

Department of Human Services  
Bureau of Human Service Licensing

December 1, 2022

[REDACTED]

ST JUDES HAVEN INC  
1072 MT. AIRY DRIVE  
JOHNSTOWN, PA, 15904

RE: ST. JUDE'S HAVEN PERSONAL CARE  
HOME  
1072 MT. AIRY DRIVE  
JOHNSTOWN, PA, 15904  
LICENSE/COC#: 30787

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/13/2022, 04/14/2022, 04/15/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,  
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

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

**Facility Information**

Name: *ST. JUDE'S HAVEN PERSONAL CARE HOME* License #: *30787* License Expiration: *06/20/2022*  
Address: *1072 MT. AIRY DRIVE, JOHNSTOWN, PA 15904*  
County: *CAMBRIA* Region: *CENTRAL*

**Administrator**

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

**Legal Entity**

Name: *ST JUDES HAVEN INC*  
Address: *1072 MT. AIRY DRIVE, JOHNSTOWN, PA, 15904*  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *09/23/2000* Issued By: *D L&I*

**Staffing Hours**

Resident Support Staff: Total Daily Staff: *19* Waking Staff: *14*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
Reason: *Complaint* Exit Conference Date: *04/15/2022*

**Inspection Dates and Department Representative**

04/13/2022 - On-Site: [REDACTED]  
04/14/2022 - On-Site: [REDACTED]  
04/15/2022 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *17* Residents Served: *15*

**Secured Dementia Care Unit**

In Home: <i>No</i>	Area:	Capacity:	Residents Served:
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**Hospice**

Current Residents: *0*

**Number of Residents Who:**

Receive Supplemental Security Income: <i>0</i>	Are 60 Years of Age or Older: <i>15</i>
Diagnosed with Mental Illness: <i>0</i>	Diagnosed with Intellectual Disability: <i>0</i>
Have Mobility Need: <i>4</i>	Have Physical Disability: <i>0</i>

## Inspections / Reviews

04/13/2022 - Partial

Lead Inspector: [REDACTED] Follow Up Type: *POC Submission* Follow Up Date: *05/22/2022*

08/22/2022 POC Submission

Submitted By: [REDACTED] Date Submitted: *11/18/2022*  
Reviewer: [REDACTED] Follow Up Type: *POC Submission* Follow Up Date: *08/29/2022*

11/04/2022 POC Submission

Submitted By: [REDACTED] Date Submitted: *11/18/2022*  
Reviewer: [REDACTED] Follow Up Type: *Document Submission* Follow Up Date: *11/18/2022*

12/01/2022 Document Submission

Submitted By: [REDACTED] Date Submitted: *11/18/2022*  
Reviewer: [REDACTED] Follow Up Type: *Not Required*

## 42b - Abuse

**1. Requirements**

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

**Description of Violation**

The most recent assessment and support plan, dated [REDACTED] 2021 for Resident #1, indicates that the resident requires the assistance of 2 direct care staff persons for transfer and mobility. On [REDACTED]/2021 at approximately [REDACTED] am, the resident did not receive this assistance as required. Staff Person D assisted the resident to stand without the assistance of a second staff person. As a result, the resident fell, [REDACTED]

**POC Submission****Directed [REDACTED] - 11/01/2022)**

Staff member was verbally warned at a meeting I held after inspection, written up, and then terminated for continued noncompliance of this issue. All other staff members do understand the importance of using 2 people to transfer and this was addressed at the meeting. I have Conemaugh Home Health in the process of setting up our yearly fall safety and transfers classes that will be held in person here and done by a physical therapist to ensure all staff is up to date on transfers, how to properly do them for their safety and resident safety, and the importance of working together.

*Directed -*

The Administrator will conduct an audit of all current resident records by 11/21/22 to ensure that an accurate assessment of the current needs and abilities of each resident, and how the needs of each resident will be addressed by the home.

The Administrator will educate all staff on reporting changes in residents' abilities/needs and on reviewing/following the RASP by 11/21/22.

The Administrator will develop a system to track all resident falls by 11/18/22. The results of the tracking will be included in the home's next Quality Management Review, to be held no later than 11/30/22.

[REDACTED] 11/1/22

**Directed Completion Date: 11/18/2022****Implemented ([REDACTED] - 12/01/2022)**

## 51 - Criminal Background Check

**2. 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 Person C was first scheduled on [REDACTED]/2022 and provided resident care. As of the date of this inspection, a criminal background check had not been completed for Staff Person C.

## 51 - Criminal Background Check (continued)

## POC Submission

Directed (████) - 11/01/2022)

*I have double checked staff folders ensuring all criminal checks are done and that they are done in a timely manner. The control number will be documented for future purposes of needing to reprint criminal check off as papers sometimes get misplaced. All criminal checks will be done upon initial paperwork with newly hired staff to ensure all paperwork is in compliance.*

Directed -

*The Administrator obtained Staff A's criminal history background check by █████/22.*

████ - 11/1/22

Directed Completion Date: 11/18/2022

Implemented █████ - 12/01/2022)

## 60a - Staff/Support Plan

## 3. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

## Description of Violation

*On █████/2022 and █████/2022, Staff Person D was alone on the █████ pm █████ am shift and is not currently trained as a Medication Technician, thus leaving the home without someone to pass medications if needed.*

*On █████/2022, █████/2022, █████/2022, █████/2022, █████/2022, █████/2022, █████/2022, █████/2022, █████/2022 and █████/2022, Staff Person G and Staff Person I were scheduled together on the █████ pm █████ am shift. Neither staff person is currently trained as a Medication Technician, thus leaving the home without someone to pass medications if needed.*

*On █████/2022, Staff Person I was alone on the █████ pm █████ am shift and is not currently trained as a Medication Technician, thus leaving the home without someone to pass medications if needed.*

## POC Submission

Directed (████) - 11/01/2022)

*Staff person D was trained through the modified medication training on █████/2020.*

*Our PCP has written orders for the two residents who needs medication at night to have it at bedside as they are of their sound mind.*

*Staff persons are being trained to ensure there is a med tech on all shifts to ensure if any other resident needs medication they are compliant to do so. Med techs will be staffed on all shifts.*

Directed -

*The Administrator will review staff schedule each week to ensure all resident needs are met, such as number of hours, staff training, etc, to begin by 11/7/22.*

60a - Staff/Support Plan (continued)

█ - 11/1/22

Directed Completion Date: 11/07/2022

Implemented █ - 12/01/2022)

63a - First Aid/CPR Training

4. 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 █/2022, █/2022, █/2022, █/2022, █/2022, and █/2022, Staff Person D and Staff Person H were the only staff present in the home on the █ pm █ pm shift and neither is certified in First Aid and CPR.

On █/2022, █/2022, and █/2022, Staff Person G was the only staff person on the █ pm █ am shift and was not certified in First Aid and CPR.

On █/2022, █/2022, █/2022, and █/2022. Staff Person C and Staff Person G were the only staff on the █ pm █ am shift and neither is certified in First Aid and CPR.

On █/2022 and █/2022, Staff Person D was the only staff person on the █ pm █ am shift and was not certified in First Aid and CPR.

POC Submission

Directed (█ 11/01/2022)

Our CPR has expired and we currently (all staff) have renewed our CPR training on 7/12/2022 with █ of iaQuest hospice.

Staff person G is actually current from previous training. █ card was not in █ file but I do have the original sign in sheet that shows █ was trained on █/21 with █.

The other staff members identified were expired and have since been recertified. A list of dates of renewal has been made and posted to my board as a visual reminder of anyone needing recertifications. Any new staff hired without CPR will be scheduled with a staff member who is current and will be required to also have the CPR training.

Directed -

The Administrator will complete an audit of all current staff records by 11/18/22 to ensure all staff are up to date.

The Administrator will maintain all staff training and certifications in the staff record.

The Administrator will develop a system (calendar, checklist, etc) by 11/18/22 to ensure all staff are trained timely.

All staff training needs will be addressed at the next Quality Management Meeting to be held by 11/30/22.

63a - First Aid/CPR Training (continued)

Directed Completion Date: 11/18/2022

Implemented ( [REDACTED] 12/01/2022)

65a - FS Orientation 1st Day

5. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Person C, who was first on the schedule as of [REDACTED]/2022, did not receive orientation until [REDACTED]/2022 on the following topics:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

POC Submission

Directed [REDACTED] - 11/01/2022)

Staff persons will be trained prior to entering the floor. If staff member is not compliant they will not be able to be employed here. All trainings, especially fire safety must be done in a timely manner to ensure resident and staff safety in an emergency.

Staff member was terminated for non compliance.

Directed -

The Administrator will develop a system (such as new hire checklist) by 11/18/22 to track and ensure all staff receive training in a timely manner.

The Administrator will complete an audit of all current staff files by 11/18/22 to ensure all training is up to date.

65a - FS Orientation 1st Day (continued)

All new hires and all staff training needs will be reviewed at the next Quality Management review to be held by 11/30/22.

█ - 11/1/22

Directed Completion Date: 11/18/2022

Implemented (█ - 12/01/2022)

65b - Rights/Abuse 40 Hours

6. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Person C was first on the schedule as of █ 2022, however, this staff person did not complete training in the following topics until █/2022:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

POC Submission

Directed (█ - 11/01/2022)

Staff persons will be trained prior to entering the floor to avoid this issue in the future. If staff member is not compliant they will not be able to be employed here. All trainings must be done in a timely manner to ensure resident and staff safety in an emergency, conditions of abuse, and the resident rights.

Staff member was terminated for non compliance.

Directed -

The Administrator will develop a system (such as new hire checklist) by 11/18/22 to track and ensure all staff receive training in a timely manner.

The Administrator will complete an audit of all current staff files by 11/18/22 to ensure all training is up to date. All new hires and all staff training needs will be reviewed at the next Quality Management review to be held by 11/30/22.

MD - 11/1/22

Directed Completion Date: 11/18/2022

Implemented (█ 12/01/2022)

## 65b - Rights/Abuse 40 Hours (continued)

## 81b - Resident Personal Equipment

## 7. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

**Description of Violation**

On [REDACTED] 2022, Resident #8 had a portable, 53-inch long bed rail on the bed that is 80 inches. The bed rail was not attached to the bed frame, but slides between the mattress and the bed frame. The resident's assessment and support plan (RASP), dated [REDACTED]/2021, states "has bedside rail for support," but did not include a plan to protect the resident from the potential hazards of using the rail.

**POC Submission**

Directed ([REDACTED] - 11/01/2022)

Resident RASP has been updated for [REDACTED] yearly and it includes more detail as to [REDACTED] bed rail which has been replaced with one half the size. It does slide out so it is not a restraint but is available to assist [REDACTED]. [REDACTED] can not get stuck or caught in this frame. If [REDACTED] rolls and slides out [REDACTED] has a documented fall mat to protect [REDACTED]. [REDACTED] has been assessed and will continue to be routinely assessed that [REDACTED] can properly use the rail.

[REDACTED] RASP will include all documentation to support this

Directed -

Note: An enabler can not be portable and must be firmly attached to the bed's frame.

The Administrator will complete an audit of all the beds in the home by 11/11/22 to ensure all enablers are acceptable, properly attached, and that if a resident doesn't or can't use the enabler, it will be removed from the bed. All residents with enablers will be assessed for ability to properly use the enabler and have their RASPS updated by the Administrator by 11/18/22 to reflect use of the enabler(s).

The Administrator will educate all staff by 11/30/22 on proper use of the enabler.

The use of enablers and staff training needs will be reviewed at the next Quality Management review to be held by 11/30/22.

[REDACTED] \*11/1/22

Directed Completion Date: 11/18/2022

Implemented ([REDACTED] - 12/01/2022)

91 - Telephone Numbers

8. Requirements

2600.

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

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in Resident #4's room.

POC Submission

Directed (redacted) - 11/01/2022)

Resident #4 is legally blind and hardly has any vision. (redacted) vision is completely gone in (redacted) left eye. (redacted) can not see to use a telephone as staff has to charge it, dial (redacted) numbers, and hang up when complete. (redacted) can not see the numbers regardless of size but I have added them into (redacted) room. (redacted) would not be able to utilize (redacted) phone in an emergency but the numbers are largely posted in (redacted) room in the event (redacted) needs us to dial one of those numbers.

This is documented in (redacted) RASP.

Directed -

Note - Emergency numbers are required to be posted at all phones with outside lines. This is for the resident, as well as anyone else who would need to make an emergency call from the resident's room.

The Administrator will complete an audit of all phones with outside lines to ensure the phone numbers are listed, by 11/18/22.

(redacted) - 11/1/22

Directed Completion Date: 11/18/2022

Implemented (redacted) - 12/01/2022)

103f - Refrigerator/Freezer Temps

9. 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 4/14/2022, at approximately 10:10 am, the temperature in the taller Frigidaire freezer in the garage was 19 degrees Fahrenheit. This freezer contained tater tots, hot dogs, pepperoni, bags of cheese, pies, fries, and pizza crusts.

The temperature in the shorter Frigidaire freezer in the garage was 10 degrees Fahrenheit. This freezer contained bags of meatballs, whole turkeys, hams, and individually wrapped meat such as roasts and hamburger.

POC Submission

Directed (redacted) 11/01/2022)

We have been watching the temperature of the freezers closely. Staff has been educated to report to me with any temp below range. We have since not had any issues but will continue to monitor all thermometers. A monthly

103f - Refrigerator/Freezer Temps (continued)

checklist has been created to document freezer temps and note any issues with it.

Directed -

The Administrator will ensure that the temperatures of all refrigerator/freezers are checked daily to ensure temperatures are in the correct range starting 11/1/22.

The Administrator will educate all staff by 11/30/22 on the correct temperature for safe food storage of the refrigerator/freezers and staff will be informed to notify Administrator immediately of any temperatures outside of the correct range.

█ - 11/1/22

Directed Completion Date: 11/01/2022

Implemented █ - 12/01/2022)

132a Monthly Fire Drill

10. Requirements

2600.

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of December 2021.

POC Submission

Directed █ - 11/01/2022)

Monthly unannounced fire drills are conducted. I have created a monthly list of required items to be done and the monthly fire drills are included on this list to ensure none are missed. The fire drills will then be properly documented on the form required.

Directed -

Beginning November 2022, the Administrator will ensure that monthly fire drills are completed and properly documented on the fire drill log.

█ - 11/1/22

Directed Completion Date: 08/29/2022

Implemented █ - 12/01/2022)

132b Safety Inspection/Fire Drill

11. 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.

Description of Violation

The home failed to have an annual fire safety inspection and fire drill conducted by a fire safety expert by 12/31/21.

POC Submission

Directed █ 11/01/2022)

We did the annual fire safety class along with a fire extinguisher class on July 27th at 2pm to ensure we are compliant for the year. Richland Fire Dept. will be conducting our annual fire drill to ensure it is not missed. I have a yearly education list which will include this fire drill so it is not missed and we remain compliant and up to date to provide residents and staff with the safest environment possible.

132b - Safety Inspection/Fire Drill (continued)

Directed -

The Administrator will schedule a fire safety inspection and fire drill, to be conducted by a fire safety expert, to be held by 11/30/22.

Fire drills and staff training needs will be reviewed at the next Quality Management review to be held by 11/30/22.

11/1/22

Directed Completion Date: 11/30/2022

Implemented ( - 12/01/2022)

141a - Medical Evaluation

12. 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 #4 was admitted on /2021 and a medical evaluation has not yet been completed.

POC Submission

Directed ( - 11/01/2022)

Resident #4 - PCP did not comply with sending required paperwork back. Unless it is an emergency admission all DME's will have to be completed prior to admission to ensure compliance. This will help ensure that if PCP does not comply they have time to change physicians and be seen within 30 days.

Directed -

Note: The home is responsible for completion of all paperwork.

The Administrator will complete an audit of all current resident records for completed, up to date DME's by 11/18/22. Any records found to be out of compliance will have a DME completed by 11/30/22.

The Administrator will develop a system (new admission checklist, calendar, etc) by 11/18/22 to ensure DME's are complete and timely.

- 11/1/22.

Directed Completion Date: 11/18/2022

Implemented ( - 12/01/2022)

141b1 - Annual Medical Evaluation

13. Requirements

2600.

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

Description of Violation

Resident #9's most recent medical evaluation was completed on /21.

## 141b1 - Annual Medical Evaluation (continued)

**POC Submission****Directed** (████ - 11/01/2022)

DME's and RASPS are added to my monthly checklist to ensure they are reviewed and not missed in the month. Residents are seen every 2 months by PCP and I will ensure the forms are completed in a timely manner.

Directed -

The Administrator will complete an audit of all current resident records for completed, up to date DME's by 11/18/22. Any records found to be out of compliance will have a DME completed by 11/30/22.

████ - 11/1/22.

**Directed Completion Date:** 11/18/2022

**Implemented** (████ 12/01/2022)

## 161b - Well-Balanced Meals

**14. Requirements**

2600.

161.b. At least three nutritionally well-balanced meals shall be offered daily to the resident. Each meal shall include an alternative food and drink item from which the resident may choose.

**Description of Violation**

Resident #10 is a vegetarian and does not receive well-balanced meals. This resident is served peanut butter and jelly or tomato sandwiches per staff, as no alternatives are available.

**POC Submission****Directed** (████ - 11/01/2022)

Resident # 10 is a vegetarian. █████ is offered eggs, pancakes, waffles, french toast, pastas, soups, fish, veggie sandwich alternatives, veggie burgers, and so on. In addition to these, I am going to have a dietician come in and sit with █████ and myself to see what other nutritional options would be ideal for █████ and what █████ would like. A list will then be kept in the kitchen as well as documented in the RASP. We want to ensure █████ nutritional values are kept up and well as █████ preference for meals.

Directed -

Note: Per conversation with an agents of the Department at the inspection's closing conference, the home shall consult with a dietician and meet with the resident to develop a menu for Resident #10, showing a variety of nutritious, well-balanced vegetarian meals and alternatives. Include the dietician's information as well as the date of the meeting with the dietician and the resident.

The Administrator will meet with Resident #10 and document the resident's likes/dislikes by 11/14/22. The Administrator will arrange for a well balanced, healthy menu for Resident #10 to be put into place by 11/30/22. The menu, likes/dislikes shall be maintained in the resident's record as well as being available for kitchen staff.

The Administrator shall arrange for education for all staff providing dietary services on healthy, well-balanced meals by 11/30/22.

████ 11/1/22

**Directed Completion Date:** 11/18/2022

**Implemented** (████ 12/01/2022)

161b - Well-Balanced Meals (*continued*)

## 162c - Menus Posted

**15. Requirements**

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

**Description of Violation**

*On inspection dates of 4/13/2022, 4/14/2022, and 4/15/2022, no current or future menus were posted. The only menu posted was from 3/13/2022.*

**POC Submission****Directed (████ - 11/01/2022)**

*Menu's will be made at least one month in advance to ensure they are always kept up to date. They are included on the monthly checklist to ensure they are not forgotten. They will be balanced and options provided.*

*Directed -*

*By 11/14/22, the Administrator shall ensure that menus are posted for residents at least a week in advance (at minimum, 2 weeks of menus meets the requirement for this regulation).*

████ - 11/1/22

**Directed Completion Date: 11/18/2022****Implemented (████ - 12/01/2022)**

## 182b - Prescription Medication

**16. Requirements**

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

**Description of Violation**

*Resident #3 is prescribed ██████████ to be injected 40 ml every day for 30 days.*

*Staff Person A administered this injection on █████/2022, █████/2022, █████ 2022, █████/2022, █████/2022 and █████/2022 and is not qualified to administer this type of injection.*

*Staff Person D administered this injection on █████ 2022 who has not successfully completed the Department-approved medications administration course and is not qualified to administer this type of injection.*

*Staff Person E administered this injection on █████/2022 and █████/2022 and is not qualified to administer this type of injection.*

182b - Prescription Medication (continued)

POC Submission

Directed (MD 11/01/2022)

Any injection ordered other than insulin or epi pen will have to be administered by home health agency or an oral supplement provided instead. Staff has been reeducated on this regulation to ensure compliance and resident safety.

Directed -

The Administrator will review MARs monthly to ensure all injections are given by properly, starting November 2022. All training needs will be addressed at the next Quality Management review to be held by 11/30/22.

11/1/22

Directed Completion Date: 11/18/2022

Implemented (12/01/2022)

183a - Original Containers and Injections

17. 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 /2021, Staff Person B worked the pm shift and removed Resident #4's from blister pack #8 to leave for the pm am shift.

On /2021, Staff Person H worked the pm shift and removed Resident #4's from blister pack #4. The staff person also removed a for Resident #2 for the pm am shift. Staff Person H instructed the staff on the pm am shift to place the pills back into the blister packs and tape shut if these were not used.

POC Submission

Directed ( - 11/01/2022)

Staff has been reeducated on the medication regulation pertaining to sanitation and safety. Any medication that is removed and either refused or accidentally opened must be destroyed in the drug buster and then documented. Taping the medication back in the packet is not permitted under any circumstance. No medication is permitted to be pre poured or administered by anyone other than the person administering the medications.

Directed -

Note: Residents are unable to keep medication at bedside, unless they have been assessed as able to do so (RASP and DME/Dr order), as well as medications must be locked in the room, whether the resident has a private room and has a key and locks the door every time they leave, or a locked medication lock box, and the resident must take the key when they leave the room.

The Administrator shall complete weekly audits of the medication cart to ensure proper storage of medication, beginning November 2022.

All training needs will be addressed at the next Quality Management review to be held by 11/30/22.

11/1/22

## 183a - Original Containers and Injections (continued)

Directed Completion Date: 11/01/2022

Implemented ( [REDACTED] 12/01/2022)

## 183b - Meds and Syringes Locked

## 18. 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]/2022 at approximately [REDACTED] am, a small bottle of [REDACTED] and a tube of [REDACTED] belonging to Resident #11 were unlocked and accessible inside a box in an unused shower in the salon/shower room.

## POC Submission

Directed ( [REDACTED] - 11/01/2022)

personally removed any poisons from the area and also educated staff on the importance of looking at the labels for poison control and keeping them locked away for all resident safety. This area will be routinely checked to ensure no other poisons make their way in the shower area.

Directed -

The Administrator removed these items on 4/13/22.

The Administrator will review this area weekly, beginning 11/7/22 to ensue no poisonous items are accessible.

[REDACTED] 11/1/22

Directed Completion Date: 11/07/2022

Implemented ( [REDACTED] - 12/01/2022)

## 183d - Prescription Current

## 19. 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]/2022, 2 boxes of [REDACTED] prescribed for Resident #12, were in the home's medication cart; however, Resident #12 has been deceased since [REDACTED] 2022,

A foil-backed, unlabeled card of [REDACTED] with one tablet removed, expired 9/2021, and was found in the medication room.

183d - Prescription Current (continued)

Also found was a bottle of [REDACTED] belonging to Resident #4, that was not currently listed on the Medication Administration Record (MAR). There is no current order for this medication.

POC Submission

Directed ([REDACTED] 11/01/2022)

have added medication cart review to the monthly checklist to ensure we check for any expired medications or medications missed from any resident that has passed away. I also have been monitoring the medication room as an extra set of eyes so nothing is missed.

Directed -

The Administrator will re-educate staff on proper medication storage policies and procedures by 11/18/22. Medication cart audits will be reviewed at the next Quality Management review to be held by 11/30/22.

[REDACTED] - 11/1/22

Directed Completion Date: 11/18/2022

Implemented ([REDACTED] - 12/01/2022)

183e - Storing Medications

20. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer s instructions.

Description of Violation

On [REDACTED] 2022, a blister pack of [REDACTED] belonging to Resident #3 was observed with a large tear over one blister and the tablet was readily accessible. The blister was not sealed and the medication was not stored under proper conditions of sanitation.

POC Submission

Directed ([REDACTED] 11/01/2022)

Once a medication is opened, even if on accident by tearing, it muse be disposed of in the drug buster so that it can not become contaminated. The disposal must be documented so that medication has been accounted for. Staff has been reeducated on this and the importance of storing medications in the most sanitary conditions to ensure resident safety.

Directed -

The Administrator will conduct monthly medication cart audits beginning 11///7/22 to ensure medications are stored properly.

[REDACTED] 11/1/22

183e - Storing Medications (continued)

Directed Completion Date: 11/07/2022

Implemented (████ - 12/01/2022)

185a - Implement Storage Procedures

21. 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

The home has not implemented a system to account for the safe storage, access, security and distribution and use of medications as evidenced by the home not counting regularly-administered ██████████ which is a Schedule IV controlled substance, as follows:

Three blister packages plus a bottle containing one ██████████ for Resident #7 were observed in the medication cart. The home failed to account for the one ██████████ in the bottle.

Resident #13 receives regularly scheduled ██████████ three times a day. The home accounts for the PRN ██████████ but fails to account for the regularly scheduled ██████████

POC Submission

Directed (████ - 11/01/2022)

All routinely scheduled controlled medications have been moved to the double locked storage space in the med cart. Those pills are part of the ██████████ count for each shift as well as have the pharmacy administration sheet as an extra counter to ensure all medications are accounted for. They will be kept here at all times and accounted for each shift regardless if they are PRN or scheduled ██████████

Directed -

The Administrator will educate staff on the safe storage, access, security, distribution and use of medications by 11/18/22.

The Administrator will audit the medication carts monthly beginning 11/7/22 to ensure medications are stored properly.

██████ - 11/1/22

Directed Completion Date: 11/18/2022

Implemented (████ - 12/01/2022)

187a - Medication Record

22. Requirements

2600.

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

- 14. Name and initials of the staff person administering the medication.

Description of Violation

The Medication Administration Record (MAR) for Resident #3 was not initialed for the following prescriptions:

187a - Medication Record (continued)

- [REDACTED] take 1 tablet by mouth twice a day for 5 days, on [REDACTED]/2022, [REDACTED]/2022 and [REDACTED]/2022 at am.
- [REDACTED] 1 1/2 tablet twice a day, on [REDACTED] 2022, [REDACTED]/2022 and [REDACTED]/2022 at [REDACTED] am.
- [REDACTED] - take 1 every day, on [REDACTED] 2022, [REDACTED]/2022 and [REDACTED] 2022 at [REDACTED] am.

The Medication Administration Record (MAR) for Resident #4 was not initialed for the following prescriptions:

- [REDACTED] to given twice a day, on [REDACTED] 2022, [REDACTED]/2022 and [REDACTED]/2022 at [REDACTED] am.
- [REDACTED] to be given once per day, on [REDACTED]/2022, [REDACTED]/2022 and [REDACTED]/2022 at [REDACTED] am.

POC Submission

Directed ([REDACTED] 11/01/2022)

Our internet issues have been resolved. In the event this happens again, paper MAR's will be used to document any medications given so they are accounted for and all staff knows that the medications were administered. This will ensure accuracy as well as safety for the residents in regards to medication administration

Directed -

Note: The home is responsible for documenting the administration of medications, regardless of internet issues.

The Administrator will develop a backup plan (paper MAR vs eMar) on documentation of medication if the internet/system goes down by 11/18/22 and all staff will be educated by 11/30/22.

The Administrator will maintain adequate technology if eMARs are to be utilized as of November 2022.

The Administrator will begin a random weekly audit of MARs by 11/14/22 to ensure they are complete and accurate.

Medication audits will be reviewed at the next Quality Management review to be held by 11/30/22.

MD - 11/1/22

Directed Completion Date: 11/18/2022

Implemented ([REDACTED] - 12/01/2022)

187d - Follow Prescriber's Orders

23. Requirements

2600.

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

Description of Violation

According to the Medication Administration Record (MAR), Resident #3 did not receive the following prescribed medications:

- [REDACTED], take 1 tablet by mouth twice a day for 5 days, on [REDACTED]/2022, [REDACTED]/2022 and [REDACTED]/2022 at 8 am.
- [REDACTED] take 1 1/2 tablet twice a day, on [REDACTED] 2022, [REDACTED] 2022 and [REDACTED] 2022 at 8 am.
- [REDACTED] - take 1 every day, on [REDACTED] 2022, [REDACTED] 2022 and [REDACTED]/2022 at 8 am.

According to the MAR, Resident #4 did not receive the following prescribed medications:

- [REDACTED] to given twice a day, on [REDACTED] 2022 and [REDACTED]/2022 at 8 am.
- [REDACTED] to be given once per day, on [REDACTED]/2022, [REDACTED]/2022 and [REDACTED]/2022 at 8 am.

187d - Follow Prescriber's Orders (continued)

**POC Submission**

*Directed (MD 11/01/2022)*

*Our internet issues have been resolved. In the event this happens again, paper MAR's will be used to document any medications given so they are accounted for and all staff knows that the medications were administered. This will ensure accuracy as well as safety for the residents in regards to medication administration*

*Directed -*

*Note: The home is responsible for documenting the administration of medications, regardless of internet issues.*

*The Administrator will develop a backup plan (paper MAR vs eMar) on documentation of medication if the internet/system goes down by 11/18/22 and all staff will be educated by 11/30/22.*

*The Administrator will maintain adequate technology if eMARs are to be utilized as of November 2022.*

*The Administrator will begin a random weekly audit of MARs by 11/14/22 to ensure they are complete and accurate.*

*Medication audits will be reviewed at the next Quality Management review to be held by 11/30/22.*

█ - 11/1/22

**Directed Completion Date: 11/18/2022**

**Implemented █ - 12/01/2022)**

190a - Completion Medication Course

**24. Requirements**

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

**Description of Violation**

*Staff Person B, who has not successfully completed the Department-approved medications administration course, administered medications to residents including the following:*

*On █/2022, █/2022, █/2022, █/2022, █/2022, █/2022, █/2022, and █/2022 Staff Person B administered medications to Resident #3, Resident #4, and Resident #13.*

*Staff Person C, who has not successfully completed the Department-approved medications administration course, administered medications to residents including the following:*

*On █/2022, on the █pm-█ am shift, Staff Person C administered █ to Resident #4.*

*Staff person D, who has not successfully completed the Department-approved medications administration course, administered medications to residents including the following:*

*On █2022, Staff Person D administered medications to Resident #3, Resident #4, and Resident #13.*

*Staff Person H, who has not successfully completed the Department-approved medications administration course, administered medications to residents including the following:*

*On █/2022, Staff Person H administered █ to Resident #4 and to Resident #5 and █ to Resident #1*

## 190a - Completion Medication Course (continued)

on the [REDACTED] pm-[REDACTED] pm shift.

**POC Submission****Directed (MD 11/01/2022)**

Staff persons B, D, and H are all trained under the Modified Medication training. I do have certificates for proof.

Staff person C had no right to be in that medication room and is no longer employed here. We have changed our key passing procedure. All leads pass the medication key to the next lead coming on staff and the leads must keep the medication key on them at all times to ensure no one else has access to them. This prevents any staff person who is not medication trained from entering the med room or touching medications.

Staff passes keys to the med room off shift to shift to ensure no keys are left around for anyone to enter the med room.

Directed -

The Administrator will re-educate all staff that pass medications on proper storage, locking the medication room/cart, passing of the keys, and training by 11/18/22.

The Administrator will develop a system (checklist, calendar, etc) by 11/18/22 to ensure all staff are trained in a timely manner as well as a new hire checklist to ensure new staff are trained prior to passing medications.

All staff training needs will be addressed at the next Quality Management review to be held by 11/30/22.

[REDACTED] -11/1/22

Directed Completion Date: 11/18/2022

Implemented ([REDACTED] - 12/01/2022)

## 224a - Preadmission Screen Form

**25. 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**

A preadmission screening was not completed for Resident #6 and Resident #7.

**POC Submission****Directed ([REDACTED] 11/01/2022)**

The preadmission screen will be completed prior to resident entering the home. I have made a visual list for items needed prior to resident admission and this will be on the list as a preventive measure to ensure it is not missed through the paperwork process.

Directed -

The Administrator will conduct an audit of all current resident records by 11/18/22 to ensure that a pre-assessment screening was completed. If a prescreen was not completed, the Administrator will complete an assessment of the resident to be sure the home is able to meet the resident's needs.

224a - Preadmission Screen Form (continued)

The Administrator will develop and implement a system (checklist) by November 2022 to ensure all required documents are completed.

11-1-22

Directed Completion Date: 11/18/2022

Implemented ( - 12/01/2022)

225a Assessment 15 Days

26. 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

The following residents did not have a resident assessment completed;

- Resident #2, admitted on /2021
- Resident #4, admitted on /2021
- Resident #6, admitted on /2021
- Resident #7, admitted on /2021

POC Submission

Directed ( - 11/01/2022)

RASP's have been added to my admission list as a visual to not forget to complete them. All assessments with be completed within their first 15 days of admission and will have all documented information needed including any needs relating to diet, bed rails, fall mats, or any other adaptive equipment. RASP's are also included on my monthly checklist as another measure to ensure they are not forgotten.

Directed -

The Administrator will complete an audit of all current resident records by 11/18/22 to ensure all have admission assessments. Any found to not have an assessment, shall have an assessment completed and in place by 11/30/22.

- 11/1/22

Directed Completion Date: 11/18/2022

Implemented ( - 12/01/2022)

225c Additional Assessment

27. Requirements

2600.

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

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #3's current assessment, dated /22, identifies the resident as having no mobility needs . The resident currently has mobility needs

225c - Additional Assessment (continued)

██████████. A significant change assessment was not completed to reflect these changes.

Resident #9's most recent assessment was completed on 1/12/2021.

**POC Submission**

**Directed (██████████ - 11/01/2022)**

All significant changes will be addressed and rewritten in the RASP within 5 days of that change. Staff will then be notified that the specific RASP needs reviewed by them to ensure that residents needs will be fully met with their new changes.

Directed -

The Administrator will complete an audit of all current resident records by 11/18/22 to ensure all have current assessments. Any found to not have an assessment, shall have an assessment completed and in place by 11/30/22.

██████████ 11/1/22

Directed Completion Date: 11/18/2022

**Implemented (██████████ 12/01/2022)**

227d - Support Plan Medical/Dental

**28. Requirements**

2600.

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

**Description of Violation**

The Resident Assessment and Support Plan (RASP) for Resident #8, dated ██████████ 2021, does not include a plan to protect the resident from the potential hazard of using a portable bed rail, nor does it mention the resident's use of a bed alarm and fall mat ██████████.

**POC Submission**

**Directed (██████████ - 11/01/2022)**

The long rail has since been replaced with a shorter rail ██████████ yearly RASP was just updated and includes the rail, bed alarm, and fall mat. In addition to documentation, ██████████ has been assessed for proper use of the bed rail to assist ██████████ getting up in the mornings and that ██████████ can safely do so. ██████████ does have history of ██████████ but has full range of motion and strength in ██████████ arms. ██████████ will continue to be assessed for proper usage so that it is not a hazard to ██████████ These assessments will be documented and dated in ██████████ RASP moving forward.

Directed -

The Administrator will complete an audit of all residents which require enablers by 11/18/22 and update their RASPs on the ability and use of enablers, as well as other equipment used by 11/30/22.

A review and use of enablers will be addressed at the next Quality Management review to be held by 11/30/22.

██████████ - 11/1/22

227d - Support Plan Medical/Dental (continued)

Directed Completion Date: 11/18/2022

Implemented (████ - 12/01/2022)

252 - Record Content

29. Requirements

2600.

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

23. If the resident dies in the home, a copy of the official death certificate.

Description of Violation

Resident #6's record does not include a death certificate.

POC Submission

Directed (████ - 11/01/2022)

*f funeral home does not get me the death certificate within 2 weeks of the resident passing, I will be contacting resident family for a copy for my files. If family does not comply, I will then make an in person trip to the funeral home for a copy.*

Directed -

*The Administer will obtain and keep a copy of the death certificate with the resident's record.*

*The Administrator will develop a system (such as closed record checklist) by 11/18/22 for ensuring death certificates are requested and received upon the death of a resident in the home.*

████ - 11/1/22

Directed Completion Date: 11/18/2022

Implemented (████ - 12/01/2022)

254a - Records Discharge/Active

30. Requirements

2600.

254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

*Upon entrance to the home at approximately █████ am on █████ 2022, the records for Resident #7 and #8 were unlocked, unattended, and accessible in the Administrator's office. The door was unlocked and the door was ajar.*

*Upon entrance to the home at approximately █████ am on █████ 2022, the Administrator's office door was closed, but unlocked, leaving resident records unattended and accessible. No one was in the office.*

POC Submission

Accept (████ - 11/01/2022)

*have since reeducated staff on the HIPPA and importance of keeping the door locked after I leave as I know they need access to items in the office. I will also ensure files are put into locked cabinet incase staff member would*

254a - Records Discharge/Active (continued)

*forget to lock my door if they need access which will ensure nothing is left out to violate HIPPA law.*

**Licensee's Plan Completion Date:** 11/01/2022

**Implemented (**  **12/01/2022)**