pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: April 14, 2023

[redacted]
Fair Oaks OPCO LLC
[redacted]

RE: Fair Oaks Senior Living
License/COC #: 452862

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on June 23, 2022, June 24, 2022, June 27, 2022, August 22, 2022, August 23, 2022, November 15, 2022, November 16, 2022, November 17, 2022, December 7, 2022, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from April 14, 2023 to October 14, 2023.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

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	X Fine Per resident Per day	= Calculated Fine Per day	Mandated Correction Date (to avoid Fine)
51	II	83	$5	$415	5 calendar days from mailing date of this letter
101(j)(7)	II	83	$5	$415	5 calendar days from mailing date of this letter
183(b)	II	83	$5	$415	5 calendar days from mailing date of this letter
187(d)	II	83	$5	$415	5 calendar days from mailing date of this letter
225(c)	II	83	$5	$415	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 issue a PROVISIONAL 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. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
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.

Sincerely,

Jamie L. Buchenauer

Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *FAIR OAKS SENIOR LIVING* **License #:** *45286* **License Expiration:** *02/19/2023*

Address: *2200 WEST LIBERTY AVENUE, PITTSBURGH, PA 15226*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *FAIR OAKS OPCO LLC*

Address: *2200 WEST LIBERTY AVENUE, PITTSBURGH, PA, 15226*

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

Certificate(s) of Occupancy

Type: *Other* **Date:** *01/16/2017* **Issued By:** *City of Pittsburgh*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *107* **Waking Staff:** *80*

Inspection Information

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

Reason: *Complaint, Provisional* **Exit Conference Date:** *12/07/2022*

Inspection Dates and Department Representative

11/15/2022 - On-Site: [redacted]
11/16/2022 - On-Site:
11/17/2022 - On-Site:
12/07/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served:** *83*

Secured Dementia Care Unit

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

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *81*

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

Have Mobility Need: *24* **Have Physical Disability:** *0*

Inspections / Reviews

11/15/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/18/2022*

12/21/2022 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/01/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/28/2022*

12/29/2022 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/01/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/01/2023*

02/23/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *02/01/2023*

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

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #1's support plan, dated 8/19/22, indicates resident #1 is occasionally incontinent of bladder and needs daily assistance from staff members related to [redacted] management, and also requires hands-on assistance from staff members with showering. According to the home's call bell log, resident #1 waited in excess of over 1 hour for staff member assistance on numerous occasions, to include the following dates and times:

- *11/17/22 at 1:46 am-Response time of 1 hour, 23 seconds*
- *11/16/22 at 7:47 pm-Response time of 1 hour, 10 minutes*
- *11/16/22 at 8:48 am-Response time of 1 hour, 6 minutes*
- *11/16/22 at 4:54 am-Response time of 1 hour, 3 minutes*
- *11/15/22 at 12:31 pm-Response time of 1 hour, 29 minutes*
- *11/14/22 at 10:33 pm-Response time of 1 hour, 8 minutes*
- *11/13/22 at 4:15 am-Response time of 1 hour, 30 minutes*

Plan of Correction ***Directed ([redacted] - 12/29/2022)***

Upon receiving violation 2600.23a the Administrator evaluated the placement of the pendant monitoring system due to the

number of delayed response times for resident #1. The pendant monitoring system was moved to Security Managers desk on

October 8, 2022 which is monitored 24 hours per day. Security Managers were instructed to monitor and notify the Resident

Care Aides/Med Techs via walkie- talkie of any resident pendant active for periods extending from 10 – 15 minutes. Security

will log any pendant that is active longer than15 minutes. Moving forward the process is: Pendant is alarmed and it is 12

minutes (example) The Security Manager walkie-talkies the Resident Care Aides to notify them of the pendant that is still

alarmed. [redacted] waits approximately another minute and sees that it is still not being responded to, [redacted] will walkie-talkie them

again, [redacted] will then wait to see if it is responded to within a minute and if not he will go to floor to see what the issue may be

of no response and if help is needed. Ongoing the Security Manager will be responsible for monitoring the response time of

the pendants ensuring that the residents receive assistance in an appropriate time. Security Manager is present in the

building 24 hours per day. (DIRECTED: All security staff persons shall be educated on the new system. Documentation of the education shall be kept. [redacted] 12/29/22).

DIRECTED: Within 10 calendar days of receipt of the plan of correction: All direct care staff persons shall be educated on timely responses to resident call bells to ensure timely ADL assistance is provided to all residents in accordance with their assessments and support plans. Documentation of the education shall be kept. [redacted] 12/29/22

23a - Activities of Daily Living Assistance (continued)

DIRECTED: Beginning on 1/1/23: The administrator/Director of Nursing shall review the home's call bell reports daily for 1 month, then weekly thereafter, to ensure timely responses to call bells are met to ensure residents are receiving timely assistance with ADL's. [redacted] 12/29/22

Directed Completion Date: *01/06/2023*

Not Implemented [redacted] - 02/23/2023)

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 #2's resident-home contract, dated 8/26/21, is not signed by the resident.

Plan of Correction ***Directed [redacted] - 12/29/2022)***

All contracts will be reviewed by the Administrator and Marketer by January 6. Any unsigned at that time will be pulled and

that contract will be signed before being filed again. Going forward the Marketing Director will use the new admission

checklist and will complete the contracts making sure it contains signatures and dates at the time of admission to the home. (DIRECTED: Copies of the completed new admission checklists shall be kept in each resident's record. [redacted] 12/29/22).

The Administrator will review every contract after completed by the Marketer to ensure all signatures and dates are present. (DIRECTED: The administrator review of all new admission contracts shall begin within 72 hours of receipt of the plan of correction, and the administrator reviews shall be completed within 24 hours of admission for all newly-admitted residents. [redacted] 12/22/22).

Resident #2 contract is now signed 12/26/22. A new admission checklist will be implemented 01/06/23. Staff Education will

be 01/06/23. (DIRECTED: Documentation of the education shall be kept. [redacted] 12/29/22).

Directed Completion Date: *01/06/2023*

Not Implemented ([redacted] - 02/23/2023)

51 - Criminal Background Check

3. Requirements

2600.

51 - Criminal Background Check *(continued)*

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

A Pennsylvania criminal background check was not completed for staff member A, who was hired on [redacted]

REPEAT VIOLATION: 11/1/2021, et. al.

Plan of Correction ***Directed ([redacted] - 12/29/2022)***

Employee files were reviewed, and staff member A did have a Criminal Background Check completed on 07/21/21. It was misfiled. An annual review of employment files was conducted by Georgette B. on 12/13th through12/28th to ensure all files are up to date and contain the correct documentation. A "New Hire Checklist" was implemented on10/13/22, which states all necessary documents needed for hire to ensure compliance. Background checks will be done by the Administrator using the New Hire Checklist. Going forward the Administrator will be doing orientation for new hires and will be responsible for proper documents. (DIRECTED: Copies of the completed new hire checklists shall be kept in each staff person's record.[redacted] 12/29/22)

Directed Completion Date: *01/01/2023*

Not Implemented[redacted] - 02/23/2023)

54a - Direct Care Staff

4. Requirements

2600.

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

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff member A, who was hired on [redacted] *does not have a high school diploma, GED diploma or active registry status on the Pennsylvania nurse aide registry.*

Plan of Correction ***Directed ([redacted] - 12/29/2022)***

Staff member A did have a High School Diploma, it was misfiled. Ongoing a "New Hire Checklist" was implemented on 10/13/22 for all new hired employees to ensure that all necessary documentation is kept and is in compliance. (DIRECTED: Copies of the completed new hire checklists shall be kept in each staff person's record.[redacted] 12/29/22) The Administrator will be responsible for using checklist and maintaining proper documentation. (Audits were done by [redacted] on 12/13 through 12/28.)

54a - Direct Care Staff (continued)

DIRECTED: Within 7 calendar days of receipt of the plan of correction: The administrator shall review all current direct care staff person records to ensure documentation of qualifications in accordance with 2600.54a are present for each direct care staff person.[redacted] 12/29/22

Directed Completion Date: *01/03/2023*

Not Implemented[redacted] - 02/23/2023)

57d - Waking Hours

5. 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

The home is required to provide a minimum of 1 hour of personal care services for each mobile resident and 2 hours of personal care services for each resident who has mobility needs.

On 11/5/22, there were 76 residents in the home, including 22 with mobility needs, requiring a minimum of 73.5 hours of direct care staffing during waking hours. However, on this date, only 70.62 hours of direct care staffing were provided during waking hours.

Plan of Correction ***Directed[redacted] - 12/29/2022)***

The homes monitoring steps for ensure adequate coverage and during call offs are as such:
The staff are to call the HSD or her assistant two hours before if they are calling off. Meeting was held 12/28/22 by
HSD and assistant to re-enforce this protocol. (Documentation will be kept) Since violation HSD now schedules 2
extra staff on each shift 2 for 7a-3p, 2 for 2p-10p, 2 for 11p-7a. to account for potential call -off scenarios. This is to
ensure resident's needs are being met. HSD is responsible for call offs, hours, and accuracy. Administrator will assist if
needed for back up and support to ensure hours are being met along with resident care needs.
DIRECTED: Within 24 hours of receipt of the plan of correction: The administrator/Director of Nursing shall review the home's staffing schedule on a daily basis to ensure adequate staffing coverage in accordance with 2600.57a, 2600.57b, 2600.57c, 2600.57d, 2600.60a.[redacted] 12/29/22.

Directed Completion Date: *12/30/2022*

Not Implemented[redacted] - 02/23/2023)

91 - Telephone Numbers

6. Requirements

2600.

91 - Telephone Numbers *(continued)*

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 11/17/22, none of the emergency telephone numbers indicated in 2600.91 were on or near the telephone on the side table in resident #1's bedroom.

Plan of Correction ***Directed ([redacted] - 12/29/2022)***

Upon receiving violation for 2600.91 all rooms inspected for emergency telephone numbers to be posted in all resident rooms. ~~Going~~

~~forward by entry door in all resident rooms there will be a 4x6 posting of all emergency numbers. This will be consistent in all rooms.~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. [redacted] 12/29/22)

(DIRECTED: Within 5 calendar days of receipt of the plan of correction: The security manager shall inspect all telephones with an outside line, including the telephone in resident #1's bedroom, to ensure all telephone numbers indicated in 2600.91 are posted on or near each telephone. [redacted] 12/29/22).

The Security Manager was educated on extra duty. Room audits started 11/18/22 , this is included in the Security Manager monthly safety

inspection. Security Manager will audit all rooms monthly. (First week is floor 6 and 5, second week is floor 4 and 3, third week is 2 and 1.) (DIRECTED: The monthly audits shall begin on 2/1/23 and shall include an inspection of all telephones with an outside line to ensure all telephone numbers indicated in 2600.91 are posted on or near each telephone. Documentation of the audits shall be kept.[redacted] 12/29/22).

Staff will be educated (01/06/23) on location of emergency numbers, in the event, one is missing between audits. Staff is to notify Security

Manager, in which it will be immediately replaced. This is to ensure all emergency numbers will be maintained in rooms.

Directed Completion Date: *02/01/2023*

Not Implemented [redacted] - 02/23/2023)

101j5 - Bedside Table/Shelf

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

Description of Violation

On 11/16/22, resident #5 did not have a bedside table or shelf.

Plan of Correction ***Accept [redacted] - 12/29/2022)***

Immediately a table was placed in resident #5 room.

Going forward the Security Manager was educated on the extra duty when doing his monthly safety inspections in

resident rooms along with checking emergency numbers will also check that all rooms/residents will have a bedside table.

101j5 - Bedside Table/Shelf (continued)

The audits started 11/18/22. (First week is floor 6 and 5, second week is floor 4 and 3, third week is 2 and 1.) Security

Manager will be responsible for ensuring that all residents have a bedside table or shelf.

Licensee's Proposed Overall Completion Date: *12/28/2022*

Not Implemented [redacted] - 02/23/2023)

101j7 - Lighting/Operable Lamp

8. 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 11/16/22, resident #5 did not have an operable lamp or other source of lighting that could be turned on/off at bedside.

REPEAT VIOLATION: 11/1/2021, et. al.

Plan of Correction ***Directed [redacted] - 12/29/2022)***

An operable lamp was placed at bedside of resident #5 at time of inspection on 11/16/22.. Going forward the Security

Manager was notified of extra duty, when making monthly safety inspection rounds of all resident rooms will also include

auditing for an operable lamp and /or source of lighting. (First week, floors 6 &5, second week 4 & 3, Third week 2 & 1)
(DIRECTED: The monthly audits conducted by the security manager shall begin within 72 hours of receipt of the plan of correction. [redacted] 12/29/22).

Implemented 12/27/22 all residents will have a push button light within reach; therefore every resident will have a lamp and

or a push button light to ensure residents will always have a source of light at their bedside. (DIRECTED: The security manager shall ensure all tap lights are operable during the monthly audits.[redacted] 12/29/22).

Directed Completion Date: *01/01/2023*

Not Implemented [redacted] - 02/23/2023)

102i - Soap Dispenser

9. 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 11/16/22, there was an unlabeled bar of soap present on the sink in the shared bathroom of residents #3 and #4.

102i - Soap Dispenser *(continued)*

Plan of Correction ***Directed [redacted] - 12/29/2022)***

Upon receiving the violation 2600.102i, bar soap was removed that day during survey,11/16/22. Resident #3 and #4 shared room, were furnished with a wall-mounted soap dispenser on 11/16/22. All dual-occupancy rooms will be furnished with wall-mounted soap dispensers by 12/28/22. Housekeeping and staff members will now be responsible for monitoring and replacing soap as needed. Staff will be educated on new duty on 01/06/23. (DIRECTED: Documentation of the education shall be kept. [redacted] 12/29/22).

DIRECTED: Beginning on 1/1/23: The Housekeeping Supervisor shall inspect all bathrooms monthly to ensure a dispenser with soap is present within reach of each bathroom sink and that there are no unlabeled bars of soap present in any bathroom. [redacted] 12/29/22

Directed Completion Date: *01/06/2023*

Not Implemented [redacted] - 02/23/2023)

102k - No Common Towel

10. Requirements

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

On 11/16/22, there was a used, unlabeled towel in the shared bathroom of residents #3 and #4. Also, there were no paper towels, mechanical hand dryer or other sanitary means of hand drying present in this shared bathroom.

Plan of Correction ***Directed [redacted] - 12/29/2022)***

The used towel was removed on the day of survey 11/16/22. All dual rooms will be furnished with paper towel holder, soap dispenser and two towel racks that will be labeled with their own name by 12/28/22. Ongoing Housekeeping and Resident Care Aides will monitor and replace towels daily and as needed. Staff will be educated on changes and duties on 01/06/23. (DIRECTED: Documentation of the education shall be kept.[redacted] 12/29/22).

DIRECTED: Beginning on 1/1/23: The Housekeeping Supervisor shall inspect all bathrooms monthly to ensure there are no unlabeled, common towels present. [redacted] 12/29/22

Directed Completion Date: *01/06/2023*

Not Implemented [redacted] - 02/23/2023)

132b - Safety Inspection/Fire Drill

11. 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 most recent fire safety inspection and supervised fire drill conducted by a fire safety expert was completed on 11/28/22; however, the home does not have documentation from the previous fire safety inspection and supervised fire drill that was conducted by a fire safety expert, so it is unable to be determined if the most recent fire safety inspection and supervised fire drill conducted on 11/28/22 was completed timely.

Plan of Correction ***Directed [redacted] - 12/29/2022)***

Upon receiving the violation to 2600.132d, the home was unable to provide documentation for a fire safety inspection. On October 1, 2021, Fair Oaks Senior Going forward, the fire safety inspections and drills will be scheduled annually by the Administrator and Security Manager

to ensure compliance. The Safety Manager is Certified to hold fire drills and documentation will be kept.

On October 1, 2021, Fair Oaks Senior Living was purchased by HSL-Care and all records held by the previous personal care

home were removed from the premises. There have been no changes or modification to the building as of 12/31/21.

DIRECTED: Within 72 hours of receipt of the plan of correction: The administrator shall develop and implement procedures to ensure documentation of all fire safety inspections and supervised fire drills conducted by a fire safety expert are present in the home and provided to the Department upon request. [redacted] 12/29/22

Directed Completion Date: *01/01/2023*

Not Implemented [redacted] - 02/23/2023)

132d - Evacuation

12. 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

According to documentation from a fire safety expert, dated 11/28/22, the maximum safe evacuation time to the home's numerous fire-safe areas is 8 minutes, 30 seconds. However, the home does not have documentation from a fire safety expert prior to 11/28/22 which indicates an evacuation time from the building or to fire-safe areas that exceeds 2 minutes, 30 seconds. During the following fire drills, the evacuation time exceeded 2 minutes, 30 seconds:

- *10/12/22 at 4:15 pm-Evacuation time of 7 minutes, 13 seconds*

132d - Evacuation (continued)

- *9/26/22 at 2:20 pm-Evacuation time of 7 minutes, 52 seconds*
- *8/8/22 at 6:25 pm-Evacuation time of 7 minutes, 13 seconds*
- *7/11/22 at 3:20 am-Evacuation time of 8 minutes, 27 seconds*
- *6/20/22 at 4:45 pm-Evacuation time of 7 minutes, 33 seconds*
- *5/8/22 at 2:35 pm-Evacuation time of 7 minutes, 45 seconds*
- *4/10/22 at 10:30 am-Evacuation time of 7 minutes, 5 seconds*
- *3/15/22 at 7:35 am-Evacuation time of 7 minutes, 10 seconds*
- *2/24/22 at 2:15 pm-Evacuation time of 7 minutes, 3 seconds*
- *1/1/22 at 6:45 am-Evacuation time of 8 minutes, 17 seconds*

Plan of Correction ***Directed (- 12/29/2022)***

Going forward the Administrator will reach out to the Fire Safety Expert, , and schedule a time for a fire safety inspection and drills. (DIRECTED: Within 72 hours of receipt of the plan of correction: The administrator shall develop and implement a tracking system to ensure a fire safety inspection and fire drill conducted by a fire safety expert is scheduled and completed at least annually. Documentation of the system shall be kept. 12/29/22). Documentation of The Administrator will notify Security Manager to assist with and work with Fire Safety Expert, along with to ensure drills are being conducted properly and paperwork is correct and in compliance. Security Manager will be responsible for conducting drills and Administrator will monitor to ensure compliance. Presently the home has a certified fire safety expert who was trained by which is the Security Manager. is the designated person who will monitor fire drill records monthly to ensure all residents evacuate with in the time specified in writing. (DIRECTED: Within 72 hours of receipt of the plan of correction: The security manager 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. /29/22).

Directed Completion Date: *01/01/2023*

Not Implemented (02/23/2023)

141a 1-10 Medical Evaluation Information

13. Requirements

2600.

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

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #6's medical evaluation, dated 11/2/22, does not include the resident's ability to self-administer medications. This section of the form is blank.

Resident #7's medical evaluation, dated 3/17/22, does not include resident #7's special health/dietary needs, body positioning/movement, ability to self-administer medications or cognitive functioning. These sections of the form are blank.

Plan of Correction ***Directed [redacted] - 12/29/2022)***

Going forward the home will implement a new admission checklist on 01/06/23. Resident #6 DME was not returned to the physician because resident had CTB on 12/15/22. On resident #7 was updated on 04/07/22. [redacted] reviewed resident records and was completed by 10/26/22 to ensure they had a timely and complete DME. The HSD will be responsible for ensuring the accuracy and timely DMEs ongoing.

Resident #7's has a more recent DME dated 04/20/22 as the resident was supposed to be respite but did not move in until April. The correct DME will be provided with the plan of correction.

DIRECTED: Within 7 calendar days of receipt of the plan of correction: The administrator shall develop and implement a new admission checklist to ensure a medical evaluation is completed in its entirety within 60 days prior to admission or within 30 days after admission for all newly-admitted residents. Copies of the completed new admission checklists shall be kept in each resident's record. All staff persons involved in the admission process shall be educated on the new checklist by 1/7/23. Documentation of the education shall be kept. [redacted] 12/29/22

Directed Completion Date: *01/07/2023*

Not Implemented [redacted] - 02/23/2023)

161d - Dietary Needs

14. Requirements

2600.
161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

161d - Dietary Needs *(continued)*

Description of Violation

On 11/2/22, resident #6 was prescribed a mechanical soft diet; however, from 11/15/22 through 11/17/22, resident #6 was served a regular diet.

Plan of Correction ***Directed (- 12/29/2022)***

During the state inspection on 11/16/22, Resident #6 was found to be in violation for 2600.161d. The resident arrived from another personal care home on a regular/soft diet and was assessed by home health as finger food appropriate and then assessed again by hospice as regular diet from 11/15 to 11/17 which is why the resident was served a regular diet on those days.
The nursing department notifies the dietary department of dietary changes when they get the order. The HSD physically takes the change of diet paper and hands it to the cook in the kitchen. The cook then posts it and tells the staff of the diet change of that resident. The Nursing department after notifying the dietary then charts and documents changes in resident documents and on the RASP. (DIRECTED: By 1/7/23: All staff persons involved in reviewing new orders from physicians, physician assistants or certified registered nurse practitioners shall be re-educated on the home's procedures for immediate notification to the dietary department upon receipt of new or changes to resident diets. Documentation of the education shall be kept. 12/29/22).
The audit was done by on 10/26/22. The cook and HSD will monthly will review the diet report and make sure it matches what the orders for the residents to ensure that diets are followed. (DIRECTED: The monthly reviews shall begin on 1/1/23 to ensure all residents are receiving the current prescribed diet. 12/29/22).

Directed Completion Date: *01/07/2023*

Not Implemented (- 02/23/2023)

162c - Menus Posted

15. Requirements

2600.
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 11/15/22, the only menu posted in the home was for the week of 11/11/22 through 11/19/22.

Plan of Correction ***Directed - 12/29/2022)***

After receiving violation 2600.162c, the menu for the second week was corrected at time of inspection.
Ongoing the Dietary Director will now post the current week's menu as well as the following week's menu on
each floor in a common area. It will be monitored by the Administrator to ensure compliance. (DIRECTED: Beginning on 1/1/23. The cook shall inspect the home weekly to ensure the current week's menu, as well as the menu 1 week in advance, is posted in a public and conspicuous place in the home. 12/29/22).

Directed Completion Date: *01/01/2023*

Not Implemented - 02/23/2023)

183b - Meds and Syringes Locked

16. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 11/16/22 at 12:20 pm, there were 10 vitamins unlocked, unattended and accessible in a clear pill cup on a table in resident #8's bedroom.

REPEAT VIOLATION: 3/18/2022, et. al.; 11/1/2021, et. al.

Plan of Correction ***Directed [redacted] - 12/29/2022)***

Upon receiving the violation to 2600.183b, the cited medication were removed at time of discovery. Resident's room was inspected for any additional meds. Med Cart was inspected to ensure medications were locked accordingly. Med Techs will be retrained by Train-the -Trainer with emphasis on the importance of not leaving medication anywhere, and to watch the resident take the medication. Also the appropriate way to deliver medications. What are the 5 rights. Review the basics. Training for each Med Tech will be completed by 01/06/23 Documentation will be kept. Along with paper documentation the Train-the-Trainer or the HSD or ED (all nurses) will shadow the Med Techs while passing meds to observe accuracy is passing medications. They will be signed off on this practicum. Documentation of this will also be kept.

DIRECTED: Beginning on 1/1/23: A med tech shall inspect the home and all medication storage areas daily for one month, then weekly thereafter, to ensure all prescription medications, OTC medications, CAM and syringes are kept in an area or container that is locked. Documentation of the audits shall be kept. [redacted] 12/29/22

Directed Completion Date: *01/01/2023*

Not Implemented [redacted] - 02/23/2023)

185a - Implement Storage Procedures

17. Requirements

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

Description of Violation

Resident #3 is prescribed Lorazepam 2mg/2ml-Take 0.25ml (0.5mg) under the tongue every 4 hours as needed. However, on 11/16/22, this medication was not available in the home for administration.

On 11/16/22, resident #9's glucometer was not set to the correct time.

Plan of Correction ***Directed [redacted] - 12/29/2022)***

The Lorazepam was not delivered to the home. The resident went to the hospital. Resident #3 was on hospice, Health Services Director notified hospice and the home was awaiting delivery of the medication. Educated Med Techs to notify the Health Services Director when they are down to the last five doses of hospice provided medications and to include this in their daily duties and documentation will be provided. Med cart audit was done by [redacted] to

185a - Implement Storage Procedures (continued)

ensure all medications were present and available. Med Techs will sign from pharmacy medications delivered to home and will review them against the MAR or any new orders, if any questions will notify HSD. Med Techs were educated that day, however reiteration of med issues, such as notifying the HSD, auditing carts, passing medications properly, not leaving meds.... will be a retaining on 01/06/23. Documentation will be kept.
Glucometers are being audited weekly and monitored by [redacted] All glucometers are checked. Med Techs document reading and document it. When next shift comes on readings are read to upcoming shift to ensure glucometers were checked and have current date and time. It is a double check. Implementation will begin 01/06/23 when Med Techs are educated. Med Techs will preform the accucheck and enter reading and [redacted] will monitor that it is complete.

On 11/16/22 the glucometer had not been recalibrated for daylight savings time, causing the record to reflect an incorrect time. Effective immediately, daylight savings time will be programmed into a calendar to auto-send emai/textl reminders to the Administrator and Health Services Director to recalibrate the glucometer on the spring and fall day light savings dates.

Resident #3 no longer resides in the home. [redacted] 12/29/22

DIRECTED: Beginning on 1/1/23: The administrator shall review the medications for at least 10 residents weekly to ensure all prescribed medications are present and available in the home for administration. [redacted] 12/29/22

Directed Completion Date: *01/06/2023*

Not Implemented [redacted] - 02/23/2023)

225a - Assessment 15 Days

18. 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 #1's assessment, dated [redacted], indicates resident #1 requires prompting/queuing assistance with toileting; however, resident #1 requires the physical assistance of 1 staff member with toileting.

Resident #3's assessment, dated [redacted] indicates resident #3 requires prompting/queuing assistance to transfer in/out of bed/chair; however, resident #3 requires total physical assistance of 2 staff persons to transfer in/out of bed/chair.

Resident #10's assessment, dated [redacted] does not include an assessment of resident #10's care needs related to eating and drinking. These sections of the assessment are blank.

On 7/21/22, resident #10 was prescribed a mechanical soft diet; however, this is not indicated on resident #10's assessment, dated 7/29/22.

225a - Assessment 15 Days *(continued)*

Plan of Correction ***Directed [redacted] - 12/29/2022)***

Upon receiving the violation for 2600.225a:
Resident #1: RASP was reviewed and reevaluated and was determined that the resident does in fact need assistance of one for toileting. on 12/14/22 the RASP was updated. All RASPs were reviewed for accuracy by HSD, RCC, Administrator,[redacted]
Resident #3: RASP was reviewed and resident reassessed, however the resident was on hospice and passed on 12/13/22 at the hospital so the RASP will not be updated.
Resident #10: RASP was reviewed to discover the draft had been printed and placed in file. Personal care needs and degree, eating & drinking portion left blank. This will also include details about the mechanical soft diet. The completed pages were printed and updated and will be included with the plan of correction.
HSD has a tickler file for the RASPs with dates for updating and significant changes. The HSD is responsible for making changes and updating the RASPs. (DIRECTED: By 1/7/23: The HSD shall be re-educated on the home's procedures for updating resident assessment and support plans to ensure resident assessments and support plans are kept current and updated as resident care needs change. Documentation of the education shall be kept.[redacted] 12/29/22). The HSD will review with the staff intermittently about any changes in certain residents when the RASPs are do or for any questionable changes. (DIRECTED: The HSD reviews with staff shall begin on 1/7/23 and shall occur at least monthly. [redacted] 12/29/22).

DIRECTED: Beginning on 1/1/23: The administrator shall review at least 3 resident records monthly to ensure resident assessments and support plans are current and completed in their entirety. [redacted] 12/29/22

Directed Completion Date: *01/07/2023*

Not Implemented [redacted] - 02/23/2023)

225c - Additional Assessment

19. Requirements

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

On 9/13/22, resident #2 was prescribed a puree diet with allowance for soft pleasure food desserts upon request; however, resident #2's most recent assessment, dated 9/6/22, indicates resident #2 is on a regular diet.

REPEAT VIOLATION: 11/1/2021, et. al.

Plan of Correction ***Directed [redacted] - 12/29/2022)***

Upon receiving the violation for 1600.225c, the Administrator and HSD reviewed the RASP and chart and resident #2 which was updated on 12/20/22.
Is on a pureed diet. On 12/14/22 HSD, RCC (her assistant), Administrator, [redacted] reviewed all other

225c - Additional Assessment (continued)

resident RASP's

for accuracy. The HSD has a tickler file for the RASP's for updating them. When new orders, or significant changes happen

the HSD is notified by knowing and doing the order [redacted] or by the RCC (her assistant) giving [redacted] the notification. If

changes occur on other shifts, notes are put into [redacted] bin outside of her door, which [redacted] reviews them daily. [redacted] then will

update the RASP's as needed and change the dates on the tickler file. Monthly the Administrator will randomly choose

three files a month and review them with the staff and HSD to ensure accuracy and compliance. (DIRECTED: The administrator monthly reviews shall begin on 1/1/23). Staff was educated on this protocol since they are also a part of the resident and may know of a change which needs to be addressed. (DIRECTED: Documentation of the education shall be kept. [redacted] 12/29/22).

DIRECTED: By 1/7/23: The HSD shall be re-educated on the home's procedures for updating resident assessment and support plans to ensure resident assessments and support plans are kept current and updated as resident care needs change. Documentation of the education shall be kept.[redacted] 12/29/22.

Directed Completion Date: *01/07/2023*

Not Implemented ([redacted] - 02/23/2023)

227d - Support Plan Medical/Dental

20. 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 #1 uses a wheeled walker to ambulate for short distances, however, resident #1's support plan, dated 8/19/22, does not indicate the use of a wheeled walker.

Resident #3 is currently receiving hospice services; however, resident #3's support plan, dated 5/16/22, does not indicate the specific hospice services or the frequency of hospice services resident #3 is receiving. Also, resident #3 requires the assistance of 2 staff persons to transfer in/out of bed/chair; however, this is not indicated on resident #3's support plan, dated 5/16/22

Resident #10 uses a catheter for urinary incontinence and uses a Hoyer lift to transfer in/out of bed/chair; however, resident #10's support plan, dated 7/29/22, does not indicate use of a catheter for urinary incontinence or the use of a Hoyer lift for transfers.

227d - Support Plan Medical/Dental *(continued)*

Plan of Correction ***Directed [redacted]/29/2022)***

Upon receiving the violation for 2600.227d, the home will:
On 10/26/22 all RASPs were reviewed by HSD, RCC, Administrator, [redacted] for accuracy
Resident #1: RASP reviewed and updated for the use of a wheeled-walker
Resident #3: RASP reviewed and updated however the resident was on hospice and has since passed at the hospital. No changes will be made to RASP.
Resident #10: RASP reviewed and updated for use of catheter and Hoyer lift.

Staff received in-service training on Hoyer lift use by Fox Rehab and Gallagher Home Health provided training on catheter care. Ongoing the Health Services Director and Assistant Director will review and update RASPs regarding changes and updates to residents. HSD has a tickler file for updating RASPs as resident care needs change. Education of staff will be held 01/06/23 to inform staff that if they notice any changes in a resident that they are to notify their supervisor.

DIRECTED: By 1/7/23: The HSD shall be re-educated on the home's procedures for updating resident assessment and support plans to ensure resident assessments and support plans are kept current and updated as resident care needs change. Documentation of the education shall be kept. [redacted] 12/29/22.

DIRECTED: Beginning on 1/1/23: The administrator shall review at least 3 resident records monthly to ensure resident assessments and support plans are current and completed in their entirety. [redacted] 12/29/22

Directed Completion Date: *01/07/2023*

Not Implemented [redacted] 02/23/2023)