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

March 6, 2023

[redacted]
MERAKEY PENNSYLVANIA
[redacted]

RE: MERAKEY PENNSYLVANIA
1071 PAGE ROAD
HARRISBURG, PA, 17111
LICENSE/COC#: 32100

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/19/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MERAKEY PENNSYLVANIA* **License #**: *32100* **License Expiration**: *06/02/2023*

Address: *1071 PAGE ROAD, HARRISBURG, PA 17111*

County: *DAUPHIN* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *MERAKEY PENNSYLVANIA*

Address: *4251 CRUMS MILL ROAD, HARRISBURG, PA, 17112*

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

Certificate(s) of Occupancy

Type: *R-4* **Date**: *11/15/2006* **Issued By**: *Lower Paxton Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *8* **Waking Staff**: *6*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *01/19/2023*

Inspection Dates and Department Representative

01/19/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *8* **Residents Served**: *8*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *7* **Are 60 Years of Age or Older**: *3*

Diagnosed with Mental Illness: *8* **Diagnosed with Intellectual Disability**: *0*

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

Inspections / Reviews

01/19/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/03/2023*

02/10/2023 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/17/2023*

Inspections / Reviews *(continued)*

02/24/2023 - POC Submission

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

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

03/06/2023 - Document Submission

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

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

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

The home's management held an internal meeting with staff person C on [redacted] to address concerns that were raised regarding staff person C verbally abusing residents in the home. A report was not completed and sent to Area Agency on Aging until [redacted] for this particular allegation.

Plan of Correction ***Accept (AC - 02/24/2023)***

Beginning February 6, 2023, all instances of reported suspected abuse, from individuals or staff, will be reported to the Department of Human Services and Older Adult Protective Services within 24 hours and documented on the appropriate incident reporting form by the Assistant Program Director. On February 9, 2023, all completed incident reports which are completed by the Assistant Program Director, will be filed by the Assistant Program Director, and maintained in a secure location. Beginning the week of February 6, 2023, the Assistant Director will review all incidents reported with the Program Director during regularly scheduled supervision. Beginning February 17, 2023, and monthly ongoing, all incident reports are reviewed as part of the monthly Performance Quality Improvement process. Retraining on incident management and reporting of all instances of suspected abuse will be provided to all staff by February 28, 2023, by the Incident Manager and Assistant Program Director, which will include when, how, and where to report when an incident occurs. All instances of suspected abuse will be reported to the Assistant Program Director who will complete the incident report. On February 9, 2023, the Program Director discussed the importance and processes for incident management and reporting and reviewed the DHS Abuse and Abuse Reporting guide with the Assistant Program Director.

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

Implemented (AC - 03/06/2023)

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

The home's management held an internal meeting with staff person C on [redacted] to address concerns that were raised regarding staff person C verbally abusing residents in the home. A report was not completed and sent to the Department until [redacted] for this particular allegation.

16c - Written Incident Report *(continued)*

Plan of Correction ***Accept (AC - 02/24/2023)***

Beginning February 6, 2023, all instances of reported suspected abuse, from individuals or staff will be reported to The Department of Human Services and Adult Protective Services within 24 hours and documented on the appropriate incident reporting form by the Assistant Program Director. On February 9, 2023, all completed incident reports, which are completed by the Assistant Program Director, will be filed by the Assistant Program Director, and maintained in a secure location. Beginning the week of February 6, 2023, the Assistant Director will review all incidents reported with the Program Director during regularly scheduled supervision. Beginning February 17, 2023, and monthly ongoing, all incident reports are reviewed as part of the monthly Performance Quality Improvement process. Retraining on incident management and reporting of all instances of suspected abuse will be provided to all staff by February 28, 2023, by the Incident Manager and Assistant Program Director, which will include when, how, and where to report when an incident occurs. All instances of suspected abuse will be reported to the Assistant Program Director who will complete the incident report. On February 9, 2023, the Program Director discussed the importance and processes for incident management and reporting and reviewed the DHS Abuse and Abuse Reporting guide with the Assistant Program Director.

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

Implemented (AC - 03/06/2023)

18 - Compliance With Laws

3. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The flu awareness poster is not posted in the home as required by the Influenza Awareness Act (NH 1785).

Plan of Correction ***Accept (AC - 02/24/2023)***

A Flu Awareness Poster was ordered by the Assistant Program Director on January 19, 2023. The poster was posted in the home February 2, 2023 by the Assistant Program Director. Beginning February 6, 2023, the Assistant Program Director or designee will complete a weekly walk-through which includes ensuring flu awareness posters are present in the home. Beginning February 6, 2023, a weekly walk-through checklist will be utilized for the weekly walk-through. Beginning February 6, 2023, if a flu awareness poster is not present in the home a request to be replaced to the Assistant Program Director will be completed by the staff member completing the walk-through or a designee within 24 hours. Beginning February 6, 2023, the Assistant Program Director will be responsible for purchasing the flu awareness posters within 72 hours after notification is received and ensuring the flu awareness posters are posted in the home upon receipt.

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

Implemented (AC - 03/06/2023)

42b - Abuse

4. 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.

42b - Abuse *(continued)*

Description of Violation

Over the past 5-6 months, staff member C has been verbally abusive towards several residents in the home. Staff member C caused both resident #4 and resident #5 to cry from the verbal abuse. Staff member C called resident #5 a "slob", "foul mouth", "disgusting" and "rude". Staff member C has cursed at resident #2. Staff member C would "bark" orders at residents and could be heard yelling at residents throughout the home by other staff. Resident #2 reported to his/her psychiatrist on 1/19/23 that staff member C was making him/her upset. Staff member C would get close to residents' faces and start shaking his/her finger at the residents.

Plan of Correction ***Accept (AC - 02/24/2023)***

Beginning February 6, 2023, all instances of reported suspected abuse,from individuals or staff, will be reported to the Department of Human Services and Older Adult Protective Services within 24 hours and documented on the appropriate incident reporting form by the Assistant Program Director. On February 9, 2023, all completed incident reports which are completed by the Assistant Program Director, will be filed by the Assistant Program Director, and maintained in a secure location. Beginning the week of February 6, 2023, the Assistant Director will review all incidents reported with the Program
Director during regularly scheduled supervision. Beginning February 17, 2023, and monthly ongoing, all incident reports are reviewed as part of the monthly Performance Quality Improvement process. Retraining on incident management and reporting of all instances of suspected abuse will be provided to all staff by February 28, 2023, by the Incident Manager and Assistant Program Director, which will include when, how, and where to report when an incident occurs. All instances of suspected abuse will be reported to the Assistant Program Director who will complete the incident report. On February 9, 2023, the Program Director discussed the importance and processes for incident management and reporting and reviewed the DHS Abuse and Abuse Reporting guide with the Assistant Program Director.
Internal investigation was initiated on December 21, 2022, by Quality and Compliance Organization, Certified Investigator. The staff member was placed on Administrative Leave on [redacted], prior to [redacted] next scheduled shift following receipt of the Adult Protective Service complaint on January 6, 2023. As part of the investigation process, all individuals impacted were interviewed by the Certified Investigator. Full finalization of the investigation is currently pending, and staff will remain on Administrative Leave until finalization occurs. On February 15, 2023, all individuals will be verbally debriefed individually by the Program Director which will be documented on a Narrative Note completed and filed in the individual's chart by the Program Director.

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

Implemented (AC - 03/06/2023)

65d - Initial Direct Care Training

5. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

65d - Initial Direct Care Training *(continued)*

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, hired on [redacted] was observed providing unsupervised ADL services on [redacted]. However, there is no documentation that the staff person completed and passed the Department-approved direct care training course and pass the competency test.

Direct care staff person B, hired on [redacted] was observed providing unsupervised ADL services on [redacted]. However, there is no documentation the staff person completed and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Accept (AC - 02/24/2023)***

Direct Care Staff Persons A and B completed the Direct Care Training Course on [redacted], the training certificate has been filed in their staff record by the Assistant Program Director. Beginning February 6, 2023, when a new staff member is hired, the Assistant Program Director or Trainer is responsible for scheduling the staff member for all required trainings. Once a training is completed, beginning on February 1, 2023, the Assistant Program Director is responsible for ensuring receipt of the training certificate and will add the training date to the training tracker. The certificate will be filed in the staff records. Prior to scheduling to provide services, the Assistant Program Director will verify that all training has been completed by review the training tracker. The Assistant Program Director will review the training tracker monthly beginning February 1, 2023, to identify staff who will need renew trainings. The Assistant Program Director will assign the staff the required trainings for renewal. Beginning February 1, 2023, the Assistant Program Director will ensure receipt of the training certificate and will update the tracker accordingly.

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

Implemented (AC - 03/06/2023)

66b - Training Plan Content

6. Requirements

2600.
66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

Description of Violation

The home's staff training plan does not include dates, times and locations for the trainings.

Plan of Correction ***Directed (AC - 02/24/2023)***

The training plan template will be updated to include dates, times, and locations of the trainings. The Assistant Program Director will update the training plan for the 2023 calendar year to include required information by March 1, 2023, all annual trainings following will be completed by the Assistant Program Director by March 15, 2923.

66b - Training Plan Content (continued)

[Directed]
The training plan template will be updated to include dates, times, and locations of the trainings. The Assistant Program Director will update the training plan for the 2023 calendar year to include required information by March 1, 2023. Assistant Program Director will complete annual training schedule by December 15th each year for the following year.

Directed Completion Date: *03/15/2023*

Implemented (AC - 03/06/2023)

94b - Non-Skid Surface

7. Requirements

2600.
94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

Description of Violation

The porch at the bottom of the 2nd floor outside staircase does not have a non-skid surface. This area is used as an emergency exit route.

Plan of Correction ***Accept (AC - 02/24/2023)***

A work order to add a nonskid surface to the outside staircase on the porch at the bottom of the 2nd floor was completed by the Assistant Program Director on January 19, 2023. On February 14, 2023, a facility request was submitted by the Program Director to have a temporary nonskid surface installed until weather permits for the permanent nonskid to be applied. The temporary mats were added to the deck area on February 15, 2023. The Assistant Program Director will continue to follow up on the requests to ensure the nonskid surface is applied to the outside area. Beginning February 6, 2023, the Assistant Program Director or designee will complete a weekly walk-through which includes checking that all interior stairs, exterior steps and ramps have nonskid surfaces. Beginning February 6, 2023, a weekly walk-through checklist will be utilized for the weekly walk-through. Beginning February 15, 2023, any interior stairs, exterior steps and ramps that do not have a nonskid surface will be reported by the staff member completing the walk-through to the Assistant Program Director within 24 hours to have a work order completed. Beginning February 6, 2023, the Assistant Program Director will be responsible for following up on the work order request to ensure the request is completed within 72 hours of notification and the nonskid surface is placed.

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

Implemented (AC - 03/06/2023)

95 - Furniture and Equipment

8. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

Resident #1's room has a hole on the wall closest to the hallway, the hole measures approximately 3''x7''.

Resident #2 is missing the top drawer of his/her dresser due to the drawer being damaged.

95 - Furniture and Equipment (continued)

Resident #3 and #4's room has drag marks on the wall where paint has been scraped off, exposing the bare dry-wall opposite of bedroom door.

Plan of Correction ***Accept (AC - 02/24/2023)***

A work order to repair the furniture and equipment identified was completed by the Assistant Program Director on January 19, 2023. The needed repairs for the furniture and equipment were completed on February 2, 2023, by the Maintenance Supervisor. Beginning February 6, 2023, the Assistant Program Director or designee will complete a weekly walk-through which includes checking furniture or equipment for repairs needed. Beginning February 6, 2023, a weekly walk-through checklist will be utilized for the weekly walk-through. Any furniture or equipment identified as needing will be reported by the staff member completing the walk-through to the Assistant Program Director within 24 hours to have a work order completed. Beginning February 6, 2023, the Assistant Program Director will be responsible for following up on the work order request to ensure the request is completed within 72 hours of notification and the furniture or equipment is fully repaired.

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

Implemented (AC - 03/06/2023)

100a - Exterior - Free of Hazards

9. Requirements

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

Description of Violation

The gutter above kitchen window has debris in it, including leaves and other plant matter which is visible from the ground level. The amount of debris present in the gutter appears to severely limit water flow through the gutter and into the downspout.

Plan of Correction ***Accept (AC - 02/24/2023)***

A work order to remove the debris from the gutter above the kitchen window was completed by the Assistant Program Director on January 19, 2023. The gutters were cleaned January 27, 2023 by Maintenance Staff. The Assistant Program Director or designee will complete a weekly walk-through which includes checking that the exterior of the building and the building grounds or yard are in good repair and free of hazard. Beginning February 6, 2023, a weekly walk-through checklist will be utilized for the weekly walk-through. Notification of any concerns identified with the exterior of the building or grounds will be provided to the Assistant Program Director from the staff member completing the walk-through or a designee within 24 hours. Beginning February 6, 2023, the Assistant Program Director or designee will complete the appropriate procedures to ensure the exterior of the building and the building grounds are in good repair and free of hazard.

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

Implemented (AC - 03/06/2023)

101j7 - Lighting/Operable Lamp

10. 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 his/her bedside.

Plan of Correction ***Accept (AC - 02/24/2023)***

On January 19, 2023, a lamp was placed on the bedside table for Resident #2 LPN Supervisor. The Program Director reminded staff on January 19, 2023, of the importance of the regulation and that each resident should have access to an operable lamp or other source of lighting that can be turned on at bedside. Beginning February 6, 2023, the Assistant Program Director or designee will complete a weekly walk-through which includes checking for an operable lamp or other source of lighting. Beginning February 6, 2023, a weekly walk-through checklist will be utilized for the weekly walk-through. If an operable lamp or other source of light is not available at the resident's bedside, the staff member completing the walk-through will notify the Program Director within 24 hours. Beginning February 6, 2023, the Assistant Program Director or designee will complete the appropriate procedures to ensure it is replaced or repaired for the resident within 72 hours after notification.

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

Implemented (AC - 03/06/2023)

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

11. Requirements

2600.
102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

The public bathroom to the immediate left of the main entrance to the home has a long, gray rug placed right in front of the shower. The rug moves very easily and has no non-skid backing.

Plan of Correction ***Accept (AC - 02/24/2023)***

On January 19, 2023, the grey carpet in the public bathroom to the immediate left of the main entrance was removed from the home by nursing staff. The Assistant Program Director on January 19, 2023, inspected all bathrooms with bathtubs or showers to ensure that slip resistant surfaces were present. Beginning February 6, 2023, the Assistant Program Director or designee will complete a weekly walk-through which includes checking that bathrooms with bathtubs and showers have slip-resistant surfaces. Beginning February 6, 2023, a weekly walk-through checklist will be utilized for the weekly walk-through. Beginning February 6, 2023, if anything is identified in the bathrooms with bathtubs and showers that create a not-slip-resistance surface, the Assistant Program Director or designee will complete the appropriate procedures to ensure it is removed or mended to ensure it is a slip-resistant surface.

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

Implemented (AC - 03/06/2023)

131f - Fire Extinguisher Inspection

12. Requirements

131f - Fire Extinguisher Inspection *(continued)*

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

Description of Violation

The fire extinguishers in the home have not been inspected by a fire safety expert since December 2021.

Plan of Correction ***Accept (AC - 02/24/2023)***

On January 25, 2023, the fire extinguisher was inspected by a fire safety expert from the [redacted] Corporation.. The Assistant Program Director verified the date of inspection was present on the fire extinguisher. Beginning January 25, 2023, by January 15 every year, a fire safety inspection, fire drill conducted, and fire extinguisher inspection by a fire safety expert will be scheduled annually by the Assistant Program Director and will be included on the fire drill schedule. This year's fire safety inspection will be completed on February 16, 2023. This will be completed by March 1st of each year.

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

Implemented (AC - 03/06/2023)

132a - Monthly Fire Drill

13. 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 for December 2021, February 2022, April 2022, June 2022 or October 2022.

Plan of Correction ***Accept (AC - 02/24/2023)***

Beginning February 1, 2023, a calendar which includes fire drills for the entire year is created by the Assistant Program Director and posted by March 1st every year in an administrative area which includes a schedule for when fire drills are to be conducted. Beginning February 1, 2023, the Assistant Program Director is responsible for ensuring the schedule is updated and posted yearly. On February 14, 2023, the Assistant Program Director reminded staff the importance of utilizing the fire drill calendar and completing regularly scheduled fire drills the week following the inspection. Beginning February 17, 2023, after completing a fire drill, the Assistant Program Director or designee will be responsible for completing a fire drill log and submitting it to the Program Director for review within 24 hours after completing the drill. Beginning February 18, 2023, the Program Director will review the log to ensure completion and have the log filed. Beginning January 17, 2023, if a fire drill cannot be completed on the scheduled day, the Assistant Program Director is responsible for rescheduling another fire drill within the same month within 72 hours of cancellation and notifying staff of the reschedule.

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

Implemented (AC - 03/06/2023)

132b - Safety Inspection/Fire Drill

14. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

132b - Safety Inspection/Fire Drill *(continued)*

Description of Violation

There was no fire safety inspection and supervised fire drill conducted by a fire safety within the last year. There was no documentation provided as to when this was last completed.

Plan of Correction ***Accept (AC - 02/24/2023)***

On February 6, 2023, the Program Director began coordinating with a fire safety expert to inspect, designate an evacuation time, and complete a fire drill. On February 16, 2023, these items were completed. Documentation of the fire safety inspection and fire drill log will be reviewed by the Program Director to ensure completion and will be filed for record keeping within 24 hours of the fire safety inspection and fire drill completion. Beginning February 1, 2023, the Assistant Program Director will be responsible for ensure a fire safety inspection and fire drill conducted by a fire safety expert will be scheduled annually and included on the fire drill schedule by March 1st every year.

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

Implemented (AC - 03/06/2023)

132c - Fire Drill Records

15. 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 12/17/22 does not include what escape routes were used, if there were any issues and if the fire alarm/smoke was operative.

Plan of Correction ***Accept (AC - 02/24/2023)***

A fire drill log which includes date, time, 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 is utilized. The Assistant Program Director provided retraining on completing the fire drill log correctly the week following the inspection. The training was completed with all employees on February 14, 2023. Beginning February 17, 2023, after completing a fire drill, the Assistant Program Director or designee will be responsible for completing a fire drill log and submitting it to the Program Director for review within 24 hours. The Program Director will review the log to ensure completion and have the log filed beginning February 18, 2023. Beginning February 17, 2023, Assistant Program Director will be responsible for scheduling the annual fire drill and fire safety inspection by March 1st of each year. The Assistant Program Director will be responsible for fire drills that are over the allotted time and determine what is able to be done to fix this.

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

Implemented (AC - 03/06/2023)

132d - Evacuation

16. Requirements

2600.

132d - Evacuation *(continued)*

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills: 1/17/22 fire drill was completed in 3 minutes, 3/25/22 fire drill was completed in 7 minutes and 3 seconds, 5/17/22 fire drill was completed in 5 minutes, and 12/17/22 Fire drill was completed in 2 minutes and 35 seconds.

Plan of Correction ***Accept (AC - 02/24/2023)***

On February 6, 2023, the Program Director began coordinating with a fire safety expert to inspect, designate an evacuation time, and complete a fire drill. The maximum safe evacuation time specified during the inspection by the fire safety expert will be the new measure for all fire drills moving forward. This was completed February 16, 2023. Beginning February 18, 2023, within 48 hours following the first fire drill after a new evacuation time is identified by the fire safety expert, program leadership will assess and correct any barriers identified that prohibit the maximum safe evacuation time being met. Beginning February 18, 2023, within 24 hours of the fire safety inspection and fire drill, documentation of the fire safety inspection and fire drill log will be reviewed by the Program Director to ensure completion and to ensure the maximum safe evacuation time is documented and will be filed for record keeping. Beginning February 18, 2023, a fire safety inspection and fire drill conducted by a fire safety expert will be scheduled annually and included on the fire drill schedule by the Assistant Program Director. This will be completed on February 16, 2023, for this year and by March 1st for every year following.

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

Implemented (AC - 03/06/2023)

141a 1-10 Medical Evaluation Information

17. 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 #2's medical evaluation dated [redacted] *did not have sections 8 and 9 completed.*

Resident #5's medical evaluation dated [redacted] *did not have section 4 completed.*

141a 1-10 Medical Evaluation Information (continued)

Plan of Correction ***Accept (AC - 02/24/2023)***

Both residents DME's were updated on [redacted], by their PCP. By February 13, 2023, all staff will be reminded to review documents for completion prior to leaving any appointments with residents. The training was completed by the Assistant Program Director. This will also be discussed with all staff during regularly scheduled supervision by February 28, 2023. Beginning February 13, 2023, upon returning to facility, any DME paperwork will be turned in for Assistant Program Director Director/Designee to review. If blanks are found, the PCP will be notified within 24 hours by the Assistant Program Director. All charts will be audited to ensure that all DME forms are completed in their entirety by the Assistant Program Director or designee by February 15, 2023. If a form is not complete, the Assistant Program Director/Designee will coordinate with the individual's PCP to complete the DME fully. Ongoing, Assistant Program Director or designee will audit charts by the 15th of each month, informing the Residential Program Director of any deficits.

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

Implemented (AC - 03/06/2023)

162c - Menus Posted

18. 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

Only one week of menus was posted in the home, the week of 1/16-1/22/23.

Plan of Correction ***Accept (AC - 02/24/2023)***

A copy of the next weeks menu was posted in the home by the Assistant Program Director. The Assistant Program Director is responsible for updating the menus by Thursday of every week beginning January 23, 2023. Beginning February 6, 2023, the Assistant Program Director or designee will complete a weekly walk-through checking that a copy of the menu for the same week and next week is posted in the home. Beginning February 6, 2023, a weekly walk-through checklist will be utilized for the weekly walk-through. If a menu is identified as missing, a copy of the menu will be posted by the staff member completing the walk-through or a designee within 24 hours beginning February 1, 2023.

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

Implemented (AC - 03/06/2023)

185a - Implement Storage Procedures

19. 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 #2's PRN Clobetasol CRE 0.05% was not available on site on 1/18/23.

185a - Implement Storage Procedures (continued)

Resident #5's Furosemide bubble pack had a rip in Day 5. The medication was still in the Day 5 bubble.

Resident #5's Paliperidone Tab had a rip in Day 8 and was taped over the back. Medication was still in Day 8 bubble.

Resident #5's Acetamin had a rip in Day 25 and was taped over the back. Medication was still in Day 25 bubble.

Plan of Correction ***Accept (AC - 02/24/2023)***

Resident #2 medication was replaced by LPN Supervisor on January 20, 2023. On January 19, 2023, all medications were reviewed and any medications that could have been contaminated were disposed according to Merakey policy by LPN Supervisor. A memo was posted on January 19, 2023, by nursing staff to remind staff that any medication that could have been contaminated should be disposed of properly and that medication should not be removed until a new prescription is received. By February 28, 2023, the Assistant Program Director will meet with all staff during their individual supervisions to remind them of the process for checking medication, MAR documentation, and disposing any medications with potential contaminations. Medication audits are completed weekly by Assistant Program Director or LPN Supervisor beginning January 23, 2023. to ensure that medications have no potential contaminations and that the medications present match the MAR documentation. Incoming medications are reviewed by nursing staff or designee prior to storage beginning January 23, 2023, to ensure no contamination could have occurred and that they match the MAR documentation.

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

Implemented (AC - 03/06/2023)

227d - Support Plan Medical/Dental

20. Requirements

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

Description of Violation

The home's staff and Administrator report that resident #5 has behaviors when [redacted] is irritable or becomes agitated. These behaviors include yelling at staff and residents and throwing objects such as his/her cane and radio. However, in resident's current support plan dated [redacted], under "Support Plan – Behavioral or Cognitive Care Needs" everything is listed as "A" meaning "No Problem", including irritability, agitation and communication of needs.

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

Plan of Correction ***Accept (AC - 02/24/2023)***

Resident #5 RASP was updated by Assistant Program Director on [redacted]. Program utilizes a Progress Note Binder to capture the services provided to the residents and a Nursing Note Binder that captures medical services. Beginning March 1, 2023, the Assistant Program Director will review the Progress Note Binder and Nursing Note Binder to identify any updates that may need to occur prior to completing a RASP. By February 13, 2023, a memo will be posted by Assistant Program Director to remind staff to include information like behavioral changes in their Progress Notes and to report any identified changes that need to be updated in the RASP to the Assistant Program Director immediately. This will also be discussed with all staff during regularly scheduled supervision by February 28, 2023. By February 28, 2023, the Assistant Program Director will complete an audit to ensure that all current residents' RASPs accurately reflect residents' behaviors and cognitive care needs and update any necessary information within 3 days.

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

Implemented (AC - 03/06/2023)

227g -Support Plan Signatures

21. Requirements

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

Description of Violation

Resident #5's Initial Resident Assessment Support Plan (RASP) dated [redacted] is not signed by Assessor.

Plan of Correction ***Accept (AC - 02/10/2023)***

By February 15, 2023, the Assistant Program Director or Designee will complete a chart audit to ensure that all individual's RASPs contain all required signatures. Beginning February 13, 2023, upon completion of all RASPs, the Assistant Program Director or Designee will review the RASPs to ensure completion and that all signatures are captured. The Assistant Program Director reviewed the citation and regulations for understanding the importance that all RASPs include the required signatures on January 19, 2023.

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

Implemented (AC - 03/06/2023)