CERTIFIED MAIL – RETURN RECEIPT

REQUESTED MAILING DATE: **FEBRUARY 28, 2023**

TLC Healthcare, LLC

RE: Dunlevy Manor
2218 Route 88
Dunlevy, Pennsylvania 15432
License/COC #: 447544

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on August 16, 2022, October 4, 2022, October 5, 2022, October 11, 2022, and November 14, 2022, of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 447544) to operate the above facility. The Department's decision to revoke your license is based on the violations attached to this notice and your failure to comply with the Department's regulations, gross incompetence, negligence and misconduct in operating the facility, mistreatment or abuse of residents being cared for in the facility, and failure to submit and comply with an acceptable plan to correct noncompliance items and is made pursuant to 62 P.S. § 1026 (b)(1); (4); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (6) (relating to conditions for denial, nonrenewal or revocation).

In accordance with 55 Pa. Code § 2600.269 (b) (relating to ban on admissions) no new resident admissions are permitted after the date of this letter.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
17	II	15	$5	$75	5 calendar days from mailing date of this letter
101(j)(7)	II	15	$5	$75	5 calendar days from mailing date of this letter
132(d)	II	15	$5	$75	5 calendar days from mailing date of this letter
141(a)	II	15	$5	$75	5 calendar days from mailing date of this letter
141(b)(1)	II	15	$5	$75	5 calendar days from mailing date of this letter
183(d)	II	15	$5	$75	5 calendar days from mailing date of this letter
187(b)	II	15	$5	$75	5 calendar days from mailing date of this letter
225(a)	II	15	$5	$75	5 calendar days from mailing date of this letter
225(c)	II	15	$5	$75	5 calendar days from mailing date of this letter
227(a)	II	15	$5	$75	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not

been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to REVOKE your license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

The enclosed violation report specifies plans of correction and dates by which corrections must be made. If you choose to appeal, an acceptable plan of correction must be followed during your operation pending your appeal. Dunlevy Manor is required to remain in full compliance with all applicable statutes and regulations, including but not limited to Article X of the Human Services Code, 62 P.S. §§ 1001 et seq., and 55 Pa. Code Ch. 2600 (relating to Personal Care Homes)

Sincerely,

Jamie L. Buchenauer

Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

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

Facility Information

Name: *DUNLEVY MANOR* **License #**: *44754* **License Expiration**: *02/05/2023*

Addre : *2218 ROUTE 88, DUNLEVY, PA 15432*

County: *WASHINGTON* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *TLC HEALTHCARE LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/20/1996* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *25* **Waking Staff**: *19*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional* **Exit Conference Date**: *10/28/2022*

Inspection Dates and Department Representative

10/04/2022 - On-Site:
10/05/2022 - On-Site:
10/11/2022 - On-Site:
11/14/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* **Residents Served**: *15*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *15*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *10* **Have Physical Disability**: *0*

Inspections / Reviews

10/04/2022 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *11/26/2022*

11/28/2022 POC Submi ion

Submitted By: [redacted] **Date Submitted:** *01/11/2023*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *12/02/2022*

12/12/2022 POC Submi ion

Submitted By: [redacted] **Date Submitted:** *01/11/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *01/12/2023*

01/17/2023 Document Submi ion

Submitted By: [redacted] **Date Submitted:** *01/11/2023*

Reviewer: [redacted] **Follow Up Type:** *Enforcement*

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

On 10/4/22 at 9:32 am, the privacy coding document was attached to the license inspection summary, dated 2/8/22, et. al., and was posted in a red binder at the entrance of the home. The privacy coding document contained the names of residents #1 and #2.

On 10/4/22 at 9:32 am, the privacy coding document was attached to the license inspection summary, dated 5/16/22, and was posted in a red binder at the entrance of the home. The privacy coding document contained the names of residents #3. #4, #5 and #6.

On 10/4/22 at 10:25 am, the medication room was unlocked and unattended, which contained hospice binders for numerous residents, including residents #2 and #3. The hospice binders included progress notes and treatment plans for residents #2 and #3. Also, the home's controlled substance binder was present in the unlocked medication room, which included the controlled substance record for resident #3's Lorazepam-1mg tablet.

REPEAT VIOLATION: 2/8/2022, et. al.

Plan of Correction ***Directed - 12/09/2022)***

Privacy coding documents were removed from the binder on 10/4/22 and shredded.
The medication room door was immediately closed and locked on 10/4/22. The medication room door will remain locked when not attended, ensuring the confidentiality of records, and the keys will be maintained by the med tech, administrator or designee. The medication room door security will be inspected daily by the administrator or designee to ensure it is locked when unattended and documented on a checklist that will be maintained in the administrator's office. (DIRECTED: The daily checks shall begin within 72 hours of receipt of the plan of correction. 12/9/22). All staff were educated on the importance of maintaining resident record confidentiality. (DIRECTED: All staff persons shall be educated ensuring all resident information and medications are kept in an area that is locked. Documentation of the education shall be kept. 12/9/22). All future POC postings will be reviewed by the administrator at the time of the posting to ensure no names are included in the postings. The administrator/designee will monitor daily to ensure all resident information is kept in a locked area and document on a checklist maintained in the administrator's office. (DIRECTED: The daily monotilings shall begin within 72 hours of receipt of the plan of correction. 12/9/22).

Directed Completion Date: *12/15/2022*

Not Implemented - 01/17/2023)

25b - Contract Signatures

2. Requirements

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

Description of Violation

Resident #7's resident-home contract, dated 7/29/22, is not signed by the resident.

Resident #12's resident-home contract, dated 9/24/22, is not signed by the resident.

Plan of Correction ***Directed (- 12/09/2022)***

Resident(s) # 7 and 12's resident home contracts have been signed by the resident on 11/19/22. All resident charts were revied by the administrator/designee to ensure they were signed by the resident.
A monthly audit will be conducted by the administrator/designee beginning on 11/25/22 on all resident charts to ensure the resident - home contracts have been signed by the resident and documented on a checklist that will be maintained in the administrator's office beginning on 11/25/22. (DIRECTED: Copies of the completed new admission checklist shall be kept in each newly-admitted resident's record. 12/9/22). Staff responsible for the checklist were educated on the checklist on 11/25/22.

Directed Completion Date: *12/12/2022*

Not Implemented - 01/17/2023)

42b - Abuse

3. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On or around 10/2/22 at approximately 5:15 pm, staff person B and resident #9 were in the home's dining room. Resident #9 and staff person B began arguing with each other about resident #9 bringing food back to the resident's bedroom. Resident #9 became agitated with staff person B and told staff person B, "Your mother should have you at birth." Later that evening, staff person B along with staff person C, went to resident #9's bedroom so staff person B could apologize to the resident for staff person B's tone earlier in the day. Resident #9 told staff person C to get staff person B out of bedroom, and that the resident did not want to talk to staff person B. Staff person B became upset with resident #9, and left the resident's room, yelling at resident #9, "Your mother should have you at birth".

Plan of Correction ***Directed (- 12/09/2022)***

Staff person B was immediately suspended for three weeks. Resident #9 was reassured of his safety at the facility and verbalized feeling safe and secure. Resident #9 verbalized to the administrator that he felt safe and secure in the home. Resident # 9 was provided with the administrator's personal phone number to access should the resident ever feel threatened or uncomfortable in the home. Adult protective services was contacted and requested to provide an inservice to ALL staff which was completed on 11/15/22 by Adult Protective Services. (DIRECTED:

42b - Abuse (continued)

Documentation of the staff education shall be kept. ██ 12/9/22). Additionally, staff person B was counseled extensively and given a final written warning/last chance agreement on 10/29/22, before returning to work. Staff person B was placed on a plan of supervision for one week after returning to work following the three week suspension. Five residents will be interviewed in private monthly by the administrator/designee beginning 12/10/22 to ensure residents are free from abuse and neglect and documented.
See attached.

Within 30 calendar days of receipt of the plan of correction: The home will conduct a quality management plan review and evaluation. The Administrator will place an increased emphasis on these plans of correction and take action to improve the quality of its resident rights and Older Adult Protective Services Act (OAPSA) training for all newly hired staff within 40 scheduled working hours in accordance with §2600.65(b)(1) and §2600.65(b)(3) and annually in accordance with §2600.65(g)(3) and §2600.65(g)(4). Documentation of the quality management review shall be kept. ██ 12/9/22

Directed Completion Date: *01/12/2023*

Not Implemented (██ - 01/17/2023)

42c Treatment of Residents

4. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On or around 9/20/22, resident #3's cable television became inoperable. Resident #3 requested assistance from staff person D to fix his cable television. Staff person D was overheard talking to resident #3 in a loud and berating tone regarding the cable, and that there was nothing the home could do about it. Staff person D's loud and berating tone caused resident #3 to cry for approximately 20 minutes.

Plan of Correction ***Directed (██ - 12/09/2022)***

Resident #3 was reassured of his safety at the facility and verbalized feeling safe and secure by the administrator. Resident #3 verbalized to the administrator that ██ did feel safe and secure in the home. Resident # 3 was provided with the administrator's personal phone number to access should the resident ever feel threatened or uncomfortable n the home. Adult Protective Services was contacted and requested to provide an inservice to all staff which was completed on 11/15/22 by Adult Protective Services. (DIRECTED: Documentation of the education shall be kept. ██ 12/9/22). Additionally, staff person D was immediately placed on a plan of supervision and counseled. Staff person D is no longer on a plan of supervision. Five residents will be interviewed in private monthly by the administrator/designee beginning 12/10/22 to ensure residents are free from abuse and neglect and documented.

Within 30 calendar days of receipt of the plan of correction: The home will conduct a quality management plan review and evaluation. The Administrator will place an increased emphasis on these plans of correction and take action to improve the quality of its resident rights and Older Adult Protective Services Act (OAPSA) training for all newly hired staff within 40 scheduled working hours in accordance with §2600.65(b)(1) and §2600.65(b)(3) and annually in accordance with §2600.65(g)(3) and §2600.65(g)(4). Documentation of the quality management review shall be kept. ██ 12/9/22

Directed Completion Date: *01/09/2023*

Not Implemented ██ - 01/17/2023)

42c - Treatment of Residents *(continued)*

42s Privacy

5. Requirements

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

Description of Violation

The locking mechanisms on the bathroom doors between bedrooms #11 and #12 are not operable and do not provide privacy while using the bathroom.

On 10/5/22, a camera was mounted to the ceiling of resident #3's bedroom. According to staff persons, the home's owners can access the home's cameras in the home by using an app on their cellular telephones.

Plan of Correction ***Accept (12/09/2022)***

The locking mechanisms on the bathroom doors between bedrooms #11 and #12 have been replaced and are operable. All bathroom door locks were inspected on 11/19/22 and found to be operable. All bathroom door locks will be inspected monthly beginning 11/25/22 by the administrator/designee to ensure proper operation and resident privacy and documented on a checklist that will be maintained in the administrator's office.
There are no active video cameras in the home. This was explained during the survey. The non-operable camera mounted in the room of resident #3 was removed in the interest of comfort.
See attached.

Licensee's Proposed Overall Completion Date: *12/05/2022*

Not Implemented (- 01/17/2023)

54a - Direct Care Staff

6. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, e cept as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care staff person A, hired on , does not have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Directed (12/09/2022)***

Direct care staff person A's diploma was mis-filed. Staff person A graduated from Lawrence County Vocational School in 2002. Staff person A's diploma was placed in file. All direct care staff person files were reviewed by the administrator on 11/25/22 and found to have high school diplomas, GEDs or active registry status on the Pennsylvania nurse aide registry.. A monthly audit of direct care staff person's files will be conducted by the administrator/designee beginning 11/25/22 to ensure they have high school diplomas, GEDs or active registry status on the Pennsylvania nurse aide registry, and documented on a checklist that will be maintained in the

54a - Direct Care Staff (continued)

administrator's office. Staff responsible for completing the monthly audits were educated on 11/25/22. See attached

DIRECTED: Within 7 calendar days of receipt of the plan of the plan of correction: The administrator shall develop and implement a new hire checklist to ensure all newly-hired direct care staff persons are qualified at time of hire in accordance with 2600.54a and that documentation of the qualifications are obtained and kept in each staff person's record. Copies of the completed new hire checklist shall be kept in each staff person's record. ███ 12/9/22

Directed Completion Date: *12/19/2022*

Not Implemented (███ - 01/17/2023)

60a - Staff/Support Plan

7. 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 10/3/22 and 10/4/22, the home served 15 residents, including 10 residents with mobility needs. Of the 10 residents with mobility needs, 2 of the residents require the physical assistance of 2 staff persons to transfer in/out of bed/chair, and 1 of the residents requires the physical assistance of 2 staff persons to transfer in/out of bed/chair with the use of a Hoyer lift. The home does not have documentation from a fire safety expert within the past year which indicates a maximum safe-evacuation time to the outside of the building that exceeds 2 minutes, 30 seconds. The home routinely only schedules 2 staff persons during the 11:00pm through 7:00am shift, including on 10/3/22 and 10/4/22, which is not adequate to safely evacuate all residents of the home in the event of an emergency.

Plan of Correction ***Directed (███ - 12/09/2022)***

A fire safety inspection was completed on 11/22/22 by a fire safety expert. The maximum safe evacuation time to a public throughfare was determined to be four (4) minutes and ten (10) seconds. The home will continue to schedule annual fire safety inspections. A monthly review of staffing to ensure resident needs are meet will be completed by the administrator/designee and documented on a checklist maintained in the administrator's office.
See Attached. A fire drill will be held during sleeping hours in the 1st quarter of 2023 and documented on the form designated by the Department. (DIRECTED: By 1/9/22: The home shall conduct a fire drill during sleeping hours with the minimum number of staff persons to ensure all residents evacuate the building or evacuate to a fire-safe area indicated in writing within the past year by a fire safety expert, within the time specified in writing within the past year by a fire safety expert. If the fire drill is unsuccessful, immediate remedial action occur, which may include adding additional staff persons, and the home shall conduct another fire drill during sleeping hours within 10 calendar days of the unsuccessful fire drill. Documentation of all fire drills shall be kept. ███ 2/9/22). The administrator/designee will review the home's staffing daily to ensure it is adequate beginning 12/8/22

Directed Completion Date: *01/09/2023*

Not Implemented (███ - 01/17/2023)

65d - Initial Direct Care Training

8. Requirements

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

Description of Violation

Direct care staff person A, hired on [redacted] has not successfully completed and passed the Department-approved direct care training course and pass the competency test. Direct care staff person A provides unsupervised ADL services to residents.

Plan of Correction ***Directed ([redacted] - 12/09/2022)***

Direct Care Staff person A completed and passed the Department approved direct care training course and passed the competency test prior to providing unsupervised ADL services. Staff person A re accomplished the Department approved direct care training course and passed the competency test on 10/15/22 and the certificate was placed in his file. All Direct care staff person files were audited by the administrator on 11/20/22 and found to have a department approved direct care training course completion certificate. The administrator/designee will audit all direct care staff person files monthly beginning 11/25/22 to ensure there is a Department approved direct care training course certificate, and document on a checklist to be maintained in the administrator's office. The assistant administrator was educated on completing the checklist/tool on 11/25/22.

DIRECTED: Within 7 calendar days of receipt of the plan of the plan of correction: The administrator shall develop and implement a new hire checklist to ensure all newly hired direct care staff persons successfully complete and pass the Department approved direct care training course and pass of the competency test prior to performing any unsupervised ADL services to residents. Copies of the completed new hire checklist shall be kept in each staff person's record. [redacted] 12/9/22

Directed Completion Date: *12/19/2022*

Not Implemented ([redacted] - 01/17/2023)

81b - Resident Personal Equipment

9. Requirements

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

Description of Violation

On 10/5/22, a thick layer of dust and debris was present on the wheels and bottom of resident #9's wheelchair . Also there was an approximate 1" crack of the vinyl on resident #9's right arm rest.

Plan of Correction ***Accept ([redacted] - 12/09/2022)***

Resident #9s wheelchair was found to be no longer serviceable. With resident permission, Resident #9s wheel chair was discarded and the resident was provided with a clean and serviceable wheelchair on 11/22/22. All resident wheelchairs were inspected by the administrator on 11/25/22 and found to be clean and serviceable. The administrator/designee will perform a monthly inspection of all wheel chairs in use beginning 11/25/22 to ensure they are clean and serviceable and document the findings on a checklist that will be maintained in the administrator's office.

81b - Resident Personal Equipment *(continued)*

Licensee's Proposed Overall Completion Date: *12/06/2022*

Not Implemented █ - 01/17/2023)

91 - Telephone Numbers

10. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 10/4/22, no emergency telephone numbers were posted on or near the telephone located on the home's kitchen counter.

Plan of Correction ***Accept █ - 12/09/2022)***

Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline near the home's kitchen counter were moved for cleaning. The telephone number list was placed back near the phone while the surveyor was present. The administrator ensured that all phones had the list of emergency phone numbers posted as required on 11/15/22. The administrator/designee will conduct a daily audit of the telephones beginning 11/25/22 to ensure the required emergency numbers are posted and document the findings on a checklist maintained in the administrator's office.

Licensee's Proposed Overall Completion Date: *12/06/2022*

Implemented █ - 01/17/2023)

92 - Windows

11. Requirements

2600.

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

Description of Violation

On 10/4/22, there were numerous tears in the bottom screen of the 2nd window to the left of the exit door leading from the courtyard into the dining room.

On 10/4/22, there was a tear in the bottom screen of the window to the right of the exit door leading from the courtyard into the dining room. The tear was in the shape of a "X", which was approximately 7" x 5".

Plan of Correction ***Accept █ - 12/09/2022)***

The screens for 2nd window to the left of the exit door leading from the courtyard into the dining room and he window to the right of the exit door leading from the courtyard into the dining room were repaired on 11/5/22 All screens were inspected by the administrator and found to be in good repair on 11/5/22. The administrator/designee will inspect all window screens monthly beginning on 11/25/22 and repair/replace as needed. The screen inspection will be documented on a checklist that will be maintained in the administrator's office.

92 - Windows *(continued)*

Licensee's Proposed Overall Completion Date: *12/05/2022*

Not Implemented (01/17/2023)

101j6 Mirror

12. Requirements

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

Description of Violation

On 10/5/22, no mirror was present in resident #3's bedroom.

Plan of Correction ***Directed (12/09/2022)***

A mirror was placed in resident #3s bedroom on 11/5/22. All resident rooms were inspected by the administrator to ensure they had a mirror on 11/5/22. The administrator/designee will conduct a monthly audit beginning 11/22 to ensure each resident bedroom has a mirror and document the findings on a checklist that will be maintained in the administrator's office. All staff were educated on resident bedroom requirements on 11/15/22. (DIRECTED: Documentation of the education shall be kept. 12/9/22).

Directed Completion Date: *12/12/2022*

Not Implemented - 01/17/2023)

101j7 - Lighting/Operable Lamp

13. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 10/5/22, resident #8's bedside lamp was approximately 3 feet from the resident's bedside and could not be turned on/off at bedside.

On 10/5/22, resident #9's bedside lamp was approximately 5 feet from the resident's bedside and could not be turned on/off at bedside.

REPEAT VIOLATION: 2/8/2022, et. al.

Plan of Correction ***Directed - 12/09/2022)***

Resident #8 and #9 bedside lamps were immediately repositioned so that they could be turned on at bedside. The administrator checked all resident bedside lamps on 11/5/22 to ensure that they could be turned on at bedside. The administrator/designee will perform a daily check beginning 11/25/22 to ensure all resident bedside lamps can be turned on at bedside, and document this on a checklist that will be maintained in the administrator's office. All staff were educated on resident bedroom requirements on 11/15/22. (DIRECTED: Documentation of the education shall be kept. 12/9/22).

Directed Completion Date: *12/12/2022*

101j7 - Lighting/Operable Lamp *(continued)*

Not Implemented - 01/17/2023)

101r - Bedroom - shades/drapes/window covering

14. Requirements

2600.
101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

On 10/5/22, there was a valance at the top of resident #13's bedroom window, which did not completely cover the window to allow for privacy.

On 10/5/22, there was a V-shaped netted drape hanging from the top of the window in the shared bedroom of residents #1 and #10, which does not completely cover the window to allow for privacy.

Plan of Correction ***Directed - 12/09/2022)***

The blinds/curtains/valance in resident #13, #1 and #10 bedrooms were replaced on 11/5/22 so that coverings are clean, in good repair, provide privacy and cover the entire window when drawn. The administrator checked all resident bedrooms on 11/5/22 and found that the blinds/curtains/valance were clean, in good repair, provide privacy and cover the entire window when drawn. The administrator/designee will conduct monthly checks of all resident bedrooms beginning 11/25/22 to ensure the blinds/curtains/valance were clean, in good repair, provide privacy and cover the entire window when drawn and document the findings on a checklist that will be maintained in the administrator's office. All staff were educated on resident bedroom requirements on 11/15/22. (DIRECTED: Documentation of the education shall be kept. 12/9/22).

Directed Completion Date: *12/12/2022*

Not Implemented (- 01/17/2023)

126a - Furnace Inspection

15. Requirements

2600.
126.a. A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

Description of Violation

The home's furnace has not been inspected by a professional furnace cleaning company or trained maintenance staff person since 2/19/21.

Plan of Correction ***Accept - 11/28/2022)***

The furnaces were inspected by a professional furnace cleaning company on 11/18/22. The furnace will be inspected annually by a professional furnace cleaning company or trained maintenance staff person. In order to track this, the administrator/designee have added this requirement as a task on Outlook calendar.
See attached.

Licensee's Proposed Overall Completion Date: *11/22/2022*

Implemented - 01/17/2023)

130g - Smoke Detector Repair

16. Requirements

2600.
130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

On 6/24/22, the home's fire alarm system became offline due to a water leak in the home's roof, however, the system was not repaired until approximately 7/1/22.

Plan of Correction ***Directed - 12/09/2022)***

The smoke detector/alarm company were contacted immediately by the administrator/designee when the alarm system went offline, but the company was unable to provide a technician to the home until 7/1/22. All smoke detectors/fire alarms are currently on-line in the home. All staff were educated 11/15/22 on emergency procedures mplemented when the fire alarms and smoke detectors become inoperable - a fire watch will be initiated, and rounds will be made throughout the home every 30 minutes and documented. (DIRECTED: Documentation of education shall be kept. /9/22).

DIRECTED: Within 72 hours of receipt of the plan of correction: A supervisor shall inspect the home's fire alarm system daily to ensure it is operable. If the fire alarm system becomes inoperable, the home shall immediately mplement their fire watch policy and ensure repairs are made to the fire alarm system within 48 hours. 12/9/22

Directed Completion Date: *12/15/2022*

Not Implemented (- 01/17/2023)

130h - Inoperable Smoke Detector

17. Requirements

2600.
130.h. The home’s emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

The home's emergency procedures indicate when the fire alarms and smoke detectors become inoperable, a fire watch will be initiated and rounds will be made throughout the home every 30 minutes. From approximately 6/24/22 through 7/1/22, the home's fire alarm system was offline; however, no fire watches were completed during this time.

Plan of Correction ***Directed - 12/09/2022)***

All staff were educated on the home's emergency procedure for when the fire alarm and smoke detectors become noperable to include implementing a fire watch being implemented and rounds made throughout the home every 30 minutes on 11/15/22. (DIRECTED: Documentation of the education shall be kept. 12/9/22). Any future fire watch rounds will be recorded every 30 minutes and reviewed by the administrator/designee.

DIRECTED: Within 72 hours of receipt of the plan of correction: A supervisor shall inspect the home's fire alarm system daily to ensure it is operable. If the fire alarm system becomes inoperable, the home shall immediately

130h - Inoperable Smoke Detector (continued)

mplement their fire watch policy and ensure repairs are made to the fire alarm system within 48 hours. 12/9/22

Directed Completion Date: *12/15/2022*

Not Implemented (/17/2023)

132d - Evacuation

18. 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 fire drill conducted on 7/10/22 at 5:17pm was completed in 2 minutes, 37 seconds; however, the home does not have documentation from a fire safety expert within the past year indicating a maximum safe-evacuation time to a public thoroughfare which exceeds 2 minutes, 30 seconds.

REPEAT VIOLATION: 5/16/2022

Plan of Correction ***Directed - 12/09/2022)***

A fire safety inspection was completed on 11/22/22 by a fire safety expert. The maximum safe evacuation time to a public throughfare was determined to be four (4) minutes and ten (10) seconds. The home will continue to schedule annual fire safety inspections. All future fire drills will be timed by the administrator/designee to evaluate the time needed to evacuate all residents from the home in the time specified by the fire safety expert.
See attached.

DIRECTED: By 1/9/22: The home shall conduct a fire drill during sleeping hours with the minimum number of staff persons to ensure all residents evacuate the building or evacuate to a fire-safe area indicated in writing within the past year by a fire safety expert, within the time specified in writing within the past year by a fire safety expert. If the fire drill is unsuccessful, immediate remedial action occur, which may include adding additional staff persons, and the home shall conduct another fire drill during sleeping hours within 10 calendar days of the unsuccessful fire drill. Documentation of all fire drills shall be kept. 12/9/22.

DIRECTED: Within 72 hours of receipt of the plan of correction: The administrator shall review all fire drill records monthly to ensure all residents 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. 12/9/22

Directed Completion Date: *01/09/2023*

Not Implemented (- 01/17/2023)

141a - Medical Evaluation

19. Requirements

2600.

141a - Medical Evaluation *(continued)*

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #7 was admitted to the home on ; however, resident #7's medical evaluation was completed on 12/9/20.

Resident #8's medical evaluation, dated , does not include resident #8's height or a list of resident #8's current medications. These sections of the form are blank. Resident #8 is prescribed numerous medications, including Bisacodyl-10mg and Lorazepam-0.5mg tablet.

REPEAT VIOLATION: 2/8/2022, et. al.

Plan of Correction ***Directed 12/09/2022)***

Medical evaluations for residents # 7 and 8 were completed by a CRNP who came to the facility on 11/19/22. All resident medical evaluations were reviewed by the administrator on 11/19/22 and found to be complete and timely. All resident medical evaluations will be reviewed monthly by the administrator/designee and documented on a checklist the will be maintained in the administrator's office. (DIRECTED: The monthly audits conducted by the administrator shall begin on 1/1/23. 12/9/22).
An admission checklist will be implemented for all new admissions beginning 12/1/22 (DIRECTED: Copies of the completed new admission checklist shall be kept in each newly-admitted resident's record. 12/9/22).

Directed Completion Date: *01/01/2023*

Not Implemented (- 01/17/2023)

141b1 - Annual Medical Evaluation

20. Requirements

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

Description of Violation

Resident #1's most recent medical evaluation was completed on .

Resident #5's most recent medical evaluation, dated does not include the medical professional's license number. This section of the form is blank.

Resident #9's most recent medical evaluation, dated , does not include the medical professional's license number. This section of the form is blank.

REPEAT VIOLATION: 5/16/2022, 2/8/2022, et. al.

Plan of Correction ***Directed (12/09/2022)***

Annual medical evaluations for resident's #1, 5 and 9 were completed on 11.25.22. All annual medical evaluations were reviewed by the administrator on 11/25/22 to ensure timely completion. All annual medical evaluation will be reviewed monthly by the administrator/designee to ensure timely completion and documented on a checklist

141b1 - Annual Medical Evaluation (continued)

maintained in the administrator's office beginning 11/25/22. A form that includes tracking annual medical evaluations will be implemented beginning 12/7/22. The assistant administrator was educated on the requirement 12/7/22. (DIRECTED: Beginning on 1/1/23: The new tracking system shall be reviewed monthly by the administrator to ensure all residents have a medical evaluation completed in its entirety at least annually. Documentation of the tracking system shall be kept. 12/9/22).

Directed Completion Date: *01/01/2023*

Not Implemented - 01/17/2023)

183d - Prescription Current

21. Requirements

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

Description of Violation

Resident #3 was prescribed Earwax removal-Place 5 drops into each ear 2 times a day for 7 days. This medication was completed on 8/25/22; however, the medication was still present in the home's medication cart on 10/5/22.

On 10/5/22, a tube of Cortizone maximum strength-10 plus cream, which expired in 12/2021, was present in the home's first aid kit.

REPEAT VIOLATION: 2/8/2022, et. al.

Plan of Correction ***Directed (- 12/09/2022)***

Medications for residents not living in the home were removed from the home on 11/15/22. All medications were checked by the administrator on 11/15/22 to ensure there were none for individuals not living in the home. All medications will be checked monthly by the administrator/designee beginning 11/25/22 to ensure there are no medications for individuals not living in the home. Education was provided to staff persons who administer medications on 11/15/22, the education included the home's procedures for removing medications immediately upon receipt of orders from prescriber. (DIRECTED: Documentation of the education shall be kept. 12/9/22).

Directed Completion Date: *12/12/2022*

Not Implemented 01/17/2023)

184a - Resident's Meds Labeled

22. 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.

184a - Resident's Meds Labeled *(continued)*

Description of Violation

Resident #3 is prescribed Lorazepam 1mg-Take by mouth 1 tablet twice a day; however, the pharmacy label indicates Lorazepam 1 mg-Take by mouth 1 tablet twice daily as needed.

Plan of Correction ***Directed (- 12/09/2022)***

The prescription label was corrected by the pharmacy to reflect the correct dosing and a new prescription card/medication sent to the home on 11/15/22. All medication labels were checked by the administrator on 11/15/22 and found to have the correct resident's name, name of the medication, date the prescription was issued, prescribed dosage and instructions for administration, name and title of the prescriber. All medication containers will be checked monthly by the administrator/designee beginning 11/25/22 to ensure correct resident's name, name of the medication, date the prescription was issued, prescribed dosage and instructions for administration, name and title of the prescriber and documented on a checklist maintained in the administrator's office. Staff education was provided for staff persons who administer medications on 11/15/22. The education included the home's procedures for updating pharmacy labels immediately upon receipt of orders from prescriber. (DIRECTED: Documentation of the education shall be kept. 12/9/22).

See attached.

Directed Completion Date: *12/12/2022*

Not Implemented - 01/17/2023)

191 - Resident Right to Refuse

23. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

There is no documentation present in resident #7's record indicating resident #7 has been educated on their right to question or refuse a medication if the resident believes there may be a medication error. Resident #7 was admitted to the home on

There is no documentation present in resident #8's record indicating resident #8 has been educated on their right to question or refuse a medication if the resident believes there may be a medication error. Resident #8 was admitted to the home on .

There is no documentation present in resident #10's record indicating resident #10 has been educated on their right to question or refuse a medication if the resident believes there may be a medication error. Resident #10 was admitted to the home on .

There is no documentation present in resident #11's record indicating resident #11 has been educated on their right to question or refuse a medication if the resident believes there may be a medication error. Resident #11 was admitted to the home on

There is no documentation present in resident #12's record indicating resident #12 has been educated on their right to question or refuse a medication if the resident believes there may be a medication error. Resident #12 was admitted

191 - Resident Right to Refuse (continued)

to the home on [redacted].

Plan of Correction ***Directed ([redacted] - 12/09/2022)***

All residents are educated on the right to refuse a medication if the resident believes there may be a medication error at the time of admission . Documentation on the right to refuse was completed for resident # 7, 8, 10, 11 and 12 on 11/25/22. All resident records were reviewed by the administrator on 11/25/22 and found to have documentation of the right to refuse. All resident records will be reviewed monthly by the administrator/designee beginning 11/25/22 to ensure documentation of the resident's right to refuse is completed and documented on a checklist maintained in the administrator's office. An admission checklist was implemented on 12/7/22 and the assistant administrator was educated on the process that day. (DIRECTED: Copies of the completed new admission checklist shall be kept in each newly-admitted resident's record. [redacted] 12/9/22).

Directed Completion Date: *12/12/2022*

Not Implemented ([redacted] - 01/17/2023)

224a - Preadmission Screen Form

24. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #7's preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home. This section of the form is blank.

Resident #8's preadmission screening form, dated [redacted] does not include a determination that the needs of the resident can be met by the services provided by the home. This section of the form is blank.

Resident #9's preadmission screening form, dated [redacted], does not include a determination that the needs of the resident can be met by the services provided by the home. This section of the form is blank. Also, resident #9's preadmission screening form does not include the printed name or signature of the person who completed the form. This section of the form is also blank.

Resident #10's preadmission screening form, dated [redacted] does not include a determination that the needs of the resident can be met by the services provided by the home. This section of the form is blank.

Resident #11's preadmission screening form does not include a determination that the needs of the resident can be met by the services provided by the home. This section of the form is blank. Also, the form is dated "0-21-2022".

No preadmission screening was completed for resident #12, who was admitted to the home on [redacted].

Plan of Correction ***Directed ([redacted] - 12/09/2022)***

Preadmission screening forms were completed to include a determination that the needs of the resident can be met by the services provided by the home for residents # 7, 8, 9, 10, 11 and 12. Al resident preadmission screening forms were reviewed by the administrator on 11/25/22 and found to be complete. All resident preadmission screening forms will be reviewed monthly by the administrator/designee beginning 11/25/22 and documented on a checklist maintained in the administrator's office.

224a - Preadmission Screen Form (continued)

An admission checklist will be implemented on 12/7/22 and completed by the administrator/designee. (DIRECTED: Copies of the completed new admission checklist shall be kept in each newly-admitted resident's record. 12/9/22).

Directed Completion Date: *12/12/2022*

Not Implemented - 01/17/2023)

225a - Assessment 15 Days

25. 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 #3 requires total physical assistance of 2 staff persons to transfer in/out of bed/chair with the use of a Hoyer lift; however, resident #3's assessment, dated indicates resident #3 requires some physical assistance to transfer in/out of bed/chair.

No assessment was completed for resident #7, who was admitted to the home on

Resident #8 was admitted to the home on however, resident #8’s assessment was not completed until 9/12/22.

As of 10/11/22, no assessment was completed for resident #11, who was admitted to the home on .

As of 10/11/22, no assessment was completed for resident #12, who was admitted to the home on

REPEAT VIOLATION: 5/16/2022, 2/8/2022, et. al.

Plan of Correction ***Directed (- 12/09/2022)***

Resident #3's initial assessment was corrected on to reflect the need for the use of a mechanical (hoyer) ift. Initial assessments were completed for residents # 7, 8, 11 and 12 on 11/25/22 by the administrator. All resident initial assessments were reviewed on 11/25/22 and found to be completed timely. All resident initial assessments will be reviewed monthly by the administrator/designee beginning 11/25/22 and documented on a checklist maintained in the administrator's office. An admission checklist was implemented on 12/7/22 and education provided to the assistant administrator. (DIRECTED: Copies of the completed new admission checklist shall be kept in each newly-admitted resident's record. 12/9/22).

Directed Completion Date: *12/12/2022*

Not Implemented (- 01/17/2023)

225c - Additional Assessment

26. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

225c - Additional Assessment *(continued)*

2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #1's most recent assessment was completed on [redacted]; however, resident #1's previous assessment was completed on 6/27/20.

REPEAT VIOLATION: 5/16/2022, 2/8/2022, et. al.

Plan of Correction ***Directed [redacted] - 12/09/2022)***

Resident #1's annual assessment was completed on [redacted]. All resident annual assessments were reviewed by the administrator on 11/25/22 and found to be completed timely. All resident annual assessments will be reviewed monthly by the administrator/designee beginning 11/25/22 to ensure they are completed timely and documented on a checklist that will be maintained in the administrator's office. An admission checklist that includes annual medical assessment implemented 12/7/22. Assistant administrator educated on the requirement 12/7/22.

DIRECTED: By 1/1/23: The administrator shall develop and implement a tracking system to ensure each resident has an assessment completed in its entirety at least annually. Documentation of the tracking system shall be kept and reviewed at least monthly by the administrator, beginning on 1/1/23. [redacted] 12/9/22).

Directed Completion Date: *01/01/2023*

Not Implemented [redacted] - 01/17/2023)

227a Support Plan 30 Days

27. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

No support plan was completed for resident #7, who was admitted to the home on [redacted]

REPEAT VIOLATION: 5/16/2022, 2/8/2022, et. al.

Plan of Correction ***Directed ([redacted] 12/09/2022)***

Support plan for resident #7 was completed on [redacted]. All resident support plans were reviewed by the administrator on 11/25/22 to ensure they were complete. All resident support plans will be reviewed monthly by the administrator/designee beginning 11/25/22 to ensure they are complete and documented on a checklist that will be maintained in the administrator's office.
An admission checklist was implemented on [redacted] and the assistant administrator educated on the process that day. (DIRECTED: Copies of the completed new admission checklist shall be kept in each newly-admitted resident's record. [redacted] 12/9/22).

Directed Completion Date: *12/12/2022*

Not Implemented [redacted] - 01/17/2023)

227d - Support Plan Medical/Dental

28. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #3 requires total physical assistance of 2 staff persons to transfer in/out of bed/chair with the use of a Hoyer lift; however, resident #3's support plan, dated 2/23/22, indicates resident #3 is transferred in/out of bed/chair with the use of a sit to stand lift.

Plan of Correction ***Accept (- 12/09/2022)***

The support plan medical/dental for resident #3 was corrected on 11/15/22 to reflect the need for a mechanical hoyer) lift. All resident support plans were reviewed on 11/25/22 and found to be accurate and complete. All resident support plans will be reviewed monthly beginning 11/25/22 by the administrator/designee for accuracy and documented on a checklist that will be maintained in the administrator's office.
See attached.

Licensee's Proposed Overall Completion Date: *12/08/2022*

Not Implemented (01/17/2023)

227g -Support Plan Signatures

29. Requirements

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

Description of Violation

Resident #10's support plan, dated 7/10/22, is not signed by the resident and does not indicate if the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

Plan of Correction ***Accept - 12/09/2022)***

The support plan for resident #10 has been signed by the resident on 11/5/22. All support plans were reviewed on 11/5/22 and found to be signed and dated by Individuals who participate in the development of the support plan. All support plans will be reviewed monthly beginning 11/25/22 for completeness by the administrator/designee and document on a checklist that will be maintained in the administrator's office. All staff persons involved in completion of resident support plans were educated on 11/15/22.

Licensee's Proposed Overall Completion Date: *12/06/2022*

Not Implemented (01/17/2023)