

Department of Human Services
Bureau of Human Service Licensing

April 25, 2022

[REDACTED], ADMINISTRATOR
[REDACTED]

RE: THE HICKMAN
400 N. WALNUT STREET
WEST CHESTER, PA, 19380
LICENSE/COC#: 14093

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/14/2022, 03/15/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[REDACTED]

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *THE HICKMAN* License #: *14093* License Expiration: *03/13/2023*
Address: *400 N. WALNUT STREET, WEST CHESTER, PA 19380*
County: *CHESTER* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

[REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *01/28/2018* Issued By: *Borough of West Chester*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *111* Waking Staff: *83*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *03/15/2022*

Inspection Dates and Department Representative

03/14/2022 - On-Site: [REDACTED]
03/15/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* Residents Served: *74*

Secured Dementia Care Unit

In Home: *Yes* Area: *Darlington* Capacity: *22* Residents Served: *22*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *74*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *37* Have Physical Disability: *36*

Inspections / Reviews

03/14/2022 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/08/2022*

Inspections / Reviews (*continued*)

04/12/2022 - POC Submission

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *04/22/2022*

04/25/2022 - Document Submission

Reviewer: [REDACTED] Follow-Up Type: *Not Required*

82c - Locking Poisonous Materials

1. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 3/14/22 at 2:45pm, in the secure dementia care unit in bedroom J217 in an unlocked cabinet there was morning fresh tooth paste and ultra sure deodorant labeled contact poison control if swallowed.

Plan of Correction

Accept

Each bathroom in the Dementia unit has a locked cabinet for storing these materials ensuring safety. Each staff member has been provided a universal key to keep on their person during each shift. Additionally, the housekeeping check list is inclusive of ensuring that the locks are in good working order. The Housekeeping staff also has a copy of the key. The Program Manager or Director of Resident Services will perform unannounced environmental rounds to ensure continued compliance.

Completion Date: 04/04/2022

Document Submission

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 3/14/22 at 2:40pm, the trash can in Memory care kitchen did not have a lid.

Plan of Correction

Accept

It is the standard policy that all trashcans should be equipped with a lid to prevent penetration. Additional lids were acquired to keep onsite to replace non functional lids. Moving forward it has been added as a "check off" item for the servers to complete daily. Additionally, the Dining Director will monitor compliance weekly when performing environmental rounds.

Completion Date: 03/23/2022

Document Submission

Implemented

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 3/14/22 at 2:30pm, in bathroom J219 the water temperature was 125.2 degrees Fahrenheit

Plan of Correction

Accept

Weekly monitoring of the water temperature is completed throughout the buildings as evidenced by the attached log noting temperatures out of range. Upon further investigation, it was discovered that there was a faulty mixing valve which has been ordered and will be installed as soon as it arrives.

Completion Date: 04/08/2022

89b - Hot Water Temperature (continued)

Document Submission

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 3/14/22 there were no emergency telephone numbers to include the nearest hospital and fire department on or by the telephones in the following areas: Bedroom J105, Memory care kitchen, 3rd floor personal care kitchen

Plan of Correction

Accept

Emergency phone number cards were immediately placed into all locations noted. Facilities Manager will include in the duties of the housekeeping staff to inspect for and replace any missing emergency telephone stickers during scheduled weekly cleaning. The facilities manager will ensure that this task has been completed during her weekly quality assurance inspections.

Completion Date: 03/30/2022

Document Submission

Implemented

97 - Elevators/Lifting Devices

1. Requirements

2600.

- 97. Elevators and Stair Glides - Each elevator and stair glide must have a certificate of operation from the Department of Labor and Industry or the appropriate local building authority in accordance with 34 Pa. Code Chapter 405 (relating to elevators and other lifting devices).

Description of Violation

The home has 3 elevators that do not have current certificates of operation from the Department of Labor and Industry or appropriate local building authority.

Plan of Correction

Accept

The inspections have been completed however the Department of Labor & Industry have been remiss in proving proof of Certification. We have successfully secured 2 of the 3 Certifications attached from L&I. Unfortunately in this circumstance we are reliant on another entity to remain compliant. Standard practice is that the Director of Facilities schedules the inspections 60 days in advance of expiration.

Completion Date: 04/07/2022

Document Submission

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.

Description of Violation

On 3/14/22 at 2:30pm in bedroom J219 the bedside lamp was inoperable

101j7 - Lighting/Operable Lamp (continued)

Plan of Correction**Accept**

Residents may use their own furnishings and are encouraged to replace any non-functional items. The Hickman is happy to provide furnishings for any resident who may need them. The personal lamp was immediately replaced with a facility lamp for the resident. Facilities Manager will include in the duties of the housekeeping staff to inspect for and report any missing operational lamps/lights during scheduled weekly cleaning. The facilities manager will ensure that this task has been completed during her weekly quality assurance inspections.

Completion Date: 04/08/2022

Document Submission**Implemented**

103f - Refrigerator/Freezer Temps

1. Requirements

2600.

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

Description of Violation

On 3/14/22 at 2:35pm there was not a thermometer in the memory care freezer.

On 3/14/22 at 2:50pm there was not a thermometer in the 3rd floor PC freezer.

3/15/22 at 11:05am there was not a thermometer in the main kitchen ice cream freezer.

Plan of Correction**Accept**

All kitchen Thermometers were replaced with new shatter proof non battery operated Thermometers. Dining servers are currently required to log refrigerator temps at the beginning of each shift from thermometers rather than the reading the temperature from the unit itself. This has been included as a check off item to be completed and submitted to the Dining Director daily by each server. Additionally, the Dining Director will ensure functionality on weekly environmental rounds.

Completion Date: 03/22/2022

Document Submission**Implemented**

103g - Storing Food

1. Requirements

2600.

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

Description of Violation

On 3/14/22 at 2:50pm there were 9 opened and unsealed ice creams in the 3rd floor PC kitchen freezer.

Plan of Correction**Accept**

All 9 ice creams were immediately discarded upon discovery. They were identified as Ice cream scooped during the meal 1 hour prior to environmental rounds. All the servers working on that floor that day were given an additional in service on storage, dating and labeling as well as completing their server checklist which requires them to not only date and label, but check all Refrigerators & Freezers and the end of their shift to ensure nothing was missed. Addition signage was also posted on all units. Completed 3/15. This is included in the attached check list and will be monitored on weekly environmental rounds completed by the Dining Director.

Completion Date: 03/15/2022

103g - Storing Food (*continued*)Document Submission*Implemented*

107c - Food/Water 3 Day Supply

1. Requirements

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 3/15/22, the home served 74 residents, requiring 222 gallons of emergency drinking water. However, the home had only 90 gallons. The home does not have a contract with a local bottled water supplier.

Plan of Correction*Directed*

The Hickman did have a Contract in place with a food distributor effective 1/1/2022. Additionally we have secured another contract which is attached to ensure adequate nutritional needs are met in the event of an emergency. Considering that the first contract was in place but was not furnished at the time of inspection, I would like to formally request removal of this citation please.

DPOC - SP - 04-12-2022

Home will maintain a 3 day food and water supply for the residents at all times. If the home has a water contract it will be made available for Department representatives at all times.

Completion Date:Document Submission*Implemented*

Please find 2 contracts available for review which will be updated in advance of expiration. The Director of Dining Services will ensure contracts are maintained and an adequate supply of emergency food and water are available.

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 3/14/22, resident 11's cat was present at the home. The home does not have a current certificate of rabies vaccination for resident 11's cat.

Plan of Correction*Accept*

The vaccination record for resident #11 feline was scheduled however not completed as of the date of the inspection. Attached, please find confirmation of vaccination. Moving forward the Community Life Manager will

Completion Date: 03/28/2022Document Submission*Implemented*

132b - Safety Inspection/Fire Drill

1. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

132b - Safety Inspection/Fire Drill (continued)**Description of Violation**

There was not a fire safety inspection observed by a fire safety expert conducted from 3/4/2019 through 2/28/22.

Plan of Correction**Accept**

Please see attached supporting documents for fire safety inspections performed in 2019, 2020, and 2022.

Regarding 2021 inspection; due to COVID protocols of the inspector, he did not inspect in buildings with positive cases which we had during his scheduled date of December 2021. Going forward, the Facilities Manager/Designee will secure an inspection date 30 days prior to the designated inspection date. The inspection date will be reconfirmed 5 days prior to the inspection by the Facilities Manager/Designee. The Facilities Manager/Designee will secure an alternative inspector in the event that the initial inspector is unable to conduct the inspection. Inspection dates will be entered in the preventative maintenance annual calendar.

Completion Date: 02/28/2022

Document Submission**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

Resident #3 entered the home on [REDACTED]. However their initial medical evaluation was completed on [REDACTED].

Plan of Correction**Directed**

Attached please find Original DME for Resident #1 which was completed within the required timeframe. Additionally please find updated DME when resident moved to SDU. This coincides with 234a. Respectfully request removal of this violation.

DPOC - SP - 04-14-2022

Home will ensure residents have Documented Medical Evaluations completed by timeframes specified in regulation 2600.141a. Home is responsible for maintaining documentation and making it available for Department review.

Completion Date:

Document Submission**Implemented**

The Director of Resident Services has audited all charts and required documentation which is date driven to ensure compliance. An auditing file "tickler" has been updated and will be monitored monthly. Additionally, a Move in Check List has been added to the admissions process.

182c - Medication Administration**1. Requirements**

2600.

182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.

182c - Medication Administration (continued)

5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.

Description of Violation

On [REDACTED]/22 at [REDACTED] am, Staff member B removed a pill from the blister pack in the medication office where resident #12 was not present, walked it to resident #12's bedroom, gave resident #12 the medication, then returned to the medication room to document the medication as administered.

Plan of Correction**Accept**

Resident #12 was in room napping at the time the medication was prescribed to be given. Historically residents are requested to present to the medication room for med administration. The Hickman strives to nurture a "homelike" environment devoid of med carts in the hallways. Additionally, the EMAR system is located on a desk top in the medication room. Administration will acquire a laptop for times that the med cart needs to be taken to a residents room if they are ill or unable to present to the med room.

Completion Date: 04/29/2022

Document Submission**Implemented****183a - Original Containers and Injections****1. Requirements**

2600.

183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

On 3/15/22 at 9:50am there were 7 loose pills in the 2nd floor med cart.

Plan of Correction**Accept**

The Medication Carts are audited weekly by the Nurse Managers and the Med Techs have been instructed to assess the carts during each pass to ensure no pills have dislodged from the packaging. The Director of Resident Services will also perform a weekly audit of the carts to ensure that they are in good order.

Completion Date: 04/08/2022

Document Submission**Implemented****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 [REDACTED]/22 at [REDACTED] am, [REDACTED] prescribed for resident #10 was unlocked, unattended, and accessible in the resident #10's room.

Plan of Correction**Accept**

The Med tech that left the lotion in the room was counseled immediately. Proper procedure was reviewed with all Med Techs and the Director of Resident Services will make frequent rounds to assure that those who are identified as able to self medicate have their medications stored properly. These residents are reevaluated every 6 months.

Completion Date: 04/08/2022

183b - Meds and Syringes Locked (continued)

Document Submission

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 [redacted]/22, [redacted] [redacted] prescribed for resident #7, was in the home's medication cart; however, the medication was discontinued on 2/5/22.

On [redacted] [redacted] prescribed for resident #9, was in the home's medication cart; however, the medication was discontinued on 2/3/22.

Plan of Correction

Accept

Discarding discontinued and expired medications was reviewed with all Med Techs. The Nurse Managers will monitor the Dashboard of the EMAR system for discontinued medications and promptly remove them from the cart. The Nurse managers will perform a weekly med cart audit and The Director of Resident Services will audit the carts monthly.

Completion Date: 04/08/2022

Document Submission

Implemented

183f - Discontinued Medications

1. Requirements

2600.

183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

On [redacted]/22, [redacted] [redacted] belonging to resident #8 were on the home's medication cart. However, the medication expired on [redacted]/22.

Plan of Correction

Accept

Discarding discontinued and expired medications was reviewed with all Med Techs. The Nurse Managers will monitor the Dashboard of the EMAR system for discontinued medications and promptly remove them from the cart. The Nurse managers will perform a weekly med cart audit and The Director of Resident Services will audit the carts monthly.

Completion Date: 04/08/2022

Document Submission

Implemented

184a - Labeling OTC/CAM

1. Requirements

2600.

184a - Labeling OTC/CAM (continued)

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

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #10 receives a straight order of [REDACTED] sublingually twice daily scheduled. However, the controlled substance log reads take every 4 hours as needed for agitation.

Plan of Correction**Accept**

The Hospice provider was immediately contacted to secure the appropriate medication with the appropriate label. The straight order medication had run out and the identical PRN dose was being utilized until straight order medication was received. The Hospice provider was reminded that we must have matching medication for each prescription and may not substitute. The Med Techs were also provided instruction. Nurse Managers will assure that all medications have been ordered and received timely. The Director of Resident Services will audit all medication coming from a Hospice Provider for accuracy.

Completion Date: 04/08/2022

Document Submission**Implemented****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 [REDACTED]/22 at [REDACTED] am there was a [REDACTED] bone health that was not labeled for resident or room number.

On [REDACTED]/22 at [REDACTED] am on the 3rd floor med cart there were bottles of [REDACTED], and [REDACTED] that was not labeled for a resident or room number

Plan of Correction**Accept**

All CAM should be labeled with the residents name and room number. Med Techs have been counseled on the 5 Rights and proper storage. The Nurse Managers will perform med cart audits weekly and the Director of Resident Services will review for accuracy and completion.

Completion Date: 04/08/2022

Document Submission**Implemented****187d - Follow Prescriber's Orders****1. Requirements**

2600.

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

Description of Violation

Resident #1 is prescribed [REDACTED] tablet 1 tab daily for insomnia . However, this medication was not administered to resident #1 on [REDACTED]/22 because the medication was not available in the home.

187d - Follow Prescriber's Orders (continued)

Resident #10 is prescribed [REDACTED] sublingually twice daily scheduled. However, this medication was not administered to resident #10 on [REDACTED]/22, [REDACTED]/22, and [REDACTED]/22 because the medication was not available in the home. The home instead administered Lorazepam take .25ml (.5MG) by mouth or under tongue every 4 hours as needed.

Plan of Correction**Accept**

While we understand the importance of the medication being available at all times, we are dependent on the pharmacy to provide refills timely. A Review of re-ordering instructions were provided to the Med Techs and the Nurse Managers will ensure availability during weekly audits. The Director of Resident Services will also perform a monthly Med Cart Audit.

Completion Date: 04/08/2022

Document Submission**Implemented**

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's preadmission screening form, dated [REDACTED]/22, does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction**Accept**

While the document was completed according to the prescribed timeframe, a check box was omitted. The Nurse Managers have been provided in-service training and a refresher of the required paperwork. The Director of Resident Services will be responsible for reviewing all new admission paperwork for completion.

Completion Date: 04/08/2022

Document Submission**Implemented****2. 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 #6 was admitted to the home on [REDACTED]/21; however, the resident's did not have a preadmission screening completed.

Plan of Correction**Accept**

The Nurse Managers have been provided in-service training and a refresher of the required paperwork. The Director of Resident Services will be responsible for reviewing all new admission paperwork for completion.

Completion Date: 04/08/2022

Document Submission**Implemented**

225a - Assessment 15 Days

1. Requirements

225a - Assessment 15 Days (*continued*)

2600.

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

Description of Violation

Resident #2 was admitted on [REDACTED]/20; however, the resident's assessment was not completed until [REDACTED]/20.

Plan of Correction**Accept**

The policy and procedure for written assessment was reviewed with the Nurse Managers who complete the Assessments and final RASP. The Director of Resident Services will keep a tickler file of each unit for new admissions as well as annual updates which will be date driven to assure completion.

Completion Date: 04/08/2022

Document Submission**Implemented**

231b - Medical Evaluation

1. Requirements

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]/19; however, the resident's medical evaluation was completed on [REDACTED]/20.

Plan of Correction**Directed**

Attached is the initial DME completed prior to move in as well as the DME required for transfer to the SDU. I would respectfully request this citation be removed as the documents are within the prescribed timeframes.

DPOC - SP - 04-14-2022

Home will ensure residents have Documented Medical Evaluations completed by timeframes specified in regulation 2600.231b. Home is responsible for maintaining documentation and making it available for Department review.

Completion Date:

Document Submission**Implemented**

The Director of Resident Services has audited all charts and required documentation which is date driven to ensure compliance. An auditing file "tickler" has been updated and will be monitored monthly. Additionally, a Move in Check List has been added to the admissions process.

231c - Preadmission Screening

1. Requirements

2600.

231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]/22. However, the resident #1's written cognitive preadmission screening dated [REDACTED]/22 does not indicate that the needs of the resident require secured care

231c - Preadmission Screening (continued)

due to Alzheimer's disease or other dementia.

Plan of Correction**Accept**

While the Prescreen was completed on time a "check box" was omitted which made the form incomplete. The Director of Resident Services will audit all new admission paperwork for completion.

Completion Date: 04/08/2022

Document Submission**Implemented****234a - Admission Support Plan****1. Requirements**

2600.

234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]/19. However, the resident's initial support plan was completed on [REDACTED]/20.

Plan of Correction**Directed**

Please find Resident #3's Initial RASP after admission to the SDU. This document was in not discovered in the chart during the inspection. Respectfully request removal of citation.

DPOC - SP - 04-14-2022

Home will ensure residents have Resident Assessment Support Plans completed by timeframes specified in regulation 2600.234a. Home is responsible for maintaining documentation and making it available for Department review.

Completion Date:

Document Submission**Implemented**

The Director of Resident Services has audited all charts and required documentation which is date driven to ensure compliance. An auditing file "tickler" has been updated and will be monitored monthly. Additionally, a Move in Check List has been added to the admissions process.

252 - Record Content**1. Requirements**

2600.

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

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.

Description of Violation

Resident #1's record does not include hair color, eye color, and identifying marks.

Resident #2's record does not include hair color and eye color.

Resident #3's record does not include eye color.

252 - Record Content (continued)

Resident #4's record does not include resident photo, hair color, and eye color and identifying marks.

Resident #5's record does not include hair color and eye color.

Resident #6's record does not include resident photo, hair color, and eye color and identifying marks.

Plan of Correction**Accept**

Each resident record will be updated to reflect content indicated above. An audit will be completed by the Director of Resident Services and updated pictures and demographics will be placed in each chart.

Completion Date: 04/29/2022

Document Submission**Implemented**

Please see attached example of updated Face Sheet.

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

Staff member A was hired on [REDACTED]/20. However, their criminal background check was not completed until [REDACTED]/20

Repeat: 2/9/21

Plan of Correction**Accept**

Staff member A was hired on [REDACTED]/2020 prior to the [REDACTED]/2020 start date of the current Human Resources Manager. During the audit of files, this omission was discovered and immediately addressed on [REDACTED]/2020. The current Human Resources Manager uses a punch list to ensure the background check is completed prior to or on the hire date. Please see the attached list currently in use for potential new hires.

Completion Date: 04/08/2022

Document Submission**Implemented****86b - Bathroom****1. Requirements**

2600.

- 86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathroom in room J219, does not have an operable window or ventilation fan. The fan is inoperable and there is no window in the bathroom.

Repeat: 2/9/21

Plan of Correction**Accept**

A Facilities Manager will include in the duties of the housekeeping staff to inspect for a non-functional bathroom

86b - Bathroom (continued)

vent during scheduled weekly cleaning. The facilities manager will ensure that this task has been completed during her weekly quality assurance inspections.

Completion Date: 04/06/2022

Document Submission

Implemented