



pennsylvania
DEPARTMENT OF HUMAN SERVICES

E-mailed on: 1/18/24

[REDACTED], President
EMBASSY DARLINGTON LLC

RE: LAKEVIEW PERSONAL CARE
498 LISBON ROAD
DARLINGTON, PA 16115
LICENSE/COC #: 45161

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on 4/4/23, and 4/5/23 of the above facility, we have determined that your submitted plan of correction is not fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

[REDACTED]

Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: LAKEVIEW PERSONAL CARE License #: 45161 License Expiration: 06/21/2023
Address: 498 LISBON ROAD, DARLINGTON, PA 16115
County: BEAVER Region: WESTERN

Administrator

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

Legal Entity

Name: EMBASSY DARLINGTON LLC
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 06/23/1992 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 55 Waking Staff: 41

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal Exit Conference Date: 04/05/2023

Inspection Dates and Department Representative

04/04/2023 - On-Site: [REDACTED]
04/05/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 92 Residents Served: 49

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 49
Diagnosed with Mental Illness: 4 Diagnosed with Intellectual Disability: 1
Have Mobility Need: 6 Have Physical Disability: 0

Inspections / Reviews

04/04/2023 - Full

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/23/2023

05/01/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/27/2023

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 05/08/2023

05/12/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/27/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 05/27/2023

01/18/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/27/2023

Reviewer: [REDACTED]

Follow-Up Type: Exception

42c - Treatment of Residents

1. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 4/4/23, there was a sign observed on the door of the nurse's station by the front patio entrance indicating "Resident #1 Stay Out!!! There is nothing in here that you need!! Thank You!"

Plan of Correction Accept ([redacted] - 05/11/2023)

On 4/4/23 The Administrator [redacted] removed the sign on the door by the nurses station by the patio entrance. On 4/4/23, the Administrator posted a notice in the medication room that it is not allowed to post signs with a residents name on it. On 4/6/23 the Administrator [redacted] re-educated all staff about HIPPA laws, privacy etc.

Licensee's Proposed Overall Completion Date: 05/02/2023

Implemented [redacted] - 06/30/2023)

51 - Criminal Background Check

2. 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

On 4/4/23, ancillary staff A, hired [redacted]/23, did not have a criminal background check.

Direct care staff B was re-hired to the home on [redacted]/22, after an absence of over one year. However, as of 4/4/23 an updated criminal background check was not completed on re-hire.

Plan of Correction Accept [redacted] - 05/11/2023)

On 4/4/23 Direct Care Staff B's criminal background check was resubmitted. Ancillary staff A is no longer employed by Lakeview.

On 4/5/23 the Administrator [redacted] had a meeting with the Business Office Manager [redacted] about ensuring that all criminal background checks are being completed for all new staff or any staff that are returning that have been out of the community for longer than a year.

Ongoing the administrator will review each new hire with the Business Office manager to ensure that the Criminal Background Checks are being completed appropriately.

Beginning on 4/5/23 all new hires will have the required criminal background checks completed prior to beginning employment.

Licensee's Proposed Overall Completion Date: 05/02/2023

Implemented (JW - 01/18/2024)

65a - FS Orientation 1st Day

3. Requirements

2600.

65a - FS Orientation 1st Day (*continued*)

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

On 4/4/23, records indicated that ancillary staff A, hired [REDACTED]/23 did not receive orientation in the following content areas: designated meeting place outside/interior fire safe area and smoking safety procedures/policy.

Direct care staff B was re-hired to the home on [REDACTED]/22, after an absence of over one year. However as of 4/4/23 a new initial staff orientation was not completed on the first day of work after re-hire.

Plan of Correction

Accept [REDACTED] - 05/11/2023)

Direct Care Staff A is no longer employed by Lakeview.

On 4/5/23, Direct Care Staff B completed a new initial staff orientation.

Ongoing, the Wellness Director [REDACTED] will ensure that all new hires complete the initial staff orientation prior to their first day of work. The Administrator [REDACTED] will review the training prior to the new employee starting on the floor.

Direct Care staff member A was terminated on [REDACTED] 23. (No longer needed agency).

Beginning 4/6/23 the Wellness Director [REDACTED] ensure that new hires complete initial staff orientation.

Licensee's Proposed Overall Completion Date: 05/02/2023

Not Implemented [REDACTED] - 01/18/2024)

65b - Rights/Abuse 40 Hours

4. 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

On 4/4/23, records indicated that ancillary staff A, hired [REDACTED] 23, did not receive orientation in the following content areas: reporting reportable incidents and conditions.

Direct care staff B was re-hired to the home on [REDACTED]/22, after an absence of over one year. However, on 4/4/23 records indicated that a new initial staff orientation was not completed within the first 40 hours of work after re-hire.

65b - Rights/Abuse 40 Hours (continued)

Plan of Correction

Accept [REDACTED] - 05/11/2023)

Direct Care Staff A is no longer employed by Lakeview.

On 4/5/23, Direct Care Staff B completed a new initial staff orientation. within the first 40 hours of work after re-hire.

Direct Care staff member A was terminated on [REDACTED]/23. (No longer needed agency).

Ongoing, the Wellness Director [REDACTED] will ensure that all new hires complete the initial staff orientation within the first 40 hours of work after re-hire.

The Administrator [REDACTED] will review the training prior to the new employee starting on the floor.

Beginning 4/6/23 the Wellness Director [REDACTED] ensure that new hires complete initial staff orientation. Direct Care staff member A was terminated on [REDACTED] 23. (No longer needed agency).

Licensee's Proposed Overall Completion Date: 05/02/2023

Implemented [REDACTED] - 01/18/2024)

65e - 12 Hours Annual Training

5. Requirements

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.

Description of Violation

On 4/4/23 records indicated that direct care staff C, hired [REDACTED] 14, only completed 6.5 hours of annual training in the 2022 training year.

Plan of Correction

Accept [REDACTED] - 05/12/2023)

On 4/5/23 Direct Care Staff C completed the 5.5 hours required for [REDACTED] annual training.

Ongoing the Wellness Director [REDACTED] will ensure that all direct care staff complete the required 12 hour annual training required for their job duties.

On 4/5/23 the Wellness Director [REDACTED] performed an audit of all current staff files to ensure that all staff are current with their yearly trainings.

Beginning 4/6/23, The Administrator [REDACTED] will audit the employee files monthly to ensure that all staff trainings are current.

Beginning 4/6/23 the Wellness Director [REDACTED] ensure that new hires complete initial staff orientation.

Licensee's Proposed Overall Completion Date: 05/02/2023

Implemented [REDACTED] - 07/05/2023)

65f - Training Topics

6. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.

Description of Violation

On 4/4/23 records indicated that direct care staff C, hired [REDACTED]/14, did not complete training in the following content areas during the 2022 training year: medication self-administration, infection control and personal care service needs of the resident.

Plan of Correction**Accept [REDACTED] - 05/12/2023)**

On 4/5/23 Direct Care Staff C completed the required training for medication self-administration, infection control and personal care service needs of the resident.

Ongoing the Wellness Director [REDACTED] will ensure that all direct care staff complete the required 12 hour annual training required for their job duties.

On 4/5/23 the Wellness Director [REDACTED] performed an audit of all current staff files to ensure that all staff are current with their yearly trainings.

Ongoing, the Administrator [REDACTED] will audit the employee files monthly to ensure that all staff trainings are current.

Beginning 4/6/23, The Administrator [REDACTED] will audit the employee files monthly to ensure that all staff trainings are current.

Beginning 4/6/23 the Wellness Director [REDACTED] ensure that new hires complete initial staff orientation.

Licensee's Proposed Overall Completion Date: 05/02/2023

Implemented [REDACTED] 07/05/2023)

65g - Annual Training Content

7. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
5. Falls and accident prevention.

Description of Violation

On 4/4/23 records indicated that direct care staff C, hired [REDACTED]/14, did not complete training in the following content areas during the 2022 training year: fire safety, emergency preparedness and fall and accident prevention.

65g - Annual Training Content (continued)

Plan of Correction

Accept [redacted] - 05/12/2023)

On 4/5/23 Direct Care Staff C completed the required training for Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

5. Falls and accident prevention.

Ongoing the Wellness Director [redacted] will ensure that all direct care staff complete the required 12 hour annual training required for their job duties.

On 4/5/23 the Wellness Director [redacted] performed an audit of all current staff files to ensure that all staff are current with their yearly trainings.

Ongoing, the Administrator [redacted] will audit the employee files monthly to ensure that all staff trainings are current.

Beginning 4/6/23, The Administrator [redacted] will audit the employee files monthly to ensure that all staff trainings are current.

Beginning 4/6/23 the Wellness Director [redacted] ensure that new hires complete initial staff orientation.

Licensee's Proposed Overall Completion Date: 05/02/2023

Implemented [redacted] - 07/05/2023)

65i - Training Record

8. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

On 4/4/23 the record of training for the home's Management Techniques training in July 2022 did not indicate the length of the training.

Plan of Correction

Accept [redacted] - 05/12/2023)

On 4/5/23, the Administrator [redacted] edited the homes Management Techniques training to indicate the length of training.

On 4/5/23, the Administrator [redacted] reviewed the homes training materials to ensure that they reflect the required information needed for the state records.

Licensee's Proposed Overall Completion Date: 05/02/2023

Implemented [redacted] - 07/05/2023)

81b - Resident Personal Equipment

9. Requirements

2600.

81b - Resident Personal Equipment (continued)

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 4/4/23, there were 17 large oxygen tanks found to be stored on the ground, and not in storage racks or carrying carts, in the storage area by the laundry room.

Plan of Correction

Accept [redacted] - 05/12/2023)

On 4/5/23 the 17 large oxygen tanks were placed on storage racks or carrying carts,

On 4/10/23 the Administrator [redacted] educated the staff that oxygen tanks cannot be stored without being in a storage rack or carrying cart, and off the floor.

Ongoing the Maintenance Director [redacted] will ensure that all oxygen tanks are stored properly.

The Maintenance Director [redacted] will perform a monthly inspection of the community to ensure that all oxygen tanks are secured and properly stored.

Licensee's Proposed Overall Completion Date: 05/02/2023

Implemented [redacted] - 07/05/2023)

85a - Sanitary Conditions

10. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 4/4/23, there was a 1 x 2 inch smear of feces observed on the toilet seat in the common shower room across from bedroom A7.

Repeat Violation: 2/1/22

Plan of Correction

Accept [redacted] - 05/12/2023)

on 4/4/23 the entire restroom across from the common shower room across from rooms A-7 was completely cleaned and sanitized by the Maintenance Director [redacted]

on 4/5/23 the Administrator [redacted] met with all care staff and housekeeping staff to re-educate them that all restrooms must be clean at all times.

On 4/5/23 the Administrator [redacted] directed the housekeeping staff that they must perform an hourly inspection of all communal restrooms and sanitize when needed.

Licensee's Proposed Overall Completion Date: 05/02/2023

Implemented [redacted] - 07/05/2023)

85d - Trash Receptacles

11. Requirements

2600.

85d - Trash Receptacles (continued)

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 4/4/23, the lid to the trash can was observed to be broken and missing in the common bathroom by the front TV room.

Repeat Violation: 2/1/22

Plan of Correction

Accept [redacted] - 05/12/2023)

On 4/5/23 the Maintenance Director [redacted] purchased a new trash can and replaced the broken one with it in the common restroom by the front TV room.

Beginning on 4/5/23 [redacted] is performing a monthly inspection of all trash cans in the community to ensure that they are in good condition and have working lids.

Not Implemented [redacted] - 01/18/2024

Licensee's Proposed Overall Completion Date: 05/02/2023

85e - Trash Outside Home

12. 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 4/4/23, there were 5 chairs, 1 table, 1 metal door and 2 full trash bags observed on the ground outside the home's rear garage area.

Plan of Correction

Accept [redacted] - 05/12/2023)

On 4/4/23 all of the recyclable trash by the back garage doors was removed. On 4/4/23 the Administrator [redacted] met with the Maintenance Director [redacted] to discuss that we cannot have any trash outside of the building.

Beginning on 4/5/23 the Administrator [redacted] will perform a weekly inspection of the exterior of the community to ensure that there is not any loose trash or garbage that needs to be placed in the garbage.

Licensee's Proposed Overall Completion Date: 05/02/2023

Implemented [redacted] - 07/05/2023)

88a - Surfaces

13. Requirements

2600.

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

Description of Violation

On 4/4/23, there were 3 ceiling tiles with black/brown water damaged areas measuring approximately 4 x 4 inches, 6 x 18 inches and 4 x 4 inches, and water damage observed on the wall on the lower-level hallway by the ramp near the pantry.

88a - Surfaces (continued)

On 4/4/23, there was a 3 x 3-inch hole observed in the wall, and a damaged area of drywall, measuring approximately 4 x 6 inches, found above the sink in the shared bathroom in bedroom B1/B2.

Plan of Correction**Accept** [REDACTED] - 05/12/2023)

On 4/5/23, 3 ceiling tiles with black/brown water damaged areas on the lower-level hallway by the ramp near the pantry were replaced by the Maintenance Director [REDACTED]. The wall was repaired as well.

Beginning on 4/5/23 the Administrator [REDACTED] and the Maintenance Director [REDACTED] will perform a weekly inspection of all ceiling tiles and replace any tiles that are found to be in poor repair.

Licensee's Proposed Overall Completion Date: 05/02/2023

Implemented [REDACTED] - 07/05/2023)**95 - Furniture and Equipment****14. Requirements**

2600.

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

Description of Violation

On 4/4/23, the grab bars were found to be unsecured and moved back and forth approximately 3 to 4 inches on both sides of the toilet, creating a potential fall hazard, in the common bathroom the front TV room.

On 4/4/23, there was no face plate installed on the electrical outlet behind the door in bedroom A9.

On 4/4/23, the door knob to the shared bathroom in bedroom C9 was found to be partially detached.

On 4/4/23, the bathroom sink basin was deteriorated in an approximate 3 x 2 inch area, exposing the wood underneath in the shared bathroom in bedroom C9.

On 4/4/23 the home's industrial dishwasher was inoperable and according to interviews, has been since January 2023.

Plan of Correction**Accept** [REDACTED] - 05/12/2023)

On 4/5/23, the grab bars found to be unsecured in the common bathroom the front TV room were inspected and secured by the Maintenance Director [REDACTED]. Ongoing the Maintenance Director and the Administrator will complete a monthly inspection of all hand/grab bars and repair as needed.

On 4/5/23, the Maintenance Director [REDACTED] replaced the face plate on the electrical outlet behind the door in bedroom A9. . Ongoing the Maintenance Director and the Administrator will complete a monthly

95 - Furniture and Equipment (continued)

inspection of all outlet in the community to ensure that all faceplates are present and in good repair.

On 4/5/23, the Maintenance Director [REDACTED] tightened the door knob to the shared bathroom in bedroom C9. Ongoing the Maintenance Director and the Administrator will complete a monthly inspection of all door handles within the community to ensure that they are secure and in good working order.

On 4/5/23, the Maintenance Director [REDACTED] replaced the bathroom Vanity in the shared bathroom in bedroom C9. Ongoing the Maintenance Director and the Administrator will complete a monthly inspection of all restrooms and repair and or replace any worn sinks or vanities.

On 4/15/23 the home's industrial dishwasher was repaired.

Beginning on 4/5/23 the Administrator [REDACTED] and the Maintenance Director [REDACTED] will perform a weekly Inspection of the community for any damages and repairs that are needed. They will meet on a daily basis to discuss and prepare a plan of action for any items.

Licensee's Proposed Overall Completion Date: 05/02/2023

Implemented [REDACTED] - 07/05/2023)

103e - Left Overs**15. Requirements**

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 4/4/23, there was an unlabeled and undated plastic bag containing 9 frozen hamburger patties found in the freezer section of the silver refrigerator/freezer in the kitchen.

Plan of Correction

Accept [REDACTED] - 05/12/2023)

On 4/5/23 the Administrator [REDACTED] met with the Dining Services Manager [REDACTED] and [REDACTED] dining services staff to discuss the importance of ensuring that all opened items must be dated and secured properly. They were trained that we cannot simply tie the bags shut and that they need to be tied shut with a twist tie.

On 4/4/23 the Dining Services Manager [REDACTED] untied the plastic bags and secured them with a twist tie. [REDACTED] also did an audit of the freezers and dated any items that were not dated.

Beginning 4/3/23, the Dining Services Manager will perform a weekly audit of all opened items in the kitchen and

103e - Left Overs (continued)

ensure that there are all dated and secured properly.

Licensee's Proposed Overall Completion Date: 05/02/2023

Implemented [redacted] - 07/05/2023)

103f - Refrigerator/Freezer Temps

16. 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 4/4/23, at 10:47 a.m., the temperature in the Beef and Fish freezer measured +15 degrees Fahrenheit and +6 degrees Fahrenheit at 2:42 p.m.

Repeat Violation: 2/1/22

Plan of Correction

Accept [redacted] - 05/12/2023)

On 4/4/23 the Dining Services Manager [redacted] completely defrosted the Beef and Fish freezer. The freezer was restarted and is now reading 0 degrees. Beginning 4/4/23 the Dining Services Manager and the dining services staff are checking the freezer daily to ensure that it is in proper working order.

Licensee's Proposed Overall Completion Date: 05/02/2023

Not Implemented [redacted] - 01/18/2024)

103g - Storing Food

17. Requirements

2600.

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

Description of Violation

On 4/4/23, there was an unsealed plastic bag containing 9 frozen hamburger patties found in the freezer section of the silver refrigerator/freezer in the kitchen.

On 4/4/23, there was a box containing an unsealed plastic bag containing cooked egg patties in the "Chicken and Breakfast" upright freezer in the lower-level pantry.

On 4/4/23, there were two unsealed plastic bags containing green beans and mixed vegetables found in the trunk freezer in the lower-level pantry.

Plan of Correction

Accept [redacted] - 05/12/2023)

On 4/5/23 the Administrator [redacted] met with the Dining Services Manager [redacted] and her dining services staff to discuss the importance of ensuring that all opened items must be dated and secured properly. They were trained that we cannot simply tie the bags shut and that they need to be tied shut with a twist tie.

On 4/4/23 the Dining Services Manager [redacted] untied the plastic bags and secured them with a twist tie.

[redacted] also performed an audit of the freezers and dated any items that were not dated.

Beginning 4/5/23, the Dining Services Manager will perform a weekly audit of all opened items in the kitchen and ensure that there are all dated and secured properly.

103g - Storing Food (continued)

Not Implemented () - 01/18/2024

Licensee's Proposed Overall Completion Date: 05/02/2023

104b - Dishes/Glassware/Utensils

18. Requirements

2600.

104.b. Dishes, glassware and utensils shall be provided for eating, drinking, preparing and serving food. These utensils must be clean, and free of chips and cracks. Plastic and paper plates, utensils and cups for meals may not be used on a regular basis.

Description of Violation

According to multiple resident and staff interviews, the home's industrial dishwasher has been inoperable since January 2023 and paper plates, cups and silverware have been used on a regular basis since then.

Plan of Correction

Accept () - 05/12/2023)

Upon learning that the dishwasher machine was broken, The Administrator () contacted AIS (Repair Company) and had a technician come to the community to assess what repairs were needed. The Administrator () received a bid for repairs and ordered the parts immediately.

The Administrator () directed the dietary staff to utilize paper plates and plastic utensils until repairs could be made.

On 4/15/23 the home's industrial dishwasher was repaired. The Administrator The Administrator () is working with the product maintenance company to see if it is feasible to keep spare parts in the community to avoid any lag time in ordering parts.

The Administrator () is working to set up a quarterly maintenance agreement with AIS to be proactive for any anticipated repairs.

Licensee's Proposed Overall Completion Date: 05/02/2023

Implemented () - 07/05/2023)

121a - Unobstructed Egress

19. Requirements

2600.

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

Description of Violation

On 4/4/23, the exit door leading from the A hallway to the back walkway was found to be stuck, difficult to open and was partially blocked by leaves and debris.

Repeat Violation: 6/21/22

Plan of Correction

Accept () - 05/12/2023)

On 4/4/23 the Maintenance Director () removed the leaves and debris from the door leading from the A hallway to the back walkway.

121a - Unobstructed Egress (continued)

On 4/5/23 The Administrator [REDACTED] met with the Maintenance Director and discuss with [REDACTED] that the exit doors need to be cleared at all times to ensure that there is an easy exit in case of a fire, even if there was a storm the day prior.

Beginning on 4/5/23 the Administrator [REDACTED] will perform a weekly inspection of the exit area to ensure that it is clear and free of leaves/branches and ensure that the door is working properly.

Licensee's Proposed Overall Completion Date: 05/02/2023

Implemented [REDACTED] - 07/05/2023)

130g - Smoke Detector Repair

20. Requirements

2600.

130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

On 4/4/23, the home's fire panel indicated a "Trouble" alert and indicated 3 dirty smoke detectors, which according to staff interviews need replaced. The alerts were dated 11/27/22, 11/28/22 and 4/4/23.

Plan of Correction

Accept [REDACTED] - 05/12/2023)

On 4/5/23 the Administrator contacted Fire Foe (Fire system Maintenance) to repair the 3 smoke detectors that are dirty. [REDACTED] stated that the staff are not qualified to recommend that they need to be replaced. [REDACTED] also stated that the system is working properly and will alarm even though the detectors are dirty.

Fire Foe is schedule to clean the entire system on May 15th, 2023.

Beginning on 4/5/23 the Maintenance Director [REDACTED]

Ongoing Fire Foe is on a quarterly schedule to clean the smoke detectors and clean the entire system.

Licensee's Proposed Overall Completion Date: 05/10/2023

Not Implemented [REDACTED] - 01/18/2024)

131f - Fire Extinguisher Inspection

21. Requirements

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

On 4/4/23, there were multiple fire extinguishers in the home which were last inspected in November 2021 to include:

- *the extinguisher located in the dish washing room
- *the extinguisher located dining area next to the exit to the deck
- *the extinguisher located in the hallway next to room D4 and D3
- *the extinguisher located in the lower level utility room
- *the extinguisher located in the pump room
- *the extinguisher located in the smoking area next to the pond
- *the extinguisher located in the smoking area on the back porch

Plan of Correction

Accept [REDACTED] - 05/12/2023)

On 4/14/23 all fire extinguishers were inspected/replaced.

131f - Fire Extinguisher Inspection (continued)

On 4/5/23 the Administrator [REDACTED] spoke with the manager of Cintas to see why the inspection had not occurred in the contracted time. (See Letter) We set up a new inspection schedule to ensure that the extinguishers are inspected annually as required.

Ongoing, Cintas is contracted to perform a yearly inspection of all extinguishers and replace any that need repaired etc.

Licensee's Proposed Overall Completion Date: 05/10/2023

Implemented [REDACTED] - 07/05/2023)

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's safe evacuation time is 5 minutes 27 seconds. However, records indicated that the home exceeded this safe evacuation time during the fire drill conducted on 11/17/22 at 5:00 a.m. with an evacuation time of 5 minutes 52 seconds.

Plan of Correction

Accept [REDACTED] - 05/12/2023)

On 4/12/23 the Fire Chief [REDACTED] of the South Beaver Township Volunteer Fire Department performed a fire safety inspection. The new evacuation time is 5 minutes and forty eight seconds.

Ongoing, the Administrator [REDACTED] will work with the Maintenance Director [REDACTED] and all of the staff to ensure that we can evacuate the community within the guidelines set by the fire department.

A training was held on 4/12/23 all staff were retrained about the proper evacuation time for the community on all shifts.

Licensee's Proposed Overall Completion Date: 05/10/2023

Not Implemented [REDACTED] - 01/18/2024)

132f - Alternate Exit Routes

23. Requirements

2600.

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

Description of Violation

The home's fire drill record indicated that the front door, rear deck and downstairs dining room exits were used as the exit route during the fire drills conducted on 3/31/23, 2/27/23, 1/12/23, 12/14/23, 11/17/23.

Plan of Correction

Accept [REDACTED] - 05/12/2023)

On 4/12/23 South Beaver Township Fire Department presented a training to the Maintenance Director [REDACTED] [REDACTED] about the importance of utilizing alternative exits during fire drills.

132f - Alternate Exit Routes (continued)

On 4/12/23 a fire drill was performed utilizing the side entrance near the pop machine as an exit and the rear entrance near the maintenance area as alternate exits.

Ongoing the Administrator (██████████) will meet with ██████████ (Maintenance Director) prior to the community fire drills to ensure that alternate exits are being utilized each month.

Licensee's Proposed Overall Completion Date: 05/10/2023

Not Implemented ██████████ - 01/18/2024)

141b1 - Annual Medical Evaluation**24. Requirements**

2600.

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

Description of Violation

Resident #6's annual medical evaluation was conducted on ██████████/23. However, records indicate that the previous medical evaluation was conducted on ██████████/22.

Repeat Violation: 4/18/22, 2/1/22

Plan of Correction

Accept ██████████ - 05/12/2023)

On 4/5/23 Resident #6 annual medical evaluation we completed. The Wellness Director ██████████ had a brief discussion with the resident and discussed the importance of participating with this annual review but ██████████ said that ██████████ will not participate as ██████████ did the last time.

On 4/5/23 the Wellness Director discussed this with the residents physician and the family to see what will do on the future.

Ongoing the Wellness Director (██████████) will meet with residents a week prior to the yearly medical evaluation to discuss the importance of participating in the evaluation. If the residents refuses ██████████ will report it to the family and the residents physician.

Licensee's Proposed Overall Completion Date: 05/10/2023

Not Implemented ██████████ - 01/18/2024)

162c - Menu Posted**25. 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 4/4/23, the weekly menu's posted outside the dining area indicate Week #1, Week #2, Week #3 and Week #4. However, there was no posting indicating what week the home was currently serving.

Plan of Correction

Accept ██████████ - 05/12/2023)

On 4/5/23 the Administrator ██████████ met with the Dining Services Director ██████████ about ensuring that the weekly dining services menu indicates the week that the menu is on.

Beginning on 4/5/23 The Administrator ██████████ will discuss with the Dining Services Director that the current

162c - Menu Posted (continued)

posted Menu is correct.

Ongoing the Administrator will discuss with the dining services manager during the daily morning meeting what week we are on for the menu and is is posted correctly.

On 4/5/23 the community menu was posted outside of the dining room.

Licensee's Proposed Overall Completion Date: 05/10/2023

Implemented [REDACTED] - 07/05/2023)

184a - Resident's Meds Labeled**26. Requirements**

2600.

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

4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #2 is prescribed Cimetidine 200mg – take 2 tablets (400mg) by mouth two times a day. However, the resident's medication label indicated Tagamet HB 200mg – swallow 1 tablet with a glass of water.

Resident #3's Humalog quickpen 200u/ml and Tresiba Flextouch insulin pen 200u/ml were stored in the medication cart with pharmacy labels.

Resident #3 is prescribed Humalog Kwikpen 15 units before meals and per sliding scale – 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, >400 = 16 units. However, the medication label attached to the medication stored in the medication refrigerator indicated Humalog Kwikpen 15 units before meals and per sliding scale

Repeat Violation: 2/1/22

Plan of Correction

Accept [REDACTED] - 05/12/2023)

Resident #2 is prescribed Cimetidine 200mg – take 2 tablets (400mg) by mouth two times a day. However, the resident's medication label indicated Tagamet HB 200mg – swallow 1 tablet with a glass of water.

On 4/5/23 the Wellness Director [REDACTED] contacted the residents pharmacy and had the correct label sent to the community. The pharmacy label now indicates the correct physicians order.

On 4/5/23 Resident #3's Humalog quickpen 200u/ml and Tresiba Flextouch insulin pen 200u/ml were stored in the medication cart with pharmacy labels. Resident #3 Humalog quickpen 200u/ml and Tresiba Flextouch insulin pen 200u/ml is now stored in the refrigerator.

On 4/5/23 Resident #3 is prescribed Humalog Kwikpen 15 units before meals and per sliding scale – 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, >400 = 16 units. The Kwikpen is now stored in a separate baggie with the full correct medication label.

Beginning on 4/5/23) will be in contact with the residents pharmacies to ensure

184a - Resident's Meds Labeled (continued)

Beginning on 5/1/23 the Wellness Director [REDACTED] will perform a complete med audit of all medications that are delivered for the new month, and monthly there after to ensure that that the medication labels are correct and match the physicians orders.

Licensee's Proposed Overall Completion Date: 05/10/2023

Implemented [REDACTED] - 07/05/2023)

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

Resident #4's glucometer indicated a blood sugar reading of 99 on 3/28/23 at 7:51 a.m. However, on 4/4/23 the resident's medication administration record (MAR) indicated a blood sugar reading of 66 on 3/28/23 at 8:00 a.m.

Plan of Correction

Accept [REDACTED] - 05/12/2023)

On 4/5/23 the Wellness Director [REDACTED] met with all med techs and discussed the importance of reading the glucometers accurately. [REDACTED] discussed with them to make sure that they are looking at the glucometer in the upright position so as to not read it upside-down.

On 4/5/23 the correct reading was logged into the residents med chart.

Ongoing 4/5/23 the acting Med Teck will review their glucometer readings at the end of their shifts to ensure that the readings are correct and that they are logged in correctly.

Licensee's Proposed Overall Completion Date: 05/10/2023

Not Implemented [REDACTED] - 01/18/2024)

190b - Insulin Injections**28. Requirements**

2600.

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

As of 4/4/23 direct care staff C has not had diabetic training in the past 12 months, however administered blood glucose checks to resident #3s on 3/25//23.

As of 4/4/23 direct care staff D has not had diabetic training in the past 12 months, however, administered blood glucose checks to resident #3 on 3/27/23.

Plan of Correction

Accept [REDACTED] - 05/12/2023)

On 4/12/23 [REDACTED] Wellness Director) presented a diabetic training. to all med-tech staff.

Beginning on 4/5/23 the Wellness Director [REDACTED] will ensure that all staff members are properly

190b - Insulin Injections (continued)

trained or re-trained properly annually for diabetic care.

Ongoing the Wellness Director [REDACTED] will present a quarterly diabetic training to all med techs and how to provide proper insulin injections.

Licensee's Proposed Overall Completion Date: 05/10/2023

Implemented [REDACTED] - 07/05/2023)

224c - Preadmission Screening**29. Requirements**

2600.

224.c. The preadmission screening shall be completed by the administrator or designee. If the resident is referred by a State-operated facility, a county mental health and intellectual disability program, a drug and alcohol program or an area agency on aging, a representative of the referral agent may complete the preadmission screening.

Description of Violation

on 4/4/23 resident #5's pre-admission screening, dated [REDACTED]/22, was incomplete. Section II-G Level of Supervision, II-H Mobility Needs, II-I Ability to self administer medications, resident's ability to safely use and avoid poisonous materials and Part III: Determinations were blank.

On 4/4/23 resident #6 did not have a pre-admission screening completed.

Repeat Violation: 2/1/22

Plan of Correction

Accepted [REDACTED] - 05/12/2023)

On 4/5/23 the pre-admission screening for resident #5 was completed to reflect Section II-G Level of Supervision, II-H Mobility Needs, II-I Ability to self administer medications, resident's ability to safely use and avoid poisonous materials and Part III: Determinations was completed by the Administrator [REDACTED]

Beginning on 4/5/23 the Wellness Director will begin reviewing all pre-admission screenings prior to any resident being admitted into the community.

On 4/5/23 the Administrator [REDACTED] completed a pre-admission screening for resident #6.

Licensee's Proposed Overall Completion Date: 05/10/2023

Not Implemented [REDACTED] - 01/18/2024)