Department of Human Services
Bureau of Human Service Licensing

September 9, 2022

MERAKEY PENNSYLVANIA
4251 CRUMS MILL ROAD
HARRISBURG, PA, 17112

RE: MERAKEY PENNSYLVANIA
1460 PEIFFERS LANE
STEELTON, PA, 17113
LICENSE/COC#: 31036

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/14/2022, 07/15/2022 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: *MERAKEY PENNSYLVANIA* **License #**: *31036* **License Expiration**: *03/28/2023*

Address: *1460 PEIFFERS LANE, STEELTON, PA 17113*

County: *DAUPHIN* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *MERAKEY PENNSYLVANIA*

Address: *4251 CRUMS MILL ROAD, HARRISBURG, PA, 17112*

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *03/24/2006* **Issued By**: *Swatara Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *6* **Waking Staff**: *5*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/15/2022*

Inspection Dates and Department Representative

07/14/2022 - On-Site [redacted]

07/15/2022 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *6* **Residents Served**: *6*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *6* **Are 60 Years of Age or Older**: *2*

Diagnosed with Mental Illness: *6* **Diagnosed with Intellectual Disability**: *1*

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

Inspections / Reviews

07/14/2022 - Full

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

08/15/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/22/2022*

08/31/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/08/2022*

09/09/2022 - Document Submission

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

42s - Privacy

1. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

There is a camera located on the front of the building, facing towards the driveway. The camera is recording, however, there are no signs posted about video recording.

Plan of Correction ***Accept***

Plan of Correction: On 7/15/22, Capital Region ABH Program Director discussed potential violation with Merakey Facilities Department. On 7/18/2022, the work order was submitted by the Program Director to Merakey Facilities to install signs to alert individuals that they are on camera. On 7/25/22 Merakey Facilities installed the new signs.

Completion Date: *07/25/2022*

Document Submission ***Implemented***

Plan of Correction: On 7/15/22, Capital Region ABH Program Director discussed potential violation with Merakey Facilities Department. On 7/18/2022, the work order was submitted by the Program Director to Merakey Facilities to install signs to alert individuals that they are on camera. On 7/25/22 Merakey Facilities installed the new signs.

54a - Direct Care Staff

1. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care Staff Member A's record does not show that he/she has a high school diploma, GED diploma, or active registry status on the Pennsylvania nurse aid registry.

Plan of Correction ***Accept***

On 7/15/2022 Program Director telephoned the Merakey File Hub to have the file hub send a copy of the GED to Pieffers Lane. It was determined that the records Merakey had weren't correct. On 7/20/2022 the Program Director contacted HACC to ask for protocols for getting proof of GED. On 7/20/2022, Program Director contacted Staff (RQ) and informed (RQ) that PA Department of Education was the appropriate place to receive proof of ███ GED. As of 8/8/2022 staff purchased letter of verification and diploma which staff will receive in 10 business days. Staff will then send to Merakey HR and DHS. As of 8/11/22 the staff received a copy of ███ GED from the PA Dept. of Education. A copy of the Staff GED was put in the cart As of 8/1/22 the new hire checklist will be re-implemented, and all documents will be gathered and scanned to the Merakey Protected Server by the Program Director/Designee on an annual basis. By 11/21/22 all current staff charts will be audited. This violation was sent to the Quality and Compliance Department for further review.

Completion Date: *11/21/2022*

Document Submission ***Implemented***

On 7/15/2022 Program Director telephoned the Merakey File Hub to have the file hub send a copy of the GED to Pieffers Lane. It was determined that the records Merakey had weren't correct. On 7/20/2022 the Program Director contacted HACC to ask for protocols for getting proof of GED. On 7/20/2022, Program Director contacted Staff

54a - Direct Care Staff (continued)

(RQ) and informed (RQ) that PA Department of Education was the appropriate place to receive proof of ███ GED. As of 8/8/2022 staff purchased letter of verification and diploma which staff will receive in 10 business days. Staff will then send to Merakey HR and DHS. As of 8/11/22 the staff received a copy of her GED from the PA Dept. of Education. A copy of the Staff GED was put in the cart As of 8/1/22 the new hire checklist will be re-implemented, and all documents will be gathered and scanned to the Merakey Protected Server by the Program Director/Designee on an annual basis. By 11/21/22 all current staff charts will be audited. This violation was sent to the Quality and Compliance Department for further review.

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

Direct care Staff Member A's record does not show that ███ has successfully completed and passed the Department approved direct care training course and passed the competency test.

Plan of Correction ***Accept***

As of 8/1/22, Program Director can't locate completed training or observation for staff. By 9/1/22 staff will complete the direct care training course online module and competency test. As of 8/1/22 the new hire checklist will be re-implemented, and all documents will be gathered and scanned to the Merakey Protected Server by the Program Director/Designee on an annual basis. By 11/21/22 all current staff charts will be audited. This violation was sent to the Quality and Compliance Department for further review.

Completion Date: *11/21/2022*

Document Submission ***Implemented***

As of 8/1/22, Program Director can't locate completed training or observation for staff. By 9/1/22 staff will complete the direct care training course online module and competency test. As of 8/1/22 the new hire checklist will be re-implemented, and all documents will be gathered and scanned to the Merakey Protected Server by the Program Director/Designee on an annual basis. By 11/21/22 all current staff charts will be audited. This violation was sent to the Quality and Compliance Department for further review.

66b - Training Plan Content

1. Requirements

2600.
66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

Description of Violation

The home's staff training plan does not include the following: (1) The name, position and duties of each direct care staff person, (2) The required training courses for each staff person, or (3) The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Plan of Correction ***Accept***

Program Director collaborated with Residential Product Line to obtain examples of other training plans to utilize and then create. Program Director will create an individualized training plan per staff by 9/1/22 with dates, times and

66b - Training Plan Content (continued)

locations of the schedule's trainings for the upcoming calendar year.

Completion Date: *09/01/2022*

Document Submission ***Implemented***

Program Director collaborated with Residential Product Line to obtain examples of other training plans to utilize and then create. Program Director will create an individualized training plan per staff by 9/1/22 with dates, times and locations of the schedule's trainings for the upcoming calendar year.

94b - Non-Skid Surface

1. Requirements

2600.
94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

Description of Violation

The exterior side ramp located by the entrance on the right side of the home is not covered in any type of non-skid surface.

Plan of Correction ***Accept***

On 7/15/22, Capital Region ABH Program Director discussed potential violation with Merakey Facilities Department. On 7/18/2022, the Work order was submitted by the Program Director to Merakey Facilities to install non-skid protection. On 8/2/2022 a non-skid runner was nailed in place on the ramp. Inspect Nonskid Surface on Ramps has been added to the PCH Weekly Walk-Through Checklist. The Site Supervisor will review the Weekly Walk-Through Checklist upon completion.

Completion Date: *08/29/2022*

Document Submission ***Implemented***

On 7/15/22, Capital Region ABH Program Director discussed potential violation with Merakey Facilities Department. On 7/18/2022, the Work order was submitted by the Program Director to Merakey Facilities to install non-skid protection. On 8/2/2022 a non-skid runner was nailed in place on the ramp. Inspect Nonskid Surface on Ramps has been added to the PCH Weekly Walk-Through Checklist. The Site Supervisor will review the Weekly Walk-Through Checklist upon completion.

100a - Exterior - Free of Hazards

1. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The gutters along the front and rear sides of the house have vegetation growing out of them visible from the ground. In addition, there are areas of overgrowth and low-hanging branches impeding the use of the rear patio area, and creating a hazard for those walking through the area and around the rear yard.

Plan of Correction ***Accept***

On 5/18/2022 Merakey Facilities contacted Easy Siders (gutter repair company) to obtain a price estimate on replacing the gutters. On 7/6/2022 Merakey Facilities ordered services from Easy Siders for the replacement of the gutters. As of 7/15/2022, Easy Siders stated that they would start the work within two weeks. Residents have been informed that this work will be taking place in August and to not walk in rear yard. On 7/15/22, Capital Region ABH Program Director discussed potential violation with Merakey Facilities Department. On 7/18/2022, the Work order was submitted by the Program Director to Merakey facilities to cut down the overgrowth and low-hanging

100a - Exterior - Free of Hazards (continued)

branches. 8/10/22 Easy Siders replaced the gutters.

Completion Date: *09/01/2022*

Document Submission ***Implemented***

On 5/18/2022 Merakey Facilities contacted Easy Siders (gutter repair company) to obtain a price estimate on replacing the gutters. On 7/6/2022 Merakey Facilities ordered services from Easy Siders for the replacement of the gutters. As of 7/15/2022, Easy Siders stated that they would start the work within two weeks. Residents have been informed that this work will be taking place in August and to not walk in rear yard. On 7/15/22, Capital Region ABH Program Director discussed potential violation with Merakey Facilities Department. On 7/18/2022, the Work order was submitted by the Program Director to Merakey facilities to cut down the overgrowth and low-hanging branches. 8/10/22 Easy Siders replaced the gutters.

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 #4 does not have access to a source of light that can be turned on/off at their bedside.

Plan of Correction ***Accept***

On 7/14/22 program replaced bed side lamp. PCH weekly walk-through check list will continue to be completed by staff. Completed check lists will be reviewed by PCH Director for any issues.
8/29/2022 a PCH Regulation Reminder Memo was distributed to staff, educating staff on the regulation stating that each resident will have a lighting source that can be turned on at the bedside.

Completion Date: *08/29/2022*

Document Submission ***Implemented***

On 7/14/22 program replaced bed side lamp. PCH weekly walk-through check list will continue to be completed by staff. Completed check lists will be reviewed by PCH Director for any issues.
8/29/2022 a PCH Regulation Reminder Memo was distributed to staff, educating staff on the regulation stating that each resident will have a lighting source that can be turned on at the bedside.

103d - Storing Food Off Floor

1. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 7/14/22 at approximately 9:30 AM, Mandarin orange fruit cups, Chef Boyardee cans, single serving cereal packages and peanut butter jars were stored on the floor of small closet in the basement.

Plan of Correction ***Accept***

As of 7/14/22 the food items were placed appropriately on shelves. The closet was altered at the end of July to not allow for food to be placed on the floor. The PCH Weekly Walk-Through Check List was updated on 8/1/22 to include proper storage of food. Program Director will review the updates on the check list during 8/12/2022 shift

103d - Storing Food Off Floor (continued)

report and document in notes.

Completion Date: *08/05/2022*

Document Submission ***Implemented***

As of 7/14/22 the food items were placed appropriately on shelves. The closet was altered at the end of July to not allow for food to be placed on the floor. The PCH Weekly Walk-Through Check List was updated on 8/1/22 to include proper storage of food. Program Director will review the updates on the check list during 8/12/2022 shift report and document in notes.

103f - Refrigerator/Freezer Temps

1. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

The freezer section of the Whirlpool upright refrigerator/freezer did not contain a thermometer.

Plan of Correction ***Accept***

On 7/14/2022 prior to inspection, Thermometers were ordered. Thermometers arrived on 7/16/22 and as of 8/1/22 all refrigerators/freezers contained thermometers. Checking for thermometers was added to weekly walk-through checklist by Program Director. Program Director will review the updates on the check list by 8/12/2022 shift report and document agenda items/attendance.

Completion Date: *08/01/2022*

Document Submission ***Implemented***

On 7/14/2022 prior to inspection, Thermometers were ordered. Thermometers arrived on 7/16/22 and as of 8/1/22 all refrigerators/freezers contained thermometers. Checking for thermometers was added to weekly walk-through checklist by Program Director. Program Director will review the updates on the check list by 8/12/2022 shift report and document agenda items/attendance.

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 home was not able to provide any maintenance records showing that the dryer ductwork had been cleaned within the past 12 months according to the manufacturers specifications.

Plan of Correction ***Accept***

On 7/22/2022 Program Director created a new dryer vent cleaning log for future cleanings to occur during the months of January and July. The new document will be kept in the fire drill binder to be completed by Merakey Facilities upon cleaning. Merakey Facilities was informed of this update on 7/22/22. The PCH Weekly Walk-Through Check List was updated on 8/1/22 to review the outside dryer area. Program Director will review the updates on the check list by 8/12/2022 shift report and document in minutes.

Completion Date: *08/12/2022*

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

Document Submission ***Implemented***

On 7/22/2022 Program Director created a new dryer vent cleaning log for future cleanings to occur during the months of January and July. The new document will be kept in the fire drill binder to be completed by Merakey Facilities upon cleaning. Merakey Facilities was informed of this update on 7/22/22. The PCH Weekly Walk-Through Check List was updated on 8/1/22 to review the outside dryer area. Program Director will review the updates on the check list by 8/12/2022 shift report and document in minutes.

132f - Alternate Exit Routes

1. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

No alternate exits were used during fire drills conducted between August 2021 and June 2022.

Plan of Correction ***Accept***

PCH Director will update the fire drill schedule to include location of exit by 8/5/22. All staff will be made aware of the update during shift report on 8/12/2022. A fire drill memo was provided to staff by the Program Director via email on August 29, 2022, which reminded staff of the importance of using alternative exit routes during fire drills. The PCH director will monitor monthly completed drills, noting which of the two exits were utilized. When needed, the PCH Director will remind staff to consistently use the alternative exit.

Completion Date: *08/29/2022*

Document Submission ***Implemented***

PCH Director will update the fire drill schedule to include location of exit by 8/5/22. All staff will be made aware of the update during shift report on 8/12/2022. A fire drill memo was provided to staff by the Program Director via email on August 29, 2022, which reminded staff of the importance of using alternative exit routes during fire drills. The PCH director will monitor monthly completed drills, noting which of the two exits were utilized. When needed, the PCH Director will remind staff to consistently use the alternative exit.

141a 1-10 Medical Evaluation Information

1. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

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 Ability to Self-Administer Medications Section is not completed on resident #3's last DME dated [redacted]

Plan of Correction ***Accept***

By 9/1/22 resident #3 PCP will be contacted by PCH Director/Designee to recomplete DME form in its entirety. During shift report on 8/12, all staff will be reminded to review documents for completion prior to leaving any appointments with residents. Upon returning to facility, any DME paperwork will be turned in for PCH Director/Designee to review. If blanks are found, the PCP will be notified.
All charts will be audited to ensure that all DME forms are completed in their entirety by the PCH Director by 9/16/22. If a form is not complete, the Program Director/Designee will coordinate with the individual's PCP to complete the DME fully. Ongoing, PCH Director will audit charts on a monthly basis, informing the Residential Program Director of any deficits.

Completion Date: *08/29/2022*

Document Submission ***Implemented***

By 9/1/22 resident #3 PCP will be contacted by PCH Director/Designee to recomplete DME form in its entirety. During shift report on 8/12, all staff will be reminded to review documents for completion prior to leaving any appointments with residents. Upon returning to facility, any DME paperwork will be turned in for PCH Director/Designee to review. If blanks are found, the PCP will be notified.
All charts will be audited to ensure that all DME forms are completed in their entirety by the PCH Director by 9/16/22. If a form is not complete, the Program Director/Designee will coordinate with the individual's PCP to complete the DME fully. Ongoing, PCH Director will audit charts on a monthly basis, informing the Residential Program Director of any deficits.

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.

144c1 - Smoking Area Guidelines *(continued)*

Description of Violation

The cushions on love seat located in the smoking area on back porch are not flame resistant.

Plan of Correction ***Accept***

7/15/2022 cushion was removed and destroyed by Program Director. No future cushions will be utilized. On 8/29/22, this was added to the PCH Weekly Walkthrough by the Program Director. The PCH Weekly Walkthrough will be utilized weekly by the Program Director to ensure no cushions are placed.
On August 29, 2022 a PCH Regulation Reminder Memo from the Program Director to educate staff regarding the need for flame resistant materials in the smoking area.

Completion Date: *08/29/2022*

Document Submission ***Implemented***

7/15/2022 cushion was removed and destroyed by Program Director. No future cushions will be utilized. On 8/29/22, this was added to the PCH Weekly Walkthrough by the Program Director. The PCH Weekly Walkthrough will be utilized weekly by the Program Director to ensure no cushions are placed.
On August 29, 2022 a PCH Regulation Reminder Memo from the Program Director to educate staff regarding the need for flame resistant materials in the smoking area.

144c2 - Smoking Area Distance

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:
2. 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: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

The home has two designated smoking areas. One of these areas is directly behind the side door area, which is the main entry/exit of the home. This smoking area is directly behind a common walkway and exit.

Plan of Correction ***Accept***

On 7/15/2022 a review of potential citation with facilities occurred by Program Director. On 7/18/2022 a barrier was put into place to prevent easy access to this section of the side porch. It is the barrier which prevents egress to the back yard during wintertime. On 7/18/2022 the residents were educated regarding the nonsmoking and smoking areas of the PCH. 8/29/2022 the Residential Program Director wrote a memo reminding staff of the smoking/non-smoking area as well as asking staff to remind residents of the proper smoking area if they are smoking in a non-smoking area. Merakey's smoking policy is still being utilized and is attached for reference (Smoking Rules Pieffers 3 2021). On 8/1/22 Program Director followed up with Merakey Facilities about placing a sign in the smoking area. Signs will be displayed by 9/1/22.

Completion Date: *08/29/2022*

Document Submission ***Implemented***

On 7/15/2022 a review of potential citation with facilities occurred by Program Director. On 7/18/2022 a barrier

144c2 - Smoking Area Distance (continued)

was put into place to prevent easy access to this section of the side porch. It is the barrier which prevents egress to the back yard during wintertime. On 7/18/2022 the residents were educated regarding the nonsmoking and smoking areas of the PCH. 8/29/2022 the Residential Program Director wrote a memo reminding staff of the smoking/non-smoking area as well as asking staff to remind residents of the proper smoking area if they are smoking in a non-smoking area. Merakey's smoking policy is still being utilized and is attached for reference (Smoking Rules Pieffers 3 2021). On 8/1/22 Program Director followed up with Merakey Facilities about placing a sign in the smoking area. Signs will be displayed by 9/1/22.

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

a loose white pill identified as was found in resident #1's orange PRN bin.

On #1's for the the However resident #1's shows a

Resident #1's is not correctly calibrated with time and date. For example, the last was taken in the morning However, the is showing that reading as being taken on

Plan of Correction ***Accept***

On 7/16/22 PCH Director updated the date and time on Resident #1's MAR was updated on 7/16/22 to inform staff to visually view the r reading after each use. will be implemented by 9/1 and completed monthly by PCH Director. On 8/29/22 the Residential Program Director provided a memo to educate staff regarding the need to check the for the correct information. The memo also addressed the need to check the med bins each time they are used to be certain there are no loose pills. At shift change, the person coming on and leaving shift should check the bins and log it on the bin checklist. Starting on 9/16/22, the Program Director will review the bin checklist weekly to ensure there are no discrepancies. The person administering the medication should check for any loose pills. If a pill is found, identify the pill, and then destroy the pill using DPW Medication Administration Protocols. Document the destroyed pill on the Medication destruction log. The staff was educated on 8/29/2022 by a memo from the Residential Program Director the process and importance of utilizing the bin checklist.
There are no other residents who utilize a at this point in time.

Completion Date: *08/29/2022*

Document Submission ***Implemented***

On 7/16/22 PCH Director updated the date and time on Resident #1's MAR was updated on 7/16/22

185a - Implement Storage Procedures (continued)

to inform staff to visually view the [redacted] reading after each use. [redacted] will be implemented by 9/1 and completed monthly by PCH Director. On 8/29/22 the Residential Program Director provided a memo to educate staff regarding the need to check the [redacted] for the correct information. The memo also addressed the need to check the med bins each time they are used to be certain there are no loose pills. At shift change, the person coming on and leaving shift should check the bins and log it on the bin checklist. Starting on 9/16/22, the Program Director will review the bin checklist weekly to ensure there are no discrepancies. The person administering the medication should check for any loose pills. If a pill is found, identify the pill, and then destroy the pill using DPW Medication Administration Protocols. Document the destroyed pill on the Medication destruction log. The staff was educated on 8/29/2022 by a memo from the Residential Program Director the process and importance of utilizing the bin checklist.
There are no other residents who utilize a [redacted] this point in time.

2. Requirements

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

Description of Violation

Resident #1 is prescribed [redacted] as needed. On [redacted] medication was not available in the home.

Plan of Correction ***Accept***

On July 28th, 2022, PCH Director completed an audit of all individual's medication to make sure it matched their MAR. Starting August 1, 2022, The House Supervisor will utilize MAR checklist weekly to check all medication on the availability of the prescribed medication as well as for expired medication. Any medication reaching 7 days left will be reordered from the pharmacy. If needed the prescribing medical practitioner will need to provide a new prescription. If a medication identified on the MAR but is not present in the medication bin, medication trained staff will contact the pharmacy to reorder or the prescriber if a new script is needed.

Completion Date: *09/01/2022*

Document Submission ***Implemented***

On July 28th, 2022, PCH Director completed an audit of all individual's medication to make sure it matched their MAR. Starting August 1, 2022, The House Supervisor will utilize MAR checklist weekly to check all medication on the availability of the prescribed medication as well as for expired medication. Any medication reaching 7 days left will be reordered from the pharmacy. If needed the prescribing medical practitioner will need to provide a new prescription. If a medication identified on the MAR but is not present in the medication bin, medication trained staff will contact the pharmacy to reorder or the prescriber if a new script is needed.

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:

Description of Violation

Resident #1's medication administration record is missing diagnoses for the following medications; resident's [redacted]

187a - Medication Record (continued)

Prescriber's orders for Resident #1's [redacted] is not listed on medication administration record.

Resident #2's [redacted] on his medication administration review for [redacted]

Resident #3's [redacted] were blank on medication administration record.

Plan of Correction ***Accept***

LifeTree Pharmacy is responsible to update the MAR when notified of changes to diagnosis or medications. PCH Director will contact LifeTree by 8/22 to update Resident #1's information. All staff will be reminded on 8/5 during shift review to notify PCH Director/ Designee of any changes in diagnosis or medications discussed at residential appointments. PCH Director will then notify Life Tree to update the resident's MAR. Shift report process of checking the MAR will be discussed with staff again at shift change on 8/12/2022. 9/1/2022 the MAR checklist will be utilized by the PCH Director to review the medical records to ensure correct dosage, diagnosis, and route for current information and accuracy monthly by PCH Director when new MARS are received. If information is missing, the PCH Director will coordinate with Life Tree Pharmacy as identified.

Completion Date: *08/29/2022*

Document Submission ***Implemented***

LifeTree Pharmacy is responsible to update the MAR when notified of changes to diagnosis or medications. PCH Director will contact LifeTree by 8/22 to update Resident #1's information. All staff will be reminded on 8/5 during shift review to notify PCH Director/ Designee of any changes in diagnosis or medications discussed at residential appointments. PCH Director will then notify Life Tree to update the resident's MAR. Shift report process of checking the MAR will be discussed with staff again at shift change on 8/12/2022. 9/1/2022 the MAR checklist will be utilized by the PCH Director to review the medical records to ensure correct dosage, diagnosis, and route for current information and accuracy monthly by PCH Director when new MARS are received. If information is missing, the PCH Director will coordinate with Life Tree Pharmacy as identified.

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

Resident #2 refused [redacted] There was no documentation provided regarding prescriber being notified of resident's refusals of this medication.

Plan of Correction ***Accept***

On 8/12/2022 all staff will be reminded that any scripted medication refusal must be brought to the attention of the PCH Director/Designee within 24 hours. PCH Director will then notify prescriber and complete the Physician Form for proof of contact and file in the chart. The House Supervisor will utilize MAR checklist weekly to identify if refusals are occurring and if so documented properly.

Completion Date: *08/12/2022*

187c - Refusal of Medication *(continued)*

Document Submission ***Implemented***

On 8/12/2022 all staff will be reminded that any scripted medication refusal must be brought to the attention of the PCH Director/Designee within 24 hours. PCH Director will then notify prescriber and complete the Physician Form for proof of contact and file in the chart. The House Supervisor will utilize MAR checklist weekly to identify if refusals are occurring and if so documented properly.

190a - Completion Medication Course

1. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Member A is a Medication Technician who administers medications to all residents. This staff member has no record of successfully completing the Department-approved medication administration course.

Staff Member B has no record of completing an annual practicum and observation as defined by the course.

Plan of Correction ***Accept***

Program Director reviewed files and located training documentation for Staff A&B for DPW Medication Training. Staff A received DPW Medication Training again on 8/9/22 and 8/10/22.
As of 9/12/2011 the Assistant Program Director will review all staff files to make certain that all appropriate documentation is in the file for all employees. If forms can't be located staff will complete training again prior to passing any medication. Classes are to be taught by the Assistant Program Director based on the availability of staff.
As of 8/1/22 the new hire checklist will be re-implemented, and all documents, including new and annual trainings, will be gathered and scanned to the Merakey Protected Server by the Program Director/Designee on an annual basis.
By 11/31/2022 the PCH Director will audit the staff charts ensuring all the information on the new hire checklist, training tracker, and corresponding documentation is completed. This will be completed annually for existing staff and for new hires upon completion of orientation. Trainings will be taught by the Assistant Program Director for new hires as the need arises. This violation was sent to the Quality and Compliance Organization for possible review.

Completion Date: *09/01/2022*

Document Submission ***Implemented***

Program Director reviewed files and located training documentation for Staff A&B for DPW Medication Training. Staff A received DPW Medication Training again on 8/9/22 and 8/10/22.
As of 9/12/2011 the Assistant Program Director will review all staff files to make certain that all appropriate documentation is in the file for all employees. If forms can't be located staff will complete training again prior to passing any medication. Classes are to be taught by the Assistant Program Director based on the availability of staff.
As of 8/1/22 the new hire checklist will be re-implemented, and all documents, including new and annual trainings, will be gathered and scanned to the Merakey Protected Server by the Program Director/Designee on an annual basis.
By 11/31/2022 the PCH Director will audit the staff charts ensuring all the information on the new hire checklist, training tracker, and corresponding documentation is completed. This will be completed annually for existing staff and for new hires upon completion of orientation. Trainings will be taught by the Assistant Program Director for

190a - Completion Medication Course (continued)

new hires as the need arises. This violation was sent to the Quality and Compliance Organization for possible review.

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 [redacted]0; however, the resident's preadmission screening form was completed on [redacted]

Plan of Correction ***Accept***

Upon initial contact with an individual being considered for placement in the care home, a preadmission screening will be completed by the PCH Director or Designee. The Preadmission Screening will be reviewed by the PCH Administrative Team prior to making a determination of admission. By September 16, 2022, an audit will be completed to review all individual's preadmission screening forms to verify compliance by the Program Director or Designee. Starting September 2022, monthly chart audits will be completed by the PCH Director or Designee. The PCH Director or Designee will inform the Residential Program Director of any deficits.

Completion Date: *09/16/2022*

Document Submission ***Implemented***

Upon initial contact with an individual being considered for placement in the care home, a preadmission screening will be completed by the PCH Director or Designee. The Preadmission Screening will be reviewed by the PCH Administrative Team prior to making a determination of admission. By September 16, 2022, an audit will be completed to review all individual's preadmission screening forms to verify compliance by the Program Director or Designee. Starting September 2022, monthly chart audits will be completed by the PCH Director or Designee. The PCH Director or Designee will inform the Residential Program Director of any deficits.

227g -Support Plan Signatures

1. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #2's last support plan dated [redacted] was not signed by assessor.

Plan of Correction ***Accept***

Resident #2's Support Plan will be updated again in [redacted] all appropriate signatures obtained. The PCH Director or Designee will review Resident #2's Support Plan upon completion to ensure all signatures were obtained. By September 16, 2022, the Program Director or Designee will complete a chart audit to ensure that all individual's support plans contain all signatures. Starting September 1, 2022, upon completion of all individual's support plans, the Program Director or Designee will review the support plan to ensure completion and that all signatures are captured. Administrative staff were informed via email from the Program Director the expectation of

227g -Support Plan Signatures (continued)

reviewing all individual's support plans for completion and signatures present on August 29, 2022.
This was reported to the QCO for further review and investigation.
Completion Date: 8/1/2022 and 11/1/2022

Completion Date: *11/01/2022*

Document Submission ***Implemented***

Resident #2's Support Plan will be updated again in [redacted] with all appropriate signatures obtained. The PCH Director or Designee will review Resident #2's Support Plan upon completion to ensure all signatures were obtained. By September 16, 2022, the Program Director or Designee will complete a chart audit to ensure that all individual's support plans contain all signatures. Starting September 1, 2022, upon completion of all individual's support plans, the Program Director or Designee will review the support plan to ensure completion and that all signatures are captured. Administrative staff were informed via email from the Program Director the expectation of reviewing all individual's support plans for completion and signatures present on August 29, 2022.
This was reported to the QCO for further review and investigation.
Completion Date: 8/1/2022 and 11/1/2022