Department of Human Services
Bureau of Human Service Licensing

October 11, 2022

ALWAYS ON CARE LLC
4 FAIRFIELD DRIVE
WILKES-BARRE, PA, 18702

RE: ALWAYS ON CARE
600 NORTH LAUREL STREET
HAZELTON, PA, 18201
LICENSE/COC#: 23006

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/22/2022, 06/23/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Human Services Licensing Supervisor

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: *ALWAYS ON CARE* **License #**: *23006* **License Expiration**: *06/03/2022*

Address: *600 NORTH LAUREL STREET, HAZELTON, PA 18201*

County: *LUZERNE* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *ALWAYS ON CARE LLC*

Address: *4 FAIRFIELD DRIVE, WILKES-BARRE, PA, 18702*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *04/22/2010* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *20* **Waking Staff**: *15*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *06/23/2022*

Inspection Dates and Department Representative

06/22/2022 - On-Site: [redacted]

06/23/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served**: *19*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *7* **Are 60 Years of Age or Older**: *17*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *1* **Have Physical Disability**: *1*

Inspections / Reviews

06/22/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/19/2022*

07/29/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/04/2022*

08/31/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/05/2022*

10/11/2022 - Document Submission

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The home did not have the current license posted in the home as required.
The home did not have the license inspection summary (LIS) dated 09/30/2021 posted as required.

Plan of Correction ***Do Not Accept***

The current license has been received and placed in the main hallway on a bulletin board on the first floor, for viewing. Attached is a copy of the last inspection summary for public viewing located on the first floor. Attached are the photos.

The administrator will monitor the adherence to this requirement.

Completion Date: *06/07/2022*

Update: *07/29/2022*

Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The current license has been received and placed in the main hallway on a bulletin board on the first floor, for viewing.

The administrator will monitor ongoing compliance.

Completion Date: *08/30/2022*

Document Submission ***Implemented***

The current license has been received and placed in the main hallway on a bulletin board on the first floor, for viewing.

The administrator will monitor ongoing compliance.

Update: *10/02/2022*

On-site POC Verification conducted by [redacted] on 9-6-2022.

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 6/9/2022 the home ordered an x-ray of resident #1's knee due to swelling of the knee. On 6/9/22 the results of the x-ray showed a fracture of the lateral femoral condyle. The home did not report the fracture to the department's regional

16c - Written Incident Report (continued)

office as required.

Plan of Correction ***Do Not Accept***

Medical team presumed the fracture may be related to cancer metastasizing throughout the body and the home was not aware of any injury, emergency services were not utilized. In addition, the resident nor staff did not recall any injury.

Completion Date: *06/22/2022*

Update: *07/29/2022*

Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The administrator is responsible for writing incident reports.

On 6/9/22, the home ordered an x-ray of resident #1's knee. The x-ray showed a fracture that the medical team presumed may be related to [redacted] throughout the body. The home was not aware of any injury, emergency services were not utilized. In addition, the resident nor staff did not recall any injury.

If an injury does occur at the facility, an incident report will be written by the administrator.

The administrator will monitor the ongoing compliance.

Completion Date: *08/30/2022*

Document Submission ***Implemented***

The administrator is responsible for writing incident reports.

On 6/9/22, the home ordered an x-ray of resident #1's knee. The x-ray showed a fracture that the medical team presumed may be related to [redacted] throughout the body. The home was not aware of any injury, emergency services were not utilized. In addition, the resident nor staff did not recall any injury.

If an injury does occur at the facility, an incident report will be written by the administrator.

The administrator will monitor the ongoing compliance.

Update: *10/11/2022*

Documentation review 10-11-2022.

18 - Compliance With Laws

1. Requirements

2600.

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

Description of Violation

The home did not have a carbon monoxide monitor installed near the home’s gas fired water heater in the basement as required. Repeat violation from 09/30/2021.

18 - Compliance With Laws *(continued)*

Plan of Correction ***Do Not Accept***

There is a carbon monoxide detector in the hallway approximately 30 feet away from the gas fired hot water heater, and an additional carbon monoxide detector has been placed in the room where the gas fired hot water heater is located.

Completion Date: *06/24/2022*

Update: *07/29/2022*

Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The administrator is responsible to making sure the facility complies with laws.

There is a carbon monoxide detector in the hallway approximately 30 feet away from the gas fired hot water heater, and an additional carbon monoxide detector has been placed in the room where the gas fired hot water heater is located on 6/24/22.

The administrator will monitor the ongoing compliance.

Completion Date: *08/30/2022*

Document Submission ***Implemented***

The administrator is responsible to making sure the facility complies with laws.

There is a carbon monoxide detector in the hallway approximately 30 feet away from the gas fired hot water heater, and an additional carbon monoxide detector has been placed in the room where the gas fired hot water heater is located on 6/24/22.

The administrator will monitor the ongoing compliance.

Update: *10/02/2022*

On-site POC Verification conducted by AD on 9-6-2022.

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #2 was admitted to the home on [redacted]. Resident #2's contract dated [redacted] was not signed by the resident. Resident #2 did not sign a contract until [redacted].

Plan of Correction ***Do Not Accept***

Resident's original contract was signed by the resident on [redacted] and was placed in the back [redacted] file. A revised contract was signed by resident on [redacted] after making changes regarding the percentage of funds to be collected from the rent rebate.

25b - Contract Signatures (continued)

Attached is the original contract.

The administrator will monitor the adherence to this requirement.

Completion Date: *12/02/2021*

Update: *07/29/2022*

Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The administrator is responsible for making sure the contracts are signed.

Resident's original contract was signed by the resident on [redacted] and was placed in the back [redacted] file. A revised contract was signed by resident on [redacted] after making changes regarding the percentage of funds to be collected from the rent rebate.

The administrator will monitor the ongoing compliance.

Completion Date: *08/30/2022*

Document Submission ***Implemented***

The administrator is responsible for making sure the contracts are signed.

Resident's original contract was signed by the resident on [redacted] and was placed in the back of [redacted] file. A revised contract was signed by resident on [redacted] after making changes regarding the percentage of funds to be collected from the rent rebate.

The administrator will monitor the ongoing compliance.

Update: *10/02/2022*

On-site POC Verification conducted [redacted] on 9-6-2022.

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 person A was hired on [redacted] The home did not have a criminal background completed for staff person A as required. Repeat violation from 09/30/2021.

Plan of Correction ***Do Not Accept***

Administrator completed criminal background check. Administrator will be held responsible to making sure that criminal background checks are completed for employees within 30 days of start date. Attached is the completed background check.

Completion Date: *07/08/2022*

51 - Criminal Background Check *(continued)*

Update: *07/29/2022*

Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The administrator is responsible for making sure all criminal background checks are completed.

Administrator completed criminal background check on [redacted]. Administrator will be held responsible to making sure that criminal background checks are completed for employees within 30 days of start date.

The administrator will monitor the ongoing compliance.

Completion Date: *08/30/2022*

Document Submission ***Implemented***

The administrator is responsible for making sure all criminal background checks are completed.

Administrator completed criminal background check on [redacted]. Administrator will be held responsible to making sure that criminal background checks are completed for employees within 30 days of start date.

The administrator will monitor the ongoing compliance.

Update: *10/02/2022*

On-site POC Verification conducted by [redacted] on 9-6-2022.

66a - Staff Training Plan

1. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

The home did not develop an annual staff training plan for 2022 as required. The home has a policy regarding the development of an annual staff training plan, but the home did not have documentation of an annual training plan for the 2022 training year.

Plan of Correction ***Do Not Accept***

Attached is the remainder of the 2022 staff training plan.

Completion Date: *06/29/2022*

Update: *07/29/2022*

Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The administrator is responsible for developing a staff training plan annually.

66a - Staff Training Plan (continued)

The administrator completed the staff training schedule on 6/29/22.

The administrator will monitor the ongoing compliance.

Completion Date: *08/30/2022*

Document Submission ***Implemented***

The administrator is responsible for developing a staff training plan annually.

The administrator completed the staff training schedule on 6/29/22.

The administrator will monitor the ongoing compliance.

Update: *10/02/2022*

On-site POC Verification conducted by AD on 9-6-2022.

81b - Resident Personal Equipment

1. 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

The bed for resident #1 had [REDACTED] attached to both sides with an approximate [REDACTED] between the top and bottom [REDACTED] The [REDACTED] were not covered to prevent the risk of entrapment.

Plan of Correction ***Do Not Accept***

The [REDACTED] were removed by the [REDACTED]e provider the same evening of the inspection.

The administrator will monitor the adherence to this requirement.

Completion Date: *06/22/2022*

Update: *07/29/2022*

Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The administrator is responsible for fixing the issues related to resident's personal equipment.

The [REDACTED]were removed by the [REDACTED]e provider the same evening of the inspection on 6/22/22

The administrator will monitor the ongoing compliance.

Completion Date: *08/30/2022*

Document Submission ***Implemented***

The administrator is responsible for fixing the issues related to resident's personal equipment.

The [REDACTED] were removed by the[REDACTED] provider the same evening of the inspection on 6/22/22

81b - Resident Personal Equipment (continued)

The administrator will monitor the ongoing compliance.

Update: *10/02/2022*

On-site POC Verification conducted by [redacted] on 9-6-2022.

92 - Windows

1. Requirements

2600.

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

Description of Violation

The windows in the 2nd floor men's and women's bathrooms were open during a physical site inspection. The windows did not have screens.

Plan of Correction ***Do Not Accept***

Screens were placed in both the men/women's bathroom on 6/24/2022. Attached are the photos inside the bathrooms.

The administrator will monitor the adherence to this requirement.

Completion Date: *06/24/2022*

Update: *07/29/2022*

Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The administrator is responsible for fixing the issue.

The administrator inserted screens in both the men/women's bathroom on 6/24/2022.

The administrator will monitor ongoing compliance.

Completion Date: *08/30/2022*

Document Submission ***Implemented***

The administrator is responsible for fixing the issue.

The administrator inserted screens in both the men/women's bathroom on 6/24/2022.

The administrator will monitor ongoing compliance.

Update: *10/02/2022*

On-site POC Verification conducted [redacted] on 9-6-2022.

96a - First Aid Kit

1. Requirements

2600.

96a - First Aid Kit *(continued)*

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

The home's first aid kit was missing tape, scissors, and gloves. Repeat violation from 09/30/2021.

Plan of Correction ***Do Not Accept***

The home has placed the scissors, tape and gloves in the first aid kit and will keep more than one first aid kit available for use. Attached are the photos of the additions to the kit that were missed.

The administrator will monitor the adherence to this requirement.

Completion Date: *06/25/2022*

Update: *07/29/2022*

Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The administrator is responsible for making sure the First Aid Kits are complete.

The home has placed the scissors, tape and gloves in the first aid kit on 6/25/22, and will keep more than one first aid kit available for use.

The administrator will monitor the ongoing compliance.

Completion Date: *08/30/2022*

Document Submission ***Implemented***

The administrator is responsible for making sure the First Aid Kits are complete.

The home has placed the scissors, tape and gloves in the first aid kit on 6/25/22, and will keep more than one first aid kit available for use.

The administrator will monitor the ongoing compliance.

Update: *10/02/2022*

On-site POC Verification conducted by ██ on 9-6-2022.

101j6 - Mirror

1. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
6. A mirror.

Description of Violation

Resident room #2 did not have a mirror in it.

101j6 - Mirror *(continued)*

Plan of Correction ***Do Not Accept***

A mirror has been placed in the resident's room. Attached is the photo.

The administrator will monitor the adherence to this requirement.

Completion Date: *06/28/2022*

Update: *07/29/2022*

Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The administrator is responsible for fixing the problem with the mirror.

A mirror was placed in the resident's room on 6/28/22.

The administrator will monitor ongoing compliance.

Completion Date: *08/30/2022*

Document Submission ***Implemented***

The administrator is responsible for fixing the problem with the mirror.

A mirror was placed in the resident's room on 6/28/22.

The administrator will monitor ongoing compliance.

Update: *10/02/2022*

On-site POC Verification conducted by AD on 9-6-2022.

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

Resident room #2 is occupied by two residents. The bed to the right of the room did not have an operable lamp or other source of lighting at bedside.
Resident room #3 did not have an operable lamp or other source of lighting at bedside. There was a table located to the left of the bed with a lamp on it which the resident stated could not be reached from the bed.

Plan of Correction ***Do Not Accept***

For Resident Room #2, there was a lamp situated between both resident's bed within arm's reach. This lamp was moved by the resident in the room and placed behind her bed. The lamp has been placed back on the position between both resident's bed and they have been informed not to move it. Attached is a photo of the lamp.

For Resident Room #3, the lamp source has been moved to be within reach of the resident. Attached is the photo.

101j7 - Lighting/Operable Lamp (continued)

The administrator will monitor the adherence to this requirement.
Completion Date: *06/25/2022*

Update: *07/29/2022*
Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The administrator is responsible for fixing the lamp issue.

For Resident Room #2, there was a lamp situated between both resident's bed within arm's reach. This lamp was moved by the resident in the room and placed behind her bed. The lamp has been placed back on the position between both resident's bed and they have been informed not to move it.

For Resident Room #3, the lamp source has been moved to be within reach of the resident on a night stand.

The administrator will monitor the ongoing compliance.
Completion Date: *08/30/2022*

Document Submission ***Implemented***

The administrator is responsible for fixing the lamp issue.

For Resident Room #2, there was a lamp situated between both resident's bed within arm's reach. This lamp was moved by the resident in the room and placed behind her bed. The lamp has been placed back on the position between both resident's bed and they have been informed not to move it.

For Resident Room #3, the lamp source has been moved to be within reach of the resident on a night stand.

The administrator will monitor the ongoing compliance.

Update: *10/02/2022*
On-site POC Verification conducted by ███ on 9-6-2022.

102k - No Common Towel

1. Requirements

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

During the initial walk through, the bathroom across from resident room ███ did not have paper towels or a mechanism for hand drying installed in it.

Plan of Correction ***Accept***

Paper towels were placed in the paper towel dispenser the day of the inspection and will be checked in the morning each day to ensure there are paper towels available.

102k - No Common Towel (continued)

The administrator will monitor the adherence to this requirement.
Completion Date: *06/22/2022*

Document Submission ***Implemented***

Paper towels were placed in the paper towel dispenser the day of the inspection and will be checked in the morning each day to ensure there are paper towels available.

The administrator will monitor the adherence to this requirement.

Update: *10/02/2022*

On-site POC Verification conducted by ██ on 9-6-2022.

105g - Lint Removal and Duct Cleaning

1. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

The lint trap of the dryer located in the home's basement was found to have a thick layer of lint in the lint trap.

Plan of Correction ***Do Not Accept***

The clothes had not been removed from the dryer after the last use. The lint traps are cleaned after each use and will continued to be cleaned after each use of the dryer. There are two dryers in the laundry room and one dryer's lint trap was clear of any lint on the morning of being inspected and the other dryer had a thin layer of lint after the black clothes being dried that cycle because they were full of lint from being washed with towels.

The administrator will monitor the adherence to this requirement.
Completion Date: *06/24/2022*

Update: *07/29/2022*

Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The administrator is responsible for the lint removal and duct cleaning.

The lint traps will be cleaned after each use of the dryer, and were cleaned after the inspection on 6/22/22.

The administrator will monitor the ongoing compliance.
Completion Date: *08/30/2022*

Document Submission ***Implemented***

The administrator is responsible for the lint removal and duct cleaning.

The lint traps will be cleaned after each use of the dryer, and were cleaned after the inspection on 6/22/22.

105g - Lint Removal and Duct Cleaning (continued)

The administrator will monitor the ongoing compliance.

Update: *10/02/2022*

On-site POC Verification conducted by AD on 9-6-2022.

132a - Monthly Fire Drill

1. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The home did not conduct fire drills in the month of December 2021, or in the months of January through May of 2022.

Plan of Correction ***Accept***

An unannounced fire drill was held and witnessed by the Hazleton Fire Department on 06/29/2022 and will continue to occur and be documented at least once monthly. We are awaiting the documentation to support that.

The administrator will monitor the adherence to this requirement.

Completion Date: *06/29/2022*

Update: *07/29/2022*

Please send proof of compliance.

Document Submission ***Implemented***

An unannounced fire drill was held and witnessed by the Hazleton Fire Department on 06/29/2022 and will continue to occur and be documented at least once monthly. We are awaiting the documentation to support that.

The administrator will monitor the adherence to this requirement.

Update: *10/11/2022*

Documentation review 10-11-2022.

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.

Description of Violation

The home has not had a fire drill supervised by a fire safety expert since 6/30/2020.

Plan of Correction ***Accept***

The home has a copy of a fire safety inspection dated 08/04/2021 completed by the Hazleton Fire Department and the home was re-inspected on 06/28/2022, and are awaiting the documentation. Hazleton Fire Department also witnessed a fire drill on the same day of the inspection, we are awaiting the documentation to support that. Attached is the inspection from 8/21/22.

The administrator will monitor the adherence to this requirement.

Completion Date: *08/04/2021*

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

Update: *07/29/2022*

Please send proof of compliance.

Document Submission ***Implemented***

The home has a copy of a fire safety inspection dated 08/04/2021 completed by the Hazleton Fire Department and the home was re-inspected on 06/28/2022, and are awaiting the documentation. Hazleton Fire Department also witnessed a fire drill on the same day of the inspection, we are awaiting the documentation to support that. Attached is the inspection from 8/21/22.

The administrator will monitor the adherence to this requirement.

Update: *10/02/2022*

On-site POC Verification conducted [redacted] on 9-6-2022.

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

The documentation of medical evaluation (DME) form dated [redacted] for resident #2 was missing the resident's temperature and cognitive functioning.

Plan of Correction ***Do Not Accept***

The DME has been revised by the physician's office and each DME will be reviewed by Administration to ensure the form is completed.

Attached is the updated DME.

Completion Date: *06/29/2022*

Update: *07/29/2022*

Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The administrator is responsible recording medical evaluation information.

141a 1-10 Medical Evaluation Information (continued)

For Resident #2, the DME has been revised by the physician's office on [redacted] and each DME will be reviewed by the administrator to ensure the form is completed.

The administrator will monitor the ongoing compliance.

Completion Date: *08/30/2022*

Document Submission ***Implemented***

The administrator is responsible recording medical evaluation information.

For Resident #2, the DME has been revised by the physician's office on [redacted] and each DME will be reviewed by the administrator to ensure the form is completed.

The administrator will monitor the ongoing compliance.

Update: *10/11/2022*

Documentation review 10-11-2022.

141b1 - Annual Medical Evaluation

1. Requirements

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

Description of Violation

Resident #1's most recent completed DME form was dated [redacted] No annual DME was completed for resident #1. Repeat violation from 09/30/2021.

Plan of Correction ***Accept***

A DME was completed on 0[redacted] for resident #1 by her physician and was in her file the day of the inspection; however all fields were not completed by the doctor. (The form was reviewed and approved by the resident's physician). Administration will utilize Tabular Pro's tracking tool to ensure all DME's are completed on an annual basis. Physician completed the form again to ensure compliance.

The administrator will monitor the adherence to this requirement.

Completion Date: *06/27/2022*

Update: *07/29/2022*

Please send proof of Resident 1's DME.

Document Submission ***Implemented***

A DME was completed on [redacted] for resident #1 by her physician and was in her file the day of the inspection; however all fields were not completed by the doctor. (The form was reviewed and approved by the resident's physician). Administration will utilize Tabular Pro's tracking tool to ensure all DME's are completed on an annual basis. Physician completed the form again to ensure compliance.

The administrator will monitor the adherence to this requirement.

Update: *10/02/2022*

On-site POC Verification conducted by [redacted] on 9-6-2022.

162c - Menus Posted

1. 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

The home did not have the current week's menu or the following week's menu posted in the home.

Plan of Correction ***Do Not Accept***

Menus were placed in the main hallway of the home and taken down to create a 6 week menu to be followed by the home. Six weeks of menus were available and shown the day of the inspection. These menus will be rotated every 6 weeks and placed in the main hallway for viewing.

Completion Date: *06/22/2022*

Update: *07/29/2022*

Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

Administrator is responsible for fixing the problem. The administrator placed menus in the main hallway of the home on 6/22/22. These menus will be rotated every 6 weeks and placed in the main hallway for viewing. The administrator will monitor ongoing compliance.

Completion Date: *08/30/2022*

Document Submission ***Implemented***

Administrator is responsible for fixing the problem. The administrator placed menus in the main hallway of the home on 6/22/22. These menus will be rotated every 6 weeks and placed in the main hallway for viewing. The administrator will monitor ongoing compliance.

Update: *10/02/2022*

On-site POC Verification conducted [redacted] on 9-6-2022.

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

A plastic Ziploc bag containing 7 [redacted] was found in the medication cart marked with the first name of resident #4 only.
Also, a plastic Ziploc bag containing [redacted] with the [redacted] on them was found with no other information labeled on the bag.

Plan of Correction ***Accept***

All loose medication in the med cart has been disposed of. All medication in the med cart is in the original

183a - Original Containers and Injections (continued)

container. Administrator has reviewed the policy on original containers and injections with staff to ensure they are aware and understand the proper way to store medication and to ensure medication is not poured more than 2 hours before administering. Administrator will routinely check the med cart to ensure it is clear from loose medication.

Completion Date: *06/28/2022*

Update: *07/29/2022*

Please send proof of staff training.

Document Submission ***Implemented***

All loose medication in the med cart has been disposed of. All medication in the med cart is in the original container. Administrator has reviewed the policy on original containers and injections with staff to ensure they are aware and understand the proper way to store medication and to ensure medication is not poured more than 2 hours before administering. Administrator will routinely check the med cart to ensure it is clear from loose medication.

Update: *10/02/2022*

On-site POC Verification conducted by [redacted] on 9-6-2022.

183e - Storing Medications

1. 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

The [redacted] belonging to resident #2 was not labeled with the date it was opened for use. The [redacted]y [redacted] is to be discarded 6 weeks after opening for use according to the manufacturer's instructions.
The [redacted] belonging to resident #3 was not labeled with the date [redacted] was opened for use. The [redacted] [redacted] is to be discarded 28 days after opening for use according to the manufacturer's instructions.

Plan of Correction ***Do Not Accept***

All medications in the med cart have been labeled to show date of opening. Administrator has reviewed policy on storing medications with staff and they acknowledge understanding of the proper way to store all medication and the importance of labeling date opened on each medication in accordance with manufacturer's instructions.

Completion Date: *06/25/2022*

Update: *07/29/2022*

Who will monitor ongoing compliance?

Plan of Correction ***Accept***

All medications in the med cart have been labeled to show date of opening. Administrator has reviewed policy on storing medications with staff and they acknowledge understanding of the proper way to store all medication and the importance of labeling date opened on each medication in accordance with manufacturer's instructions.

The administrator will monitor the ongoing compliance.

Completion Date: *08/30/2022*

183e - Storing Medications *(continued)*

Update: *08/31/2022*

Please send proof of staff training.

Document Submission ***Implemented***

All medications in the med cart have been labeled to show date of opening. Administrator has reviewed policy on storing medications with staff and they acknowledge understanding of the proper way to store all medication and the importance of labeling date opened on each medication in accordance with manufacturer's instructions.

The administrator will monitor the ongoing compliance.

Update: *10/02/2022*

On-site POC Verification conducted by [redacted] on 9-6-2022.

184a - Labeling OTC/CAM

1. Requirements

2600.

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

4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #5 has an order for [redacted] in the morning. The pharmacy label indicated the medication was to be held for [redacted]. The pharmacy label was not updated to reflect that the physician's order for this medication changed and this parameter was no longer in effect.

Plan of Correction ***Accept***

Staff administering medication will ensure all medication orders match pharmacy labels when received prior to administering medication. Administrator has reviewed medication orders received in the last 60 days to ensure they match pharmacy labels.

The administrator will monitor the adherence to this requirement.

Completion Date: *06/25/2022*

Update: *07/29/2022*

Please send proof of staff training.

Document Submission ***Implemented***

Staff administering medication will ensure all medication orders match pharmacy labels when received prior to administering medication. Administrator has reviewed medication orders received in the last 60 days to ensure they match pharmacy labels.

The administrator will monitor the adherence to this requirement.

Update: *10/02/2022*

On-site POC Verification conducted by [redacted] on 9-6-2022.

185a - Implement Storage Procedures

1. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

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

Loose pills were found in the bottom of both the 2nd and 3rd drawers of the medication cart. Approximately 8 pills were found in the 2nd drawer and approximately 10 pills were found in the 3rd and bottom drawers of the cart.
Resident #1 has a [redacted]. The home did not have the medication on hand.
The [redacted] belonging to resident #5 was not calibrated to the correct date and time.

Plan of Correction ***Accept***

All loose pills have been removed from the med cart and all staff administering medication will ensure the med cart remains clear of loose medication. The [redacted] for Resident #1 was not on stock, and was awaiting a reorder status to be filled. For Resident #5, there is [redacted] prescribed.

The administrator will monitor the adherence to this requirement.

Completion Date: *06/26/2022*

Update: *07/29/2022*

Please provide proof of staff training.

Document Submission ***Implemented***

All loose pills have been removed from the med cart and all staff administering medication will ensure the med cart remains clear of loose medication. The [redacted] Resident #1 was not on stock, and was awaiting a reorder status to be filled. For Resident #5, there is no [redacted] prescribed.

The administrator will monitor the adherence to this requirement.

Update: *10/02/2022*

On-site POC Verification conducted by [redacted] on 9-6-2022.

187a - Medication Record

1. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
14. Name and initials of the staff person administering the medication.

Description of Violation

The following medications for resident #1 were not initialed as administered on 06/13/22:
[redacted]
The following medications for resident #5 were not initialed as administered on 06/13/22:
[redacted]
The following medications for resident #7 were not initialed as administered on 6/13/22:
[redacted].
All of the above medications for all 3 residents were to be administered at [redacted].

187a - Medication Record *(continued)*

Plan of Correction ***Do Not Accept***

Medications were administered and documented in the QuikMar on this date for all residents listed; this must be explained by a system error. Administration will ensure the QuikMar and computer is updated as required.

Completion Date: *06/24/2022*

Update: *07/29/2022*

Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The administrator is responsible for the recording of medications.

Medications were administered and documented electronically on 6/13/22 for all residents listed. There must be have been a system error. The administrator will ensure the electronic Mar is updated accordingly.

The administrator will monitor the ongoing compliance.

Completion Date: *08/30/2022*

Document Submission ***Implemented***

The administrator is responsible for the recording of medications.

Medications were administered and documented electronically on 6/13/22 for all residents listed. There must be have been a system error. The administrator will ensure the electronic Mar is updated accordingly.

The administrator will monitor the ongoing compliance.

Update: *10/11/2022*

Documentation review 10-11-2022.

187c - Refusal of Medication

1. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident’s record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 0 resident #5 refused the following medications: . The home did not notify the physician regarding the resident’s refusal of these medications.

Plan of Correction ***Do Not Accept***

Resident #5's physician was notified of the missed medication and will be notified of missed medication in the future.
Administrator will continue to review med administration records and ensure there are not missed medications not reported to physician's office,

Completion Date: *06/25/2022*

187c - Refusal of Medication *(continued)*

Update: *07/29/2022*

What action that person will take, and when that action will happen - (date).
Staff training?
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

On 6/25/22, Resident #5's physician was notified of the missed medication and will be notified of missed medication in the future.

Staff were educated on the importance of med administration and providing notes to support.

Administrator will continue monitor ongoing compliance of med administration records and ensure there are not missed medications not reported to physician's office.

Completion Date: *08/30/2022*

Update: *08/31/2022*

Please send proof of staff training.

Document Submission ***Implemented***

On 6/25/22, Resident #5's physician was notified of the missed medication and will be notified of missed medication in the future.

Staff were educated on the importance of med administration and providing notes to support.

Administrator will continue monitor ongoing compliance of med administration records and ensure there are not missed medications not reported to physician's office.

Update: *10/02/2022*

On-site POC Verification conducted by AD on 9-6-2022.

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

On [redacted] resident #5's medication [redacted] was not administered and was documented as [redacted] and [redacted]. Per staff interview the medications were not administered due to not being available to administer.
From [redacted] the home did not administer several medications to resident #1 and explained it was due to the resident's [redacted] the medications. The home did not have documentation that the resident's physician ordered the medications to be held and the home did not notify the resident's doctor that the medications were not being administered. The medications include: [redacted]

Plan of Correction ***Do Not Accept***

[redacted] was not administered to Resident #5 on [redacted] because the script had expired and a new

187d - Follow Prescriber's Orders (continued)

medication, was started. A note was sent on to the physician's office to determine the medication to be administered to control and the physician's office provided a written order for both medications to be administered for .

0 , resident #1 began experiencing difficulty a small tablet during medication administration and routine medications were held. The provider was initially notified on and on two other occasions the resident was experiencing difficulty during medication administration and they informed the home they would notify physician. a note was received from the physician's office to hold all routine medications and continue comfort pack medications.

Attached is documentation to support that.

Completion Date: *06/29/2022*

Update: *07/29/2022*

Who is responsible for fixing the problem and what did they do to fix it?
What action that person will take, and when that action will happen - (date).
Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The administrator compiled notes to support to stop and start of medication to Resident #5 and Resident #1.

was not administered to Resident #5 on because the script had expired and a new medication, was started. A note was sent on to the physician's office to determine the medication to be administered to control the physician's office provided a written order for both medications to be administered for

0 , resident #1 began experiencing difficulty a small tablet during medication administration and routine medications were held. The provider was initially notified on and on two other occasions the resident was experiencing difficulty during medication administration and they informed the home they would notify physician. 0 2 a note was received from the physician's office to hold all routine medications and continue comfort pack medications. Attached is documentation to support that.

The administrator will monitor ongoing compliance.

Completion Date: *08/30/2022*

Document Submission ***Implemented***

The administrator compiled notes to support to stop and start of medication to Resident #5 and Resident #1.

was not administered to Resident #5 on because the script had expired and a new medication, was started. A note was sent on the physician's office to determine the medication to be administered to control and the physician's office provided a written order for both medications to be administered for .

, resident #1 began experiencing difficulty a small tablet during medication administration and routine medications were held. The provider was initially notified on and on two other occasions the resident was experiencing difficulty during medication administration and they informed

187d - Follow Prescriber's Orders (continued)

the home they would notify her physician. ██████ a note was received from the physician's office to hold all routine medications and continue comfort pack medications. Attached is documentation to support that.

The administrator will monitor ongoing compliance.

Update: *10/02/2022*

On-site POC Verification conducted ████ on 9-6-2022.

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 #2 was admitted to the home on ██████ The home did not complete a preadmission screen form for the resident.
The preadmission screen form for resident #5 dated ██████ was incomplete. The form did not indicate the resident's supervision needs, ability to avoid poisonous materials, or the Part III determination indicating whether the home can meet the needs of the resident.

Plan of Correction ***Accept***

Resident #2 was admitted to the home on ██████ The preadmission screening form was completed, but we did not have the means to print for the investigator at the time. The form is attached.

For resident #5, the form has now been completed as of ██████.

The administrator will manage the adherence to this policy but reviewing all forms required during admission.
Completion Date: *07/11/2022*

Update: *07/29/2022*

Please send proof of staff 2 and 5's preadmission screening form.

Document Submission ***Implemented***

Resident #2 was admitted to the home on ██████. The preadmission screening form was completed, but we did not have the means to print for the investigator at the time. The form is attached.

For resident #5, the form has now been completed as of ██████

The administrator will manage the adherence to this policy but reviewing all forms required during admission.

Update: *10/02/2022*

On-site POC Verification conducted by ██ on 9-6-2022.