



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: OCTOBER 12, 2023

████████████████████
██████████
Bristol House Memory Care, LLC
████████████████████
████████████████████

RE: Bristol House Memory Care
2527 Bristol Road
Warrington, Pennsylvania 18976
License #: 144581

Dear ██████████:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection March 21, 2023, May 15, 2023, and July 6, 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 issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 12, 2023 to April 12, 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.

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)
141a	II	45	\$5	\$225	5 calendar days from mailing date of this letter
190a	II	45	\$5	\$225	5 calendar days from mailing date of this letter
231c	II	45	\$5	\$225	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.

[REDACTED]

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]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

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]
[REDACTED]
[REDACTED]
[REDACTED]

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

Facility Information

Name: *BRISTOL HOUSE MEMORY CARE* License #: *14458* License Expiration: *04/13/2023*
Address: *2527 BRISTOL ROAD, WARRINGTON, PA 18976*
County: *BUCKS* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *BRISTOL HOUSE MEMORY CARE LLC*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *1-2* Date: *03/19/2019* Issued By: *Warrington Twp*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *88* Waking Staff: *66*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *03/21/2023*

Inspection Dates and Department Representative

03/21/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* Residents Served: *44*

Secured Dementia Care Unit

In Home: *Yes* Area: *Entire Home* Capacity: *48* Residents Served: *44*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *44*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *44* Have Physical Disability: *0*

Inspections / Reviews

03/21/2023 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/08/2023*

Inspections / Reviews (*continued*)

04/10/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/30/2023

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 04/15/2023

04/19/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/30/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 04/30/2023

08/09/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/30/2023

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 3/21/23 the home's current license, dated April 13, 2022, was not posted in a conspicuous and public place in the home.

Plan of Correction

Accept (████) - 04/19/2023)

Violation - The home current license wasn't posted in conspicuous and public place in the home.

The Executive Director has posted the current license on 4/8/23.

Executive Director will check monthly to make sure current license is posted monthly and always updated beginning 4/8/2023 for the duration of 1year

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented (████) 05/25/2023)

16c - Written Incident Report

2. Requirements

2600.

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

Description of Violation

On approximately 3/7/22, Resident #1 fell and struck █████ face requiring evaluation for fractures. The home did not report this incident to the department.

Plan of Correction

Accept (████) - 04/19/2023)

Violation - The home didn't report fall to the department.

Executive Director has trained Nursing Director on 4/7/2023 on reportable falls to the state.

The Nursing Director will make sure all reportable falls are to be reported to the department and if █████ has any questions to ask the Executive Director. The Nursing Director is now trained on documenting incidents and the conditions of the resident. Nursing Director will be sure to include date, frequency, duration and title of responsible persons on shift during fall. Nursing Director also trained on email to send reportable fall to. This audit will happen for the duration 6months

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented (████) - 05/25/2023)

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.

18 - Compliance With Laws (continued)

Description of Violation

Personal care and assisted living homes must post the required influenza information in a public place in the home year-round as required by the Influenza Awareness Act (HB 1785). On 3/21/23, the home did not have an influenza poster anywhere.

Plan of Correction

Accept () - 04/19/2023

Violation - Home shall have the influenza information posted in a public place at all times.

Executive Director has posted the influenza poster on 4/07/2023.

Executive Director will check monthly starting 4/7/2023 and ensure it's posted daily, to include in front desk responsibilities moving forward for daily checks. The monthly checks will last for 6months.

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented () - 05/25/2023

41c - Rights Poster

4. Requirements

2600.

41.c. The Department's poster of the list of resident's rights shall be posted in a conspicuous and public place in the home.

Description of Violation

On 3/21/23, the Department's resident's rights poster is not posted in a conspicuous and public place in the home.

Plan of Correction

Accept () 04/19/2023

Violation - Resident rights poster wasn't posted in a public place in the home.

Executive Director has posted the resident right poster on 4/7/2023.

Executive Director will check monthly starting on 4/7/2023 to ensure that resident rights poster is current and in public area in home. The Duration of the monthly checks will be for 6months

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented () - 05/25/2023

51 - Criminal Background Check

5. Requirements

2600.

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

Description of Violation

Staff Member A, hired on /23, did not have a criminal background check completed until 3/13/23.

Plan of Correction

Accept () - 04/19/2023

Violation - The home shall have background check submit it before start date.

Dementia Care Coordinator has got the background check clear on staff member A

Executive Director has train Dementia Care Coordinator on 4/8/2023. Dementia Care Coordinator will ensure that background checks are done prior to date of hire. Dementia Care Coordinator will collect information needed on

51 - Criminal Background Check (continued)

Date of Hire, Executive Director will intervene on Date of Hire to ensure background check is done before end of day on Date of Hire. Executive Director will also check every month on recent new hires paperwork beginning 4/08/2023. This will happen for the duration of 1year.

Licensee's Proposed Overall Completion Date: 04/19/2023

Not Implemented [REDACTED] - 05/25/2023)

54a - Direct Care Staff**6. Requirements**

2600.

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

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person B, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry. Staff person B also did not have a record of identity or age on file.

Plan of Correction

Accept [REDACTED] - 04/19/2023)

Violation - The home didn't have high school diploma, GED, or Pennsylvania nurse aide registry on staff person B. Dementia Care Coordinator asked to retain information and worker didn't supply information. Then Executive Director let worker go until paperwork could be answer.

Executive Director has train Dementia Care Coordinator on state requirements for new hire paperwork on 4/7/2023. Executive Director will check monthly and as needed on recent new hires to ensure all paperwork is being done correctly. Monthly reviews will begin 4/7/2023. Staff B was terminated [REDACTED]/2023 due to failure to provide proper documentation needed on file for employment. These monthly check/reviews will happen for a duration of 6months

Licensee's Proposed Overall Completion Date: 04/19/2023

Not Implemented [REDACTED] - 05/25/2023)

65a - FS Orientation 1st Day**7. Requirements**

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

*Staff person A, whose first day of work was [REDACTED]/23, did not receive orientation on the following topics:
(1) Evacuation procedures.*

65a - FS Orientation 1st Day (continued)

- (2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
- (3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
- (4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
- (5) The location and use of fire extinguishers.
- (6) Smoke detectors and fire alarms.
- (7) Telephone use and notification of emergency services.

Staff Person B, hired on [REDACTED]/22, did not receive orientation on the required topics until 11/8/22.

Plan of Correction

Accept ([REDACTED] - 04/19/2023)

Violation - Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following

Dementia Care Coordinator has trained Staff Member A on these topics on 4/07/2023.

Executive Director train Dementia Care Coordinator on new hire process and new hire paperwork on 4/7/2023.

Executive Director will check once a month starting on 4/7/2023 on recent new hires to ensure new hire process and paperwork is good. These monthly audit will happen for the duration of 6months

Licensee's Proposed Overall Completion Date: 04/19/2023

Not Implemented ([REDACTED] - 05/25/2023)

65b - Rights/Abuse 40 Hours

8. Requirements

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

- 1. Resident rights.
- 2. Emergency medical plan.
- 3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101—10225.5102).
- 4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A completed [REDACTED] 40th scheduled work hour on 3/18/23. However, this staff person did not complete training in the following topics:

- (1) Resident rights.
- (2) Emergency medical plan.
- (3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § 10225.101-10225.5102).
- (4) Reporting of reportable incidents and conditions.

Plan of Correction

Accept ([REDACTED] - 04/19/2023)

Violation - within 40 scheduled working hours need to have a orientation and covers this violation topics.

Dementia Care Coordinator has train staff person A on these topics and gave orientation on 4/7/2023.

Executive Director train Dementia Care Coordinator on new hire process and new hire paperwork 4/7/2023.

Dementia Care Coordinator will check monthly on new hire workers paperwork to ensure this doesn't happen again.

The Duration of these checks will happen for 6months

65b - Rights/Abuse 40 Hours (continued)

Licensee's Proposed Overall Completion Date: 04/19/2023

Not Implemented () - 05/25/2023

65d - Initial Direct Care Training

9. Requirements

2600.

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

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

Description of Violation

Direct care staff person A, hired on /23, began providing unsupervised ADL services on 3/3/23. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction

Accept () 04/19/2023

Violation - All workers need to pass Department-approved direct care training course and pass the competency test.

Dementia Care Coordinator has the state require paperwork for staff person A.

Staff A completed paperwork at previous Job 3/2022.

Executive Director trained Dementia Care Coordinator on getting new hire paperwork and the state requirements on this Violation on 4/7/2023. Executive Director will check on all new hires paperwork monthly beginning on 4/8/2023 which will last for a duration of 6months with Employee File Audits.

Licensee's Proposed Overall Completion Date: 04/19/2023

Not Implemented () - 05/25/2023

66a - Staff Training Plan

10. Requirements

2600.

66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have a staff training plan for 2023.

Plan of Correction

Accept () - 04/19/2023

Violation - Home shall have staff training plan for 2023.

Executive Director has added the staff training plan for 2023 and made a binder for it on 4/08/2023.

Executive Director will make sure all monthly requirements for staff training is being done beginning 4/08/2023 and add it to the binder monthly for the duration of 1 year. Executive Director will check monthly to ensure nothing is being miss.

Licensee's Proposed Overall Completion Date: 04/19/2023

Not Implemented () - 05/25/2023

82c - Locking Poisonous Materials

11. Requirements

82c - Locking Poisonous Materials (continued)

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

Toothpaste, with a manufacturer's label indicating "If more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away" was unlocked, unattended, and accessible to residents. A container of Gold Bond Powder, with a manufacture's label indicating "If swallowed, get medical help or contact the Poison Control Center immediately" was identified in an unlocked cabinet in the bathroom of room [REDACTED], occupied by Resident #2.

Not all the residents of the home, including Resident #2, have been assessed capable of recognizing and using poisons safely.

Plan of Correction

Accept [REDACTED] - 04/19/2023)

Violation - All poisonous materials shall be kept locked and inaccessible to the residents.

Executive Director train all staff on what is consider poisonous control and all staff went around putting any poisonous materials away. Staff was trained on hazardous materials and poisonous materials 4/6/2023.

Executive Director and Nursing Director will check every two weeks beginning on 4/08/2023 to ensure staff is keeping up with putting loose poisonous materials away. The audits will last for the duration of 1 year.

Licensee's Proposed Overall Completion Date: 04/19/2023

Not Implemented [REDACTED] - 05/25/2023)

85a - Sanitary Conditions

12. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 3/21/23, there were no paper towels, mechanical hand dryer or other sanitary means of hand drying in the common bathroom across from the employee break room.

Plan of Correction

Accept [REDACTED] - 04/19/2023)

Violation - Sanitary conditions shall be maintained.

Executive Director added paper towels to machine 3/21/2023.

Executive Director trained all housekeeping and nursing staff about added paper towels to machine on 4/6/2023.

Executive Director will check monthly beginning 4/6/2023 to ensure that there are paper towels in machine the duration of the monthly checks will continue for 6months.

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented [REDACTED] - 05/25/2023)

85d - Trash Receptacles

13. Requirements

85d - Trash Receptacles (continued)

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 3/21/23 at approximately 11am, there was a trash can, uncovered, and unattended in the common bathroom across from the employee break room.

On 3/21/23, at approximately 3:00pm, an uncovered trashcan was identified in the bathroom of room # [REDACTED]. An uncovered trashcan was identified in the kitchenette located in the Gold Finch section of the home.

Plan of Correction**Accepted [REDACTED] - 04/19/2023)**

Violation - Trash cans in kitchens and bathrooms shall have covers on them.

Executive Director has trained all staff about having trash can cover at all times on 4/6/2023 and we have ordered and received new trash cans with cover lids on 4/08/2023.

Executive Director will check weekly beginning 4/08/2023 that trash can lids in public space is cover and check monthly for all resident rooms to have a lid on them. This audit of these weekly checks will be for 3months.

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented [REDACTED] - 05/25/2023)**96a - First Aid Kit****14. Requirements**

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the nurse's station does not include scissors.

Plan of Correction**Accepted ([REDACTED] - 04/19/2023)**

Violation - First aid kit needs all require items in there and scissors was missing.

Executive Director added a pair scissors in first aid kit on 3/22/2023.

Nursing director will check monthly beginning 4/8/2023 to ensure all items are in the first aid kits and this audit will be for the duration of 6months.

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented [REDACTED] - 05/25/2023)**100a - Exterior - Free of Hazards****15. 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

At approximately 9:30am, a broken shutter and a large PVC piece of fencing was located on the ground at the home's fenced in perimeter.

100a - Exterior - Free of Hazards (continued)

Plan of Correction

Accept [redacted] - 04/19/2023)

Violation - Home had broken shutter and large PVC piece of fencing on the ground at the home's fenced in perimeter.

Executive Director removed these items off site 3/27/2023.

Executive has trained Maintenance Director to check weekly beginning 4/8/2023 for any loose items that aren't safe for building grounds. This audit should last for the duration of 1 year.

The Maintenance Director will do a full look around the premises at the beginning of his shift on his scheduled days. Executive Director will implement checklist to ensure this regulation is being followed, Executive Director to follow up weekly to sign off that he went behind maintenance director to ensure this regulation is being followed.

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented ([redacted] - 07/06/2023)

103c - Food Protected

16. Requirements

2600.

103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 3/21/23 at approximately 3:30pm there was uncovered milk/cream stored in a mug located in the Gold Finch kitchenette refrigerator.

Repeated Violation: 10/31/21

Plan of Correction

Accept [redacted] - 04/19/2023)

Violation - uncovered milk/cream stored in a mug located in refrigerator.

Executive Director removed the ice cream mug out of refrigerator on 3/21/2023 at 6:45PM.

Executive Director has trained all med techs to keep a eye on the refrigerators moving forward with notations to ensure everything is labeled and dated. Nursing Director will check monthly beginning on 4/8/2023 on all refrigerators and ensure this doesn't happen again. This Monthly audit will last for the duration of 1 year.

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented ([redacted] - 07/06/2023)

103f - Refrigerator/Freezer Temps

17. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 3/21/23 at 3:20pm the temperature in the walk in freezer was 10 degrees Fahrenheit.

Plan of Correction

Accept [redacted] - 04/19/2023)

Violation -The temperature in the walk in freezer was 10 degrees Fahrenheit.

Executive Director check the issue and its because the door isn't shutting properly. Executive Director is waiting to hear back from company about parts being order as of 4/8/2023. Fridge was repaired 4/10/2023.

Executive director trained the Executive Chef on food require temps and if there is something not working who [redacted]

103f - Refrigerator/Freezer Temps (continued)

should report it to, Executive Chef trained on 4/7/2023. Executive director will check monthly beginning on 4/8/2023 to ensure all temps are right and is to the state standards. This Audit will last for the duration of 1year.

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented (████) - 07/06/2023)

18. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There was no thermometer in the refrigerator or in the freezer in the Gold Finch Kitchenette.

Plan of Correction

Accept (████) - 04/19/2023)

Violation - No thermometer in refrigerator or in the freezer.

Executive Director placed thermometer in refrigerator or in the freezer on 4/8/2023.

Executive Director have trained med techs to check that this is always in there and to report to either dementia care coordinator or nursing director that it is not in there, Training took place on 4/6/2023. Executive

Director will check monthly beginning 4/8/2023 for the duration of 6months to ensure this doesn't happen again.

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented (████) - 07/06/2023)

103i - Outdated Food**19. Requirements**

2600.

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

Description of Violation

There was an unlabeled, undated piece of carrot cake in the walk-in refrigerator in the main kitchen.

There was an unlabeled, undated container of ice cream in the freezer in the Gold Finch Kitchenette.

Plan of Correction

Accept (████) - 04/19/2023)

Violation - There was food not dated and unlabeled in the walk-in refrigerator. Also same for ice cream in the freezer in the gold finch kitchenette.

Executive Director remove food items from both areas 3/21/2023 at 6:45pm.

Executive Director trained the chef about the carrot cake and Executive Director trained med techs about the ice cream on 4/6/2023. Both departments were told about the importance of labeling and dating items. Executive Director will check monthly beginning 4/8/2023 for the duration of 1year on this violation to ensure that this doesn't happen again.

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented (████) - 07/06/2023)

107b - Emergency Procedures**20. Requirements**

2600.

107b - Emergency Procedures (continued)

- 107.b. The home shall have written emergency procedures that include the following:
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
 3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
 4. Means of transportation in the event that relocation is required.
 5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.

Description of Violation

The home's written emergency procedures do not include:

- (2) *The home's plan to provide the emergency medical information for each resident that ensures confidentiality.*
- (3) *Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.*
- (4) *Means of transportation in the event that relocation is required.*
- (5) *Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.*
- (6) *Alternate means of meeting resident needs in the event of a utility outage.*

Plan of Correction

Accept (████) - 04/19/2023)

Violation - The home didn't have all the requirements for the written emergency procedures .

Executive Director has made changes to the written emergency procedures on 4/10/2023

Executive Director will make sure this is updated annually and as needed beginning on 4/10/2023 and will last for the duration of 1year.

Executive Director took the steps of re-educating himself on emergency procedures and what is needed on 4/08/2023.

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented (████) - 07/06/2023)

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 Emergency Management Agency.

Plan of Correction

Accept (████) - 04/19/2023)

Violation - Home written emergency procedures wasn't submitted to the Emergency Management Agency.

Executive Director already contacted the Emergency management agency before state inspection. Just waiting on their approval. Date Submitted 11/17/2022.

Executive Director will check on emergency procedures once monthly beginning on 4/7/2023 that will last for the duration of 1year to ensure this doesn't happen again.

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented (████) 07/06/2023)

132d - Evacuation

22. Requirements

2600.

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

Description of Violation

The home exceeded the maximum safe evacuation time specified in writing within the past year by a fire safety expert. the home exceeded an evacuation time of 15 minutes during the fire drill on 1/19/23.

Plan of Correction

Accept [REDACTED] /19/2023)

Violation - The home exceeded the safety time that's allow by the safety expert.

Executive Director has trained all staff on the correct way to do fire drill on 3/24/2023. Drill took less then nine minutes.

Executive Director will check on this monthly beginning on 4/8/2023 which lasted for the duration of 3months to ensure this doesn't happen again.

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented [REDACTED] - 07/06/2023)

132e - Fire Drill Sleeping Hours

23. Requirements

2600.

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

Description of Violation

The home has not conducted a sleeping fire drill in over a year.

Plan of Correction

Accept [REDACTED] - 04/19/2023)

Violation - Fire drill wasn't done during sleeping hours.

Executive Director has trained all staff and ran a fire drill at night time 3/23/3023. Drill took ten minutes.

Executive Director will check monthly beginning 4/8/2023 and will last for the duration of 6months to ensure that fire drills are being done properly.

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented [REDACTED] - 07/06/2023)

141a 1-10 Medical Evaluation Information

24. Requirements

2600.

141a 1-10 Medical Evaluation Information (continued)

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

Description of Violation

Resident #1's medical evaluation, dated 3/30/22 did not include the following:

- (5) Allergies.*
- (6) Immunization history.*
- (7) Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.*

Resident #3's medical evaluation, dated 11/16/22 did not include the following:

- (4) Special health or dietary needs of the resident.*
- (7) Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.*

Repeated Violation: 10/13/21

Plan of Correction

Accept (████ - 04/19/2023)

*Violation - Medical Evaluation Information didn't have all information on it.
 Dementia Care Coordinator has been trained by Executive Director on 4/8/2023 to ensure this doesn't happen again.
 Executive Director will check monthly beginning 4/8/2023 on this topic. The duration of this Audit will last for 1year due to a complete chart audit that has been implemented as of 4/8/2023.
 The Following residents records have been reviewed and updated
 Resident #1 New Medical evaluation was done 3/23/2023
 Resident #3 information needed was updated 3/23/2023*

Licensee's Proposed Overall Completion Date: 04/19/2023

Not Implemented (████ - 07/06/2023)

141b1 - Annual Medical Evaluation

25. Requirements

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

Description of Violation

Resident #1 was admitted to the home on █████ 21. The resident's most recent medical evaluation was completed on 3/30/22. The resident's previous medical evaluation was not on file to be able to determine if the evaluation was completed timely.

141b1 - Annual Medical Evaluation (continued)

Resident #4 was admitted to the home on [REDACTED]/19. The resident's most recent medical evaluation was completed on 5/4/22. The resident's previous medical evaluation was not on file to be able to determine if the evaluation was completed timely.

Plan of Correction

Accept [REDACTED] - 04/19/2023)

Violation - The home shall have records from the previous medical evaluation from the past years for all residents. Dementia Care Coordinator was trained by Executive Director on proper nursing book keeping and to ensure when charts are thinned we do not remove previous years DME or Current, Dementia Care Coordinator was trained on 4/7/2023. Executive Director will check yearly beginning 4/7/2023 to see if files are kept intact to ensure this doesn't happen again. The DME will be done during residents annual reevaluation, only time a date will be different is if the resident has a significant change prior to the date of the reevaluation. This check will be included in the Chart Audit that will last for the duration of 1 year.

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented ([REDACTED] - 07/06/2023)

171b5 - First Aid Kit

26. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the home's van did not include nonporous disposable gloves, antiseptic, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Plan of Correction

Accept [REDACTED] 04/19/2023)

Violation- Home didn't have proper first aid kit in van.

Executive Director has added the right first kit to the van on 3/22/2023.

Executive Director will check monthly beginning 4/7/2023 which will last for the duration of 3 months to ensure that the van always has the correct items needed as specified in § 2600.96

Licensee's Proposed Overall Completion Date: 04/19/2023

Not Implemented ([REDACTED] - 08/09/2023)

185a - Implement Storage Procedures

27. 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

On 3/21/23 at 3:25pm, Resident #3's glucometer showed 3/21/23 2:24pm.

Plan of Correction

Accept [REDACTED] - 04/19/2023)

Violation - The glucometer time wasn't right.

Nursing director reset the glucometer to make sure device works properly, time is updated and changed as needed

185a - Implement Storage Procedures (continued)

on 3/22/2023.

Executive Director will check monthly beginning 4/7/2023 on this topic to ensure the time is accurate. which will last for the duration of 1year.

Licensee's Proposed Overall Completion Date: 04/19/2023

Not Implemented (████) - 07/06/2023)

190c - Record of Training**28. Requirements**

2600.

190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for staff person A does not include a Train the Trainer certificate.

The home's medication administration training record for staff person C does not indicate if the staff person successfully qualified or failed to re-qualify.

Plan of Correction

Accept (████) - 04/19/2023)

Violation- The home shall have proper paperwork for all med techs.

Dementia Care Coordinator is the med tech train the trainer and █████ has staff person A retrained underneath █████ as of 4/13/2023. We found staff person C correct paperwork on 3/21/2023 in Medtech binder.

Executive Director trained Dementia Care Coordinator on topics about med tech proper paperwork on 4/7/2023.

Executive Director will check monthly beginning 4/7/2023 to ensure med techs paperwork is updated. This audit will last for the duration of 6months.

Licensee's Proposed Overall Completion Date: 04/19/2023

Not Implemented (████) - 08/09/2023)

227g -Support Plan Signatures**29. Requirements**

2600.

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

Description of Violation

Resident 4 participated in the development of his/her support plan on 4/29/22. However, the resident did not sign the support plan.

Plan of Correction

Accept (████) 04/19/2023)

Violation- Support plan always need to be sign off. Home didn't do it.

Dementia Care Coordinator had resident sign off on Care plan as indicated.

Executive Director has trained Dementia Care Coordinator on this topic on 4/7/2023. Also Executive Director will check monthly Chart Audits beginning 4/7/2023 that will last for the duration of 6-months on support plans to ensure this doesn't happen again.

Licensee's Proposed Overall Completion Date: 04/19/2023

227g -Support Plan Signatures (*continued*)*Not Implemented* [REDACTED] - 08/09/2023)

233c - Key-Locking Devices

30. Requirements

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near either of the outside gate doors leading from the outdoor area of the Secure Dementia Care Unit (SDCU) to the parking lot/outside area.

Plan of Correction*Accept* [REDACTED] - 04/19/2023)

Violation- The home shall have directions for operating the locking system.

Executive Director added the number codes to the gates on 3/23/2023.

Executive Director has trained Maintenance Director on this topic 3/23/2023 and explain he needs to check on this once monthly beginning 4/7/2023. Also the Executive Director will check once monthly beginning 4/7/2023 to ensure this doesn't happen. This will happen for the duration of 6-months

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented [REDACTED] - 07/06/2023)

251b - Record Entries Legible

31. Requirements

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on resident #5's Narcotic Control Record for Lorazepam dated 3/1/23.

Repeated Violation: 10/13/21

Plan of Correction*Accept* [REDACTED] - 04/19/2023)

Violation - Home use Correction fluid and you need to leave it permanent and clear to understand the written information. Also the person needs to sign off on the entry.

Nursing Director did talk to the staff member and had [REDACTED] write up a statement on what it read from [REDACTED] best knowledge before on 3/23/2023.

Nursing Director held a Med Tech meeting to talk about this topic on 4/6/2023 and will check on this weekly at first beginning 4/8/2023 for 60 days. Then monthly once results are being shown. Executive Director will also check monthly. The monthly audits will Start 6/8/2023 and will last for the duration of 6months

Licensee's Proposed Overall Completion Date: 04/19/2023

Implemented [REDACTED] - 07/06/2023)