pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: AUGUST 4, 2023

[redacted]
Whitemarsh House, Inc.
31 West Mill Road
P.O. Box 301
Flourtown, Pennsylvania 19031

RE: Whitemarsh House
31 West Mill Road
Flourtown, Pennsylvania 19031
License #: 127861

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection January 11, 2023 and March 21, 28, and April 3, 4, 5, 6, and 11, 2023 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 127860 dated September 13, 2022 to September 13, 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. The license dated September 13, 2022 to September 13, 2023 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from August 4, 2023 to February 4, 2024.

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.

[redacted]

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
16c	II	6	$5	$30	5 calendar days from mailing date of this letter
187a	II	6	$5	$30	5 calendar days from mailing date of this letter
187d	II	6	$5	$30	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 FIRST 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.

Mr. James O'Shea, Chairman

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
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,

Juliet Marsala
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: *WHITEMARSH HOUSE* **License #:** *12786* **License Expiration:** *09/13/2023*

Address: *31 WEST MILL ROAD, FLOURTOWN, PA 19031*

County: *MONTGOMERY* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *WHITEMARSH HOUSE INC.*

Address: *PO BOX 301, 31 WEST MILL ROAD, FLOURTOWN, PA, 19031*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *01/17/1985* **Issued By:** *CWOPA L&I*

Staffing Hours

Resident Support Staff: *48* **Total Daily Staff:** *57* **Waking Staff:** *43*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *01/11/2023*

Inspection Dates and Department Representative

01/11/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *26* **Residents Served:** *6*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *4* **Are 60 Years of Age or Older:** *2*

Diagnosed with Mental Illness: *6* **Diagnosed with Intellectual Disability:** *0*

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

Inspections / Reviews

01/11/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/28/2023*

Inspections / Reviews *(continued)*

01/31/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/28/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/05/2023*

05/02/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *02/03/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/08/2023*

06/30/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/02/2023*

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 1/11/23 the home's license, dated 9/13/22 to 9/23/23, the home's most recent license inspection summary dated 8/24/21, and a copy of this chapter were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The current license was posted on 1/11/23.
The PCHA will implement a monthly checklist that will begin on 2/3/23, that will ensure that all licenses for the facility are current.
A quarterly audit will also be conducted by the Executive Director to ensure that monthly checks are being conducted.
Quarterly audits will be completed by the end of March, June, September, and December 2023.

Licensee's Proposed Overall Completion Date: *02/03/2023*

Implemented ([redacted] - 06/30/2023)

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

Resident #1 is prescribed [redacted] take 1 tablet by mouth in the morning and 1 tablet in the evening. This medication was not administered on [redacted]/23 at [redacted] pm. The home did not report this medication error to the department.

Resident #1 is prescribed [redacted], take 1 tablet by mouth every morning and 2 tablets every evening. This medication was not administered on [redacted]23 at [redacted] pm. The home did not report this medication error to the department.

Repeat Violation: 8/24/21

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The medication for this resident was given, the staff did not sign the medication out on the MAR sheet. The Director of Nursing provided verbal education to all medication administration certified staff on 1/13/23 during a staff meeting about medication documentation.
All Medication Administration certified staff will be retrained on Medication Administration and documentation on 2/2/23, by the facility Medication Administration Trainer.
The facility Nurse will conduct weekly MAR checks, beginning 2/4/23, to ensure that all Medication administration certified staff are documenting medication administration.
Monthly MAR audits will be conducted by the Nurse at the end of each month.

16c - Written Incident Report *(continued)*

Licensee's Proposed Overall Completion Date: *02/28/2023*

Not Implemented [redacted] 06/30/2023)

25a - Written Contract and Review

3. 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 explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #2, admitted [redacted]/22, does not have a resident-home contract completed.

Plan of Correction ***Accept ([redacted] - 02/06/2023)***

The Clinical Director will implement a checklist starting 2/1/23 to ensure that all new admissions have the appropriate paperwork filled out 24 hours prior to the arrival of a new admission.

The Executive Director will sign off on the checklist 24 hours before or after the new resident is admitted ensuring the paperwork is completed and placed in the residents file.

The checklist will be completed for every new admission beginning on 2/3/23.

The Clinical Director or the PCHA will conduct quarterly audits beginning in March 2023, to ensure that each resident file is in compliance.

Licensee's Proposed Overall Completion Date: *02/03/2023*

Implemented [redacted] - 06/30/2023)

26a - Quality Management Plan

4. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home's quality management policy says meetings will be held quarterly. The only meeting held in 2022 was on 5/24/22.

Plan of Correction ***Accept ([redacted] - 01/31/2023)***

A Quality Management plan is established and the Executive Director will make sure that quarterly meetings are being held and that the minutes from each meeting are documented.

Licensee's Proposed Overall Completion Date: *04/12/2023*

Implemented ([redacted] - 06/30/2023)

41e - Signed Statement

5. Requirements

2600.

41e - Signed Statement *(continued)*

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #2's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept ([redacted] - 02/06/2023)***

The Clinical Director will implement a checklist starting 2/1/23 to ensure that all new admissions have the appropriate paperwork already setup to be read, and signed off on within 48 hours of their arrival date.

The Executive Director will sign off on the checklist 24 hours before a new resident is admitted ensuring the paperwork is correct and ready for presentation upon the resident's arrival.

The checklist will be completed for every new admission beginning on 2/3/23.

The Clinical Director or the PCHA will conduct quarterly audits beginning in March 2023, to ensure that each resident file is in compliance.

Licensee's Proposed Overall Completion Date: *02/03/2023*

Implemented ([redacted] - 06/30/2023)

54a - Direct Care Staff

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

Plan of Correction ***Accept [redacted] - 02/06/2023)***

All Direct Care Staff, including agency personnel, will have a high school diploma, GED from the U.S. at the time of hire.

All administrative staff were verbally educated on 1/13/23, by the Executive director on what documentation is needed for an employee before the first day of work begins.

The Executive director will implement a checklist by 2/3/23 of required documents that must be included in the employee file before the first day of employment begins.

The Executive Director or designated person will conduct quarterly audits beginning in March 2023, to ensure that each employee file is in compliance.

Licensee's Proposed Overall Completion Date: *02/03/2023*

54a - Direct Care Staff *(continued)*

Not Implemented ([redacted] - 06/30/2023)

82a - Poisonous Materials

7. Requirements

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

Description of Violation

On 1/11/23 a spray bottle containing a blue liquid is located on the ledge in the bathroom in room 2. According to staff person B, the blue liquid contained in the spray bottle is a cleaning liquid. The original product labeling was not available.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The cleaning product was discarded from the spray bottle on 1/11/23 by the Executive Director.
The safety officer verbally educated all staff on 1/13/23, about poisonous materials and proper storage.
The safety officer will make sure that all cleaning solutions are properly labeled with the OSHA standard factory labels if not in the original container.
The safety officer will conduct weekly checks to make sure all labels are on all products being used to clean.
All staff will make sure that all cleaning products are properly locked away or stored away from residents daily on each shift after each use.
A monthly maintenance checklist will be implemented by the safety officer to ensure review of poisonous material continue to be stored properly.
Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/03/2023*

Not Implemented [redacted] - 06/30/2023)

82c - Locking Poisonous Materials

8. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

Perigard and Crest toothpaste, both with a manufacture's label indicating "if swallowed contact Poison Control immediately", was unlocked, unattended, and accessible to residents in the medicine cabinet in the first floor bathroom. Not all the residents of the home, including residents #1 and #2, have been assessed capable of recognizing and using poisons safely.

Members Mark antibacterial soap, with a manufacture's label indicating "if swallowed contact Poison Control immediately", was unlocked, unattended, and accessible to residents under the sink in the first floor bathroom. Not all the residents of the home, including residents #1 and #2, have been assessed capable of recognizing and using poisons safely.

Purrell hand sanitizer, with a manufacture's label indicating "if swallowed contact Poison Control immediately", was unlocked, unattended, and accessible to residents #1 and #2, on resident #2's bedside table. Not all the residents of the home, including residents #1 and #2, have been assessed capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials (continued)

Dermisil, with a manufacture's label indicating "if swallowed contact Poison Control immediately", was unlocked, unattended, and accessible to residents in the bathroom in room 2. Not all the residents of the home, including residents #1 and #2, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept (02/06/2023)***

The Executive director verbally educated all staff on 1/13/23, during the monthly staff meeting about Poisonous materials being kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

All staff will make sure that all products with a manufacture's label indicating "if swallowed contact Poison Control immediately are properly locked away or stored away from residents.

The director of nursing will ensure all residents will be assessed by their PCP during their annual physicals if they are capable of recognizing and using poisons safely, beginning 2/3/23.

The executive director will implement a checklist for Direct Care staff to conduct daily room and bathroom checks on each shift to make sure that all products are stored/locked away properly beginning 2/3/23.

The executive director or designated person will conduct random spot checks at least once a week to ensure compliance.

Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/03/2023*

Not Implemented (- 06/30/2023)

85a - Sanitary Conditions

9. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 1/11/23, the following unsanitary conditions were observed in the home:

- *In the dry storage pantry there was a McDonald's bag that appeared to be garbage and a bag of moldy sandwich rolls.*
- *In the kitchen, the windowsill next to food prep table was dirty and had an accumulation of dead flies.*
- *The home's stove was not clean. There was a build up of grime on all the burners.*
- *The windowsill by the kitchen sink was dirty and there was an accumulation of dead flies. There was a coffee maker sitting on the same windowsill that had spiderwebs on it.*
- *In the first floor bathroom, the toilet seat had a brown substance that appeared to be feces and there was an unlabeled washcloth and unlabeled toothbrush.*
- *In the bathroom in room 2, there were two bath towels and two washcloths all unlabeled.*
- *In the second floor bathroom, there were two unlabeled washcloths.*

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Accept [redacted] - 02/06/2023)***

On 1/13/23, the executive director verbally educated all staff during a monthly staff meeting about maintaining sanitary conditions in the facility.

A checklist will be implemented for the Kitchen, bathrooms, and resident rooms to be used on each shift daily, to begin 2/6/23 for all direct care staff, maintenance staff, and kitchen staff to conduct daily inspections on each shift, to ensure the facility is clean at all times, and that all towels and wash cloths are labeled with the residents name.

The safety officer will make sure that the kitchen stove is properly cleaned as needed, and that all windowsills are clean and clear of dirt or bugs.

The executive director or designated person will conduct random spot checks at least once a week to ensure compliance.

Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/06/2023*

Not Implemented ([redacted] - 06/30/2023)

85d - Trash Receptacles

10. Requirements

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

Description of Violation

On 1/11/23 at 12:06 pm there was a 1/2 full, uncovered, unattended trash can in the kitchen.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

On 1/13/23, all staff were verbally educated by the safety officer on making sure that all kitchen and bathroom trash cans have lids on them at all times.

An environmental safety checklist will be implemented beginning 2/6/23.

The direct care staff will use the checklist to complete a daily inspection of the facility, including the kitchen and all bathrooms to ensure that all lids remain on all trash cans.

The safety officer will be responsible for doing random spot checks to ensure that lids remain on all the trash cans at all times for compliance.

Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/06/2023*

Not Implemented ([redacted] - 06/30/2023)

85e - Trash Outside Home

11. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 1/11/23 at 12:00 pm, the home's dumpster was uncovered.

Plan of Correction ***Accept [redacted] 02/06/2023)***

Trash is collected Monday, Wednesday, and Friday, the safety officer has been verbally educated by the Executive director on 1/11/23 to make sure that the lids to the outside dumpster are closed daily after each trash pick up.

The safety officer, beginning 2/6/23, will be responsible for doing random spot checks daily to ensure that lids remain closed on all the outside trash and recycle dumpsters at all times for compliance.

Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/06/2023*

Not Implemented ([redacted] - 06/30/2023)

89b - Hot Water Temperature

12. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 1/11/23 at 12:50 pm, the hot water temperature at the bathroom sink in room 2 measured 122.3 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 02/06/2023)***

The Executive director provided verbal education to the safety officer on 1/30/23, regarding hot water temperature in areas accessible to the residents not exceeding 120°F.

An environmental safety checklist will be implemented beginning 2/6/23.

The safety officer will be responsible for conducting weekly checks to ensure that all hot water temperatures remain at the correct levels at all times for compliance.

Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/06/2023*

Not Implemented [redacted] 06/30/2023)

100a - Exterior - Free of Hazards

13. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

100a - Exterior - Free of Hazards *(continued)*

Description of Violation

On 1/11/23, on the left side of the home there is a shed in disrepair. There are multiple places where the roof of the shed has collapsed and the plywood roof is covered in moss. There are multiple large pieces of wood and wood paneling scattered on the ground around the shed posing tripping hazard.

On 1/11/23, there was trash littered in the front yard of the home.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

On 1/13/23 during a staff meeting, all employees were verbally educated on helping with keeping the facility and the grounds of the facility clean and clear of debris.

The safety officer will clear the area around the shed of any debris by 2/10/23.

The safety officer will conduct ongoing weekly inspections to make sure the grounds outside of the facility are clean and clear of debris starting 2/6/23.

The executive director or designated person will conduct random spot checks at least once a week to ensure compliance.

Audits will be reviewed during the Quality management meetings each quarter.

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

Not Implemented [redacted] - 06/30/2023)

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

Bedroom 4 is occupied by 1 resident; however, there is no chair in this room.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

A chair was immediately placed back in the resident's room on 1/11/23 room.

On 1/13/23 during a staff meeting, the executive director verbally educated all employees on implementing the environmental checklist and making sure that each room is furnished completely and is in compliance.

A daily environmental health and safety check list will be implemented on 2/6/23.
Direct care staff on will conduct daily room checks to make sure all resident rooms have all the items required, if an item is missing the direct care staff will alert the safety officer immediately, so the item can be replaced.

The safety officer or designated person will conduct random spot checks at least once a week to ensure compliance.

101j2 - Bedroom Chairs (continued)

Audits will be reviewed during the Quality management meetings each quarter.

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

Not Implemented [redacted] - 06/30/2023)

101j6 - Mirror

15. Requirements

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

Description of Violation

There is no mirror in the bedroom of resident #3.

There is no mirror in the bedroom of resident #4.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

Mirrors were replaced in both rooms on 1/13/23.

On 1/13/23 during a staff meeting, the executive director verbally educated all employees on implementing the environmental checklist and making sure that each room is furnished completely and is in compliance.

A daily environmental health and safety check list will be implemented on 2/6/23.
Direct care staff will conduct ongoing daily room checks to make sure all resident rooms have all the items required, if an item is missing the direct care staff will alert the safety officer immediately, so the item can be replaced.

The safety officer or designated person will conduct random spot checks at least once a week to ensure compliance.

Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/06/2023*

Not Implemented [redacted] - 06/30/2023)

101j7 - Lighting/Operable Lamp

16. 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

Resident 2 does not have access to a source of light that can be turned on/off at bedside.

101j7 - Lighting/Operable Lamp (continued)

Resident 5 does not have access to a source of light that can be turned on/off at bedside.

Resident 6 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept ([redacted] 02/06/2023)***

A battery was replaced in the light for resident #6 on 1/12/23.

On 1/13/23 during a staff meeting, the executive director verbally educated all employees on implementing the environmental checklist and making sure that each room is furnished completely and that all bedside lights are in working condition.

A daily environmental health and safety check list will be implemented on 2/6/23.
Direct care staff on will conduct daily room checks to make sure all resident rooms have all the items required, and that all items are in working condition, if an item is missing, or needs batteries, the direct care staff will alert the safety officer immediately, so the item or batteries can be replaced.

The executive director or designated person will conduct random spot checks at least once a week to ensure compliance.

Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/06/2023*

Not Implemented ([redacted] - 06/30/2023)

102i - Soap Dispenser

17. 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

There was an unlabeled used bar of soap in bathroom 2.

Plan of Correction ***Accept ([redacted] 02/06/2023)***

No bar soap should be in the facility. All bathrooms will have soap dispensers that contain liquid hand soap.

On 1/13/23 during a staff meeting, the executive director verbally educated all employees on implementing the environmental checklist and making sure that each bathroom has liquid hand soap available.

A daily environmental health and safety check list will be implemented on 2/6/23.

Direct care staff will conduct ongoing daily environmental facility checks on each shift to make sure all bathrooms have liquid hand soap, if it is missing or needs to be refilled the direct care staff will alert the safety officer immediately, so the item can be replaced or refilled.

102i - Soap Dispenser (continued)

The safety officer or designated person will conduct random spot checks at least once a week to ensure compliance.

Audits will be reviewed during the Quality management meetings each quarter.

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

Not Implemented ([redacted] - 06/30/2023)

103g - Storing Food

18. Requirements

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

Description of Violation

On 1/11/23, there was a bag of Doritos in the food prep area that was opened and unsealed.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

Food storage containers and labels were purchased on 1/12/23, for staff to properly date, seal and store open snacks and other food items.

On 1/13/23 during a staff meeting, the executive director verbally educated all employees on implementing the environmental checklist and making sure that all food that is opened is labeled and stored away correctly.

A daily environmental health and safety check list will be implemented on 2/6/23.
All Direct care staff will conduct daily inspections of the kitchen on each shift to ensure that all food has been labeled and stored away properly.

The safety officer or designated person will conduct random spot checks at least once a week to ensure compliance.

Audits will be reviewed during the Quality management meetings each quarter.

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

Not Implemented ([redacted] - 06/30/2023)

103i - Outdated Food

19. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

103i - Outdated Food *(continued)*

Description of Violation

There was an unlabeled, undated loaf of Italian bread in the food prep area.

There was an undated bag of Doritos in the food prep area.

There was a loaf of Italian bread with a use by date of 1/4/23 in the food prep area.

Plan of Correction ***Accept ([redacted] - 02/06/2023)***

On 1/13/23 during a staff meeting, the executive director verbally educated all employees on implementing the environmental checklist and making sure that all food used in the facility is up to date, and not expired.

A daily environmental health and safety check list will be implemented on 2/6/23.

All Direct care staff will conduct daily inspections of the kitchen on each shift to ensure that all food has been labeled properly and is not expired or not stored away properly. All open food that has not been stored away properly or expired food will be thrown in the trash.
The safety officer or designated person will conduct random spot checks at least once a week to ensure compliance.
Audits will be reviewed during the Quality management meetings each quarter.

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

Not Implemented [redacted] - 06/30/2023)

105g - Lint Removal and Duct Cleaning

20. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 1/11/23, there was an approximate 2 inch accumulation of lint in the lint trap of the dryer on the left side of the laundry area. There were no clothes in the dryer at the time.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

Signs were placed in the laundry room as a reminder to empty the lint vent after each dryer use on 1/12/23.

All staff will be retrained on fire safety.
The Fire Marshall will conduct a training on 2/6/23 at 10am for all staff on Fire Safety.
Direct care staff will conduct daily inspections of the laundry room on each shift to ensure that all dryer vents have been cleaned and are clear of lint, beginning 2/6/23.

The safety officer or designated person will conduct random spot checks at least once a week to ensure compliance.

Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/07/2023*

105g - Lint Removal and Duct Cleaning *(continued)*

Implemented ([redacted] - 06/30/2023)

107d - Procedure Emergency Management Agency Submission

21. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency management agency.

Plan of Correction ***Accept ([redacted] - 02/06/2023)***

The facility's written emergency procedure was submitted on 1/26/23 to the local emergency management agency.

A checklist has been implemented to review required annual document submissions or other policy reviews. The Safety officer will be responsible for ensuring that all documents are submitted annually.

The executive director will conduct checks 60 days before submission is required to make sure that the required paperwork is completed.

Audits will be reviewed during the Quality management meetings each quarter.

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

Implemented [redacted] - 06/30/2023)

123b - Emergency Procedures Posted

22. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures are not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept ([redacted] - 02/06/2023)***

A binder containing the facility's emergency procedures is located on the first floor behind the staff workstation where it is in a conspicuous and public place for emergencies.
The executive director and the safety officer provided verbal education to staff on 1/13/23 during a staff meeting on the location of the emergency binder and what it is used for.

Direct care staff will also use the environmental checklist daily to ensure that the binder is in the location it should be each day on each shift.

The Safety Officer or designated person will conduct random to ensure that the binder is where it should be.

Audits will be reviewed during the Quality management meetings each quarter.

123b - Emergency Procedures Posted *(continued)*

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

Not Implemented ([redacted] 06/30/2023)

124 - Notice to Fire Department

23. Requirements

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

Description of Violation

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

Plan of Correction ***Accept ([redacted] - 02/06/2023)***

The facility's written emergency procedure was submitted on 1/26/23 to the local Fire department.
A checklist has been implemented to review required annual document submissions or other policy reviews. The Safety officer will be responsible for ensuring that all documents are submitted annually.
The executive director will conduct checks 60 days before submission is required to make sure that the required paperwork is completed.
Audits will be reviewed during the Quality management meetings each quarter.

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

Implemented ([redacted] - 06/30/2023)

132a - Monthly Fire Drill

24. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the months of December 2021, January 2022, February 2022, March 2022, and December 2022.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The executive director provided verbal education on 1/12/23, to the safety officer regarding unannounced fire drills being held at least once a month.

The safety officer will conduct 1 unannounced fire drill each month.

The first fire drill for 2023 was conducted on 1/24/23 at 9:30am.

The PCHA will conduct monthly checks to make sure that the Fire Drills are being conducted each month.

Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/28/2023*

Not Implemented ([redacted] - 06/30/2023)

132a - Monthly Fire Drill *(continued)*

132c - Fire Drill Records

25. Requirements

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

Description of Violation

The fire drill record for the drill conducted on 6/9/22 at "11:00" does not specify am or pm.

The fire drill record for the drill conducted on 11/18/22 at "11:22" does not specify am or pm.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The executive director provided verbal education on 1/12/23, to the safety officer regarding unannounced fire drills being held at least once a month and that an accurate written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

The PCHA or designated person will conduct monthly checks to make sure that the Fire Drills are being completed logged correctly.

Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/28/2023*

Not Implemented ([redacted] - 06/30/2023)

132e - Fire Drill Sleeping Hours

26. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

From December 2021 to December 2022, the only fire drill conducted during sleeping hours was on 5/18/22 at 5:00am.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The executive director provided verbal education on 1/12/23, to the safety officer regarding unannounced fire drills and that an unannounced fire drill must be held during sleeping hours once every 6 months.

The safety officer will conduct 1 unannounced fire drill each month with at least 2 being during sleeping hours.

The PCHA will conduct monthly checks to make sure that the Fire Drills are being completed logged correctly beginning 2/1/23.

132e - Fire Drill Sleeping Hours *(continued)*

Licensee's Proposed Overall Completion Date: *02/28/2023*

Not Implemented [redacted] - 06/30/2023)

132f - Alternate Exit Routes

27. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The front and side doors were the only exit route used during the fire drills held from April 2022 to November 2022.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The executive director provided verbal education on 1/12/23, to the safety officer regarding unannounced fire drills and that the exit routes for the fire drills must be alternated.
The safety officer will conduct 1 unannounced fire drill each month with the exit route being alternated to other exits in the facility.
The PCHA will conduct monthly checks to make sure that the Fire Drill exit routes are being alternated beginning 2/1/23.

Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/28/2023*

Not Implemented [redacted] - 06/30/2023)

141a - Medical Evaluation

28. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

The medical evaluation for resident #2 was not complete within 60 days prior to admission or within 30 days after admission of the resident.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The Nursing Director will implement a checklist starting 2/1/23 to ensure that all new admissions 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 checklist will be completed for every new admission beginning on 2/1/23.

The Clinical Director or the PCHA will conduct monthly checks beginning to ensure that each resident file is in compliance.

141a - Medical Evaluation (continued)

Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/28/2023*

Implemented [redacted] - 06/30/2023)

141a 1-10 Medical Evaluation Information

29. Requirements

2600.

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 1's medical evaluation dated [redacted]/22 did not include a complete general physical examination, special health or dietary needs, body positioning, health status, and cognitive functioning.

Resident 2's medical evaluation dated [redacted]/22 did not include complete general physical examination, special health or dietary needs, immunization history, and body positioning.

Resident 6's medical evaluation dated [redacted]/22 did not include immunization history and the second page is missing.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The executive provided verbal education to the nursing director on 1/16/23, regarding all residents having 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:

A general physical examination by a physician, physician's assistant or nurse practitioner.

Medical diagnosis including physical or mental disabilities of the resident, if any.

Medical information pertinent to diagnosis and treatment in case of an emergency.

Special health or dietary needs of the resident.

Allergies.

Immunization history.

Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.

141a 1-10 Medical Evaluation Information (continued)

Body positioning and movement stimulation for residents, if appropriate.
Health status.
Mobility assessment, updated annually or at the Department's request.

The Nursing director will implement a checklist be completed for every new admission beginning on 2/1/23.

The Clinical Director or the PCHA will conduct monthly checks beginning 2/28/23 to ensure that each resident file is in compliance.

Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/28/2023*

Not Implemented [redacted] - 06/30/2023)

162c - Menus Posted

30. 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 1/11/23, the posted menu was for the week of 10/7/22-10/13/22. There were no additional menus posted in the home.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The menu was updated and posted on 1/13/23.

A cook has been hired, effective [redacted]/23.

The executive director and the safety officer will provide the cook with training during the week of [redacted]23 on the policy and procedures for the kitchen. The cook will also participate in the fire safety training.

The cook will be responsible for all menus, stating the specific food being served at each meal, menus prepared for 1 week in advance to be followed, and ensuring that weekly menus are posted 1 week in advance in a conspicuous and public place in the home.

The PCHA or designated person will make sure that the menu is posted weekly for two weeks according to regulations.

162c - Menus Posted (continued)

Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/06/2023*

Implemented (- 06/30/2023)

182b - Prescription Medication

31. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

Description of Violation

On /23 at am staff person C administered medications to residents to include the following; , Staff person C has not completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

On /23 at pm staff person D administered medications to residents to include the following; Staff person D has not completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Plan of Correction ***Accept - 02/06/2023)***

The executive director provided verbal education to the nursing director on 1/16/23 regarding prescription medication that is not self-administered by a resident can only be administered by medication administration certified employees or the nurse.

All staff who have completed the course for medication administration will receive in service training on medication administration on 2/2/23, by the facility Medication Administration Certification trainer.

The Nursing Director will implement a checklist starting 2/1/23 to ensure that all employees who are medication administration certified remain up to date with all observations and re-training as needed.

The Clinical Director or the PCHA will conduct monthly checks beginning 2/1/23 to ensure that each medication administration certified employee's certification is in compliance.

Audits will be reviewed during the Quality management meetings each quarter.

Licensee's Proposed Overall Completion Date: *02/28/2023*

Not Implemented - 06/30/2023)

183d - Prescription Current

32. Requirements

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

Description of Violation

The home keeps medications for individuals who live in apartments offsite and are not residents of the home in the home's medication cart.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The PCHA will apply for a waiver under Personal Care Regulations to be able to do something different to accommodate the apartment residents and have medication for all the apartment residents kept at the main house during the times that they are there.

Beginning 1/12/23, until the waiver is approved, Medication will not be kept in the facility, designated staff will go to the apartments to get medication for the apartment residents daily.

The executive was verbally educated about the unique circumstances that the facility falls under via telephone call with [redacted] on 1/26/23, and about the correct procedures to follow in regards to only having medication in the facility for the residents that reside in the main house.

The executive director verbally educated the director of Nursing on 1/26/23 regarding the guidelines and protocol for only housing medication for the residents that reside at the main house.

The executive director will submit the waiver application by 2/28/23 for approval.

The Nurse will conduct weekly checks to ensure that only residents that reside at the main house have medication in the medication cart.

Licensee's Proposed Overall Completion Date: *02/28/2023*

Not Implemented [redacted] - 06/30/2023)

184a - Resident's Meds Labeled

33. Requirements

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

Description of Violation

The home has a blister pack of Tylenol on the medication cart being used as "house Tylenol". It appears as though this medication previously belonged to a specific resident. the pharmacy label is cut off at the top where the name of the person it was prescribed to would appear.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

OTC Tylenol was purchased on 1/17/23 for residents.

The Nurse verbally provided education to the medication administration certified staff on 1/13/23, regarding making sure the original container for prescription medications are labeled according to the regulations.

184a - Resident's Meds Labeled (continued)

Medication administration certification training will be conducted on 2/2/23 for all certified medication administration staff by the Medication administration Trainer. The trainer will cover proper medication administration, medication labeling and documentation.

The Nurse will be responsible for making sure that all medication is properly labeled for each resident, a checklist will be completed weekly.

The PCHA or designated person will conduct random checks, to ensure the medications in the medication cart are in compliance.

Audits will be reviewed during the Quality management meetings each quarter.

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

Not Implemented [redacted] - 06/30/2023)

185a - Implement Storage Procedures

34. 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 1 is prescribed [redacted] as needed. On 1/11/23 the medication was not available in the home.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

[redacted] *was purchased on 1/17/23 for resident #1.*

The Direct care staff was verbally provided education by the Nursing Director on 1/13/23, in regards to implementing a checklist to be completed when OTC medication is running low and needs to be refilled.

The nurse will implement a check list for the medication cart to make sure that when medications are down to a 7 day supply, the pharmacy will be notified for refills to be ordered so that medication does not completely run out.

The Nurse or designated person will conduct monthly checks beginning 2/1/23 to ensure that each medication is available and in compliance.

The Executive director or clinical director will conduct random checks for compliance beginning 2/6/23.

Audits will be reviewed during the Quality management meetings each quarter.

185a - Implement Storage Procedures (continued)

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

Not Implemented [redacted] - 06/30/2023)

187a - Medication Record

35. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #1 is prescribed for [redacted] However, resident 1's medication administration record does not indicate diagnosis or purpose for these medications.

Repeat Violation: 8/24/21

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The executive director provided verbal education to the director of Nursing on 1/26/23 regarding the MAR's having accurate information that includes the diagnosis or purpose for each medication.
The facility Nurse contacted the pharmacy on 1/26/23 to have them add the diagnosis or purpose of the medications on the MAR for each medication for each resident.
The nurse will be responsible for inspecting the MAR's on the first day of each month to ensure that all medications listed on each MAR for each resident shows the diagnosis or purpose for each resident medication, if it is not shown, the Nurse will ensure that it is written on the MAR, and the pharmacy will be informed .
The Executive director or clinical director will conduct random checks for compliance beginning 2/6/23.
Audits will be reviewed during the Quality management meetings each quarter.

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

Not Implemented [redacted] - 06/30/2023)

36. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #1 is prescribed [redacted] . This medication was administered on [redacted]/23; however, the time it was administered is not included on resident #1's medication administration record.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

Medication administration certification training will be conducted on 2/2/23 for all certified medication administration staff by the Medication administration Trainer. The trainer will cover proper medication administration, and medication documentation on the MAR for all medications, including PRN's.

The Nurse or designated person will conduct weekly checks beginning 2/1/23 to ensure that each medication has

187a - Medication Record (continued)

been properly documented and the MAR is in compliance.
The Executive director or clinical director will conduct random checks for compliance beginning 2/6/23.
Audits will be reviewed during the Quality management meetings each quarter.

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

Not Implemented [redacted] 06/30/2023)

187d - Follow Prescriber's Orders

37. Requirements

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

Description of Violation

Resident #1 is prescribed [redacted].
This medication was not administered on [redacted] /23 at [redacted] pm.

Resident #1 is prescribed [redacted].
This medication was not administered on [redacted] /23 at [redacted] pm.

Repeat Violation: 8/24/21

Plan of Correction ***Accept [redacted] - 02/06/2023)***

Medication administration certification training will be conducted on 2/2/23 for all certified medication administration staff by the Medication administration Trainer. The trainer will cover proper medication administration, and medication documentation on the MAR for all medications, including PRN's.
The Nurse or designated person will conduct weekly checks beginning 2/1/23 to ensure that each medication has been properly documented and the MAR is in compliance.
The Executive director or clinical director will conduct random checks for compliance beginning 2/6/23.
Audits will be reviewed during the Quality management meetings each quarter.

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

Not Implemented [redacted] - 06/30/2023)

188b - Medication Error Reporting

38. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #1 is prescribed [redacted]
This medication was not administered on [redacted] 23 at [redacted] pm. The medication error was not reported to the resident, the resident's designated person and the prescriber.

Resident #1 is prescribed [redacted]

188b - Medication Error Reporting (continued)

This medication was not administered on [redacted]/23 at [redacted] pm. The medication error was not reported to the resident, the resident's designated person and the prescriber.

Plan of Correction ***Accept [redacted] - 01/31/2023)***

There was no medication error that needed to be reported. This medication was administered to the resident, however the staff person failed to sign the MAR. All medication administration certified staff will be re-trained on medication documentation. The nurse will set up a date in February for retraining staff on medication documentation.

Licensee's Proposed Overall Completion Date: *02/28/2023*

Not Implemented [redacted] - 06/30/2023)

190a - Completion Medication Course

39. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person C, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:
On [redacted]/23 at [redacted] am, [redacted] were administered to resident #1.

Staff person D, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:
On [redacted]/23 at [redacted] pm, [redacted] was administered to resident #1.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

Medication administration certification training will be conducted on 2/2/23 for all certified medication administration staff by the Medication administration Trainer. The trainer will provide the nurse with a copy of each medication administration certified employees dates for review.

The Nurse will conduct monthly checks beginning 2/1/23 to ensure that each medication administration certified employee has a valid certification.

The PCHA will ensure that the employee work schedule reflects a medication administration certified employee is available on each shift to administer medication to the residents.

The Executive director or clinical director will conduct random checks for compliance beginning 2/6/23.

Audits will be reviewed during the Quality management meetings each quarter.

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

190a - Completion Medication Course *(continued)*

Not Implemented [redacted] - 06/30/2023)

191 - Resident Right to Refuse

40. 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

Resident #2, admitted [redacted]/22, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The executive director provided verbal education to the clinical director on 1/30/23 regarding resident rights.

The clinical director will be responsible for ensuring resident Education, informing the resident of the right to question or refuse a medication if the resident believes there may be a medication error.

The Clinical Director will implement a monthly checklist starting 2/1/23 to ensure that all residents have the appropriate paperwork, signed and in their files.

The Clinical Director or the PCHA will conduct quarterly audits beginning in March 2023, to ensure that each resident file is in compliance.

Licensee's Proposed Overall Completion Date: *02/28/2023*

Not Implemented [redacted] - 06/30/2023)

221c - Post Activity Calendar

41. Requirements

2600.
221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

Description of Violation

The home does not have a current weekly activity calendar posted in a public and conspicuous place in the home. The activity calendar that is posted is dated May 2022.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The activities calendar was posted on 1/11/23.

The executive director provided verbal education to the clinical director on 1/30/23 regarding the activities calendar being posted each month.

The clinical director or designated person will ensure that the calendar is posted monthly for the residents.

The PCHA or designated person will check monthly, beginning 2/1/23 to ensure that the calendar is posted.

Licensee's Proposed Overall Completion Date: *02/03/2023*

Not Implemented (MS - 06/30/2023)

221c - Post Activity Calendar *(continued)*

224a - Preadmission Screen Form

42. Requirements

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

Description of Violation

Resident #1 was admitted to the home on [redacted]/22; however, the resident's preadmission screening form was not completed.

Resident #2 was admitted to the home on [redacted]22; however, the resident's preadmission screening form was not completed.

Resident #4 was admitted to the home on [redacted]/22; however, the resident's preadmission screening form was not completed.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The Clinical Director will implement a checklist starting 2/1/23 to ensure that all new admissions have the appropriate paperwork filled out within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

The checklist will be completed by the clinical director or designated person for every new admission beginning on 2/1/23.

The Clinical Director or the PCHA will conduct quarterly audits beginning in March 2023, to ensure that each resident file is in compliance.

Licensee's Proposed Overall Completion Date: *02/03/2023*

Implemented [redacted] - 06/30/2023)

225a - Assessment 15 Days

43. 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

An assessment was not completed for resident #1, who was admitted to the home on [redacted]/22.

An assessment was not completed for resident #4, who was admitted to the home on [redacted]/22.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The Clinical Director will implement a checklist starting 2/1/23 to ensure that all new admissions have a written initial assessment that is documented on the Department's assessment form within 15 days of admission.

225a - Assessment 15 Days (continued)

The administrator or designee, or a human service agency may complete the initial assessment.

The checklist will be completed by the clinical director or designated person for every new admission beginning on 2/1/23.

The Clinical Director or the PCHA will conduct monthly audits beginning on February 28, 2023, to ensure that each new resident file is in compliance.

Licensee's Proposed Overall Completion Date: *02/28/2023*

Implemented [redacted] - 06/30/2023)

44. 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 #2 was admitted on [redacted]/22; however, the resident's assessment was completed on [redacted]/22.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The Clinical Director will implement a checklist starting 2/1/23 to ensure that all new admissions 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.
The checklist will be completed by the clinical director or designated person for every new admission beginning on 2/1/23.
The Clinical Director or the PCHA will conduct monthly audits beginning on February 28, 2023, to ensure that each new resident file is in compliance.

Licensee's Proposed Overall Completion Date: *02/28/2023*

Implemented [redacted] - 06/30/2023)

227a - Support Plan 30 Days

45. Requirements

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

Description of Violation

Resident #1 was admitted on [redacted]/22; however, the resident's initial support plan was not completed.

Resident #2 was admitted on [redacted]/22; however, the resident's initial support plan was completed on [redacted]/22.

Resident #4 was admitted on [redacted]/22; however, the resident's initial support plan was not completed.

Plan of Correction ***Accept [redacted] - 02/06/2023)***

The Clinical Director will implement a checklist starting 2/1/23 to ensure that all residents requiring personal care

227a - Support Plan 30 Days (continued)

services have a written support plan developed and implemented within 30 days of admission to the facility. The support plan will be documented on the Department's support plan form.

The checklist will be completed by the clinical director or designated person for every new admission beginning on 2/1/23.

The Clinical Director or the PCHA will conduct monthly audits beginning on February 28, 2023, to ensure that each new resident file is in compliance.

Licensee's Proposed Overall Completion Date: *02/28/2023*

Implemented [redacted] - 06/30/2023)