Department of Human Services
Bureau of Human Service Licensing

September 1, 2022

6600 BROOKTREE COURT,STE 1000
C/O INTEGRACARE CORPORATION
WEXFORD, PA, 15090

RE: COLONIAL COURTYARD AT
BEDFORD
220 DONAHUE MANOR ROAD
BEDFORD, PA, 15522
LICENSE/COC#: 32948

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/12/2022, 07/13/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *COLONIAL COURTYARD AT BEDFORD* **License #**: *32948* **License Expiration**: *06/05/2023*

Address: *220 DONAHUE MANOR ROAD, BEDFORD, PA 15522*

County: *BEDFORD* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *TITHONUS BEDFORD LP*

Address: *6600 BROOKTREE COURT,STE 1000, C/O INTEGRACARE CORPORATION, WEXFORD, PA, 15090*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/12/2000* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *53* **Waking Staff**: *40*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/13/2022*

Inspection Dates and Department Representative

07/12/2022 - On-Site: [redacted]

07/13/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *83* **Residents Served**: *42*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *39*

Diagnosed with Mental Illness: *34* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *11* **Have Physical Disability**: *0*

Inspections / Reviews

07/12/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/31/2022*

Inspections / Reviews *(continued)*

08/01/2022 - POC Submission

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

08/11/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/01/2022*

09/01/2022 - 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

On 7/12/2022, the home's most current licensing summaries issued by the Department, dated 05/11/2020 and 10/22/2020, were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept***

Executive Operations Officer on 7/14/22, has received the home's most current licensing summaries issued by the Department, dated 05/11/2020, and 10/22/2020 and posted in a conspicuous and public place in the facility in a manner easily visible and accessible to all residents and visitors. Executive Operations Officer will complete monthly checks to ensure the required items are posted in a conspicuous and public place beginning on 7/14/22,and will do this on an ongoing basis to update all new information. On 7/13/22 this EOO was re-educated by the DHS on what LIS's should be posted, as well as on 7/13/22 education was provided by Regional Director.

Completion Date: *08/09/2022*

Document Submission ***Implemented***

Executive Operations Officer on 7/14/22, has received the home's most current licensing summaries issued by the Department, dated 05/11/2020, and 10/22/2020 and posted in a conspicuous and public place in the facility in a manner easily visible and accessible to all residents and visitors. Executive Operations Officer will complete monthly checks to ensure the required items are posted in a conspicuous and public place beginning on 7/14/22,and will do this on an ongoing basis to update all new information. On 7/13/22 this EOO was re-educated by the DHS on what LIS's should be posted, as well as on 7/13/22 education was provided by Regional Director. All steps have been completed.

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

, an allegation of abuse for a Resident to Resident incident occurred. The home became aware of the allegation at the time of the event, however the home did not report the allegation of abuse to Older Adult Protective Services

15a - Resident Abuse Report *(continued)*

Plan of Correction ***Accept***

On [redacted] the facility and all of its employees have been instructed by the Wellness Director, and EOO, to immediately report suspected abuse of a resident being served in the home in accordance with the Older Adults Protective Services Act and comply with requirements regarding restrictions on the staff persons. The Executive Operations Officer,will ensure that abuse or suspected abuse is appropriately reported and investigated immediately to Area of Aging, and DHS. This Executive Operations Officer has implemented a written policy and procedures on 07/13/2022 on prevention, reporting,notification, investigation, and management of reportable incidents and conditions. This Executive Operations Officer, and Wellness Director, has educated all staff on 7/13, and on 7/14, regarding the above and the time frames that must be followed. Staff will report any incident or condition to the regional office or the complaint hotline within 24 hours in a manner designated by the Department,and Area of Aging. This Executive Operations Officer will ensure that all staff follow the guidelines in 2600.15 in relating to abuse covered by the law. This Executive Operations Officer will ensure that she is notified immediately when any incident or condition occurs and will report to all parties immediately. EOO, and Wellness Director, on 7/13/22, reviewed with staff the method, the change of command to follow that must be follow when reporting an incident. Prevention how the facility identify and keep the each type of incident from occurring, Reporting, How will incidents be reported to the EOO.Notification, who is responsible for notification to the dept. and applicable agencies, method of notification. Investigation, what is the method who is the person responsible for investigation, and management, how will incident be recorded, stored, and trends be tracked. Staff trained by EOO, Wellness Director on 7/13/22. Staff have also been trained on 7/20/22 on prevention of abuse and the many forms of abuse, and the proper way of reporting abuse. Staff will participate in annual training on abuse. This Executive Operations Officer will immediately contact AAA, DHS, and law enforcement if necessary if abuse or an incident requires within the PA 2600 Code time frames. his Executive Operations Officer has educated all staff on 7/13/22, on the time frames that must be followed. Staff will report any incident or condition to the regional office or the complaint hotline within 24 hours in a manner designated by the Department,and Area of Aging. This Executive Operations Officer will ensure that all staff follow the guidelines in 2600.15 in relating to abuse covered by the law. This Executive Operations Officer will ensure that she is notified immediately when any incident or condition occurs and will report to all parties immediately.

Completion Date: *08/09/2022*

15a - Resident Abuse Report *(continued)*

Document Submission ***Implemented***

On [redacted], the facility and all of its employees have been instructed by the Wellness Director, and EOO, to immediately report suspected abuse of a resident being served in the home in accordance with the Older Adults Protective Services Act and comply with requirements regarding restrictions on the staff persons. The Executive Operations Officer,will ensure that abuse or suspected abuse is appropriately reported and investigated immediately to Area of Aging, and DHS. This Executive Operations Officer has implemented a written policy and procedures on 07/13/2022 on prevention, reporting,notification, investigation, and management of reportable incidents and conditions. This Executive Operations Officer, and Wellness Director, has educated all staff on 7/13, and on 7/14, regarding the above and the time frames that must be followed. Staff will report any incident or condition to the regional office or the complaint hotline within 24 hours in a manner designated by the Department,and Area of Aging. This Executive Operations Officer will ensure that all staff follow the guidelines in 2600.15 in relating to abuse covered by the law. This Executive Operations Officer will ensure that she is notified immediately when any incident or condition occurs and will report to all parties immediately. EOO, and Wellness Director, on 7/13/22, reviewed with staff the method, the change of command to follow that must be follow when reporting an incident. Prevention how the facility identify and keep the each type of incident from occurring, Reporting, How will incidents be reported to the EOO.Notification, who is responsible for notification to the dept. and applicable agencies, method of notification. Investigation, what is the method who is the person responsible for investigation, and management, how will incident be recorded, stored, and trends be tracked. Staff trained by EOO, Wellness Director on 7/13/22. Staff have also been trained on 7/20/22 on prevention of abuse and the many forms of abuse, and the proper way of reporting abuse. Staff will participate in annual training on abuse. This Executive Operations Officer will immediately contact AAA, DHS, and law enforcement if necessary if abuse or an incident requires within the PA 2600 Code time frames. his Executive Operations Officer has educated all staff on 7/13/22, on the time frames that must be followed. Staff will report any incident or condition to the regional office or the complaint hotline within 24 hours in a manner designated by the Department,and Area of Aging. This Executive Operations Officer will ensure that all staff follow the guidelines in 2600.15 in relating to abuse covered by the law. This Executive Operations Officer will ensure that she is notified immediately when any incident or condition occurs and will report to all parties immediately. All steps have been completed.

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 [redacted] an allegation of abuse for a Resident to Resident incident occurred. The home did not report this incident to the Department until [redacted]

Plan of Correction ***Directed***

This Executive Operations Officer provided education on suspected abuse on 7/13/22, has implemented a written policy and procedures on 07/13/2022 on prevention, signs and symptoms of abuse, reporting, notification, investigation, and management of reportable incidents and conditions. This Executive Operations Officer has educated all staff on 7/13/22, on the time frames that must be followed. Staff will report any incident or condition to the regional office or the complaint hotline within 24 hours in a manner designated by the Department and Area

16c - Written Incident Report (continued)

of Aging. This Executive Operations Officer will ensure that all staff follow the guidelines in 2600.15 in relating to abuse covered by the law. This Executive Operations Officer will ensure that she is notified immediately when any incident or condition occurs and will report to all parties immediately. Staff have also been trained on 7/20/22 on prevention of abuse and the many forms of abuse, and the proper way of reporting abuse. Staff will participate in annual training on abuse. This Executive Operations Officer will immediately contact AAA, DHS, and law enforcement if necessary if abuse or an incident requires within the PA 2600 Code time frames. On 7/13/22, the facility and all of its employees have been instructed to immediately report suspected abuse of a resident being served in the home in accordance with the Older Adults Protective Services Act and comply with requirements regarding restrictions on the staff persons. All reportable incidents and conditions will be reported using the Department's Reportable Incident and Condition Form and will be submitted to the Regional Office. EOO, and Wellness Director, on 7/13/22, reviewed with staff the method, the change of command to follow that must be follow when reporting an incident. Prevention how the facility identify and keep the each type of incident from occurring, Reporting, How will incidents be reported to the EOO. Notification, who is responsible for notification to the dept. and applicable agencies, method of notification. Investigation, what is the method who is the person responsible for investigation, and management, how will incident be recorded, stored, and trends be tracked. Staff trained by EOO, Wellness Director on 7/13/22.

Directed-
The Administrator will review incident reports and shift notes on a weekly basis to identify trends and ensure incidents are reported as required. These reviews will be included in the home's quality management review beginning 8/31/2022. CR 8/11/2022

Completion Date: *08/09/2022*

Document Submission ***Implemented***

This Executive Operations Officer provided education on suspected abuse on 7/13/22, has implemented a written policy and procedures on 07/13/2022 on prevention, signs and symptoms of abuse, reporting, notification, investigation, and management of reportable incidents and conditions. This Executive Operations Officer has educated all staff on 7/13/22, on the time frames that must be followed. Staff will report any incident or condition to the regional office or the complaint hotline within 24 hours in a manner designated by the Department and Area of Aging. This Executive Operations Officer will ensure that all staff follow the guidelines in 2600.15 in relating to abuse covered by the law. This Executive Operations Officer will ensure that she is notified immediately when any incident or condition occurs and will report to all parties immediately. Staff have also been trained on 7/20/22 on prevention of abuse and the many forms of abuse, and the proper way of reporting abuse. Staff will participate in annual training on abuse. This Executive Operations Officer will immediately contact AAA, DHS, and law enforcement if necessary if abuse or an incident requires within the PA 2600 Code time frames. On 7/13/22, the facility and all of its employees have been instructed to immediately report suspected abuse of a resident being served in the home in accordance with the Older Adults Protective Services Act and comply with requirements regarding restrictions on the staff persons. All reportable incidents and conditions will be reported using the Department's Reportable Incident and Condition Form and will be submitted to the Regional Office. EOO, and Wellness Director, on 7/13/22, reviewed with staff the method, the change of command to follow that must be follow when reporting an incident. Prevention how the facility identify and keep the each type of incident from occurring, Reporting, How will incidents be reported to the EOO. Notification, who is responsible for notification to the dept. and applicable agencies, method of notification. Investigation, what is the method who is the person responsible for investigation, and management, how will incident be recorded, stored, and trends be tracked. Staff trained by EOO, Wellness Director on 7/13/22.

Directed-

16c - Written Incident Report (continued)

The Administrator will review incident reports and shift notes on a weekly basis to identify trends and ensure incidents are reported as required. These reviews will be included in the home's quality management review beginning 8/31/2022. CR 8/11/2022. All steps have been completed.

20b8 - Quarterly Account

1. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

The home provides financial services for Resident #1 in the home. On [redacted], quarterly reviews of the financial records were completed on [redacted]

The home provides financial services for Resident #4 in the home. On [redacted] it was found that the last quarterly review of financial records for Resident #4 was completed on [redacted].

Plan of Correction ***Accept***

On 7/14/22, the ASD was educated and trained on managing resident's funds by Regional Director. The ASD will keep a transaction record of all and any resident's monies to ensure funds are not misused,and to protect the facility from accusations of misuse of resident's funds. This includes cash deposits and cash withdrawls of any amount, any purchases of any amount made by the provider on behalf of the resident. Receipts will be retained to verify that the item purchased accurately reflect the amount withdrawn from the resident's funds. The ASD has received additional financial management training on 7/18,7/19/22,by Regional Director. ASD will keep record of financial transactions with the resident,including the dates, amounts of deposits, withdrawls ,and current balances. ASD will complete monthly audits, and quarterly statements will be sent to representatives, POA. Funds will be available to residents at all times, and review of residents accounts with residents and /or their representatives will be available upon request. ASD will maintain all records, and monthly audits will begin 08/01/22. ASD, EOO, and, DSM will participate in the ongoing monthly audits to ensure accuracy.

Completion Date: *08/09/2022*

Document Submission ***Implemented***

On 7/14/22, the ASD was educated and trained on managing resident's funds by Regional Director. The ASD will keep a transaction record of all and any resident's monies to ensure funds are not misused,and to protect the facility from accusations of misuse of resident's funds. This includes cash deposits and cash withdrawls of any amount, any purchases of any amount made by the provider on behalf of the resident. Receipts will be retained to verify that the item purchased accurately reflect the amount withdrawn from the resident's funds. The ASD has received additional financial management training on 7/18,7/19/22,by Regional Director. ASD will keep record of financial transactions with the resident,including the dates, amounts of deposits, withdrawls ,and current balances. ASD will complete monthly audits, and quarterly statements will be sent to representatives, POA. Funds will be available to residents at all times, and review of residents accounts with residents and /or their representatives will be available upon request. ASD will maintain all records, and monthly audits will begin 08/01/22. ASD, EOO, and, DSM will participate in the ongoing monthly audits to ensure accuracy. All steps have been completed.

65d - Initial Direct Care Training

1. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Staff Member A, hired on [redacted] began providing unsupervised ADL services on [redacted] However, the staff person did not complete the Department-approved direct care training course and pass the competency test until [redacted]

Staff Member B, hired on [redacted], began providing unsupervised ADL services on [redacted] However, the staff person did not complete the Department-approved direct care training course and pass the competency test as [redacted]

Plan of Correction ***Directed***

As of 7/14/22, Executive Operations Officer, Wellness Director, and training staff, will ensure that all new hires will have training that includes a demonstration of job duties, followed by supervision, successful passing of the competency test. Initial direct care staff person training will include : Safe management techniques, ADLs, IADLs, personal hygiene, care of residents with dementia, mental illness, cognitive impairments, mental retardation, and other mental disabilities. Also, the normal aging cognitive, psychological and functional abilities of individuals that are older, nutrition, food handling, sanitation, Universal precautions infection control, care for individuals with mobility issues, and all required trainings by DHS. prior to providing any direct care. As of 07/13/22,the EOO, Wellness Director, and ASD will ensure all staff hired will complete mandatory trainings and competency test. A copy of competency test will be filed in employee's record kept in the ASD office. Staff training is held biweekly on Tuesdays and all direct care staff will complete a three day training followed by successful completion of the competency test. All required background and health testing will also be completed before providing any care to residents. As of 7/14/22, the ASD will be responsible for maintaining records. Wellness Director will ensure that all required trainings are up to date and an audit of trainings will be kept in the training log in the Director of Wellness office.

Directed-
By 8/31/2022, the Administrator will complete an audit of current staff members providing direct care to ensure they have the Department-approved direct care training course and pass the competency test. Audits completed by the Wellness Director will be reviewed at the home's quality management meeting beginning 8/31/2022. CR 8/11/2022

Completion Date: *08/09/2022*

Document Submission ***Implemented***

As of 7/14/22, Executive Operations Officer, Wellness Director, and training staff, will ensure that all new hires will have training that includes a demonstration of job duties, followed by supervision, successful passing of the competency test. Initial direct care staff person training will include : Safe management techniques, ADLs, IADLs, personal hygiene, care of residents with dementia, mental illness, cognitive impairments, mental retardation, and other mental disabilities. Also, the normal aging cognitive, psychological and functional abilities of individuals that are older, nutrition, food handling, sanitation, Universal precautions infection control, care for individuals with

65d - Initial Direct Care Training (continued)

mobility issues, and all required trainings by DHS. prior to providing any direct care. As of 07/13/22,the EOO, Wellness Director, and ASD will ensure all staff hired will complete mandatory trainings and competency test. A copy of competency test will be filed in employee's record kept in the ASD office. Staff training is held biweekly on Tuesdays and all direct care staff will complete a three day training followed by successful completion of the competency test. All required background and health testing will also be completed before providing any care to residents. As of 7/14/22, the ASD will be responsible for maintaining records. Wellness Director will ensure that all required trainings are up to date and an audit of trainings will be kept in the training log in the Director of Wellness office.

Directed-
By 8/31/2022, the Administrator will complete an audit of current staff members providing direct care to ensure they have the Department-approved direct care training course and pass the competency test. Audits completed by the Wellness Director will be reviewed at the home's quality management meeting beginning 8/31/2022. CR 8/11/2022. All steps have been completed.

82a - Poisonous Materials

1. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 7/12/2022 at approximately 12:10 PM, a gray, 2-gallon spray bottle, filled with unidentified substance, was found in the Mechanical Room in the 300 wing of the home. According to Staff Member C, the liquid substance contained in the 2-gallon spray bottle was ProvenSystem Carpet Extraction Cleaner. Original product labeling stated, "may be harmful if swallowed." A manufacturer's label was on the gray 2-gallon spray bottle.

Plan of Correction ***Accept***

On 7/13/22, Executive Operations Officer, and Maintenance Supervisor educated and reminded housekeeping staff, and facility staff that are poisonous materials must be kept in their original , labeled containers. Staff was educated by Maintenance Supervisor, that this will prevent and/or minimize the possibility that a resident or staff person will mistake a poisonous substance for a harmless substance. Executive Operations Officer will randomly check on a bi-weekly basis, beginning on 7/14/22, along with Maintenance supervisor, that all bottles are labeled to ensure that they are labeled and are in their original containers. 7/14/22. Maintenance Supervisor will oversee that this is being done on a regular basis. Maintenance Supervisor and trained staff will ensure education will be provided for any new staff.

Completion Date: *08/09/2022*

82a - Poisonous Materials *(continued)*

Document Submission ***Implemented***

On 7/13/22, Executive Operations Officer, and Maintenance Supervisor educated and reminded housekeeping staff, and facility staff that are poisonous materials must be kept in their original , labeled containers. Staff was educated by Maintenance Supervisor, that this will prevent and/or minimize the possibility that a resident or staff person will mistake a poisonous substance for a harmless substance. Executive Operations Officer will randomly check on a bi-weekly basis, beginning on 7/14/22, along with Maintenance supervisor, that all bottles are labeled to ensure that they are labeled and are in their original containers. 7/14/22. Maintenance Supervisor will oversee that this is being done on a regular basis. Maintenance Supervisor and trained staff will ensure education will be provided for any new staff. Next Squirt, quality assurance meeting will be 8/24/2022. Monthly meetings will be held on a regular basis on the first Wednesday of the month beginning in September, 2022. All steps have been completed.

82c - Locking Poisonous Materials

1. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 7 Perineal spray lotion with a manufacturer's label indicating, "call poison control if swallowed," was unlocked, unattended, and accessible to Resident #3 in the resident's bedroom. Not all the residents of the home, including Resident #3, have been assessed

Plan of Correction ***Accept***

This EEO, and Wellness Director, and all staff will ensure that all poisonous materials shall be kept locked and inaccessible to residents to protect residents who are unable to safely use or avoid poisonous materials from illness,injury,or death related to misuse of accessible poisons. Executive Operations Officer, and Wellness Director will begin weekly, and random checks of resident's rooms beginning on 7/13/22. RSS's, and housekeeping staff will also do daily checks of resident's rooms to ensure that no prescribed or OTC items are in resident's rooms. If any are found, staff will remove the items from the resident's room immediately, make sure they are labeled, and give to nurse to lock in med cart and receive a physician order if needed. Wellness Director will ensure that all RASP are current,and updated as required. 7/13/22

Completion Date: *07/28/2022*

Document Submission ***Implemented***

This EEO, and Wellness Director, and all staff will ensure that all poisonous materials shall be kept locked and inaccessible to residents to protect residents who are unable to safely use or avoid poisonous materials from illness,injury,or death related to misuse of accessible poisons. Executive Operations Officer, and Wellness Director will begin weekly, and random checks of resident's rooms beginning on 7/13/22. RSS's, and housekeeping staff will also do daily checks of resident's rooms to ensure that no prescribed or OTC items are in resident's rooms. If any are found, staff will remove the items from the resident's room immediately, make sure they are labeled, and give to nurse to lock in med cart and receive a physician order if needed. Wellness Director will ensure that all RASP are current,and updated as required. 7/13/22. All steps have been completed.

105g - Lint Removal and Duct Cleaning

1. Requirements

105g - Lint Removal and Duct Cleaning *(continued)*

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

On 7/12/2022 at approximately 12:15 PM, an accumulation of lint was observed in the lint trap of the residential laundry room covering approximately 1/3 of the lint trap screen. There were no clothes in the dryer at the time.

Plan of Correction ***Accept***

Staff was educated by Maintenance Supervisor on 7/13/22, and reminded that lint must be removed from the clothes dryers after each use, and also that staff must completed the lint log after cleaning the lint duct. Staff was educated on 7/13/22 regarding this the danger and risk of fire if lint is not removed from lint duct. On 7/14/22, Executive Operations Officer instructed and implemented a plan for checking of the dryer duct when there is a change of shift, while completing rounds to ensure this is not over looked. RSS's, housekeeping, and all staff were informed of this plan and all are also responsible for ensuring that the lint duct is cleaned. 7/14/22.

Completion Date: *08/09/2022*

Document Submission ***Implemented***

Staff was educated by Maintenance Supervisor on 7/13/22, and reminded that lint must be removed from the clothes dryers after each use, and also that staff must completed the lint log after cleaning the lint duct. Staff was educated on 7/13/22 regarding this the danger and risk of fire if lint is not removed from lint duct. On 7/14/22, Executive Operations Officer instructed and implemented a plan for checking of the dryer duct when there is a change of shift, while completing rounds to ensure this is not over looked. RSS's, housekeeping, and all staff were informed of this plan and all are also responsible for ensuring that the lint duct is cleaned. 7/14/22. All steps have been completed.

132a - Monthly Fire Drill

1. 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 April 2022.

132a - Monthly Fire Drill *(continued)*

Plan of Correction ***Accept***

This Executive Operations Officer has coordinated with maintenance supervisor on 7/14/22,to have have unannounced fire drills at least once a month on all three shifts, to have drills unannounced will help ensure that staff and residents will be prepared to evacuate without hesitation in the event of a real fire. Fire drills shall be held on different days of the week,at different times of the day and night, not to routinely held when additional staff persons are present and not only when census is low. A fire drill will be held during sleeping hours once every six months. Each fire drill will be timed to determine evacuation time by Executive Operations Officer, and/or maintenance supervisor, to ensure evacuation within the maximum evacuation time to prevent fire related death and injury. Written documentation of all fire drills will be kept in the fire log binder and maintained by this Executive Operations Officer, and will be reviewed by the maintenance supervisor. This policy will start as of 07/13/22. By 7/26/22, all staff will be educated on 2600.132(a). Documentation will be submitted to the Department.

Completion Date: *07/28/2022*

Document Submission ***Implemented***

This Executive Operations Officer has coordinated with maintenance supervisor on 7/14/22,to have have unannounced fire drills at least once a month on all three shifts, to have drills unannounced will help ensure that staff and residents will be prepared to evacuate without hesitation in the event of a real fire. Fire drills shall be held on different days of the week,at different times of the day and night, not to routinely held when additional staff persons are present and not only when census is low. A fire drill will be held during sleeping hours once every six months. Each fire drill will be timed to determine evacuation time by Executive Operations Officer, and/or maintenance supervisor, to ensure evacuation within the maximum evacuation time to prevent fire related death and injury. Written documentation of all fire drills will be kept in the fire log binder and maintained by this Executive Operations Officer, and will be reviewed by the maintenance supervisor. This policy will start as of 07/13/22. By 7/26/22, all staff will be educated on 2600.132(a). Documentation will be submitted to the Department. All steps have been completed.

132h - Designated Meeting Place

1. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 6/28/2022 at 9:33 AM, Resident #6 did not evacuate to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction ***Accept***

Executive Operations Office, and maintenance supervisor implemented a plan on 7/14/22, and educated all staff that all residents shall be evacuated to the designated area, away from the fire ,away from the building, or within within the fire safe area during each fire drill. The facility will comply with requirements PA 2600. 29 have re-educated staff on 7/14/22 by Maintenance Supervisor and EOO, of specified regulations regarding a resident remaining in the facility during a fire drill if receiving hospice care and and the requirements for all residents to evacuate the facility and the proper procedures for vacating.

Completion Date: *08/09/2022*

132h - Designated Meeting Place *(continued)*

Document Submission ***Implemented***

Executive Operations Office, and maintenance supervisor implemented a plan on 7/14/22, and educated all staff that all residents shall be evacuated to the designated area, away from the fire ,away from the building, or within within the fire safe area during each fire drill. The facility will comply with requirements PA 2600. 29 have re-educated staff on 7/14/22 by Maintenance Supervisor and EOO, of specified regulations regarding a resident remaining in the facility during a fire drill if receiving hospice care and and the requirements for all residents to evacuate the facility and the proper procedures for vacating. All steps have been completed.

144b - Policy on Smoking

1. Requirements

2600.
144.b. The home rules shall specify whether the home is designated as smoking or nonsmoking.

Description of Violation

The Clean Indoor Air Act requires that the home post a sign at each entrance that states, "Smoking Permitted in Designated Areas Only" or "No Smoking." On 7/12/2022, signs were not posted at the home's entrances to the building.

Plan of Correction ***Accept***

Executive Operations Officer posted a sign on 7/14/22, indicating that "smoking was permitted in designated areas only". On 7/14/22 signs were posted at every entrance regarding the policy on smoking, and the designated smoking area location. A written policy is in place and available for review regarding the facility smoking policy. The Maintenance Supervisor will serve as the monitoring piece to ensure the signs remain posted per regulations. This will be done by weekly routine audits, beginning 08/09/22. EEO will also ensure the signs are posted per the regulations, while doing daily safety rounds at the facility beginning on 8/10/22.

Completion Date: *08/09/2022*

Document Submission ***Implemented***

Executive Operations Officer posted a sign on 7/14/22, indicating that "smoking was permitted in designated areas only". On 7/14/22 signs were posted at every entrance regarding the policy on smoking, and the designated smoking area location. A written policy is in place and available for review regarding the facility smoking policy. The Maintenance Supervisor will serve as the monitoring piece to ensure the signs remain posted per regulations. This will be done by weekly routine audits, beginning 08/09/22. EEO will also ensure the signs are posted per the regulations, while doing daily safety rounds at the facility beginning on 8/10/22. All steps have been completed.

144c1 - Smoking Area Guidelines

1. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On 7/12/2022 at approximately 12:30 PM, the home's designated smoking area did not provide fireproof receptacles

144c1 - Smoking Area Guidelines (continued)

and ashtrays.

Plan of Correction ***Accept***

On 7/14/22, Executive Operation Officer, and Maintenance Supervisor provided two fireproof receptacles at the designated smoking area. Fire extinguishers are noticeably located near the smoking area in the event of a fire. On 7/14/22, EEO and maintenance Supervisor implemented, reviewed the smoking policy with team members which included: The location of the smoking area, the use of the receptacles, and how staff must respond to a fire in a designated smoking area, including evacuation and the location of the designated fire extinguisher. The Maintenance Supervisor will serve as the monitoring piece to ensure the fireproof receptacles remain in place per regulations. This will be done by weekly routine audits, beginning 08/09/22. EEO will also ensure the receptacles remain in place per the regulations, while doing daily safety rounds at the facility beginning on 8/10/22.

Completion Date: *08/09/2022*

Document Submission ***Implemented***

On 7/14/22, Executive Operation Officer, and Maintenance Supervisor provided two fireproof receptacles at the designated smoking area. Fire extinguishers are noticeably located near the smoking area in the event of a fire. On 7/14/22, EEO and maintenance Supervisor implemented, reviewed the smoking policy with team members which included: The location of the smoking area, the use of the receptacles, and how staff must respond to a fire in a designated smoking area, including evacuation and the location of the designated fire extinguisher. The Maintenance Supervisor will serve as the monitoring piece to ensure the fireproof receptacles remain in place per regulations. This will be done by weekly routine audits, beginning 08/09/22. EEO will also ensure the receptacles remain in place per the regulations, while doing daily safety rounds at the facility beginning on 8/10/22. All steps have been completed.

183b - Meds and Syringes Locked

1. Requirements

2600.

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

Description of Violation

On a bottle of was unlocked, unattended, and accessible in Resident #1's bedroom nightstand. Resident #1 per Resident #1's Resident Assessment and Support Plan (RASP), dated .

On a container of was unlocked, unattended and accessible in Resident #2's bathroom. Resident #2 per Resident #2's RASP,

183b - Meds and Syringes Locked *(continued)*

Plan of Correction ***Accept***

This Executive Operations Officer, and Wellness Director,removed all prescription and OTC medications from resident's room that were [redacted] on 07/13/22. Executive Operations Officer, and Wellness Director educated both residents and staff on 7/13/22,and on 7/14/22, that prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. Medications and syringes will be safe from residents who are [redacted] medications from harming themselves. Executive Operations Officer, and Wellness Director will begin weekly, and random checks of resident's rooms beginning on 7/13/22. RSS's, and housekeeping staff will also do daily checks of resident's rooms to ensure that no prescribed or OTC items are in resident's rooms. If any are found, staff will remove the items from the resident's room immediately, make sure they are labeled, and give to nurse to lock in med cart and receive a physician order if needed. Wellness Director will ensure that all RASP are current,and updated as required. 7/13/22

Completion Date: *07/28/2022*

Document Submission ***Implemented***

This Executive Operations Officer, and Wellness Director,removed all prescription and OTC medications from resident's room that were [redacted] on 07/13/22. Executive Operations Officer, and Wellness Director educated both residents and staff on 7/13/22,and on 7/14/22, that prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. Medications and syringes will be safe from residents who are [redacted] medications from harming themselves. Executive Operations Officer, and Wellness Director will begin weekly, and random checks of resident's rooms beginning on 7/13/22. RSS's, and housekeeping staff will also do daily checks of resident's rooms to ensure that no prescribed or OTC items are in resident's rooms. If any are found, staff will remove the items from the resident's room immediately, make sure they are labeled, and give to nurse to lock in med cart and receive a physician order if needed. Wellness Director will ensure that all RASP are current,and updated as required. 7/13/22. All steps have been completed.

183d - Prescription Current

1. Requirements

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

Description of Violation

On [redacted] prescribed for Resident #2, was in Resident #2's bathroom; however, the medication was discontinued on [redacted] Additionally, the pharmacy label indicated the prescription expired on [redacted]

183d - Prescription Current *(continued)*

Plan of Correction ***Accept***

The Executive Operations Officer, along with the Wellness Director will be completing monthly cart audits with a triple check done by Regional Director, and nurse, 07/28/22.,and will review with all med techs that they are removing and properly disposing of any D/C medications and that they must thoroughly review all charts and MARS before administering any medications and assure the proper checks of medication administration are complete. Med techs were re-trained 7/22/22, by Wellness Director, on D/C meds, refused meds, and expired meds on 7/22/22. Med techs were also reminded by Wellness Director, that only prescribed medications were allowed in the home. Med-techs were also re-trained in the proper steps in disposing of and handling medications properly of residents no longer in the home,expired medications, and D/C medications. In the event of a medication error,med techs will report to the resident, the resident's designated person,the physician who prescribed the medication the Executive Operations Officer, Wellness Director, and the DHS within 24 hours. On 7/15/22, initial audit of med carts and rooms to ensure all medications were current and not discontinued or expired were completed by Wellness Director and EOO. The changes have been implemented starting 7/15/22. By 7/15/22, discontinued medications for the resident #2 was disposed of per regulations. Resident's rooms will be checked daily by RSS, LPN's,and any trained staff, to ensure no medications are in resident's rooms that are not permitted to self-medicate.

Completion Date: *08/09/2022*

Document Submission ***Implemented***

The Executive Operations Officer, along with the Wellness Director will be completing monthly cart audits with a triple check done by Regional Director, and nurse, 07/28/22.,and will review with all med techs that they are removing and properly disposing of any D/C medications and that they must thoroughly review all charts and MARS before administering any medications and assure the proper checks of medication administration are complete. Med techs were re-trained 7/22/22, by Wellness Director, on D/C meds, refused meds, and expired meds on 7/22/22. Med techs were also reminded by Wellness Director, that only prescribed medications were allowed in the home. Med-techs were also re-trained in the proper steps in disposing of and handling medications properly of residents no longer in the home,expired medications, and D/C medications. In the event of a medication error,med techs will report to the resident, the resident's designated person,the physician who prescribed the medication the Executive Operations Officer, Wellness Director, and the DHS within 24 hours. On 7/15/22, initial audit of med carts and rooms to ensure all medications were current and not discontinued or expired were completed by Wellness Director and EOO. The changes have been implemented starting 7/15/22. By 7/15/22, discontinued medications for the resident #2 was disposed of per regulations. Resident's rooms will be checked daily by RSS, LPN's,and any trained staff, to ensure no medications are in resident's rooms that are not permitted to self-medicate. All steps have been completed.

185a - Implement Storage Procedures

1. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

The home's policy for accountability of controlled substance states, “Controlled Substance will be documented in the

185a - Implement Storage Procedures (continued)

resident's medical record to include the date, time medication, dosage and the quantity received. The entry will contain signature title and team of team member receiving controlled substance.'" This policy includes a procedure for the medication technician staff to sign and date the controlled substance tracking form at the time of administration. On [redacted] Staff Member D did not sign the count sheet indicating the administration of [redacted]

Plan of Correction ***Directed***

On 7/13/22, educated med techs to follow the directions of the prescriber. In addition they will follow the direction of a prescribed treatment, such as medical equipment, (glucometers). A policy was in place on 7/13/22, and staff was educated that medical equipment should be regarded in the same manner as medications and all resident's blood sugar readings must be documented on the resident's medication administration record, (MAR). Staff was informed and educated that the MAR creates a record of proper medication, will allow the physicians and emergency personnel to know when and what a medication was last administered, and creates a system to account for medications, and especially controlled substances. The facility will ensure that all controlled substances be double locked and counted each shift, with the count documented by two staff persons and a supervisor starting on 7/13/22. Staff will initial the MAR, print , and sign complete full name med tech's name, or LPN name so the staff person can be linked to the specific MAR entry. Wellness Director will complete an audit of the MARS to review medications are given as prescribed, how often, and by who. Wellness Director will begin completing MARs audits at the beginning of each month, to review the previous month report beginning on 09/01/22 . On 7/13/22, Wellness Director also trained and educated med techs own documentation of all medications on the MARS, to include staff initials his/her signature so ensure that the individual can be linked to the specific MAR entry. Med techs, Wellness Director will be able to track all medications and to ensure all medications are administered as prescribed. Staff was informed and educated that the MAR creates a record of proper medication, will allow the physicians and emergency personnel to know when and what a medication was last administered, and creates a system to account for medications, and especially controlled substances. Wellness Director will complete monthly chart audits to ensure MARS accuracy and to eliminate any chances of documentation errors.

Directed-
By 8/31/2022, the Administrator will audit all narcotic count sheets and narcotic medications to ensure that the medications are being administered as ordered and are documented as required by the home's policy. This audit will be conducted by the Administrator monthly thereafter. CR 8/11/2022
Completion Date: *08/09/2022*

Document Submission ***Implemented***

On 7/13/22, educated med techs to follow the directions of the prescriber. In addition they will follow the direction of a prescribed treatment, such as medical equipment, (glucometers). A policy was in place on 7/13/22, and staff was educated that medical equipment should be regarded in the same manner as medications and all resident's blood sugar readings must be documented on the resident's medication administration record, (MAR). Staff was informed and educated that the MAR creates a record of proper medication, will allow the physicians and emergency personnel to know when and what a medication was last administered, and creates a system to account for medications, and especially controlled substances. The facility will ensure that all controlled substances be double locked and counted each shift, with the count documented by two staff persons and a supervisor starting on 7/13/22. Staff will initial the MAR, print , and sign complete full name med tech's name, or LPN name so the staff person can be linked to the specific MAR entry. Wellness Director will complete an audit of the MARS to review medications are given as prescribed, how often, and by who. Wellness Director will begin completing MARs audits at the beginning of each month, to review the previous month report beginning on 09/01/22 . On 7/13/22, Wellness Director also

185a - Implement Storage Procedures (continued)

trained and educated med techs own documentation of all medications on the MARS, to include staff initials his/her signature so ensure that the individual can be linked to the specific MAR entry. Med techs, Wellness Director will be able to track all medications and to ensure all medications are administered as prescribed. Staff was informed and educated that the MAR creates a record of proper medication, will allow the physicians and emergency personnel to know when and what a medication was last administered, and creates a system to account for medications, and especially controlled substances. Wellness Director will complete monthly chart audits to ensure MARS accuracy and to eliminate any chances of documentation errors.

Directed-
By 8/31/2022, the Administrator will audit all narcotic count sheets and narcotic medications to ensure that the medications are being administered as ordered and are documented as required by the home's policy. This audit will be conducted by the Administrator monthly thereafter. CR 8/11/2022. All steps have been completed.

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:
11. Special precautions, if applicable.

Description of Violation

Resident #1 is prescribed [redacted] with a special instruction to administer [redacted]. However, Resident's #1's [redacted] 2022 medication administration record (MAR) does not indicate the amount of [redacted]

Plan of Correction ***Accept***

On 7/14/22, Wellness Director educated/ trained staff on the importance of correct documentation that must be documented on the Medication Administration Record, (MAR). Staff was informed and educated that the MAR creates a record of proper medication, will allow the physicians and emergency personnel to know when and what a medication was last administered, and creates a system to account for medications, and especially controlled substances. In addition,med techs were educated on the importance of tracking resident's [redacted], and [redacted] given to eliminate any inappropriate dosage, and to help maintain a consistent record of the resident's [redacted] and effectiveness of medication. Wellness Director will review MAR on a weekly basis beginning on 7/13/22, and med-techs were educated on how to report and document any medication error.

Completion Date: *07/28/2022*

187a - Medication Record *(continued)*

Document Submission ***Implemented***

On 7/14/22, Wellness Director educated/ trained staff on the importance of correct documentation that must be documented on the Medication Administration Record, (MAR). Staff was informed and educated that the MAR creates a record of proper medication, will allow the physicians and emergency personnel to know when and what a medication was last administered, and creates a system to account for medications, and especially controlled substances. In addition,med techs were educated on the importance of tracking resident's blood sugar level, and Insulin given to eliminate any inappropriate dosage, and to help maintain a consistent record of the resident's blood sugar readings and effectiveness of medication. Wellness Director will review MAR on a weekly basis beginning on 7/13/22, and med-techs were educated on how to report and document any medication error. All steps have been completed.

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #3 is prescribed [redacted], with instruction which indicates [redacted] On [redacted] Resident #3 was administered the medication; however the [redacted]

Plan of Correction ***Accept***

The med techs shall follow the directions of the prescriber. In addition, they will follow the directions of a prescribed treatment, such as the use of medical equipment or therapy. The Executive Operations Officer and Director of Wellness will monitor all of the prescribed treatments/medications to ensure that residents receive medications and treatments as ordered by the physician to ensure safety and welfare of all residents on a daily /ongoing basis. In the event of a medication error, med-techs will report to the resident, the resident's designated person, the physician who prescribed the medication, the Executive Operations Officer, the Wellness Director, and DPW within 24 hours. The med tech will document the error and the physician's response to the error and this document must be signed by the Executive Operations Officer who will then review and sign the document. The Executive Operations Office and Wellness Director educated med techs regarding the above information in training on 7/14/22. Wellness Director will complete an audit of the MARS to review medications are given as prescribed, how often, and by who. Wellness Director will begin completing MARs audits at the beginning of each month, to review the previous month report beginning on 09/01/22

Completion Date: *08/09/2022*

187d - Follow Prescriber's Orders *(continued)*

Document Submission ***Implemented***

The med techs shall follow the directions of the prescriber. In addition, they will follow the directions of a prescribed treatment, such as the use of medical equipment or therapy. The Executive Operations Officer and Director of Wellness will monitor all of the prescribed treatments/medications to ensure that residents receive medications and treatments as ordered by the physician to ensure safety and welfare of all residents on a daily /ongoing basis. In the event of a medication error, med-techs will report to the resident, the resident's designated person, the physician who prescribed the medication, the Executive Operations Officer, the Wellness Director, and DPW within 24 hours. The med tech will document the error and the physician's response to the error and this document must be signed by the Executive Operations Officer who will then review and sign the document. The Executive Operations Office and Wellness Director educated med techs regarding the above information in training on 7/14/22. Wellness Director will complete an audit of the MARS to review medications are given as prescribed, how often, and by who. Wellness Director will begin completing MARs audits at the beginning of each month, to review the previous month report beginning on 09/01/22 . All steps have been completed.

225c - Additional Assessment

1. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #5's assessment, dated [redacted] does not include the resident's care need [redacted] as indicated on the resident medical evaluation, completed [redacted]. Resident #5 wears a [redacted] which is applied to the resident's ankle; however, there is not an assessment of care need for this device.

Resident #3's assessment, dated [redacted] does not include the resident's care need for the following medical diagnoses: [redacted] These diagnoses are identified on the resident medical evaluation, completed on [redacted]

Plan of Correction ***Accept***

This Executive Operations Officer and/or the Wellness Director will complete assessments on an annual basis,and if this is a significant change, complete accurate,information that will be provided on the assessments to ensure all resident's needs can and will be met. At this point,7/14/22, Executive Operations Officer,and Wellness Director have reviewed and updated all assessments in accordance with PA code 2600.141 (a) (1) Executive Operations Officer and Wellness Director will continue to complete Pre-screen assessments,DME, RASSP, Medical evaluation forms,and all paperwork and assessments to provide the residents with the appropriate care and treatment that is recommended and prescribed. This EEO will EEO, and Wellness Director,will ensure that assessments are reviewed with the residents,signed by the residents, reviewed by a physician, and also signed by a physician all within the regulated time frames. This EEO will ensure this is completed immediately. 07/14/22.,and on an ongoing basis. Wellness Director was informed and educated on proper completion of these documents. 07/14/22. Resident #3 and Resident #5 assessments were updated on 7/14/22 by Wellness Director,to include missing information as stated in the violation, and the both entire assessments were completed by Wellness Director on 7/14/22.

Completion Date: *08/09/2022*

225c - Additional Assessment *(continued)*

Document Submission ***Implemented***

This Executive Operations Officer and/or the Wellness Director will complete assessments on an annual basis,and if this is a significant change, complete accurate,information that will be provided on the assessments to ensure all resident's needs can and will be met. At this point,7/14/22, Executive Operations Officer,and Wellness Director have reviewed and updated all assessments in accordance with PA code 2600.141 (a) (1) Executive Operations Officer and Wellness Director will continue to complete Pre-screen assessments,DME, RASSP, Medical evaluation forms,and all paperwork and assessments to provide the residents with the appropriate care and treatment that is recommended and prescribed. This EEO will EEO, and Wellness Director,will ensure that assessments are reviewed with the residents,signed by the residents, reviewed by a physician, and also signed by a physician all within the regulated time frames. This EEO will ensure this is completed immediately. 07/14/22.,and on an ongoing basis. Wellness Director was informed and educated on proper completion of these documents. 07/14/22. Resident #3 and Resident #5 assessments were updated on 7/14/22 by Wellness Director,to include missing information as stated in the violation, and the both entire assessments were completed by Wellness Director on 7/14/22. All steps have been completed.