months before the expiration date and we have another one scheduled on 8/4/2022 for any new staff that will be hired to ensure we keep everyone in the building up to date on trainings. We will schedule two a year moving forward to keep everyone up to date.
The administrator or designee will check monthly all training records to ensure all staff have all mandatory trainings and are up to date on all trainings.
This will also be discussed at each Quarterly Meeting to ensure all staff know what trainings they have and which ones they need.
This was addressed at the staff meeting on 4/4/2022.
Quarterly audits will also take place by Administrator or Designee to ensure there is no issues with trainings.

DIRECTED
Within 24 hours of receipt of the accepted plan of correction: The administrator or designee who schedules staff will ensure at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation will be present in the home at all times. 4/22/22 JK

Within 24 hours of receipt of the accepted plan of correction: The administrator or designee will review the schedule and staff working hours weekly to ensure at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and cardiopulmonary resuscitation is present in the home at all times. 4/22/22 JK

Completion Date: *04/04/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK
Not Implemented

64a - Admin Training

1. Requirements

2600.
64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:

Description of Violation

On 2/8/22 and 2/10/22 staff person A the home's administrator, did not have any documentation to verify completion of the administrator orientation program approved and administered by the Department.

Plan of Correction ***Accept***

The license was in there and [redacted] did not realize that document was not attached. I contacted Penn State Beaver and they sent me a copy. (attached).
Moving forward Administrator will check monthly to ensure all proper documents and training are [redacted] file.

Completion Date: *04/01/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK
Implemented

85a - Sanitary Conditions

1. Requirements

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

Description of Violation

On 2/8/22, at approximately 10:30 a.m., the following unsanitary conditions were in the kitchen, to include:
• There were food particles and crumbs over the entire bottom shelf of the upper cabinet that holds plates and bowls, left of the stove. There was a heavy concentration of crumbs/food partials along the left and right sides of the bottom and front corners.
• There was a heavy concentration of food crumbs/particles and dirt on the bottom of lower cabinets that baking sheets, pots pans kept, below the cooktop.
• There was dried food spatter over the interior top and interior door of the microwave in corner of countertop.

Plan of Correction ***Accept***

During the inspection there was a hired worker painting and lining the kitchen areas that is where much of the dirt was coming from the sanding and painting and staff had to work around the work zone. The kitchen has been completed and all the cabinets have been lined with cabinet liners and a deep clean has been completed on the entire kitchen.
During the 4/4/22 staff meeting sanitation was addressed with all the issues being addressed.
A check list was created and will be checked off three times a day after each meal to ensure everything is sanitary.
The administrator or designee will check 3 times a week at the lists and the kitchen to make sure everything is being cleaned properly.

Completion Date: *04/04/2022* Licensee's Proposed Date for POC Implementation 6/29/22 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 2/8/22, the walls around the toilet in the large common shower/tub room have a white textured Formica type covering. On the right wall in the toilet area the Formica has pulled away from the wall, measuring approximately 26" and a large piece of the white Formica is broken off near the vinyl baseboard exposing the drywall. The area measures approximately 12" x 7".

Plan of Correction ***Accept***

The maintenance man was there and fixed it that day it was completed before the inspector left.
During the 4/4/22 staff meeting it was addressed with staff that if they see something broken they need to report it immediately so it can be fixed.
The administrator or designee will do walk arounds 5 times a week and check to make sure there is nothing broken that needs fixed.
Maintenance many will also walk around weekly to ensure anything broken is fixed in a timely manner.

Completion Date: *02/10/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Implemented

89b - Hot Water Temperature

1. Requirements

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

89b - Hot Water Temperature *(continued)*

Description of Violation

On 2/8/22, the sink water temperature in the Jack and Jill shared bathroom between bedrooms #1 and #2 measured 133.3 degrees Fahrenheit at 1:30 p.m. A recheck measured 122.3 degrees Fahrenheit at 4:45 p.m.

On 2/8/22, the Jack and Jill shared bathroom between bedrooms #11 and #12, sink water temperature measured 135.5 degrees Fahrenheit at 1:45 p.m. and the water temperature in the shower measured 130.8 degrees Fahrenheit. A recheck of the sink water temperature measured 126.5 degrees Fahrenheit at 4:37 p.m.

On 2/8/22, the Jack and Jill shared bathroom between bedrooms #9 and #10, sink water temperature measured 132.4 degrees Fahrenheit at 2:05 p.m. A recheck measured 122.5 degrees Fahrenheit at 4:30 p.m. On 2/9/22, a recheck of the sink water temperature measured 123.4 degrees Fahrenheit at 9:55am

On 2/8/22, the Jack and Jill shared bathroom between bedrooms #7 and #8, sink water temperature measured 133.2 degrees Fahrenheit at 2:10 p.m. A recheck measured 123.4 degrees Fahrenheit at 4:42 p.m.

On 2/8/22, at approximately 2:15 p.m., the sink water temperature measured 135.0 degrees Fahrenheit in the large common shower/tub room.

Plan of Correction ***Accept***

By 6:30 pm on the inspection day it was under 120. There was a broken water piper in the building and the worker sent to fix it had to adjust the water and staff did not know that because we have never had an issue with water temperatures. This was addressed at the 4/4/22 staff meeting. A thermometer was purchased to check all rooms and it will be check twice daily for 1 month then 3 times a week moving forward to ensure that water temperature are always below 120 degrees. Administrator or designee will be responsible for ensuring this happens and documented on a check list.

Completion Date: *02/10/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK
Not Implemented

96a - First Aid Kit

1. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

On 2/9/22, at 4:40 p.m. the two first aid kits presented did not include the following items:

- *The small red plastic first aid kit did not include tape, goggles, and a breathing shield.*
- *The large white metal firs aid kit did not include tweezers, scissors and tape.*

Plan of Correction ***Accept***

All supplies were bought and placed in a first aid kit. Each first aid station had certain supplies but they were not all in on kit.

At the 4/4/22 it was addressed with staff if they use something to report it and to write down what they use on the Tablet.

Moving forward the Administrator or designee will check the First Aid Kit 2 times a week to ensure that there is nothing missing out that is required. It will be documented on a check list.

Completion Date: *02/11/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK
Implemented

100b - Removal Snow/Obstructions

1. Requirements

2600.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

On 2/8/22 and 2/9/22, approximately less than a quarter of the front parking lot was cleared of snow and ice posing serious slip/fall hazard. Interviews indicated in the event of an emergency; the designated meeting place identified was the front parking lot.

On 2/8/22, at approximately 1:55 p.m., the emergency exit by bedroom #9, exterior egress route had snow and ice covering large areas of the sidewalk, posing a slip/fall hazard from the door along the building to the front corner end of the building.

Plan of Correction ***Accept***

We had lots of issues finding someone to do snow removal this year they would say they were coming and would not show. We talked to Avalanche snow and ice removal and hired them to do our snow removal if we get any more snow this year. We are contacted a few others to get a contract signed for next year to ensure we always have our snow removed for safety.
Administrator will have a contract signed by September and a back up company just incase they cannot get to us in a timely manor.
Administrator will check daily when there is snow to ensure all snow is removed. And document on a check list.
Staff were trained on 4/4/22 about snow removal and using ice to keep the walk ways clean.
Administrator will ensure that all areas are clean of ice and snow in the winter months.

Completion Date: *04/04/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Implemented

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 2/8/22, resident [redacted]s green vinyl mattress in bedroom #1, has long cracks down the middle exposing the white threading and foam padding, to include a crack measuring approximately 12" long and another measuring approximately 9". The long front side of the mattress is in disrepair and broken down with small cracks and holes in vinyl.

Plan of Correction ***Accept***

The mattress was disposed of and a new mattress delivered on 2/12/22 the bed is a hospital bed that was ordered by [redacted] and they had ordered a new mattress prior and was waiting for it to be delivered.
this was addressed at the 4/4/22 staff meeting to ensure that if there is anything wrong with a matter to report it so another can be ordered especially when it is a hospital bed that needs to be ordered.
Moving forward the Administrator or designee will check weekly at all mattresses to ensure that if there is anything wrong with them they can be ordered for replacement. And documented on a checklist.

Completion Date: *02/12/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Not Implemented

101j2 - Bedroom Chairs

1. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

On 2/8/22, there are two residents residing in bedroom #12; however, there were no chairs in the bedroom.

Plan of Correction ***Accept***

The two chairs were fold up and under the bed because there is not a lot of extra room and the two residents do not like to sit on the chairs in their room. The chairs were taken out from under the bed and put in front of their bed.
Moving forward all the staff will know where the chairs are located in a room to ensure they can show the inspector to ensure we always stay in compliance.
This was talked about and addressed in our 4/4/22 meeting.
Moving forward the Administrator or designee will check weekly to ensure there is a visible chair in all rooms and document it on a check list and it will be discussed at the QA meetings to ensure all staff know where a chair is in each room.

Completion Date: *04/04/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Implemented

101j5 - Bedside Table/Shelf

1. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

Description of Violation

On 2/8/22, at approximately 2:00 p.m., the bed belonging to resident #[redacted] and resident #[redacted] does not have a bedside table or shelf that can be reached from bedside in the shared bedroom #9. Resident #[redacted]'s table measured approximately 52" from the resident bedside and resident #[redacted]'s table measured approximately 60" from the resident bedside.

Plan of Correction ***Accept***

The residents set up the room that way because they have a light over the bed they did not want a bedside table.
The room was rearranged for the bedside table on 2/11/2022.
This was talked about and addressed in our 4/4/22 meeting.
Moving forward the Administrator or designee will check weekly to ensure there is a bedside table in all rooms and documented on a check list and it will be discussed at the QA meetings to ensure all staff know that a bedside table has to be next to the bed.
The family was called to get them to help with the residents compliance and families will be made aware of this regulation at move in.

Completion Date: *02/11/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Implemented

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.

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

Description of Violation

On 2/8/22, at approximately 2:00 p.m., resident #[redacted] and #[redacted] did not have a source of light that can be turned on/off from bedside in bedroom #9. Resident #[redacted]s lamp measured approximately 52" from the bedside and resident #[redacted]s lamp measured approximately 60" from the bedside.

Plan of Correction ***Accept***

The lights above the beds have always been there and other inspectors have told us they are good for bedside lamps that is why there were not bedside lamps. Two lamps were put at the bedside on 2/11/22.
This was talked about and addressed in our 4/4/22 meeting.
Moving forward the Administrator or designee will check weekly to ensure there is a bedside lamp in close proximity to the bed so it can be reached if they are in bed in all rooms and documented on a checklist and it will be discussed at the QA meetings to ensure all staff know where a lamp needs to be placed.

Completion Date: *02/11/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Implemented

102i - Soap Dispenser

1. Requirements

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

Description of Violation

On 2/8/22, at approximately 1:30 p.m., there was an unlabeled used white bar of soap in original box in the shower stall in the Jack and Jill bathroom between bedroom #1 and #2.

Plan of Correction ***Accept***

The soap disposed of and a new bar was given and labeled. The residents family must have brought in the soap without letting staff know and labeling it. When checked the day before it was not there.
This was addressed at the 4/4/22 meeting
The family was contacted and reminded that anything brought in needs to be label.
The administrator or designee will check 2 times a day to ensure all shared rooms residents supplies are labeled. And documented on a checklist

Completion Date: *04/04/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Not Implemented

103g - Storing Food

1. Requirements

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

Description of Violation

On 2/8/22, at approximately 10:45 a.m., there was an open and unsealed bag of round waffles (count 2) in the freezer section of the white Frigidaire refrigerator/ freezer.

On 2/8/22, there were open and unsealed food items in the following areas, to include:
• A 5 oz. bag of Clancy's Puffed Corn in a purple basket on the third shelf of the silver shelving unit in the pantry.
• A yellow bag labeled [redacted] contained an open bag of Rold Gold pretzels Tiny Twists on the windowsill next to shelving unit by refrigerator #1.

103g - Storing Food *(continued)*

Plan of Correction ***Accept***

All food was disposed of and an any food that was not in a proper storage container was removed.
This was discussed at the 4/4/2022 staff meeting.
A check list was created and the Cook will check daily at all food to ensure that everything is in a proper container closed and sealed.
The administrator or designee will check weekly to ensure this is getting done. And document on a check list.

Completion Date: *02/10/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Implemented

[redacted]

[redacted]

VIOLATION WITHDRAWN 6/29/22 JK

[redacted]

109b - Rabies Vaccination

1. Requirements

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

Description of Violation

On 2/8/22 and 2/9/22, the home had no current rabies vaccination documentation for the dog, "Duncan", that was on-site 2/8/22 and 2/9/22 from the hours of 9:00 a.m. and 5:00 p.m. The document presented on 2/9/22, indicated the rabies vaccine expired 8/2021.

Plan of Correction ***Accept***

Duncan was removed from the premises and will not return until the dog is up to date on vaccinates. There is no vets in the area that are not booked up due to Covid shut downs.
Moving forward we will ensure that all animals are vaccinated or we will remove them from the premise. The administrator or designee will check monthly to ensure there are no animals in the building without updated

109b - Rabies Vaccination (continued)

vaccinations. When we find somewhere to get the vaccinations we will also schedule the next appt also to ensure we have an appt scheduled.

Completion Date: *02/10/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK
Not Implemented

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 2/8/22, at approximately 1:25 p.m., there was a Broda chair obstructing the emergency exit door at the end of the hallway by bedroom #1.

Plan of Correction ***Accept***

The company was coming to pick up the chair that day and a staff moved it there to get it out of the way when moving residents.
This was discussed during the staff meeting on 4/4/22
Moving forward the Administrator or designee will check daily to ensure there is nothing in front of any exit doors and documented on a checklist and it will be discussed at the QA meetings to ensure all staff know nothing can ever been in front of an exit doors.

Completion Date: *02/10/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK
Implemented

141a 1-10 Medical Evaluation Information

1. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #14's initial medical evaluation, dated [redacted]/22, is incomplete and missing page one, which includes all of the Medical Evaluation Information and Medical Professional's signature.

Plan of Correction ***Accept***

This must have fallen out and not been replaced because the evaluation was completed. the first page was printed and will be attached. Administrator went through and checked to make sure all other pages were there and everything filled out properly.
There was a training on 4/4/22 with staff and the Medical Evaluations were discussed.

141a 1-10 Medical Evaluation Information (continued)

An audit is being completed and will be completed by 4/16/22 on all residents.
And moving forward there will be a monthly audit on all files to make sure all Medical Evaluations are current, all filled out and nothing is missing. There will be documentation of the monthly audits by the administrator or designee. And a checklist was created to to ensure all newly- admitted residents have a medical evaluation, completed in its entirety, within 60 days prior to admission or within 30 days after admission. Documentation of the the checklist will be kept.

Completion Date: *04/16/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Not Implemented

141b1 - Annual Medical Evaluation

1. Requirements

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

Description of Violation

Resident #8's most recent annual medical evaluation with a date, [redacted]/2020, is incomplete and missing page one, which includes all the Medical Evaluation Information and the Medical Professionals signature.

Resident #12's initial medical evaluation was signed by the physician on [redacted]/2020. The next annual medical in-person evaluation was not completed until [redacted]/21.

Plan of Correction ***Accept***

This must have fallen out and not been replaced because the evaluation was completed for resident #8. the first page was printed and will be attached. Administrator went through and checked to make sure all other pages were there and everything filled out properly. For resident #12 The doctor canceled several time that is why that was not on time. We now have a nurse practitioner on staff so we will not have any issues with DME's moving forward.
There was a training on 4/4/22 with staff and the Medical Evaluations were discussed.
An audit is being completed and will be completed by 4/16/22 on all residents.
And moving forward there will be a monthly audit on all files to make sure all Medical Evaluations are current, all filled out and nothing is missing. There will be documentation of the monthly audits by the administrator or designee. And a checklist was created to to ensure all newly- admitted residents have a medical evaluation, completed in its entirety, within 60 days prior to admission or within 30 days after admission. Documentation of the the checklist will be kept.

Completion Date: *04/16/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Not Implemented

183d - Prescription Current

1. Requirements

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

Description of Violation

On 2/9/22, the med cart contained the following medications identified for resident #10. However, the medications are not indicated on the residents February 2022 Medication Administration Record (MAR) and the home had no physician orders for the medications, to include:

- *Vitamin B1 100mg*
- *Eliquis 5mg*
- *Donepezil 10mg*

183d - Prescription Current (continued)

On 2/9/22, the following medications prescribed for resident #13 were discontinued and were still in the med cart, to include:

- *APAP 500 mg, take one tablet every 4 hours as needed for pain. Discontinued 1/27/22.*
- *Tramadol 50mg tablet, take one tablet twice a day as needed for pain. Discontinued 2/2/2022.*

Plan of Correction ***Accept***

All medications were removed from the cart. A medication refresher training was conducted on 3/22/22. The NP went through each residents MAR and medications and orders to make sure all three match each other. The NP will do this monthly and document this to ensure that all MAR's and medications match and nothing is in the cart that should not be. The designee will do cart audits 3 times a week to make sure all medications and MAR's match correctly. The designee will document this on a check list. The med cart will be discussed at the QA meetings. The pharmacy will do monthly cart audits.

Completion Date: *04/04/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Implemented

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

Resident #12's glucometer is not set to the correct time, indicating a date of 2/9/22 and time of 12:59. The actual date 2/9/22 and time 12:05 p.m. Resident #12 is prescribed blood glucose readings to be completed twice a day (9:00 a.m. and 8:00 p.m.). However, the residents blood glucose readings are not documented in resident #9's 2022 February MAR or elsewhere.

Plan of Correction ***Accept***

All Med techs had to re-take Diabetic Training on 2/14/22 due to the glucometer issues. This was a 3 hour training and the trainer went over all the glucometer issues in the building. The new administrator is a Nurse Practitioner and also went over glucometers with the staff to prevent further issues.
Glucometers will be discussed at each QA meeting.
Moving forward Glucometer reading will be documented on the MAR and on a paper sheet that was created(attached) and The administrator or designee will check daily the glucometers and the documentation and will then document on a check list that all the glucometer reading are completed and documented in both areas and match the glucometer. This will be done daily to ensure there are no glucometer errors.

Completion Date: *04/04/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Not Implemented

225a - Assessment 15 Days

1. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #10 was admitted to the home on [redacted]/21. However, the resident's assessment was completed on [redacted]/21.

Resident #13 was admitted to the home on [redacted]/21. However, an initial assessment was not completed for the resident.

225a - Assessment 15 Days (continued)

Resident #14 was admitted to the home on [redacted]/22. However, an initial assessment was not completed for the resident.

Resident #15 was admitted to the home on [redacted]/22. However, an initial assessment was not completed for the resident.

REPEAT VIOLATION 5/19/21

Plan of Correction ***Accept***

For resident 10 the wrong date was written on the assessment it was completed on [redacted]/21 and the typed [redacted]/21 attached.
13, 14 and 15 had an assessment completed but it was not in the file. (attached).
There was a training on 4/4/22 with staff and Assessment and Support plans were were discussed at length.
An audit is being completed and will be completed by 4/16/22 on all residents.
And moving forward there will be a monthly audit on all files to make sure all Assessments and Support plans are current, all filled out and nothing is missing. There will be documentation of the monthly audits by the administrator or designee. And a checklist was created to to ensure all newly- admitted residents have a Assessment within 15 days and a Support plan within 30 days then yearly afterwards. Documentation of the the checklist will be kept.

Completion Date: *04/16/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Not Implemented

141a - Medical Evaluation

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.

Description of Violation

A medical evaluation has not been completed for resident #13, admitted on [redacted]/21.

REPEAT VIOLATION 5/19/21

Plan of Correction ***Accept***

A medical evaluation was completed but was not printed and put in file. (attached).
A medical There was a training on 4/4/22 with staff and the Medical Evaluations were discussed.
An audit is being completed and will be completed by 4/16/22 on all residents.
And moving forward there will be a monthly audit on all files to make sure all Medical Evaluations are current, all filled out and nothing is missing. There will be documentation of the monthly audits by the administrator or designee. And a checklist was created to to ensure all newly- admitted residents have a medical evaluation, completed in its entirety, within 60 days prior to admission or within 30 days after admission. Documentation of the the checklist will be kept.

Completion Date: *04/16/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK Not Implemented

187b - Date/Time of Medication Admin.

1. Requirements

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

Description of Violation

Resident #12 is prescribed blood glucose checks twice a day (9:00 a.m. and 8:00 p.m.). The resident's February 2022 MAR was initialed by staff persons as completing the blood glucose checks on multiple dates and times. However, there are no blood glucose reading on the resident's glucometer to indicate a blood glucose reading was completed, to include:
2/1/22 @ 8:00 p.m. No reading on glucometer: however, staff initialed completed.
2/3/22 @ 9:00 a.m. No reading on glucometer: however, staff initialed completed
2/4/22 @ 9:00 a.m. No reading on glucometer: however, staff initialed completed.
2/5/22 @ 9:00 a.m. and 8:00 p.m. No readings on glucometer. Staff initialed completed.
2/6/22 @ 9:00 a.m. No reading on glucometer: however, staff initialed completed.
2/7/22 @ 9:00 a.m. No reading on glucometer: however, staff initialed completed.
2/8/22 @ 8:00 p.m. No reading on glucometer: however, staff initialed completed.

REPEAT VIOLATION 5/19/21

Plan of Correction ***Accept***

They were completed they were just on a different glucometer that got thrown away. The resident got a new glucometer and they were using two glucometers for a week or so until it was discovered so one was thrown away. All Med techs had to re-take Diabetic Training on 2/14/22 due to the glucometer issues. This was a 3 hour training and the trainer went over all the glucometer issues in the building. The new administrator is a Nurse Practitioner and also went over glucometers with the staff to prevent further issues.
Glucometers will be discussed at each QA meeting.
Moving forward Glucometer reading will be documented on the MAR and on a paper sheet that was created(attached) and The administrator or designee will check daily the glucometers and the documentation and will then document on a check list that all the glucometer reading are completed and documented in both areas and match the glucometer. This will be done daily to ensure there are no glucometer errors.

Completion Date: *04/04/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK
Not Implemented

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #12 is prescribed blood glucose readings to be completed twice a day. (9:00 a.m. and 8:00 p.m.) The resident's February 2022 MAR indicates blood glucose readings complete at 9:00 a.m. and 8:00 p.m. Interviews indicated the resident's blood glucose is "tested once a day but not every day."

On 2/9/22, resident 12's glucometer was checked for the prescribed readings. However, they are inconsistent with the dates/times staff initialed as completing blood glucose readings in the residents February 2022 MAR, to include:
Date Time Glucometer MAR BG checks
2/1/22 at 8:07 a.m. 94 Staff initialed completed; however, no BSL documented.
2/1/22 @ 8:00 p.m. No reading on glucometer: however, staff initialed completed.
2/2/22 @ 8:22 a.m. 155 Staff initialed completed; however, no BSL documented.

187d - Follow Prescriber's Orders (continued)

2/3/22 @ 9:00 a.m. No reading on glucometer: however, staff initialed completed
2/4/22 @ 9:00 a.m. No reading on glucometer: however, staff initialed completed.
2/5/22 @ 9:00 a.m. and 8:00 p.m. No readings on glucometer. Staff initialed completed.
2/6/22 @ 9:00 a.m. No reading on glucometer: however, staff initialed completed.
2/7/22 @ 9:00 a.m. No reading on glucometer: however, staff initialed completed.
2/8/22 @ 7:53 a.m. 138 Staff initialed completed; however, no BSL documented.
2/8/22 @ 8:00 p.m. No reading on glucometer: however, staff initialed completed.
2/9/22 @ 7:56 a.m. 144 Staff initialed completed; however, no BSL documented.

Resident #13 was hospitalized on [redacted]22 and discharged from hospital on [redacted]22. The home did not follow the physicians discharge instructions and did not schedule an appointment with the doctor or PCP within 5 days of the resident's discharge. The hospital discharge instructions indicated the following:
• FOLLOW-UP and REFERRALS: Follow-Up: PCP/Doctor. Physician
Follow up Instructions: See your physician at the date and time below; however, no date or time indicated. If no appointment has been made, call the office to arrange an appointment within 5 days of discharge.

REPEAT VIOLATION 5/19/21

Plan of Correction ***Directed***

They were completed they were just on a different glucometer that got thrown away. The resident got a new glucometer and they were using two glucometers for a week or so until it was discovered so one was thrown away. All Med techs had to re-take Diabetic Training on 2/14/22 due to the glucometer issues. This was a 3 hour training and the trainer went over all the glucometer issues in the building. The new administrator is a Nurse Practitioner and also went over glucometers with the staff to prevent further issues.
Glucometers will be discussed at each QA meeting.
Moving forward Glucometer reading will be documented on the MAR and on a paper sheet that was created(attached) and The administrator or designee will check daily the glucometers and the documentation and will then document on a check list that all the glucometer reading are completed and documented in both areas and match the glucometer. This will be done daily to ensure there are no glucometer errors.
The Doctor will also being working with the facility on glucometer issues to ensure there are no more issues. There will be quarterly refreshers for staff to ensure glucometer are used correctly.
The administrator or designee will check daily at the glucometers to ensure there are no issues.

DIRECTED
Within 24 hours of receipt of the accepted plan of correction:: The administrator shall develop and implement a process to review all resident discharge orders to ensure all discharge orders are followed. 4/22/22/ JK

Within 24 hours of receipt of the accepted plan of correction:: The administrator shall educate all direct care staff persons on the process of reviewing and following all discharge orders of residents. 4/22/22/JK

Completion Date: *04/21/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK

Not Implemented

225c - Additional Assessment

1. Requirements

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

225c - Additional Assessment *(continued)*

Description of Violation

The most recent assessment for resident #8 was completed on [redacted]2020.

The most recent assessment for resident #12 was completed on [redacted]21.

REPEAT VIOLATION 6/2/21

Plan of Correction ***Accept***

There were assessment completed they were not in the files at day of inspection. (attached).
There was a training on 4/4/22 with staff and Assessment and Support plans were were discussed at length.
An audit is being completed and will be completed by 4/16/22 on all residents.
And moving forward there will be a monthly audit on all files to make sure all Assessments and Support plans are current, all filled out and nothing is missing. There will be documentation of the monthly audits by the administrator or designee. And a checklist was created to to ensure all newly- admitted residents have a Assessment within 15 days and a Support plan within 30 days then yearly afterwards. Documentation of the the checklist will be kept.

Completion Date: *04/16/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK

Not Implemented

227a - Support Plan 30 Days

1. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #13 was admitted to the home on [redacted]/21. However, an initial support plan was not completed for the resident.

Resident #14 was admitted to the home on [redacted]22. However, an initial support plan was not completed for the resident.

REPEAT VIOLATION 5/19/21

Plan of Correction ***Accept***

13, 14 and had a Support Plan completed but it was not in the file. (attached).
There was a training on 4/4/22 with staff and Assessment and Support plans were were discussed at length.
An audit is being completed and will be completed by 4/16/22 on all residents.
And moving forward there will be a monthly audit on all files to make sure all Assessments and Support plans are current, all filled out and nothing is missing. There will be documentation of the monthly audits by the administrator or designee. And a checklist was created to to ensure all newly- admitted residents have a Assessment within 15 days and a Support plan within 30 days then yearly afterwards. Documentation of the the checklist will be kept.

Completion Date: *04/16/2022* Licensee's Proposed Date for POC Implementation 6/29/22 JK

Not Implemented