pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: March 22, 2023

[redacted]
Southwest Behavioral Care, Inc.
[redacted]

RE: Barclay Place
320 West Pittsburgh Street
Greensburg, Pennsylvania 15601
License/COC #: 453871

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on November 9, 2022, December 5, 2022, and 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 REVOKES your certificate of compliance (license number 453870) dated September 2, 2022 - September 2, 2023, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST 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 FIRST PROVISIONAL license is enclosed and is valid from March 22, 2023 to September 22, 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.

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: *BARCLAY PLACE* **License #**: *45387* **License Expiration**: *09/02/2023*

Addre : *320 WEST PITTSBURGH STREET, GREENSBURG, PA 15601*

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

Administrator

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

Legal Entity

Name: *SOUTHWEST BEHAVIORAL CARE INC*

Address [redacted]

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

Certificate(s) of Occupancy

Type: *R-4* **Date**: *04/20/2022* **Issued By**: *City of Greensburg*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *15* **Waking Staff**: *11*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *12/08/2022*

Inspection Dates and Department Representative

12/05/2022 - On-Site: [redacted]

12/07/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *14* **Residents Served**: *12*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *10* **Are 60 Years of Age or Older**: *8*

Diagnosed with Mental Illness: *12* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *3* **Have Physical Disability**: *0*

Inspections / Reviews

12/05/2022 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/23/2022*

12/29/2022 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/04/2023*

01/05/2023 - 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*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 12/5/22, the license inspection summary, dated 8/17/22, was not posted in a public and conspicuous place in the home.

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

On 12/06/2022, Supervisor printed the License Inspection Summary (LIS) and posted it in a binder labeled LIS in a public and conspicuous place, which is on our entry table in the main hallway. After every inspection/investigation, it will be the Team Leads responsibility to ensure the LIS is posted in the binder for access.

Licensee's Proposed Overall Completion Date: *12/23/2022*

Implemented - 02/23/2023)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 10/5/22 and 11/17/22, resident #10 left the home unattended and traveled by bus to the New Kensington area. On both occasions, the home contacted the Greensburg City Police Department who responded to the home on 10/5/22 and 11/17/22; however, these incidents were not reported to the Department until 12/8/22.

Plan of Correction ***Directed - 01/05/2023)***

On 12/8/22, Supervisor submitted the incident reports to the Department. informed that although PA2600 states that you must report a resident missing for 24+ hours, if it is identified in their RASP they need supervision in the community you must report it regardless. So although the resident returned before 24 hours, it did not follow RASP. After cleared this up, Supervisor made the reports.
re-posted all RASPS in the staff office for them to review on 12/19/2022 and educated staff on 12/23/2022 that if a resident leaves the facility and the resident RASP determines they need assistance/supervision in unfamiliar areas in the community staff must alert the supervisor on call, contact the police to inform them a resident has left, and file a report to the Department within 24 hours. This was done via memo and documentation will be kept with staff signing off on the education.
During the next quarterly quality management meeting, we will ensure that all incidents that may occur are documented and reported accordingly. (DIRECTED: The home shall conduct a quality management meeting by 2/1/23, which includes a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. 1/5/23).
During the next two monthly resident meetings, the Supervisor will remind all residents that they must alert staff AND sign out prior to going into the community so staff can ensure we are following their support plans.
During the next two months during the monthly staff meetings, the supervisor will reeducate staff that if a resident

16c - Written Incident Report (continued)

eaves we have to follow their support plan so if it says they need assistance we either have to provide that assistance or ask them to wait until staff are available to go with them. If they leave without waiting or without staff, the supervisor or supervisor on call must be alerted so a report can be filed. During these meetings we will also review PA 2600.16a, which covers all of the incidents that need to be reported, as well as review how to make that report. DIRECTED: By 1/15/23: All staff persons shall be re-educated on all reportable incidents and conditions specified in 2600.16a, as well as re-educated on the home's incident reporting procedures. Documentation of the education shall be kept. [redacted] 1/5/23).

DIRECTED: Within 72 hours of receipt of the plan of correction: The administrator or supervisor shall review all nternal incidents and conditions daily to ensure all incidents specified in 2600.16a are reported to the Department, on the Department's current form, within 24 hours. [redacted] 1/5/23.

Directed Completion Date: *02/01/2023*

Implemented ([redacted] - 02/23/2023)

17 Record Confidentiality

3. Requirements

2600.

17. Resident records shall be confidential, and, e cept 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 12/5/22 at 9:14 am, there was a red binder located on the main entrance table, which contained the face sheets for numerous residents. The face sheets included medical information, including the diagnoses and medications for residents #1, #2, and #3.

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

During the last fire drill, which occurred on 11/22/2022, our two emergency binders were switched and placed in the wrong areas. One emergency binder has all of our evacuation plans, fire drill information, monitoring information, and the City of Greensburg's Emergency Plans. The other emergency binder includes all resident face sheets, emergency contacts, diagnosis and medications. After the drill concluded, they were placed in the wrong areas. The resident emergency information binder is to be locked in the staff office, where only staff have access to it. The emergency binder with all of the policies and procedures is posted in a public and conspicuous area, which is on our main table in the main hallway of the home.

On 12/5/2022, the emergency binders were placed in the correct areas of the home, making sure the resident nformation shall remain confidential.

On 12/23/2022, Supervisor educated staff via memo on the importance of placing the binders back in the correct areas to remain in compliance. Staff will sign to acknowledge they read the provided information and documentation will be kept.

During the next two months, at the monthly staff meeting, the supervisor will reeducate staff on the importance of placing the binders in the correct areas to ensure no confidential information is accessible to anyone other than the

17 - Record Confidentiality (continued)

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.

Licensee's Proposed Overall Completion Date: *02/10/2023*

Implemented [redacted] - 02/23/2023)

25a Written Contract and Review

4. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and e plain its contents to the resident and the resident s designated person if any, prior to signature.

Description of Violation

Resident #6 was admitted to the home on [redacted] however, resident #6 did not sign the resident-home contract until 10/10/22.

Plan of Correction ***Directed [redacted] 01/05/2023)***

Resident #6's contract was not signed until 10/10/2022 because he did not want to sign his contract until the amount of his rent was determined. We base their rent off of their social security income, and there was an issue when he discharged from TSH with his social security, and it was not active immediately and we did not have an income determination letter for him. [redacted] informed [redacted], that the contract still needs signed even without an amount determined for rent, it would just have to state $0 until that amount is determined. Moving forward, all resident contracts will be signed by the resident on the day of their admission, or with-in 24 hours, regardless of an amount being determined or not. The contracts will be updated as that information is obtained. On 1/3/2023, Supervisor revied all resident contracts to ensure they were completed and signed, which they were.

The supervisor or team lead will follow the resident admission checklist to ensure that everything is completed accurately and signed on the date of their admission to the home. The checklist was reviewed by the Supervisor/Team Lead on 1/3/2023 to ensure all incoming residents have all paperwork completed and signed correctly. (DIRECTED: By 1/15/23: All supervisors and team leads shall be re-educated on the home's new admission checklist. Documentation of the education shall be kept. [redacted] 1/5/23).

During the next quality management meeting, which is expected to be held after 2/13/2023 and no later than 2/28/2023, any new admissions to Barclay will be reviewed. At this time, we will check to make sure the contracts were signed within 24 hours of admission and that the resident admission checklist was completed. (DIRECTED: The home shall conduct a quality management meeting by 2/1/23, which includes a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 1/5/23).

DIRECTED: Beginning on 1/15/23: The administrator shall review the resident-home contracts for at least 3 new admissions monthly for 6 months to ensure each newly-admitted resident has a resident-home contract completed in its entirety within 24 hours. [redacted] 1/5/23

Directed Completion Date: *02/01/2023*

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

25c11 - List of Rates

5. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
11. A list of personal care services to be provided to the resident based on the outcome of the resident's support plan, a list of the actual rates that the resident will be periodically charged for food, shelter and services and how, when and by whom payment is to be made.

Description of Violation

Resident #5's resident-home contract, dated 10/11/22, does not include the charges per month for room and board. This section of the resident #5's resident-home contract is blank.

Plan of Correction ***Directed [redacted] - 01/05/2023)***

When resident #5 was admitted to Barclay, he had too much money to qualify for social security. Based on this, we were not able to determine his rent owed so we left it blank until we could determine a private pay rate within the agency.
On 12/14/2022 Supervisor [redacted] and Director [redacted] met with patients accounts manager for SPHS. During this phone call, we were able to determine Resident's #5 private pay rate.
On 12/16/2022 Resident #5s contract was updated to reflect his private pay rate. On 12/19/2022, Supervisor [redacted] mailed Resident #5's guardian his updated contract to sign.
Moving forward, if a resident does not qualify for SSI, we will update their contract to reflect our Private Pay Rate Policy.
On 1/3/2023, all resident contracts were reviewed to ensure their amount owed was listed, and it was.
During the next quality management meeting, which is expected to be held after 2/13/2023 and no later than 2/28/2023, any new admissions to Barclay will be reviewed. At this time, we will check to make sure the contracts were completed with the current rate is listed if they do not qualify for SSI/SSD. (DIRECTED: The home shall conduct a quality management meeting by 2/1/23, which includes a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 1/5/23).
The resident's guardian has not returned his contract as of 1/4/23. I called and left him a voicemail, and requested he call me back.

DIRECTED: By 1/15/23: All supervisors and team leads shall be re-educated on the home's new admission checklist. Documentation of the education shall be kept. [redacted] /5/23.

DIRECTED: Beginning on 1/15/23: The administrator shall review the resident-home contracts for at least 3 new admissions monthly for 6 months to ensure each newly-admitted resident has a resident-home contract completed n its entirety within 24 hours. [redacted] 1/5/23

Directed Completion Date: *02/01/2023*

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

25c12 - Bed Hold

6. Requirements

2600.
25.c. At a minimum, the contract must specify the following:

25c12 - Bed Hold *(continued)*

12. Charges to the resident for holding a bed during hospitalization or other extended absence from the home.

Description of Violation

Resident #5's resident-home contract, dated 10/11/22, does not include the charges for holding a bed during hospitalization or other extended absence from the home. This section of resident #5's resident-home contract is blank.

Plan of Correction ***Directed [redacted] - 01/05/2023)***

When resident #5 was admitted to Barclay, [redacted] had too much money to qualify for social security. Based on this, we were not able to determine his amount owed during a bed hold so we left it blank until we could determine a private pay rate, which would give us the bed hold rate.

On 12/14/2022 Supervisor [redacted] and Director [redacted] met with patients accounts manager for SPHS. During this phone call, we were able to determine Resident's #5 private pay rate as well as the bed hold rate.
On 12/16/2022 Resident #5s contract was updated to reflect amount owed for bed hold.
On 12/19/2022, Supervisor [redacted] mailed Resident #5's guardian his updated contract to sign.
On 1/3/2023 Supervisor reviewed all contracts to ensure that the bed hold rate was posted in each resident's contract, and it was.
Moving forward, if a resident does not qualify for SSI, we will update their contract to reflect our Private Pay Rate Policy which reflects the amount for room and board as well as a bed hold during hospitalization or other extended absence from the home.
As of 1/4/23, resident #5s guardian has not returned his contract but I called and left a voicemail asking him to return my call.

DIRECTED: By 1/15/23: All supervisors and team leads shall be re-educated on the home's new admission checklist. Documentation of the education shall be kept. [redacted] 1/5/23.

DIRECTED: Beginning on 1/15/23: The administrator shall review the resident-home contracts for at least 3 new admissions monthly for 6 months to ensure each newly-admitted resident has a resident-home contract completed in its entirety within 24 hours. [redacted] /5/23

DIRECTED: The home shall conduct a quality management meeting by 2/1/23, which includes a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 1/5/23

Directed Completion Date: *02/01/2023*

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

42b - Abuse

7. 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 12/5/22 at approximately 11:45 am, staff person F was overheard by an agent of the Department and staff

42b - Abuse (continued)

person A, the home's administrator, arguing and yelling at resident #10 regarding resident #10's morning medications. Staff person A entered the medication room to calm staff person F down, when staff person F said to staff person A, in the presence of resident #10, that resident #10 was "just causing [redacted] and I am not going to deal with it." Staff person F continued to yell at resident #10, then slammed the home's medication administration record book down on the medication cart. Resident #10 then exited the medication room and was very upset at the way staff person F treated the resident.

Plan of Correction ***Directed ([redacted] 01/05/2023)***

On 12/5/2022, Supervisor [redacted] walked into the nurse's office and witnessed staff Person F arguing and yelling with resident #10. Resident #10 left the room and [redacted] spoke with staff person F. [redacted] then removed staff person F off the floor and requested the team lead go sit with [redacted]. Director, [redacted] met with staff person F to discuss the incident, and after their conversation, she brough staff person F to [redacted] office, and we suspended [redacted] without pay due to the incident. Staff person F left the facility and was issued a written notification from HR about her suspension.
On 12/22/2022, Supervisor [redacted], Executive Director [redacted], and HR and we made the final decision to terminate her from the agency.
During the staff meeting on 1/12/2022, supervisor will review and reeducate the topics of abuse and neglect will all of the staff and maintain documentation. (DIRECTED: Documentation of the staff education shall be kept. [redacted] 1/5/23).
Supervisor will also review resident rights (including that they are free from abuse and neglect) during the resident council meeting on 1/9/2023 and maintain documentation of this.

DIRECTED: By 2/1/23: 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. [redacted] 1/5/23

DIRECTED: Within 7 calendar days of receipt of the plan of correction: The administrator shall interview at least 4 residents, in private, per month for 6 months to ensure resident rights are protected and that residents are free from abuse and neglect. Documentation of the interviews shall be kept. [redacted] 1/5/23

Directed Completion Date: *02/01/2023*

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

42s - Privacy

8. 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

On 12/5/22, there were video cameras recording in areas accessible to residents, including the home's dining room, living room, and activity room.

42s - Privacy (continued)

On 12/5/22, there were approximately 20 video cameras recording the entrances, exits and the outside of the building; however, the signs posted in these areas indicated "security cameras in use" and did not indicate that these areas were being recorded. Also, none of the residents were notified at admission that these areas are subject to video recording.

Plan of Correction ***Accept (12/29/2022)***

On 12/8/2022, our IT department turned off the recording feature on the video cameras that included the homes dining room, living room, and activity room.

On 12/8/2022, each resident received a memo to sign that informs them that we have areas that are subject to video recording. This was also added as number 6 on our resident contract under B: Resident Acknowledges the following. Moving forward all new admissions will be made aware of this during their admission, since it is now on the contract.

On 12/20/2022, [redacted] posted new signs around the house that included that the areas were being recorded, rather than only saying "security cameras in use".

Licensee's Proposed Overall Completion Date: *12/23/2022*

Implemented [redacted] - 02/23/2023)

51 - Criminal Background Check

9. Requirements

2600.

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

Staff person A was hired on [redacted] however, staff person A's Pennsylvania criminal background check was completed on 2/8/19.

Staff person B was hired on [redacted]; however, staff person B's Pennsylvania criminal background check was completed on 6/8/18.

Staff person D was hired on [redacted] however, staff person D's Pennsylvania criminal background check was completed on 3/30/19.

Staff person E was hired on [redacted] however, staff person E's Pennsylvania criminal background check was not completed until 10/22/21.

Plan of Correction ***Directed (01/05/2023)***

On 12/23/2022, RSA [redacted] worked with Supervisor [redacted] to complete an audit of all employee charts. During this time, we created a detailed list of all staff and when their Criminal Background Check was completed. Any staff member whose criminal background check was not in compliance with PA2600 regs, will have

51 - Criminal Background Check (continued)

a new criminal background check ran no later than 12/30/2022.

Any new staff that are hired, will be required to provide a criminal background check that is completed no less than 30 days before their start date. If a new hire cannot obtain a criminal background check within this time frame, SPHS will run the check for them.
Staff Person A, B, and D's new background checks will be completed on 1/5/2023. (DIRECTED: Copies of the completed Pennsylvania criminal background checks shall be kept in staff person A, B and D's records. [redacted] 1/5/23). All new hires will meet with the team lead or supervisor and will complete the new hire checklist (which will include a new criminal background check that must be done within 30 days - to be marked off). This documentation will be kept in their file. This checklist will be implemented starting the next orientation date for SPHS which is 1/16/2023. We will review all new hire charts during the next QM meeting, between 2/13/23 and 2/28/23 to ensure the checklist s complete and the paperwork is correct. (DIRECTED: The home shall conduct a quality management meeting by 2/1/23, which includes a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept [redacted] 1/5/23).

Directed Completion Date: *02/01/2023*

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

65a FS Orientation 1st Day

10. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire safe area in the event of an actual fire.
4. Smoking safety procedures, the home s smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Ancillary staff person C, hired on [redacted], did not receive orientation on any of the topics specified in 2600.65a.

Plan of Correction ***Directed [redacted] 01/05/2023)***

Staff person C, who was hired on [redacted] received the orientation on the topics specified in PA 2600.65a, however he failed to submit the signed paperwork to the supervisor documenting that the trainings were completed. After meeting with the supervisor, staff person C recompleted the trainings again, and submitted the appropriate documentation dated for 12/13/2022.

Staff will follow the new hire orientation procedure outline to ensure all trainings are completed on time. We already have a new hire checklist that outlines the training schedule, so the Supervisor will be responsible for reviewing it is

65a - FS Orientation 1st Day (continued)

completed with new hires. We will review the process with the staff and hold them accountable to completing their trainings on time, and then following up with Team Lead/Supervisor within 30 days of their start date to verify everything was completed. (DIRECTED: By 1/15/23: All staff persons involved in the hiring process shall be re-educated on the home's new hire checklist to ensure all newly-hired staff persons receive orientation on all topics specified in 2600.65a prior to or during the work work day. Documentation of the education shall be kept. Copies of the completed new hire checklists, as well as documentation of the orientation received, shall be kept in each staff person's record. [redacted] 1/5/23).

During the next quality management meeting, which will be between 2/13/23 and 2/28/23 based on management's availability, we will review each new hire training binder and chart to ensure their trainings were completed on time and reviewed by the team lead. (DIRECTED: The home shall conduct a quality management meeting by 2/1/23, which includes a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 1/5/23).

All other staff records will be reviewed no later than 1/11/2022 to ensure they have all completed the trainings. DIRECTED: By 1/15/23: The administrator shall review all current staff records to ensure each staff person has received orientation on all topics specified in 2600.65a. Documentation of the orientation received shall be kept in each staff person's record. [redacted] 1/5/23).

Directed Completion Date: *02/01/2023*

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

65b - Rights/Abuse 40 Hours

11. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Ancillary staff person C, hired on [redacted]*, did not receive orientation on any of the topics specified in 2600.65b.*

Plan of Correction ***Directed*** [redacted] ***- 01/05/2023)***

Staff person C, who was hired on [redacted] *received the orientation on the topics specified in PA 2600.65b, however* [redacted] *failed to submit the signed paperwork to the supervisor documenting that the trainings were completed. After meeting with the supervisor, staff person C recompleted the trainings again, and submitted the appropriate documentation dated for 12/13/2022.*

Staff will follow the new hire orientation procedure outline to ensure all trainings are completed on time. We already have a new hire checklist that outlines the training schedule, so the Supervisor will be responsible for reviewing it is completed with new hires. We will review the process with the staff and hold them accountable to

65b - Rights/Abuse 40 Hours (continued)

completing their trainings on time, and then following up with Team Lead/Supervisor within 30 days of their start date to verify everything was completed. (DIRECTED: By 1/15/23: All staff persons involved in the hiring process shall be re-educated on the home's new hire checklist to ensure all newly-hired staff persons receive orientation on all topics specified in 2600.65b within 40 scheduled working hours. Documentation of the education shall be kept. Copies of the completed new hire checklists, as well as documentation of the orientation received, shall be kept in each staff person's record. [redacted] 1/5/23).

During the next quality management meeting, which will be between 2/13/23 and 2/28/23 based on management's availability, we will review each new hire training binder and chart to ensure their trainings were completed on time and reviewed by the team lead. (DIRECTED: The home shall conduct a quality management meeting by 2/1/23, which includes a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 1/5/23).

All staff records will be reviewed no later than 1/11/2023 to ensure all trainings for staff have been completed. (DIRECTED: By 1/15/23: The administrator shall review all current staff records to ensure each staff person has received orientation on all topics specified in 2600.65b. Documentation of the orientation received shall be kept in each staff person's record. [redacted] 1/5/23).

Directed Completion Date: *02/01/2023*

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

65c Ancillary Staff Orientation

12. Requirements

2600.
65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Ancillary staff person C, whose first day of work was [redacted], did not receive an orientation to his specific job functions.

Plan of Correction ***Directed [redacted] 01/05/2023)***

On 11/16/2022, staff person C signed a copy of [redacted] job description with our HR department. When [redacted] arrived at Barclay, [redacted] completed the requirements of 65a and then received an overview of [redacted] specific job functions which was provided by the supervisor. [redacted] was shown the kitchen area, we reviewed expectations of [redacted] work, and discussed what he would be responsible for.

All of our staff sign a job description with our HR department on the first day of the hire/orientation. This letter is then sent to the program interagency, where the supervisor signs it and sends it to our Executive Director for Approval. We will continue to follow our company wide policy where each new hire receives, reviews, and signs their ob description during the orientation.

Moving forward the supervisor will document that this occurred after new hires received an orientation to their specific job functions.

DIRECTED: By 1/15/23: The administrator shall review all current ancillary staff records to ensure each ancillary staff person has received a general orientation to their specific job functions as it relates to their position prior to working in that capacity. [redacted] 1/5/23

65c - Ancillary Staff Orientation (continued)

DIRECTED: The home shall conduct a quality management meeting by 2/1/23, which includes a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept. [redacted] 1/5/23

DIRECTED: Within 5 calendar days of receipt of the plan of correction: The administrator shall add to the home's new hire checklist that all newly-hired ancillary staff persons shall receive a general orientation to their specific job functions as it relates to their position prior to working in that capacity. Copies of the completed new hire checklists, as well as documentation of the orientation received, shall be kept in each staff person's record. All staff persons nvolved in the hiring process shall be re-educated on the new hire checklist by 1/15/23. Documentation of the education shall be kept. . [redacted] 1/5/23.

Directed Completion Date: *02/01/2023*

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

88a Surfaces

13. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 12/7/22, the bathroom door in bedroom [redacted] did not completely close into the doorframe to allow the door to be locked.

Plan of Correction ***Directed ([redacted] - 01/05/2023)***

On 12/7/2022, the bathroom door in bedroom [redacted] was swelled from the sudden change in temperature.
On 12/9/2022, Mr. Handyman of Greensburg Services came to the home for another service we had scheduled, and we informed them that the door in bedroom needs shaved down a little bit to be able to shut and lock the door.
On 12/23/2022, Supervisor [redacted] rechecked the bathroom door off of room [redacted] and it did shut and lock.

Mr. Handyman of Greensburg has been contacted to come back and fix the door in case it swell's again. This service is expected to be completed no later than 1/31/22.

Update - on 1/27/22 Mr Handyman sanded down the door so it can close and lock with ease.

Moving forward, we are going to hire Mr. Handyman to come to the home once a month to do a routine inspection to ensure all Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards. This will continue until we can hire a building technician for our program. (DIRECTED: The first monthly audit shall be conducted by 1/15/23).

DIRECTED: By 1/15/23: All staff persons shall be educated that all floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards. Documentation of the education shall be kept. [redacted] 1/5/23

Directed Completion Date: *02/01/2023*

88a - Surfaces *(continued)*

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

101j2 - Bedroom Chairs

14. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

On 12/7/22, there was only 1 chair present in the shared bedroom of residents #6 and #9.

Plan of Correction ***Directed [redacted] - 01/05/2023)***

On 12/7/2022, it was identified that Resident #9 moved [redacted] chair from [redacted] room into the hallway because [redacted] didn't want it. Supervisor took the chair from the hallway and placed it back in his room while with [redacted] suggested placing a folding chair under the bed if a resident does like the bigger chairs being in their rooms. Resident #9 was agreeable to keep his chair in his room.

After the next two staff meetings, which are expected to be on 1/12/22, and the first week of February depending on management availability, a direct care staff member will complete rounding on each resident's room and ensure all required furniture is in their rooms.

DIRECTED: Within 7 calendar days of receipt of the plan of correction, then monthly thereafter: The administrator shall inspect all resident bedrooms to ensure each resident has a chair that meets their needs. [redacted] 1/5/23

Directed Completion Date: *02/01/2023*

Implemented ([redacted]/23/2023)

121a - Unobstructed Egress

15. Requirements

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

Description of Violation

On 12/5/22 and 12/7/22, the main exit door leading to the home's front porch was locked with a deadbolt lock. On 12/7/22, resident #3 was unable to demonstrate the ability to independently unlock the deadbolt lock on main exit door, preventing egress from the home.

Plan of Correction ***Directed ([redacted] - 01/05/2023)***

On 12/9/2022, Mr. Handyman of Greensburg came to the home to provide other scheduled services. During this time, we discussed changing the lock on the front door, so the inside can remain unlocked, but the outside can be ocked. They were going to look into it, because of the age of the front doors, the parts are very limited. If they cannot find the appropriate replacement parts, we will take steps to replace the front door, but it will need to be custom ordered as it is not a traditional sized door. We expect to have this work completed no later than 1/31/2023, unless

121a - Unobstructed Egress (continued)

the custom size door presents a delay in its delivery.

On 12/23/2022, the supervisor posted signs above both doors, reminding staff and residents to not lock the doors from the inside at any time. Staff also received a memo on 12/23/2022, informing them that the doors are not to be locked at any time. During the start of each shift (12-8am, 8-4pm, and 4-12am), staff will be expected to check the doors to ensure they are not locked until they are fixed and/or replaced. (DIRECTED: The daily checks shall begin within 48 hours of receipt of the plan of correction and shall include a daily inspection of the home to ensure all stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed. [redacted] 1/5/23).

On 1/27/2022, Mr. Handyman came and uninstalled a piece of the first floor so it does not lock from the inside. The Supervisor removed the latch from the second door, so it could not be locked.

The door is unlocked, and residents are able to use it to evacuate.

Directed Completion Date: *02/01/2023*

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

123d Mobility Needs

16. Requirements

2600.
123.d. If the home serves one or more residents with mobility needs above or below grade level of the home, there shall be a fire-safe area, as specified in writing within the past year by a fire safety expert, on the same floor as each resident with mobility needs.

Description of Violation

Residents #4, #7, and #8, who are residents with mobility needs, reside on the 2nd floor of the home, which is above grade level; however, the home does not have documentation from a fire safety expert within the past year indicating the home has internal fire-safe areas within the home, to include on the 2nd floor.

Plan of Correction ***Directed ([redacted] - 01/05/2023)***

On 12/14/2022, Fire Safety Expert [redacted] came to Barclay Place and completed new fire documentation and he determined that our home does have fire safe areas within the home. The documentation was updated and sent to [redacted]
Our Fire Policy will be updated no later than 12/31/2022 to reflect the change in ability to use fire safe areas. (DIRECTED: Documentation of the updated fire procedures shall be kept. [redacted] 1/5/23).
We will hold a fire drill with the residents during the month of January with the aim to use the fire safe areas so they residents can practice. Our plan is to practice using the FS area in January so the residents know that it can be an option in the event of a fire, however we will let them know that they may use that area during all fire drills/emergency's. Each resident has access to the fire safe areas who reside on floors above grade level.

Staff were made aware that we have FS areas on 12/14/2022. Documentation has been kept. Our updated evacuation procedures will be completed no later than 1/11/2023.

DIRECTED: Within 7 calendar days of receipt of the plan of correction: All residents shall be educated on the

123d - Mobility Needs (continued)

location of the fire safe areas and re-educated on the home's evacuation procedures for fire drills. [redacted] 1/5/23

DIRECTED: Beginning on 1/15/23: The administrator shall review the home's fire drill records monthly to ensure all residents are evacuating 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 during each monthly fire drill. The monthly review shall also ensure alternate exit routes are being used during the monthly fire drills in accordance with 2600.132f. [redacted] 1/5/23

Directed Completion Date: *02/01/2023*

Implemented ([redacted] - 02/23/2023)

132d Evacuation

17. 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 e pert. For purposes of this subsection, the fire safety e pert may not be a staff person of the home.

Description of Violation

The home's maximum safe evacuation time is 2 minutes, 30 seconds; however, the home exceeded the evacuation time during the following drills:

- *11/22/22 at 11:31 am-Evacuation time of 5 minutes, 50 seconds*
- *10/19/22 at 2:35 pm-Evacuation time of 4 minutes, 58 seconds*
- *9/27/22 at 3:20 pm-Evacuation time of 3 minutes, 40 seconds*
- *8/29/22 at 11:45 pm-Evacuation time of 4 minutes, 46 seconds*
- *8/25/22 at 2:00 pm-Evacuation time of 3 minutes, 1 second*

The most recent documentation from the fire safety expert, dated 6/14/22, does not indicate if residents are to exit the building to a public thoroughfare or if the home has internal fire-safe areas. This section of the letter is blank.

Plan of Correction ***Directed ([redacted] - 01/05/2023)***

On 6/14/2022, the fire chief timed our evacuation drill time of the home and documented this as 2mins 30secs. [redacted] did not determine the approximate time it would take to evacuate the building based on its structure and everything else. On 12/14/2022, Fire Safety Expect [redacted] reevaluated the time to evacuate the home based on its structure and other factors and determines our time to evacuate is actually 5 mins 10 seconds. The paperwork is now complete. Our fire drill ran on 12/14/2022 with Tom determined that everyone evacuated in 4 mins and 10 seconds.

We will continue to hold monthly fire drills with the expectation that everyone is evacuated out of the building or to the fire safe areas within 5mins 10 secs. The Supervisor will review the next two fire drills at the quality management meeting to make sure we are evacuating in the appropriate time which will ensure we are monitoring out plan of correction. The Supervisor will review the fire drill records every month as well.

DIRECTED: Beginning on 1/15/23: The administrator shall review the home's fire drill records monthly to ensure all residents are evacuating 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 during each monthly fire drill. The monthly review shall also ensure alternate exit routes are being used during the

132d - Evacuation (continued)

monthly fire drills in accordance with 2600.132f. LM 1/5/23

DIRECTED: Within 7 calendar days of receipt of the plan of correction: All residents shall be educated on the ocation of the fire safe areas and re-educated on the home's evacuation procedures for fire drills. [redacted] 1/5/23

DIRECTED: Within 7 calendar days of receipt of the plan of correction: All staff persons shall be educated on the location of the fire safe areas and re-educated on the home's evacuation procedures for fire drills. Documentation of the education shall be kept. [redacted] 1/5/23

Directed Completion Date: *02/01/2023*

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

132h - Designated Meeting Place

18. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill conducted on 10/19/22 at 2:35 pm, 7 residents were present in the home; however, only 6 residents were evacuated.

Plan of Correction ***Directed [redacted] - 01/05/2023)***

During the fire drill on 10/19/2022, one of our residents refused to evacuate because she was tired and stated [redacted] knew it was a drill and not a real emergency". We discussed the importance of [redacted] participating in fire drills many times, and on 12/14/2022 when [redacted] was here, [redacted] also met with [redacted] r and spoke to [redacted] about the importance of evacuating or getting to a fire safe area in the home during a fire drill. This documentation was kept. If this resident fails to evacuate again, we will continue to document, and give her written notification that [redacted] may be discharged from the home for failure to comply with house rules.

During the monthly resident meetings, staff will stress the importance of evacuating during the fire drills to the residents.

DIRECTED: Beginning on 1/15/23: The administrator shall review the home's fire drill records monthly to ensure all residents are evacuating 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 during each monthly fire drill. The monthly review shall also ensure alternate exit routes are being used during the monthly fire drills in accordance with 2600.132f. [redacted] 1/5/23

DIRECTED: Within 7 calendar days of receipt of the plan of correction: All residents shall be educated on the ocation of the fire safe areas and re-educated on the home's evacuation procedures for fire drills, including that all residents must participate in all fire drills. [redacted] 1/5/23

DIRECTED: Within 7 calendar days of receipt of the plan of correction: All staff persons shall be educated on the ocation of the fire safe areas and re-educated on the home's evacuation procedures for fire drills. Documentation of the education shall be kept. [redacted] 1/5/23

132h - Designated Meeting Place *(continued)*

Directed Completion Date: *02/01/2023*

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

162c - Menus Posted

19. 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 12/5/22, the only menus posted in the home were dated 11/27/22 through 12/3/22 and 12/4/22 through 12/10/22.

Plan of Correction ***Directed [redacted] - 01/05/2023)***

On 12/6/2022, the menu for the following week was posted behind menu dated 12/4/22-12/10/2022.
The Food Service Specialist will be responsible for submitting the menus to the supervisor to review prior to them being posted, and he will then post it a week in advance on the bulletin board in the main hallway.
During the next two monthly staff meetings, the food service specialist (or direct care staff if FFS is unavailable/off) will check the bulletin board weekly to ensure the correct menu is posted as well as the menus are posted a week in advance to check that we are in compliance with 2600.162.c. Documentation of this check will be kept with the past menus for the home. (DIRECTED: Within 5 calendar days of receipt of the plan of correction, then weekly thereafter: The food service supervisor shall inspect the home at least weekly to ensure the current menu, as well as the menu for 1 week in advance, is posted in a conspicuous and public place in the home. [redacted] 1/5/23).

Directed Completion Date: *02/01/2023*

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

187d - Follow Prescriber's Orders

20. Requirements

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

Description of Violation

Resident #4 is prescribed Clozapine 100 mg-Give 2 tablets at bedtime; however, this medication was not administered at 8:00 pm on 12/3/22 and 12/5/22, because it was not available in the home.

Resident #4 is prescribed Clozapine 50 mg-Give 1 tablet in the morning; however, this medication was not administered at 8:00 am on 12/5/22 and 12/6/22, because it was not available in the home.

Resident #5 is prescribed Dronabinol 2.5 mg-Take 1 capsule by mouth 2 times a day; however, this medication was not available in the home for administration on 12/5/22.

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

Plan of Correction ***Directed [redacted] 01/05/2023)***

Supervisor contacted the pharmacy to get a refill of both doses of Clozapine for Resident #4. They were delivered to the home on 12/6/2022 around 12pm.

Resident #5 is having issues with [redacted] part d insurance, so [redacted] is currently private paying for his medications. Dronabinol is very expensive, and [redacted] did not want to pay for it out of pocket so [redacted] wanted to wait for [redacted] insurance to be fixed. Supervisor contacted his prescriber, and they issued a hold order which started on 12/7/2022. [redacted] nformed [redacted] that if a resident chooses to not pay for their meds, we should contact the prescribed to either have t held or discontinued. There is no set date for the hold order to expire per the prescriber. Our LPN will follow up to see if they would like us to continue to hold or discontinue no later than 1/6/23.

Staff (LPN, Supervisor, or direct care staff) will complete a review weekly, during the next 3 weeks to ensure all resident medication is in the home, and there is enough for the next two administration times at a minimum. The review began on 12/30/22 and will occur on 1/6/23 and 1/13/23 as well. After these weekly reviews, the LPN will complete a random audit each month to ensure we have all of the meds for the residents and that there is enough for the next two administration times at a minimum. (DIRECTED: Documentation of the weekly and monthly audits shall be kept. [redacted] 1/5/23).

DIRECTED: By 1/15/23: All staff persons qualified to administer medications shall be re-educated on the home's medication procedures, which includes ensuring timely reordering of medications to ensure all prescribed medications are present and available in the home for administration in accordance with prescribers' orders. Documentation of the education shall be kept. [redacted] 5/23

Directed Completion Date: *02/01/2023*

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

191 - Resident Right to Refuse

21. 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

Residents #4, #5, #6, #7, and #8, have not been educated to their right to question or refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Directed [redacted] 01/05/2023)***

On 12/8/2022, Supervisor updated the resident rights sheet to reflect: Z: A resident has the right to question or refuse a medication if the resident believes there may be a med error.
Each resident signed the updated contract, and it was placed in their chart with their home contract on 12/8/2022. If a resident refused to sign it was documented and they were given a copy.

191 - Resident Right to Refuse (continued)

The homes contract was also updated to reflect this change for any new admission to the home. Team lead or supervisor will ensure the new resident admission checklist is complete the day of their admission. We will review any new resident admission contracts at the next quality management meeting to ensure compliance with 2600.191. The next QM meeting is going to be held between 2/13/23 and 2/28/23 based on management's availability.
((DIRECTED: The home shall conduct a quality management meeting by 2/1/23, which includes a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept.[redacted] 1/5/23).

Directed Completion Date: *02/01/2023*

Implemented ([redacted] - 02/23/2023)

223a Description of Service

22. Requirements

2600.
223.a. The home shall have a current written description of services and activities that the home provides including the following:
1. The scope and general description of the services and activities that the home provides.
2. The criteria for admission and discharge.
3. Specific services that the home does not provide, but will arrange or coordinate.

Description of Violation

The home's current description of services indicates the home provides 2-3 staff persons onsite, 24 hours a day; however, on numerous occasions, to include on 11/28/22 and 12/4/22, there was only 1 staff person present in the home from approximately 12:00 am through 8:00 am, and from approximately 4:00 pm through 12:00 am.

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

On 12/8/2022, Barclay Place updated their program description to indicate that we will provide at least 1 staff onsite 24 hours a day.

It is our goal to hire enough staff to have 2-3 present at all times, but due to the current climate of the world staffing is a constant challenge. We are working with staffing agencies to bring in more direct care staff and are hopeful we can meet this goal.

Supervisor or Team Lead will ensure that at least 1 staff member is present in the building at all times to reflect our updated program description.

Licensee's Proposed Overall Completion Date: *12/23/2022*

Implemented [redacted] - 02/23/2023)

225a Assessment 15 Days

23. 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.

225a - Assessment 15 Days *(continued)*

Description of Violation

Resident #4 was admitted to the home on [redacted] however, resident #4's assessment was not completed until 12/5/22.

Plan of Correction ***Directed ([redacted] - 01/05/2023)***

The Team Lead or Supervisor will complete a new residents RASP within 15 days of their admission to the home. We added a step onto the form which shows that it will be signed off on the resident admission form and will be signed off on the date it was complete and who completed it. (DIRECTED: The updated resident admission form shall be mplemented within 72 hours of receipt of the plan of correction. Copies of the completed admission forms shall be kept in each resident's record. Beginning on 1/15/23: The administrator shall review the admission forms for all new admissions for the next 6 months to ensure completion. [redacted] 1/5/23).
Dring the next quality management meeting, we will review the new admissions to make sure their RASPs were completed within 15 days of admission. The next QM meeting is going to be held between 2/13/23 and 2/28/23 based on management's availability. (DIRECTED: The home shall conduct a quality management meeting by 2/1/23, which includes a review of all items specified in 2600.26b. Documentation of the quality management review shall be kept [redacted] 1/5/23).

All other resident records were reviewed on 1/3/2023 to ensure that each resident has a completed assessment within 15 days, and they were.

Directed Completion Date: *02/01/2023*

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

228h Grounds Discharge/Transfer

24. Requirements

2600.
228.h. The only grounds for discharge or transfer of a resident from a home are for the following conditions:

1. If a resident is a danger to himself or others.
2. If the legal entity chooses to voluntarily close the home, or a portion of the home.
3. If a home determines that a resident’s functional level has advanced or declined so that the resident’s needs cannot be met in the home. If a resident or the resident s designated person disagrees with the home’s decision to discharge or transfer, consultation with an appropriate assessment agency or the resident s physician shall be made to determine if the resident needs a higher level of care. A plan for other placement shall be made as soon as possible by the administrator in conjunction with the resident and the resident s designated person, if any. If assistance with relocation is needed, the administrator shall contact appropriate local agencies, such as the area agency on aging, county mental health/intellectual disability program or drug and alcohol program, for assistance. The administrator shall also contact the Department’s personal care home regional office.
4. If meeting the resident s needs would require a fundamental alteration in the home s program or building site, or would create an undue financial or programmatic burden on the home.
5. If the resident has failed to pay after reasonable documented efforts by the home to obtain payment.
6. If closure of the home is initiated by the Department.
7. Documented, repeated violation of the home rules.

Description of Violation

On 12/5/22, resident #10 was issued a 30-day notice for repeated violations of the home's rules; however, there was only 1 documented notification issued to resident #10 prior to receiving the 30-day notice notifying the resident she violated the home rules.

228h - Grounds Discharge/Transfer *(continued)*

Plan of Correction ***Directed (- 01/05/2023)***

informed that we did not properly issue a 30-day notice for Resident #10 due to lack of correctly issued documentation. The resident needs to have at least two written notifications of violations of home rules, but we included the last rule broke on the notice of discharge and not a separate document. Due to this, we issued a letter on 12/9/2022 rescinding eviction from Barclay. We also provided her with another copy of the house rules.

The Team/Lead supervisor will make sure every violation of the home rules is documented and the resident is given a copy of this, or it will be reviewed during their monthly treatment teams.

DIRECTED: Within 72 hours of receipt of the plan of correction: The administrator shall review all discharge notices prior to issuance to ensure no resident is discharged from the home unless one of the grounds specified in 2600.228h s present. Copies of all discharge notices shall be kept in each resident's record. 1/5/23

Directed Completion Date: *02/01/2023*

Implemented (- 02/23/2023)

251c - Standardized Forms

25. Requirements

2600.
251.c. The home shall use standardized forms to record information in the resident's record.

Description of Violation

On 12/5/22 at approximately 11:45 am, an incident of verbal abuse involving staff person F towards resident #10 occurred; however, the home did not submit the incident on the Department's current incident reporting form when reporting the incident to the Department on 12/5/22.

Plan of Correction ***Accept - 01/05/2023)***

On 12/5/2022, the supervisor used the AAA report for abuse and submitted it to ra-pwarlsouthwest@pa.gov. They responded and said I submitted the wrong form, so provided me with education on the correct form to submit to the Department for any incidents and how to correctly fill them out. They were resubmitted on 12/8/2022. During the next staff meeting, which is scheduled for 1/12/23, the supervisor and director will review the reporting process and correct paperwork to submit to the department and AAA with staff.

Licensee's Proposed Overall Completion Date: *01/12/2023*

Implemented (- 02/23/2023)