Department of Human Services
Bureau of Human Service Licensing

August 18, 2022

[redacted], COO

RE: LIGONIER GARDENS
2018 ROUTE 30 EAST
LIGONIER, PA, 15658
LICENSE/COC#: 42805

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/26/2022, 07/27/2022 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

Facility Information

Name: *LIGONIER GARDENS* **License #**: *42805* **License Expiration**: *11/10/2022*

Address: *2018 ROUTE 30 EAST, LIGONIER, PA 15658*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/22/1999* **Issued By**: *Dept of L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *51* **Waking Staff**: *38*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *07/27/2022*

Inspection Dates and Department Representative

07/26/2022 - On-Site:
07/27/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *71* **Residents Served**: *44*

Secured Dementia Care Unit

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

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *43*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *7* **Have Physical Disability**: *1*

Inspections / Reviews

07/26/2022 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/14/2022*

Inspections / Reviews *(continued)*

08/12/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/19/2022*

08/16/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/19/2022*

08/18/2022 - Document Submission

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than, 15 feet from any fossil-fuel burning device or appliance. The home has a gas stove in the kitchen; however, on 7/26/22 at 9:40 a.m., no carbon monoxide detector was present in close proximity to the stove.

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

Investigation showed that prior Administrator felt that the previous location was sufficient as multiple past surveys had not identified it as an issue. Current new administration is aware of the regulation, but had not caught that it wasn't installed properly.

On July 26th, 2022, at approximately 1:00 pm, Maintenance Technician installed a carbon monoxide detector within 15 feet of the gas stove i the kitchen.

Maintenance will ensure compliance by installing a carbon monoxide detector within 15 feet of any future fossil fuel burning appliances, as well as maintain current carbon monoxide detectors.

Completion Date: *07/26/2022*

Plan of Correction ***Directed***

Prior to inspection, A carbon monoxide detector is installed in the kitchen, as well as at a distance of at least 15 feet from any appliance or device that burns fossil fuels.

Carbon monoxide detector installed during annual inspection was removed, as it did not meet requirements of 2600.18

Maintenance will ensure compliance by installing a carbon monoxide detector within 15 feet of any future fossil fuel burning appliances, as well as maintain current carbon monoxide detectors.

DIRECTED
Within 10 calendar days of receipt of the accepted plan of correction: The administrator or designated staff person shall ensure all carbon monoxide detectors are at least 15 feet away from any fossil fuel burning device and meet the additional requirements of the Act. 8/16/22 █

Completion Date: *08/12/2022*

Document Submission ***Implemented***

Prior to inspection, A carbon monoxide detector is installed in the kitchen, as well as at a distance of at least 15 feet from any appliance or device that burns fossil fuels.

Carbon monoxide detector installed during annual inspection was removed, as it did not meet requirements of 2600.18

18 - Compliance With Laws (continued)

Maintenance will ensure compliance by installing a carbon monoxide detector within 15 feet of any future fossil fuel burning appliances, as well as maintain current carbon monoxide detectors.

DIRECTED
Within 10 calendar days of receipt of the accepted plan of correction: The administrator or designated staff person shall ensure all carbon monoxide detectors are at least 15 feet away from any fossil fuel burning device and meet the additional requirements of the Act. 8/16/22

65a - FS Orientation 1st Day

1. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

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

Description of Violation

Staff person A, hired , did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Plan of Correction ***Accept***

Staff person A was identified as an . Investigation showed that the binder that had been created by previous administration for the orientation of was insufficient.

Staff member A was educated on the required components of 2600.65.a on 8/10/2022. An educational binder containing the required information was created 8/5/2022 for the orientation of Agency Staff members prior to beginning first day of work.

Audits for compliance will be conducted by the Administrator, or designee, weekly for four weeks, then monthly for two months.

Completion Date: *08/10/2022*

Document Submission ***Implemented***

Staff person A was identified as an Agency employee. Investigation showed that the binder that had been created by previous administration for the orientation of Agency employees was insufficient.

65a - FS Orientation 1st Day (continued)

Staff member A was educated on the required components of 2600.65.a on 8/10/2022. An educational binder containing the required information was created 8/5/2022 for the orientation of [redacted] members prior to beginning first day of work.

Audits for compliance will be conducted by the Administrator, or designee, weekly for four weeks, then monthly for two months.

65b - Rights/Abuse 40 Hours

1. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

2. Emergency medical plan.
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A, hired [redacted], completed his/her 40th scheduled work hour; however, the staff person did not complete training in the following topics: emergency medical plan and reporting of reportable incidents and conditions.

Plan of Correction ***Accept***

Staff person A was identified as an Agency employee. Investigation showed that the binder that had been created by previous administration for the orientation of Agency employees was insufficient.

Staff member A was educated on the required components of 2600.65.b on 8/10/2022. An educational binder containing the required information was created 8/5/2022 for the orientation of [redacted] members prior to beginning first day of work.

Audits for compliance will be conducted by the Administrator, or designee, weekly for four weeks, then monthly for two months.

Completion Date: *08/10/2022*

Document Submission ***Implemented***

Staff person A was identified as an [redacted]. Investigation showed that the binder that had been created by previous administration for the orientation of [redacted] was insufficient.

Staff member A was educated on the required components of 2600.65.b on 8/10/2022. An educational binder containing the required information was created 8/5/2022 for the orientation of [redacted] members prior to beginning first day of work.

Audits for compliance will be conducted by the Administrator, or designee, weekly for four weeks, then monthly for two months.

81b - Resident Personal Equipment

1. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

81b - Resident Personal Equipment *(continued)*

Description of Violation

On 7/26/22, at 2:52 p.m., there was an uncovered enabler bar present on resident #1's bed, with openings measuring approximately 16" wide and 7" from the top of the bar to the mattress top, posing a potential entrapment hazard.

On 7/26/22, at approximately 3:00 p.m., the bed enabler attached to resident #2's bed was not securely fastened and moved approximately 2" from the middle position towards the headboard when pulled, creating a potential fall hazard.

On 7/26/22, at approximately 3:10 p.m., the bed enabler attached to resident #3's bed was not securely fastened and moved approximately 2" in each direction when pulled, creating a potential fall hazard.

REPEAT VIOLATION: 8/10/2021 et al.

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

Investigation showed that family members had brought in enabler bars without notifying administration.

The enabler bar was removed from the bed of Resident #1 on 8/5/22. A home health appointment to verify the need for an enabler bar and if so provide proper DME was scheduled for 8/9/22.

A home health appointment was scheduled for 8/9/22 for Resident #2 to verify the need for an enabler bar, and provide proper DME if needed.

A home health appointment was scheduled for 8/9/22 for Resident #3 to verify the need for an enabler bar, and provide proper DME if needed.

Education provided to staff on 8/10/22 regarding regulation 2600.81.b, including the need for staff to alert the Administrator, or designee, of the existence of malfunctioning DME. A letter will be sent to families with the next bill asking them to bring new DME to the attention of a staff member so that it can be examined for compliance before being installed.

Audits for properly functioning enabler bars will be conducted by the Administrator, or designee, weekly for two weeks, then monthly for three months.

Completion Date: *08/10/2022*

Plan of Correction ***Accept***

Investigation showed that family members had brought in enabler bars without notifying administration.

The enabler bar was removed from the bed of Resident #1 on 8/5/22. A home health appointment to verify the need for an enabler bar and if so provide proper DME was scheduled for 8/9/22, and resident was educated to alert staff via call bell system if/when assistance is needed.

A home health appointment was scheduled for 8/9/22 for Resident #2 to verify the need for an enabler bar, and provide proper DME if needed. The enabler bar was removed from the bed of Resident #2 on 8/11/22

A home health appointment was scheduled for 8/9/22 for Resident #3 to verify the need for an enabler bar, and provide proper DME if needed. The enabler bar was removed from the bed of Resident #3 on 8/12/22, and resident

81b - Resident Personal Equipment (continued)

was educated to alert staff via call bell system if/when assistance is needed.

Education provided to staff on 8/10/22 regarding regulation 2600.81.b, including the need for staff to alert the Administrator, or designee, of the existence of malfunctioning DME.
Staff educated on unsafe bed enabler situations, and that if an enabler causes an unsafe situation, it should be removed first, then reported to the designated person.
Staff educated to focus on the importance of risk for entrapment, and security of bed enablers

A letter will be sent to families with the next bill asking them to bring new DME to the attention of a staff member so that it can be examined for compliance before being installed.

A weekly audit for two weeks, then a monthly audit for three months, will be conducted by the Administrator, or designee, to ensure that enabler bars are properly functioning and are not posing safety hazards.

Completion Date: *08/12/2022*

Document Submission ***Implemented***

Investigation showed that family members had brought in enabler bars without notifying administration.

The enabler bar was removed from the bed of Resident #1 on 8/5/22. A home health appointment to verify the need for an enabler bar and if so provide proper DME was scheduled for 8/9/22, and resident was educated to alert staff via call bell system if/when assistance is needed.

A home health appointment was scheduled for 8/9/22 for Resident #2 to verify the need for an enabler bar, and provide proper DME if needed. The enabler bar was removed from the bed of Resident #2 on 8/11/22

A home health appointment was scheduled for 8/9/22 for Resident #3 to verify the need for an enabler bar, and provide proper DME if needed. The enabler bar was removed from the bed of Resident #3 on 8/12/22, and resident was educated to alert staff via call bell system if/when assistance is needed.

Education provided to staff on 8/10/22 regarding regulation 2600.81.b, including the need for staff to alert the Administrator, or designee, of the existence of malfunctioning DME.
Staff educated on unsafe bed enabler situations, and that if an enabler causes an unsafe situation, it should be removed first, then reported to the designated person.
Staff educated to focus on the importance of risk for entrapment, and security of bed enablers

A letter will be sent to families with the next bill asking them to bring new DME to the attention of a staff member so that it can be examined for compliance before being installed.

A weekly audit for two weeks, then a monthly audit for three months, will be conducted by the Administrator, or designee, to ensure that enabler bars are properly functioning and are not posing safety hazards.

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

Resident #4's prescription cream, [redacted], with a manufacturer's label indicating, "If swallowed, get medical help or contact a poison control center right away.", was unlocked, unattended, and accessible to resident #4 on her bedside table throughout the day on 7/26/22 and 7/27/22. Not all the residents of the home, including resident #4, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept***

Medicated cream was removed from Resident #4's room on 7/27/2022 by the surveyor.

It was determined that the prescription cream was left in Resident #4's room by a hospice worker after hospice care was provided. Education was provided to the hospice company on regulation 2600.82.c, as well as Ligonier Garden's staff on 8/10/22.

Audits of Resident rooms to check for compliance with regulation 2600.82.c will be conducted by the Administrator, or designee, weekly for two weeks, then monthly for three months.

Completion Date: *08/10/2022*

Document Submission ***Implemented***

Medicated cream was removed from Resident #4's room on 7/27/2022 by the surveyor.

It was determined that the prescription cream was left in Resident #4's room by a hospice worker after hospice care was provided. Education was provided to the hospice company on regulation 2600.82.c, as well as Ligonier Garden's staff on 8/10/22.

Audits of Resident rooms to check for compliance with regulation 2600.82.c will be conducted by the Administrator, or designee, weekly for two weeks, then monthly for three months.

90b - Staff Communication

1. Requirements

2600.
90.b. For a home serving 9 or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

The home does not have a system that allows staff in different parts of the home to communicate with each other in an emergency.

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

An emergency call bell system currently exists in the building which will alert staff members via pager, hallway display locations, and computers found at both nursing stations.

Staff were educated on 8/10/22 on the ability to use, and location of, the emergency notification systems contained in Resident bedrooms, as well as common areas throughout the building. This alert system alerts staff via pagers worn by staff members, display alert alert systems in the hallways of care areas, as well as via computer systems at both nurses stations. Staff were also educated on 8/10/22 on the ability to use personal cell phones to call the building phone which rings to the main nursing station, or 911, in an emergency situation.

Completion Date: *08/10/2022*

90b - Staff Communication *(continued)*

Plan of Correction ***Accept***

An emergency call bell system currently exists in the building which will alert staff members via pager, hallway display locations, and computers found at both nursing stations.

Staff were educated on 8/10/22 on the ability to use, and location of, the emergency notification systems contained in Resident bedrooms, as well as common areas throughout the building. This alert system alerts staff via pagers worn by staff members, display alert alert systems in the hallways of care areas, as well as via computer systems at both nurses stations. Staff were also educated on 8/10/22 on the ability to use personal cell phones to call the building phone which rings to the main nursing station, or 911, in an emergency situation.

Staff members in-house will have access to a cell phone to easily communicate assistance when an emergency occurs. Employee phone numbers can be found in the Agency Staff binder at the nurse's station. A copy of the phone list will be provided upon request. This is so that staff members can enter the numbers into their cell phones for easy access.

Completion Date: *08/15/2022*

Document Submission ***Implemented***

An emergency call bell system currently exists in the building which will alert staff members via pager, hallway display locations, and computers found at both nursing stations.

Staff were educated on 8/10/22 on the ability to use, and location of, the emergency notification systems contained in Resident bedrooms, as well as common areas throughout the building. This alert system alerts staff via pagers worn by staff members, display alert alert systems in the hallways of care areas, as well as via computer systems at both nurses stations. Staff were also educated on 8/10/22 on the ability to use personal cell phones to call the building phone which rings to the main nursing station, or 911, in an emergency situation.

Staff members in-house will have access to a cell phone to easily communicate assistance when an emergency occurs. Employee phone numbers can be found in the Agency Staff binder at the nurse's station. A copy of the phone list will be provided upon request. This is so that staff members can enter the numbers into their cell phones for easy access.

102i - Soap Dispenser

1. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 7/26/22, at 10:06 a.m., there was an unlabeled, used bar of soap at the sink in the downstairs common tub room.

Plan of Correction ***Accept***

The identified bar of soap was removed by a caregiver on 7/26/2022. Investigation showed that a nearby Resident in a private room was regularly bringing ██ personal bar of soap with ██ into the common tub room to wash up, and had left it there that day. Resident was educated on the importance of not leaving ██ soap in a common area, and provided a labeled container in which to keep ██ soap.

102i - Soap Dispenser (continued)

Staff were educated on regulation 2600.102.i on 8/10/22. Education contains information on the removal of bars of soap in common areas if found.

Audits of bathroom areas will be performed by Administrator, or designee, weekly for two weeks, then monthly for three months to ensure compliance with regulation 2600.102.i.

Completion Date: *08/10/2022*

Document Submission ***Implemented***

The identified bar of soap was removed by a caregiver on 7/26/2022. Investigation showed that a nearby Resident in a private room was regularly bringing ██ personal bar of soap with ██ into the common tub room to wash up, and had left it there that day. Resident was educated on the importance of not leaving his soap in a common area, and provided a labeled container in which to keep ██ soap.

Staff were educated on regulation 2600.102.i on 8/10/22. Education contains information on the removal of bars of soap in common areas if found.

Audits of bathroom areas will be performed by Administrator, or designee, weekly for two weeks, then monthly for three months to ensure compliance with regulation 2600.102.i.

121b - Locking Device Approval

1. Requirements

2600.
121.b. Doors used for egress routes from rooms and from the building may not be equipped with key-locking devices, electronic card operated systems or other devices which prevent immediate egress of residents from the building, unless the home has written approval or a variance from the Department of Labor and Industry, the Department of Health or the appropriate local building authority.

Description of Violation

On 7/26/22, at 10:30 a.m., the second floor exit door at the east stairwell, which is used as an egress route from the second floor to the back of the home, was locked with a keypad preventing immediate egress from the home.

Plan of Correction ***Accept***

The hardware of identified door was replaced on 7/26/2022 by a Maintenance Technician at approximately 1:00 pm so that door could be opened unobstructed.

Investigation showed that past administration locked the door as they feared it being an elopement risk.

Staff were educated on regulation 2600.121.b on 8/10/22.

Audits of egress doors will be conducted by Administrator, or designee, weekly for two weeks, then monthly for three months.

Completion Date: *08/10/2022*

Document Submission ***Implemented***

The hardware of identified door was replaced on 7/26/2022 by a Maintenance Technician at approximately 1:00 pm so that door could be opened unobstructed.

121b - Locking Device Approval (continued)

Investigation showed that past administration locked the door as they feared it being an elopement risk.

Staff were educated on regulation 2600.121.b on 8/10/22.

Audits of egress doors will be conducted by Administrator, or designee, weekly for two weeks, then monthly for three months.

124 - Notice to Fire Department

1. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency. The home serves seven residents with mobility needs.

Plan of Correction ***Accept***

Investigation showed that a letter had been sent to the fire department, but previous administrator did not keep a copy or proof that it had been sent. Current administration had not yet updated it since taking over.

Letter containing information required by regulation 2600.124 was sent by the Director of Properties Management on 7/26/22 and delivered to the fire department via certified letter on 8/1/2022 by the Director of Properties Management.

Administrator, or designee, will send an updated letter, as needed, to the fire department via certified mail.

Audit will be completed by Administrator, or designee, to ensure updated letter has been sent monthly for three months.

Completion Date: *08/01/2022*

Document Submission ***Implemented***

Investigation showed that a letter had been sent to the fire department, but previous administrator did not keep a copy or proof that it had been sent. Current administration had not yet updated it since taking over.

Letter containing information required by regulation 2600.124 was sent by the Director of Properties Management on 7/26/22 and delivered to the fire department via certified letter on 8/1/2022 by the Director of Properties Management.

Administrator, or designee, will send an updated letter, as needed, to the fire department via certified mail.

Audit will be completed by Administrator, or designee, to ensure updated letter has been sent monthly for three months.

132b - Safety Inspection/Fire Drill

1. Requirements

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

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection conducted by a fire safety expert was on 11/10/20, and there is no record of a fire drill conducted by a fire safety expert.

Plan of Correction ***Accept***

Upon contacting Fire Chief [redacted], it was discovered that [redacted] had done an inspection of the building in February of 2022, but had never sent the letter with the results.

A new fire safety inspection was conducted on 8/5/2022.

Witnessed fire drill was conducted by the [redacted] Volunteer Fire Companies on 8/10/22.

Documentation of this fire safety inspection and fire drill shall be kept in a compliance binder by the Administrator.

Completion Date: *08/10/2022*

Document Submission ***Implemented***

Upon contacting Fire Chief [redacted], it was discovered that [redacted] had done an inspection of the building in February of 2022, but had never sent the letter with the results.

A new fire safety inspection was conducted on 8/5/2022.

Witnessed fire drill was conducted by the [redacted] Volunteer Fire Companies on 8/10/22.

Documentation of this fire safety inspection and fire drill shall be kept in a compliance binder by the Administrator.

132c - Fire Drill Records

1. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drills conducted on 3/29/22 at 6:15 p.m., 4/27/22 at 11:00 p.m., 5/20/22 at 5:00 a.m. and at 10:30 a.m., and 6/2/22 at 6:20 p.m. indicate the exit route used is "fire safe doors" but does not specify the areas where residents were evacuated. Also, the fire drill record for the drill conducted on 4/27/22 at 11:00 p.m. does not include the amount of time to evacuate.

Plan of Correction ***Accept***

Maintenance personnel were using a form acceptable to the Department of Health, unaware that it was not acceptable to DHS.

Education was provided on 7/26/22 by surveyor to Maintenance personnel on the proper documentation of fire drills as per 2600.132.c.

132c - Fire Drill Records (continued)

Ligonier Gardens staff were educated on 2600.132.c on 8/10/22.

Future fire drills will be documented using the fire drill record form provided by the surveyor.

Audits of fire drill records will be conducted by the Administrator, or designee, monthly for 3 months.
Completion Date: *08/10/2022*

Document Submission ***Implemented***

Maintenance personnel were using a form acceptable to the Department of Health, unaware that it was not acceptable to DHS.

Education was provided on 7/26/22 by surveyor to Maintenance personnel on the proper documentation of fire drills as per 2600.132.c.

Ligonier Gardens staff were educated on 2600.132.c on 8/10/22.

Future fire drills will be documented using the fire drill record form provided by the surveyor.

Audits of fire drill records will be conducted by the Administrator, or designee, monthly for 3 months.

132d - Evacuation

1. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills:

- *12/22/21 at 9:35 a.m., evacuation time of 4 minutes 39 seconds*
- *1/31/22 at 4:23 p.m., evacuation time of 4 minutes 33 seconds*
- *3/29/22 at 6:15 p.m., evacuation time of 2 minutes 37 seconds*
- *5/20/22 at 5:00 a.m., evacuation time of 4 minutes 20 seconds*
- *5/20/22 at 10:30 a.m., evacuation time of 4 minutes 56 seconds*
- *6/2/22 at 6:20 p.m., evacuation time in excess of 6 minutes*

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

Upon contact, Fire Chief [redacted] confirmed that [redacted] had completed a fire safety inspection in February of 2022, but had neglected to send the letter afterwards. Past administration did not follow up. [redacted] confirmed that the safe evacuation time for the building is 15 minutes, making the above times well within acceptable parameters.

Fire safety expert conducted a fire safety inspection on 8/5/2022. Maximum safe evacuation time of 15 minutes was confirmed by the fire safety expert at that time.

Staff were educated on emergency evacuation procedures on 8/10/22. Emergency evacuation procedures were

132d - Evacuation (continued)

added to the Agency Staff orientation binder on 8/5/22.

Fire drills will be audited for compliance by the Administrator, or designee, monthly for 3 months.

Completion Date: *08/10/2022*

Plan of Correction ***Accept***

Upon contact, Fire Chief [redacted] confirmed that [redacted] had completed a fire safety inspection in February of 2022, but had neglected to send the letter afterwards. Past administration did not follow up. [redacted] confirmed that the safe evacuation time for the building is 15 minutes, making the above times well within acceptable parameters.

Fire safety expert conducted a fire safety inspection on 8/5/2022. Maximum safe evacuation time of 15 minutes was confirmed by the fire safety expert at that time.

Staff were educated on emergency evacuation procedures on 8/10/22. Emergency evacuation procedures were added to the Agency Staff orientation binder on 8/5/22.

If an inspection cannot be completed, and evacuation time decreases to 2 minutes and 30 seconds, Ligonier Gardens will house all immobile residents on the first floor so that evacuations can be made as quickly as possible. This housing plan would remain in effect until a fire safety review is conducted by a fire safety expert.

Fire drills will be audited for compliance by the Administrator, or designee, monthly for 3 months.

Completion Date: *08/12/2022*

Document Submission ***Implemented***

Upon contact, Fire Chief [redacted] confirmed that [redacted] had completed a fire safety inspection in February of 2022, but had neglected to send the letter afterwards. Past administration did not follow up. [redacted] confirmed that the safe evacuation time for the building is 15 minutes, making the above times well within acceptable parameters.

Fire safety expert conducted a fire safety inspection on 8/5/2022. Maximum safe evacuation time of 15 minutes was confirmed by the fire safety expert at that time.

Staff were educated on emergency evacuation procedures on 8/10/22. Emergency evacuation procedures were added to the Agency Staff orientation binder on 8/5/22.

If an inspection cannot be completed, and evacuation time decreases to 2 minutes and 30 seconds, Ligonier Gardens will house all immobile residents on the first floor so that evacuations can be made as quickly as possible. This housing plan would remain in effect until a fire safety review is conducted by a fire safety expert.

Fire drills will be audited for compliance by the Administrator, or designee, monthly for 3 months.

162c - Menus Posted

1. Requirements

2600.

162c - Menus Posted *(continued)*

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

Description of Violation

On 7/26/22 at 10:20 a.m., the menu posted in the home ended on 7/30/22.

REPEAT VIOLATION: 8/10/2021 et al.

Plan of Correction ***Accept***

Two weeks worth of menus were posted in compliance with regulation 2600.162.c on 7/29/2022 by the Dietary Manager.

Menus will be posted by the Dietary Manager, or designee, two weeks at a time, and updated weekly, in order to maintain compliance with regulation 2600.162.c.

Education on 2600.162.c was completed on 8/10/22.

Audits will be conducted by the Administrator, or designee, weekly for two weeks, and monthly for three months.

Completion Date: *08/10/2022*

Document Submission ***Implemented***

Two weeks worth of menus were posted in compliance with regulation 2600.162.c on 7/29/2022 by the Dietary Manager.

Menus will be posted by the Dietary Manager, or designee, two weeks at a time, and updated weekly, in order to maintain compliance with regulation 2600.162.c.

Education on 2600.162.c was completed on 8/10/22.

Audits will be conducted by the Administrator, or designee, weekly for two weeks, and monthly for three months.

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

Resident #4's prescription cream, [redacted], was unlocked, unattended, and accessible on [redacted] bedside table throughout the day on 7/26/22 and 7/27/22.

Plan of Correction ***Accept***

[redacted] was removed from Resident #4's room on 7/27/2022 by the surveyor.

It was determined that the prescription cream was left in Resident #4's room by a hospice worker after hospice care was provided.

Education was provided to hospice company and Ligonier Garden's staff on regulation 2600.82.c on 8/10/22.

183b - Meds and Syringes Locked (continued)

Audits of Resident rooms to check for compliance with regulation 2600.82.c will be conducted by the Administrator, or designee, weekly for two weeks, then monthly for three months.

Completion Date: *08/10/2022*

Document Submission ***Implemented***

Medicated cream was removed from Resident #4's room on 7/27/2022 by the surveyor.

It was determined that the prescription cream was left in Resident #4's room by a hospice worker after hospice care was provided.

Education was provided to hospice company and Ligonier Garden's staff on regulation 2600.82.c on 8/10/22.

Audits of Resident rooms to check for compliance with regulation 2600.82.c will be conducted by the Administrator, or designee, weekly for two weeks, then monthly for three months.

184a - Labeling OTC/CAM

1. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

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

Description of Violation

Resident #4 is prescribed [redacted] topically to stump daily at bedtime; however, the medication is not labeled with a pharmacy label.

Resident #5 is prescribed [redacted] 25 [redacted] if <70 2 or more times.

Resident #6 is prescribed [redacted] -Take 1 capsule by mouth twice a day; however, the pharmacy label on the bubble pack does not indicate the dosage of 250mg.

Plan of Correction ***Accept***

Medication labels for Residents #4, #5, and #6 were obtained and applied on 7/28/22 by LPN.

Resident #4's cream was a stock cream provided by hospice as opposed to a pharmacy. Hospice was educated on the need for a proper label.

Residents #5 and #6 were the result of the pharmacy recently being purchased by another company, leading to inconsistencies between the MAR and the label. This has been resolved.

184a - Labeling OTC/CAM (continued)

Education regarding regulation 2600.184.a was provided to Med Techs and LPNs on 8/10/22 including the notification of Administrator if labels do not contain the information as required by regulation 2600.184.a.

Audits will be conducted by Administrator, or designee, weekly for two weeks, then monthly for three months to ensure labels match the MAR.

Completion Date: *08/10/2022*

Document Submission ***Implemented***

Medication labels for Residents #4, #5, and #6 were obtained and applied on 7/28/22 by LPN.

Resident #4's cream was a stock cream provided by hospice as opposed to a pharmacy. Hospice was educated on the need for a proper label.

Residents #5 and #6 were the result of the pharmacy recently being purchased by another company, leading to inconsistencies between the MAR and the label. This has been resolved.

Education regarding regulation 2600.184.a was provided to Med Techs and LPNs on 8/10/22 including the notification of Administrator if labels do not contain the information as required by regulation 2600.184.a.

Audits will be conducted by Administrator, or designee, weekly for two weeks, then monthly for three months to ensure labels match the MAR.

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

On 7/26/22, at 3:15 p.m., the glucometers belonging to residents #5, #6, and #7 were not calibrated to the current date and time.

On the following dates and times, resident #5's blood sugar readings on her glucometer did not coincide the blood sugar readings documented on the resident's July 2022 medication administration record (MAR):

Date	Time	MAR	Glucometer
7/19	7:30am	369	399
7/19	8:00pm	365	no reading
7/23	8:00pm	448	462
7/24	8:00pm	201	no reading
7/25	4:30pm	437	487

On 7/24/22 at 8:00 p.m., resident #7's blood glucose reading of 201 was recorded on resident #5's July 2022 MAR.

The home's policy on Controlled Drugs-Handling, Storage, Disposal, and Record Keeping, dated 10/24/05, indicates that "staff persons responsible for dispensing medications will check narcotics at the beginning of every shift. The amount of narcotics on hand is counted, and each used narcotic must be accounted for on the narcotic sheet. A narcotic sheet that

185a - Implement Storage Procedures (continued)

does not check correctly must be reported immediately to the charge nurse and the administrator."
Resident #4 is prescribed morphine 10mg/0.5ml-Take 10mg one-half ml sublingually every 2 hours as needed. The home's narcotic count sheet indicates there should be 16.5ml remaining; however, only 15ml is present in the bottle.

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

Recent changes in staff and administration resulted in lax training of med techs and LPNs in regard to proper calibration of glucometers and documentation on the MAR.

Glucometers were properly calibrated by LPN for Residents #5, #6, and #7 on 7/26/22.

Education was provided to staff on 8/10/22 on regulation 2600.185.a, which included proper use of glucometers, proper medication administration procedures, proper charting of PRN medication administration, and a review of the home's policy on Controlled Drugs-Handling, Storage, Disposal, and Record Keeping.

Audits of narcotic counts and glucometer documentation on the medication administration record will be completed by Administrator, or designee, weekly for two weeks, and monthly for three months.

Completion Date: *08/10/2022*

Plan of Correction ***Accept***

Recent changes in staff and administration resulted in lax training of med techs and LPNs in regard to proper calibration of glucometers and documentation on the MAR.

Glucometers were properly calibrated by LPN for Residents #5, #6, and #7 on 7/26/22.

Education was provided to staff on 8/10/22 on regulation 2600.185.a, which included proper use of glucometers, proper medication administration procedures, proper charting of PRN medication administration, and a review of the home's policy on Controlled Drugs-Handling, Storage, Disposal, and Record Keeping.

Audits of narcotic counts and glucometer documentation on the medication administration record will be completed by Administrator, or designee, weekly for two weeks, and monthly for three months. While auditing glucometers, nursing staff will check the following: the values in the EMAR match those in the glucometer; the date and time match that of the EMAR.

Completion Date: *08/15/2022*

Document Submission ***Implemented***

Recent changes in staff and administration resulted in lax training of med techs and LPNs in regard to proper calibration of glucometers and documentation on the MAR.

Glucometers were properly calibrated by LPN for Residents #5, #6, and #7 on 7/26/22.

Education was provided to staff on 8/10/22 on regulation 2600.185.a, which included proper use of glucometers, proper medication administration procedures, proper charting of PRN medication administration, and a review of the home's policy on Controlled Drugs-Handling, Storage, Disposal, and Record Keeping.

185a - Implement Storage Procedures (continued)

Audits of narcotic counts and glucometer documentation on the medication administration record will be completed by Administrator, or designee, weekly for two weeks, and monthly for three months. While auditing glucometers, nursing staff will check the following: the values in the EMAR match those in the glucometer; the date and time match that of the EMAR.

186a - Authorized Prescriber

1. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

Resident #6 receives saccharomyces boulardii 250mg, take one capsule by mouth twice daily; however, there is no written prescription by an authorized prescriber. According to the home and the pharmacy, the medication order was obtained by fax and signed and dated by staff person B.

Plan of Correction ***Accept***

A review of the order for Resident #6 on 8/4/22 discovered the physician's signature, however signature was indistinguishable due to it blending in with other writing. A new order was obtained on 8/8/22 with a more distinguishable signature. Physician was educated via phone on the importance of a signature that is distinct from other writing.

Education was provided to staff on 8/10/22 to review received orders for distinguishable signatures from prescribers.

Education on red line procedures to verify order accuracy was provided on 8/10/22 to staff, with red lining audits beginning 8/10/22 to be performed by night shift med passers.

Audits of new orders to verify existence of prescriber's signature will be completed by Administrator, or designee, weekly for 2 weeks, then monthly for 3 months.

Completion Date: *08/10/2022*

Document Submission ***Implemented***

A review of the order for Resident #6 on 8/4/22 discovered the physician's signature, however signature was indistinguishable due to it blending in with other writing. A new order was obtained on 8/8/22 with a more distinguishable signature. Physician was educated via phone on the importance of a signature that is distinct from other writing.

Education was provided to staff on 8/10/22 to review received orders for distinguishable signatures from prescribers.

Education on red line procedures to verify order accuracy was provided on 8/10/22 to staff, with red lining audits beginning 8/10/22 to be performed by night shift med passers.

186a - Authorized Prescriber (continued)

Audits of new orders to verify existence of prescriber's signature will be completed by Administrator, or designee, weekly for 2 weeks, then monthly for 3 months.

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:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #6 is prescribed [redacted] once a day in the evening. However, the resident's July 2022 MAR indicates both [redacted] -Instill 1 drop in both eyes once a day in the evening.

Plan of Correction ***Accept***

Inconsistencies on the MAR are a result of pharmacy recently being purchased. This has since been resolved.

The Medication Administration Record for Resident #6 was corrected by an LPN on 7/27/22.

Education was provided to staff on 8/10/22 on regulation 2600.187a.

Administrator, or designee, completed an audit of Medical Administration Records for Residents on 8/8/22 to ensure accuracy.

Education on red line procedures to verify order accuracy was provided on 8/10/22 to Med Techs and LPNs, with red lining audits beginning 8/10/22 to be performed by night shift med passers.

Audits will be completed on new orders by Administrator, or designee, weekly for two weeks, and monthly for three months.

Completion Date: *08/10/2022*

Document Submission ***Implemented***

Inconsistencies on the MAR are a result of pharmacy recently being purchased. This has since been resolved.

The Medication Administration Record for Resident #6 was corrected by an LPN on 7/27/22.

187a - Medication Record (continued)

Education was provided to staff on 8/10/22 on regulation 2600.187a.

Administrator, or designee, completed an audit of Medical Administration Records for Residents on 8/8/22 to ensure accuracy.

Education on red line procedures to verify order accuracy was provided on 8/10/22 to Med Techs and LPNs, with red lining audits beginning 8/10/22 to be performed by night shift med passers.

Audits will be completed on new orders by Administrator, or designee, weekly for two weeks, and monthly for three months.

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

Resident #5 is prescribe [redacted], the resident was administered 10 units of insulin; however, the physician should have been called instead:

- *7/23/22, 8:00 p.m., blood sugar reading 462*
- *7/25/22, 4:30 p.m., blood sugar reading 487*

Resident #6 is prescribed [redacted] subcutaneously twice daily; however, the medication was administered one time daily on 7/2/22 and 7/11/22 because the medication was not available in the home.

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

Investigation showed that STAT orders were placed for the medication on both occasions but the pharmacy did not bring it until the next day.

Medication reordering will now be done 3 days prior to a medication running out to ensure presence of medication when needed.

Education was provided to staff on regulation 2600.187.d on 8/10/22.

Procedures for obtaining medications in a timely manner were reviewed by Administrator on 8/5/2022. Education was provided to staff on 8/10/22.

Audits will be performed on the med carts by the Administrator, or designee, weekly for two weeks then monthly for three months to ensure that medications are being ordered timely.

Audits of the med carts will be conducted by night shift LPN or Med Tech weekly to ensure medication availability.
Completion Date: *08/10/2022*

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

Plan of Correction ***Accept***

Resident #5

On 8/12/22, the physician was notified by phone of blood sugar measurements taken on resident #5 on 7/23/22 and 7/25/22
On 8/15/22, a reportable incident report was sent to the Department of Human Services informing the Department of a medication error for resident #5 which occurred on 7/23/22 & 7/25/22.

Resident #6

The physician was notified by fax that resident #6 had been receiving [redacted] insulin once daily rather than twice daily on 7/2/22 and 7/11/22.
On 8/12/22, a reportable incident report was sent to the Department of Human Services informing the Department of a medication error for resident #6 which occurred on 7/2/22 & 7/11/22.
Investigation showed that STAT orders were placed for the medication on both occasions but the pharmacy did not bring it until the next day/ next scheduled time.
Medication reordering will now be done 3 days prior to a medication running out to ensure presence of medication when needed.

Education was provided to staff on regulation 2600.187.d on 8/10/22.

Procedures for obtaining medications in a timely manner were reviewed by Administrator on 8/5/2022. Education was provided to staff on 8/10/22.

Audits will be performed on the med carts by the Administrator, or designee, weekly for two weeks then monthly for three months to ensure that medications are being ordered timely.

Audits of the med carts will be conducted by night shift LPN or Med Tech weekly to ensure medication availability.

Education was provided to staff on medication errors, and reportable incidents.

Completion Date: *08/12/2022*

Document Submission ***Implemented***

Resident #5

On 8/12/22, the physician was notified by phone of blood sugar measurements taken on resident #5 on 7/23/22 and 7/25/22
On 8/15/22, a reportable incident report was sent to the Department of Human Services informing the Department of a medication error for resident #5 which occurred on 7/23/22 & 7/25/22.

Resident #6

The physician was notified by fax that resident #6 had been receiving his lantus insulin once daily rather than twice daily on 7/2/22 and 7/11/22.
On 8/12/22, a reportable incident report was sent to the Department of Human Services informing the Department

187d - Follow Prescriber's Orders (continued)

of a medication error for resident #6 which occurred on 7/2/22 & 7/11/22.
Investigation showed that STAT orders were placed for the medication on both occasions but the pharmacy did not bring it until the next day/ next scheduled time.
Medication reordering will now be done 3 days prior to a medication running out to ensure presence of medication when needed.

Education was provided to staff on regulation 2600.187.d on 8/10/22.

Procedures for obtaining medications in a timely manner were reviewed by Administrator on 8/5/2022. Education was provided to staff on 8/10/22.

Audits will be performed on the med carts by the Administrator, or designee, weekly for two weeks then monthly for three months to ensure that medications are being ordered timely.

Audits of the med carts will be conducted by night shift LPN or Med Tech weekly to ensure medication availability.

Education was provided to staff on medication errors, and reportable incidents.

225a - Assessment 15 Days

1. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #5 was admitted on [redacted] however, an initial assessment was not completed until [redacted]

Resident #6's initial assessment, dated [redacted], indicates the resident cannot self-administer medications; however, the resident's initial medical examination, dated [redacted], indicates the resident can self-administer medications with assistance in remembering schedule, and the resident self-administers [redacted] and [redacted] eye drops daily.

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

Previous administration was lax in completing initial assessments in a timely manner. Current administration is aware of the regulation and will ensure timely completion.

Audit of existing initial assessments was completed by Administrative Assistant on 8/9/22 to identify existing compliance issues regarding the completion date of the initial assessment in relation to admission date.

Future initial assessments will be completed timely by Administrator, or designee.

Audits of new Resident initial assessments will be completed weekly for two weeks then monthly for 3 months by Administrator, or designee.

225a - Assessment 15 Days (continued)

Resident #6 was reevaluated by Administrator on [redacted] and it was determined that Resident can safely self administer eye drops with staff supervision. The support plan for Resident #6 was updated on [redacted]

Audits were completed by Administrator on [redacted] to ensure that initial assessments and direct medical examinations are in agreement. In instances where they are not, Resident Assessment Support Plan was reviewed and updated if needed so that correct care is being provided.

Audits of new Resident initial assessments will be completed by Administrator, or designee, weekly for two weeks then monthly for three months.

Completion Date: *08/10/2022*

Plan of Correction ***Accept***

Previous administration was lax in completing initial assessments in a timely manner. Current administration is aware of the regulation and will ensure timely completion.

A reevaluation of Resident #6 was conducted by the Administrator on 8/5/22, and it was determined that the Resident can safely self-administer medication per the initial DME. On 8/12/22, an update to the RASP addendum sheet was made to state that resident #6 can safely administer his eyedrops and store them in his room in a lock box in accordance with his physician's order. To ensure that eye drops are not expired or almost empty, the staff will continue to audit them.

Audit of existing initial assessments was completed by Administrative Assistant on 8/9/22 to identify existing compliance issues regarding the completion date of the initial assessment in relation to admission date.

Future initial assessments will be completed timely by Administrator, or designee.

Audits of new Resident initial assessments will be completed weekly for two weeks then monthly for 3 months by Administrator, or designee.

Audits were completed by Administrator on 8/9/22 to ensure that initial assessments and direct medical examinations are in agreement. In instances where they are not, Resident Assessment Support Plan was reviewed and updated if needed so that correct care is being provided.

Audits of new Resident initial assessments will be completed by Administrator, or designee, weekly for two weeks then monthly for three months.

Residents who are assessed as capable of self-administration can self-administer, if appropriate, if medication is locked. Residents who self-administer medication will continue to have their medications audited as frequently as those kept in med carts. Residents who are capable of self-administration of medications will be provided with medication addendums in their RASPs.

Completion Date: *08/15/2022*

Document Submission ***Implemented***

Previous administration was lax in completing initial assessments in a timely manner. Current administration is aware of the regulation and will ensure timely completion.

225a - Assessment 15 Days (continued)

A reevaluation of Resident #6 was conducted by the Administrator on [redacted] and it was determined that the Resident can safely self-administer medication per the initial DME. On 8/12/22, an update to the RASP addendum sheet was made to state that resident #6 can safely administer his eyedrops and store them in his room in a lock box in accordance with his physician's order. To ensure that eye drops are not expired or almost empty, the staff will continue to audit them.

Audit of existing initial assessments was completed by Administrative Assistant on [redacted] to identify existing compliance issues regarding the completion date of the initial assessment in relation to admission date.

Future initial assessments will be completed timely by Administrator, or designee.

Audits of new Resident initial assessments will be completed weekly for two weeks then monthly for 3 months by Administrator, or designee.

Audits were completed by Administrator on [redacted] to ensure that initial assessments and direct medical examinations are in agreement. In instances where they are not, Resident Assessment Support Plan was reviewed and updated if needed so that correct care is being provided.

Audits of new Resident initial assessments will be completed by Administrator, or designee, weekly for two weeks then monthly for three months.

Residents who are assessed as capable of self-administration can self-administer, if appropriate, if medication is locked. Residents who self-administer medication will continue to have their medications audited as frequently as those kept in med carts. Residents who are capable of self-administration of medications will be provided with medication addendums in their RASPs.