Department of Human Services
Bureau of Human Service Licensing

September 28, 2022

[REDACTED], ADMINISTRATOR
CMS Danville LLC
[REDACTED]

RE: VINTAGE KNOLLS
9 JUSTIN DRIVE
DANVILLE, PA, 17821
LICENSE/COC#: 228310

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/09/2022, 08/10/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[REDACTED]
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *VINTAGE KNOLLS* **License #**: *228310* **License Expiration**: *10/23/2022*

Addre : *9 JUSTIN DRIVE, DANVILLE, PA 17821*

County: *MONTOUR* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *CMS Danville LLC* **Address**:

Phone:

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *04/15/2019* **I ued By**: *PALI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *63* **Waking Staff**: *47*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *08/10/2022*

Inspection Dates and Department Representative

08/09/2022 On Site
08/10/2022 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* **Residents Served**: *55*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *55*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *8* **Have Physical Disability**: *0*

Inspections / Reviews

08/09/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/12/2022*

09/12/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/16/2022*

09/21/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *09/28/2022*

09/28/2022 - Document Submission

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

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

The License Inspection Summary dated 9/21/2021, was posted with the privacy page attached identifying resident.

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

The License Inspection Summary dated 9/21/2021, was posted with the privacy page attached identifying resident, this page was immediately removed. Executive director will not print out the privacy page when posting the yearly nspection.

Completion Date: *09/08/2022*

Update: *09/12/2022*

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

Plan of Correction ***Accept***

The License Inspection Summary dated 9/21/2021, was posted with the privacy page attached identifying resident, director is in charge of fixing this problem this page was immediately removed on 8-9-2022. Executive director is in charge of printing this page and will not print out the privacy page when posting the yearly inspection anything containing HIPPAA will also be whited out. The executive director will monitor this on a monthly basis for the next year.

Completion Date: *09/12/2022*

Update: *09/21/2022*

Please send proof (picture) of compliance.

Document Submission ***Implemented***

The License Inspection Summary dated 9/21/2021, was posted with the privacy page attached identifying resident, director is in charge of fixing this problem this page was immediately removed on 8-9-2022. Executive director is in charge of printing this page and will not print out the privacy page when posting the yearly inspection anything containing HIPPAA will also be whited out. The executive director will monitor this on a monthly basis for the next year.

57c - 2 Hours/Day

1. Requirements

2600.

57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

From 7/22/2022 to 7/24/2022 the home had 55 residents in house with 9 of those residents having mobility needs. The home is required to staff 64 direct care hours but only have verification of 63.5 hours staffed for 7/22/2022, 61 hours

57c - 2 Hours/Day (continued)

staffed for 7/23/2022, and 63 hours staffed for 7/24/2022.

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

From 7/22/2022 to 7/24/2022 the home had 55 residents in house with 9 of those residents having mobility needs. The home is required to staff 64 direct care hours but only have verification of 63.5 hours staffed for 7/22/2022, 61 hours staffed for 7/23/2022, and 63 hours staffed for 7/24/2022. The hours will be counted for each shift and the hours will be written in next to each day, on each schedule, keeping the count visible for the Executive Director and Resident Care Coordinator to physically see so that we both know that we have the appropriate daily hours verified. This will be implemented daily for the next year.

Completion Date: *09/08/2022*

Update: *09/12/2022*

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

Plan of Correction ***Accept***

From 7/22/2022 to 7/24/2022 the home had 55 residents in house with 9 of those residents having mobility needs. The home is required to staff 64 direct care hours but only have verification of 63.5 hours staffed for 7/22/2022, 61 hours staffed for 7/23/2022, and 63 hours staffed for 7/24/2022. On 8-10-2022 another staff member was hired for 3rd shift to ensure that we had adequate staffing to resident hours. The hours will be counted for each shift and the hours will be written in next to each day, on each schedule, keeping the count visible for the Executive Director and Resident Care Coordinator to physically see so that we both know that we have the appropriate daily hours verified. This will be implemented daily for the next year.The Resident Care Coordinator and executive Director will monitor the ongoing compliance of staffing hours daily.

Completion Date: *09/12/2022*

Document Submission ***Implemented***

From 7/22/2022 to 7/24/2022 the home had 55 residents in house with 9 of those residents having mobility needs. The home is required to staff 64 direct care hours but only have verification of 63.5 hours staffed for 7/22/2022, 61 hours staffed for 7/23/2022, and 63 hours staffed for 7/24/2022. On 8-10-2022 another staff member was hired for 3rd shift to ensure that we had adequate staffing to resident hours. The hours will be counted for each shift and the hours will be written in next to each day, on each schedule, keeping the count visible for the Executive Director and Resident Care Coordinator to physically see so that we both know that we have the appropriate daily hours verified. This will be implemented daily for the next year.The Resident Care Coordinator and executive Director will monitor the ongoing compliance of staffing hours daily.

57d - Waking Hours

1. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 7/23/2022 & 7/24/2022, the home had 55 residents in house with 9 of those residents having mobility needs. The home is required to staff 48 direct care waking hours but only have verification of 42 waking hours staffed for 7/23/2022 and 47.5 hours staffed for 7/24/2022.

57d - Waking Hours *(continued)*

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

On 7/23/2022 & 7/24/2022, the home had 55 residents in house with 9 of those residents having mobility needs. The home is required to staff 48 direct care waking hours but only have verification of 42 waking hours staffed for 7/23/2022 and 47.5 hours staffed for 7/24/2022.The hours will be counted for each shift and the hours will be written in next to each day, on each schedule, keeping the count visible for the Executive Director and Resident Care Coordinator to physically see so that we both know that we have the appropriate daily hours verified. This will happen for the next year on all nursing schedules.

Completion Date: *09/08/2022*

Update: *09/12/2022*

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

Plan of Correction ***Accept***

On 7/23/2022 & 7/24/2022, the home had 55 residents in house with 9 of those residents having mobility needs. The home is required to staff 48 direct care waking hours but only have verification of 42 waking hours staffed for 7/23/2022 and 47.5 hours staffed for 7/24/2022. As of 8-10-22 the hours will be counted for each shift and the hours will be written in next to each day, on each schedule, keeping the count visible for the Executive Director and Resident Care Coordinator to physically see so that we both know that we have the appropriate daily hours verified. This will happen for the next year on all nursing schedules. This will be implemented daily for the next year. The Resident Care Coordinator and executive Director will monitor the ongoing compliance of staffing hours daily.

Completion Date: *09/12/2022*

Document Submission ***Implemented***

On 7/23/2022 & 7/24/2022, the home had 55 residents in house with 9 of those residents having mobility needs. The home is required to staff 48 direct care waking hours but only have verification of 42 waking hours staffed for 7/23/2022 and 47.5 hours staffed for 7/24/2022. As of 8-10-22 the hours will be counted for each shift and the hours will be written in next to each day, on each schedule, keeping the count visible for the Executive Director and Resident Care Coordinator to physically see so that we both know that we have the appropriate daily hours verified. This will happen for the next year on all nursing schedules. This will be implemented daily for the next year. The Resident Care Coordinator and executive Director will monitor the ongoing compliance of staffing hours daily.

60a - Staff/Support Plan

1. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 7/22/2022 to 7/24/2022, the home had 55 residents in house including 9 residents with mobility needs. 3 of the residents with mobility needs require a 2 staff person assist for ambulating and transferring. On 7/22/2022 & 7/24/2022, the home only has verification of 2 direct care staff members in the home from 11pm-7am. On 7/23/2022, the home only has verification of 2 direct care staff members in the home from 11pm to 3am.

60a - Staff/Support Plan *(continued)*

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

On 7/22/2022 to 7/24/2022, the home had 55 residents in house including 9 residents with mobility needs. 3 of the residents with mobility needs require a 2 staff person assist for ambulating and transferring. On 7/22/2022 & 7/24/2022, the home only has verification of 2 direct care staff members in the home from 11pm-7am. On 7/23/2022, the home only has verification of 2 direct care staff members in the home from 11pm to 3am.On 7/22/2022 to 7/24/2022, the home had 55 residents in house including 9 residents with mobility needs. 3 of the residents with mobility needs require a 2 staff person assist for ambulating and transferring. On 7/22/2022 & 7/24/2022, the home only has verification of 2 direct care staff members in the home from 11pm-7am. On 7/23/2022, the home only has verification of 2 direct care staff members in the home from 11pm to 3am.The hours will be counted for each shift and the hours will be written in next to each day, on each schedule, keeping the count isible and ensuring that there are enough hours accounted for on 11-7 shift, The Executive Director and Resident Care Coordinator will be able to physically see that we have the appropriate daily hours verified. This will happen for the next year on all nursing schedules.

Completion Date: *09/08/2022*

Update: *09/12/2022*

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

Plan of Correction ***Accept***

On 7/22/2022 to 7/24/2022, the home had 55 residents in house including 9 residents with mobility needs. 3 of the residents with mobility needs require a 2 staff person assist for ambulating and transferring. On 7/22/2022 & 7/24/2022, the home only has verification of 2 direct care staff members in the home from 11pm-7am. On 7/23/2022, the home only has verification of 2 direct care staff members in the home from 11pm to 3am.On 7/22/2022 to 7/24/2022, the home had 55 residents in house including 9 residents with mobility needs. 3 of the residents with mobility needs require a 2 staff person assist for ambulating and transferring. On 7/22/2022 & 7/24/2022, the home only has verification of 2 direct care staff members in the home from 11pm-7am. On 7/23/2022, the home only has verification of 2 direct care staff members in the home from 11pm to 3am.As of 8-10-2022 hours have been counted for each shift and the hours will be written in next to each day, on each schedule, keeping the count visible and ensuring that there are enough hours accounted for on 11-7 shift, The Executive Director and Resident Care Coordinator will be able to physically see that we have the appropriate daily hours erified. This will happen for the next year on all nursing schedules.
This will be implemented daily for the next year. The Resident Care Coordinator and executive Director will monitor the ongoing compliance of staffing hours daily. For the next year.,

Completion Date: *09/12/2022*

Document Submission ***Implemented***

On 7/22/2022 to 7/24/2022, the home had 55 residents in house including 9 residents with mobility needs. 3 of the residents with mobility needs require a 2 staff person assist for ambulating and transferring. On 7/22/2022 & 7/24/2022, the home only has verification of 2 direct care staff members in the home from 11pm-7am. On 7/23/2022, the home only has verification of 2 direct care staff members in the home from 11pm to 3am.On 7/22/2022 to 7/24/2022, the home had 55 residents in house including 9 residents with mobility needs. 3 of the residents with mobility needs require a 2 staff person assist for ambulating and transferring. On 7/22/2022 & 7/24/2022, the home only has verification of 2 direct care staff members in the home from 11pm-7am. On

60a - Staff/Support Plan (continued)

7/23/2022, the home only has verification of 2 direct care staff members in the home from 11pm to 3am.As of 8-10-2022 hours have been counted for each shift and the hours will be written in next to each day, on each schedule, keeping the count visible and ensuring that there are enough hours accounted for on 11-7 shift, The Executive Director and Resident Care Coordinator will be able to physically see that we have the appropriate daily hours erified. This will happen for the next year on all nursing schedules.
This will be implemented daily for the next year. The Resident Care Coordinator and executive Director will monitor the ongoing compliance of staffing hours daily. For the next year.,

63a - First Aid/CPR Training

1. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 7/22/2022 to 7/24/2022, the home had 55 residents in house. They were only able to provide verification of 1 CPR certified staff member from 11pm until 7am on 7/22 and 7/24/2022, and from 11pm to 3am on 7/23/2022.

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

On 7/22/2022 to 7/24/2022, the home had 55 residents in house. They were only able to provide verification of 1 CPR certified staff member from 11pm until 7am on 7/22 and 7/24/2022, and from 11pm to 3am on 7/23/2022. All staff that work for Vintage Knolls will be trained in CPR. They will be enrolled in CPR within 3 months of orientation.
Completion Date: *09/08/2022*

Update: *09/12/2022*

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

Plan of Correction ***Accept***

On 7/22/2022 to 7/24/2022, the home had 55 residents in house. They were only able to provide verification of 1 CPR certified staff member from 11pm until 7am on 7/22 and 7/24/2022, and from 11pm to 3am on 7/23/2022. As of 8-10-2022 the schedule for nursing will have adequate CPR certified staff member for each shift. All staff that work for Vintage Knolls will be trained in CPR. They will be enrolled in CPR within 3 months of orientation to ensure that there is more than enough CPR certified staff in the building. Human Resources and the DOW will monitor this to ensure ongoing compliance.
Completion Date: *09/12/2022*

Update: *09/21/2022*

Please send proof of compliance. (CPR registration for staff - copy of CPR cards).

Document Submission ***Implemented***

On 7/22/2022 to 7/24/2022, the home had 55 residents in house. They were only able to provide verification of 1 CPR certified staff member from 11pm until 7am on 7/22 and 7/24/2022, and from 11pm to 3am on 7/23/2022. As of 8-10-2022 the schedule for nursing will have adequate CPR certified staff member for each shift. All staff that work for Vintage Knolls will be trained in CPR. They will be enrolled in CPR within 3 months of orientation to ensure that there is more than enough CPR certified staff in the building. Human Resources and the DOW will monitor

63a - First Aid/CPR Training (continued)

this to ensure ongoing compliance.

82a - Poisonous Materials

1. Requirements

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

Description of Violation

A clear plastic spray bottle was observed on a cleaning cart with no markings. Staff member identified the liquid as a cleaner.

Plan of Correction ***Accept***

A clear plastic spray bottle was observed on a cleaning cart with no markings. Staff member identified the liquid as a cleaner .Poisonous materials shall be stored in their original, labeled containers . Maintenance Director will audit housekeeping cart weekly to ensure that all bottles have the appropriate labeling

Completion Date: *09/08/2022*

Update: *09/12/2022*

Document Submission ***Implemented***

A clear plastic spray bottle was observed on a cleaning cart with no markings. Staff member identified the liquid as a cleaner .Poisonous materials shall be stored in their original, labeled containers . Maintenance Director will audit housekeeping cart weekly to ensure that all bottles have the appropriate labeling

85d - Trash Receptacles

1. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

There were 3 uncovered garbage cans in the kitchen that were not being actively used.

Plan of Correction ***Accept***

There were 3 uncovered garbage cans in the kitchen that were not being actively used. Trash in kitchens shall be kept in covered trash receptacles that prevent the penetration of insects and rodents. Staff will sign and date a sheet on each shift for the next 3 months stating that they are verifying the lids have been placed back on the can when not in use. Dietary director will verify each day that this list is signed and will audit there sign in sheet weekly for the next 3 months.

Completion Date: *09/08/2022*

Update: *09/12/2022*

Please send proof of staff training.

Document Submission ***Implemented***

There were 3 uncovered garbage cans in the kitchen that were not being actively used. Trash in kitchens shall be kept in covered trash receptacles that prevent the penetration of insects and rodents. Staff will sign and date a sheet on each shift for the next 3 months stating that they are verifying the lids have been placed back on the can when not in use. Dietary director will verify each day that this list is signed and will audit there sign in sheet weekly for the next 3 months.

103g - Storing Food

1. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

The refrigerator near the activities room had a plate of food that was not in a sealed container and was not labeled or dated.

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

The refrigerator near the activities room had a plate of food that was not in a sealed container and was not labeled or dated. Food shall be stored in closed or sealed containers. A sheet has been placed on the refrigerator and Dietary Director will sign it daily for the next 6 months, in the beginning of each shift stating that she has checked the refrigerator ensuring that all food is in a sealed container

Completion Date: *09/08/2022*

Update: *09/12/2022*

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

Plan of Correction ***Accept***

The refrigerator in the activities room had a plate of food that was not in a sealed container and was not labeled or dated. Food shall be stored in closed or sealed containers. On 8-10-2022 the uncovered food was thrown away. A sheet has been placed on the refrigerator and Activities Director will sign it daily for the next 6 months, in the beginning of each shift stating that she has checked the refrigerator ensuring that all food is in a sealed container . The activities director and Executive Director will monitor this weekly to ensure ongoing compliance

Completion Date: *09/12/2022*

Document Submission ***Implemented***

The refrigerator in the activities room had a plate of food that was not in a sealed container and was not labeled or dated. Food shall be stored in closed or sealed containers. On 8-10-2022 the uncovered food was thrown away. A sheet has been placed on the refrigerator and Activities Director will sign it daily for the next 6 months, in the beginning of each shift stating that she has checked the refrigerator ensuring that all food is in a sealed container . The activities director and Executive Director will monitor this weekly to ensure ongoing compliance

131f - Fire Extinguisher Inspection

1. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher located near the outside smoking area did not have a tag on it to determine the last time it was inspected.

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

The fire extinguisher located near the outside smoking area did not have a tag on it to determine the last time it was nspected. Maintenance director will have a sheet to sign stating that he has physically inspected all fire

131f - Fire Extinguisher Inspection (continued)

extinguishers to ensure that the date of the inspection shall be on the extinguisher.
Completion Date: *09/08/2022*

Update: *09/12/2022*

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

Plan of Correction ***Accept***

The fire extinguisher located near the outside smoking area did not have a tag on it to determine the last time it was nspected. On 8-9-2022 the maintenance Director replaced the fire extinguisher with an extinguisher that had the correct tag on it. Maintenance director will have a sheet to sign stating that he has physically inspected all fire extinguishers to ensure that the date of the inspection shall be on the extinguisher on a monthly basis. The executive director will monitor monthly yo ensure ongoing compliance
Completion Date: *09/12/2022*

Update: *09/21/2022*

Please send proof of compliance (picture).

Document Submission ***Implemented***

The fire extinguisher located near the outside smoking area did not have a tag on it to determine the last time it was nspected. On 8-9-2022 the maintenance Director replaced the fire extinguisher with an extinguisher that had the correct tag on it. Maintenance director will have a sheet to sign stating that he has physically inspected all fire extinguishers to ensure that the date of the inspection shall be on the extinguisher on a monthly basis. The executive director will monitor monthly yo ensure ongoing compliance

132g - Fire Drills Days/Times

1. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

Fire drills were held on the last or 2nd last day of the month in 9/2021, 11/2021, 12/2021, 1/2022, 2/2022, 3/2022, 4/2022, and 6/2022.

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

Fire drills were held on the last or 2nd last day of the month in 9/2021, 11/2021, 12/2021, 1/2022, 2/2022, 3/2022, 4/2022, and 6/2022. Maintenance director was educated on the importance of having fire drills on a different day and time each month. Maintenance director did a fire drill on the day of inspection which was on 8-9-22 on second shift as a show of good faith to the inspector. Executive director has preset times and days on hers and the maintenance director's calendar for each month for the next year to ensure that these fire drills are being done correctly. These fire drills are all set on on different days and shifts.
Completion Date: *09/08/2022*

Update: *09/12/2022*

Please include in plan of correction:
Who is responsible for fixing the problem and what did they do to fix it?

132g - Fire Drills Days/Times (continued)

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

Plan of Correction ***Accept***

Fire drills were held on the last or 2nd last day of the month in 9/2021, 11/2021, 12/2021, 1/2022, 2/2022, 3/2022, 4/2022, and 6/2022. Maintenance director was educated on the importance of having fire drills on a different day and time each month. Maintenance director did a fire drill on the day of inspection which was on 8-9-22 on second shift as a show of good faith to the inspector. Executive director has preset times and days on hers and the maintenance director's calendar for each month for the next year to ensure that these fire drills are being done correctly. These fire drills are all set on on different days and shifts.
The Executive Director will monitor monthly to ensure ongoing compliance.

Completion Date: *09/12/2022*

Update: *09/21/2022*

Please send fire drill log form July 2022 to current.

Document Submission ***Implemented***

Fire drills were held on the last or 2nd last day of the month in 9/2021, 11/2021, 12/2021, 1/2022, 2/2022, 3/2022, 4/2022, and 6/2022. Maintenance director was educated on the importance of having fire drills on a different day and time each month. Maintenance director did a fire drill on the day of inspection which was on 8-9-22 on second shift as a show of good faith to the inspector. Executive director has preset times and days on hers and the maintenance director's calendar for each month for the next year to ensure that these fire drills are being done correctly. These fire drills are all set on on different days and shifts.
The Executive Director will monitor monthly to ensure ongoing compliance.

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

The preadmission screening form dated [redacted] for Resident 1 was incomplete and did not indicate if the resident's needs could be met in the home.

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

The preadmission screening form dated 7/1/2022 for Resident 1 was incomplete and did not indicate if the resident's needs could be met in the home. This box was immediately checked. The resident care coordinator and director of wellness will have an audit sheet each month and will audit 5 charts per month for the next year to ensure that all preadmission screenings are filled in in its entirety.

Completion Date: *09/08/2022*

Update: *09/12/2022*

Who will monitor ongoing compliance?

Plan of Correction ***Accept***

The preadmission screening form dated [redacted] for Resident 1 was incomplete and did not indicate if the

224a - Preadmission Screen Form (continued)

resident's needs could be met in the home. On 8-9-2022 this box was immediately checked. The resident care coordinator and director of wellness will have an audit sheet each month and will audit 5 charts per month for the next year to ensure that all preadmission screenings are filled in its entirety.
The DOW and Executive Director will monitor monthly to ensure ongoing compliance.

Completion Date: *09/12/2022*

Document Submission ***Implemented***

The preadmission screening form dated [redacted] for Resident 1 was incomplete and did not indicate if the resident's needs could be met in the home. On 8-9-2022 this box was immediately checked. The resident care coordinator and director of wellness will have an audit sheet each month and will audit 5 charts per month for the next year to ensure that all preadmission screenings are filled in its entirety.
The DOW and Executive Director will monitor monthly to ensure ongoing compliance.

121a - Unobstructed Egress

1. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

There was a chair obstructing the exit leading from the stairwell to the outside smoking patio. Repeat violation from 9/21/2021.

Plan of Correction ***Accept***

There was a chair obstructing the exit leading from the stairwell to the outside smoking patio. This chair was removed immediately. This chair is one of the residents chairs. Executive Director educated resident on the mportance of keeping her chair away from the egress and she understand. Maintenance director and Executive director will observe egress daily for the next 6 months to ensure that the egress is in compliance. There will be a daily sheet to sign to ensure follow through with this task

Completion Date: *09/08/2022*

Document Submission ***Implemented***

here was a chair obstructing the exit leading from the stairwell to the outside smoking patio. This chair was removed immediately. This chair is one of the residents chairs. Executive Director educated resident on the mportance of keeping her chair away from the egress and she understand. Maintenance director and Executive director will observe egress daily for the next 6 months to ensure that the egress is in compliance. There will be a daily sheet to sign to ensure follow through with this task

125a Combustible Storage

1. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

There was a towel and washcloth observed on the exhaust vent of the dryer located in the 2nd floor laundry room. Repeat violation from 9/21/2021.

Plan of Correction ***Accept***

There was a towel and washcloth observed on the exhaust vent of the dryer located in the 2nd floor laundry room.

125a - Combustible Storage (continued)

Towel and washcloth were immediately removed. There is a sheet in the laundry room that the housekeeping will sign stating that they have removed all combustible items from the laundry room. Maintenance director will check this sheet daily for the next 6 months to ensure compliance.

Completion Date: *09/08/2022*

Document Submission ***Implemented***

There was a towel and washcloth observed on the exhaust vent of the dryer located in the 2nd floor laundry room. Towel and washcloth were immediately removed. There is a sheet in the laundry room that the housekeeping will sign stating that they have removed all combustible items from the laundry room. Maintenance director will check this sheet daily for the next 6 months to ensure compliance.