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

June 30, 2023

[redacted]
FAIR OAKS OPCO LLC
2200 WEST LIBERTY AVENUE
PITTSBURGH, PA, 15226

RE: FAIR OAKS SENIOR LIVING
2200 WEST LIBERTY AVENUE
PITTSBURGH, PA, 15226
LICENSE/COC#: 45286

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/03/2023, 05/04/2023 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: *FAIR OAKS SENIOR LIVING* **Licen e #**: *45286* **Licen e Expiration**: *10/14/2023*

Address: *2200 WEST LIBERTY AVENUE, PITTSBURGH, PA 15226*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *FAIR OAKS OPCO LLC*

Address: *2200 WEST LIBERTY AVENUE, PITTSBURGH, PA, 15226*

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *01/16/2017* **I ued By**: *City of Pittsburgh*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *89* **Waking Staff**: *67*

Inspection Information

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

Reason: *Complaint, Provisional, Fine* **Exit Conference Date**: *05/04/2023*

Inspection Dates and Department Representative

05/03/2023 On Site [redacted]

05/04/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *71*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *69*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *18* **Have Physical Disability**: *1*

Inspections / Reviews

05/03/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/25/2023*

06/13/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/29/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/20/2023*

Inspections / Reviews *(continued)*

06/21/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/29/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/28/2023*

06/30/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/29/2023*

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

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 5/3/23 from 11:10 a.m. until approximately 3:50 p.m., multiple resident records were unlocked, unattended, and accessible in staff person A's, the home's administrator's, office, including:

- *resident #1's [redacted], in the open closet on the left inside the office door.*
- *resident #2's [redacted], in the open closet on the left inside the office door.*
- *resident #3's [redacted], on the window ledge.*

Plan of Correction ***Directed ([redacted] - 06/21/2023)***

HSL and Fair Oaks Senior Living recognize the importance of Record Confidentially regulation 2600.17. Upon discovery, all folders were placed in locked cabinet in administrative office to ensure confidentiality. In addition, an electronic combination pad lock was purchased and is installed on administrative office door, which automatically ocks upon door closure. The lock combination will be maintained by Security and the Administrator. This violation will be reviewed at the QA meetings.

HSL and Fair Oaks Senior Living recognize the importance of Record Confidentiality regulations 2600.17 Upon discovery, all folders were placed in locked cabinet in administrative office to ensure confidentially. In addition, an electronic combination pad lock was put on door 5/10/23, which automatically locks upon door closure. The lock combination will be maintained by Security and the Administrator. This violation will be reviewed at the QA meetings. In addition, there will be an inservice on June 15, 16, 17, to capture all staff on the importance of Record Confidentiality. The Administrator/designee will conduct weekly rounds to ensure compliance of 2600.17.

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the requirements of Regulation 2600.17. Documentation of education shall be kept. 6/21/23 [redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit the home weekly to ensure compliance with Regulation 2600.17. 6/21/23 JK

Directed Completion Date: *06/26/2023*

Implemented ([redacted] - 06/29/2023)

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

The home did not complete a criminal history background check on the following staff persons until [redacted]23:

51 - Criminal Background Check (continued)

- *ancillary staff person B, hired on [redacted]/22.*
- *direct care staff person C, hired on [redacted]/23.*
- *ancillary staff person D, hired on [redacted]/23.*

REPEAT VIOLATION: 11/15/2022 et al.

Plan of Correction ***Accept ([redacted] - 06/13/2023)***

Part of the hiring process is to obtain a confidential background screening report in accordance with the Older Adult Protective Service Act. Direct care staff member B was hired [redacted]/23 the background request was before hire date; however, the final report was not completed till [redacted]/23, and no record was found. Ancillary staff members B and D hired[redacted]23 and[redacted]22 did not have completed background checks. They were also done[redacted]/23, with no record. An audit of all employees' files will be completed by May 31, 2023, by DOW Assistant and Administrator/Designee to assure that all records are available and in the correct order. Going forward a new checklist will be utilized to ensure all employees files are complete and in proper order. The DOW Assistant will be responsible for completing the checklist for all new employees. Audits and documentation to be reviewed at the QA meeting.

Licensee's Proposed Overall Completion Date: *05/25/2023*

Implemented ([redacted] - 06/29/2023)

63a - First Aid/CPR Training

3. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On multiple dates and times, there was not adequate staff trained in first aid present in the home for every 50 residents, including on[redacted]/23 with 71 residents present in the home:

- *From 12:00 a.m. until 7:00 a.m., direct care staff person E was the only staff person in the home trained in first aid*
- *From 3:00 p.m. until 11:00 p.m., direct care staff person F was the only staff person in the home trained in first aid*
- *From 11:00 p.m. until 12:00 a.m. on [redacted]/23., there was no staff in the home trained in first aid*

Plan of Correction ***Directed ([redacted] - 06/21/2023)***

First Aid and CPR are vital training for staff. It is important for Fair Oaks to offer complete training for the staff to be able to respond appropriately in an emergency. On various dates there was not adequate staff trained in first aid. mmediately, CPR and first aid has been scheduled for June 1st and June 27th , by Advanced Home Health, June 26th by Gateway Hospice - 2 classes scheduled, June 8th by Propriety Hospice - 2 classes scheduled. There will be a binder n the DOW office. it will be the responsibility of the DOW to ensure CPR and First Aid stays in compliance. This iolation will be reviewed in QA meeting

First Aid and CPR are vital training for staff. It is important for Fair Oaks to offer complete training for the staff to be able to respond appropriately in an emergency. On various dates there was not adequate staff trained in first aid. mmediately, CPR and first aid has been scheduled for June 1st and June 27th, by Advanced Home Health, June 26th, 2 classes scheduled by Gateway Hospice. June 8th by Propriety Hospice, 2 classes scheduled. The binder for

63a - First Aid/CPR Training (continued)

CPR/First Aid will be kept in the DOW office. In addition, the DOW will be responsible for maintaining CPR/First Aid for each shift. There will be a "red block symbol" on the master nursing schedule; this will make it much easier to see who is certified and ensure 1;50 ratio is followed; the Administrator will review nursing schedule prior to posting to ensure compliance.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall develop and implement a schedule which includes at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR is in the home at all times. 6/21/23 [redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall review the past weeks schedule to ensure at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR was present in the home at all times. 6/21/23 [redacted]

Directed Completion Date: *06/22/2023*

Implemented ([redacted] - 06/29/2023)

65a - FS Orientation 1st Day

4. Requirements

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

Description of Violation

Ancillary staff person B, whose first day of work was [redacted]22, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services unti [redacted]/23.

Ancillary staff person D, whose first day of work was [redacted]23, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services unti [redacted]23.

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

Plan of Correction ***Accept (JK - 06/13/2023)***

Ancillary staff members A and D, whose first day of work, did not complete the training of the topics in regulation 2600.65.a. On May 4th both ancillary staff members were trained in those areas. The DOW's assistant will be responsible to ensure all initial training is completed and in order then brought to Administrator's office and put on desk. The administrator will review the content of the file and if completed correctly, will be place in the proper ocation. An audit will be performed quarterly by DOW assistant and Administrator/ Designee to ensure compliance. Audit and documentation will be reviewed at the QA meeting. A new hire checklist shall be implemented mmediately. The Administrator will audit all other associate files by June 8th to ensure no other trainings missing.

Licensee's Proposed Overall Completion Date: *06/08/2023*

Implemented (- 06/29/2023)

65b - Rights/Abuse 40 Hours

5. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

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

Description of Violation

Ancillary staff person B started working in the home on /22; however, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions until 23.

Ancillary staff person D started working in the home on /23; however, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions until 23.

Plan of Correction ***Accept (- 06/13/2023)***

Ancillary staff person B started working in the home on 22; however, this staff person did not complete training n the following topics: Resident Rights, emergency medical plan, reporting of reportable incidents and conditions, mandatory reporting of abuse and neglect under the Older Ault Protective Services Act. Staff member B completed her orientation on /23. Staff member D started working in the home on 23; however, this staff person did not complete training in the following topics: Resident Rights, emergency medical plan, reporting of reportable ncidents and conditions, mandatory reporting of abuse and neglect. All employees files will be audited by June 1st by DOW assistant and Administrator. All new hire paperwork will be reviewed by the Administrator and a new hire checklist will be completed by the Administrator to ensure all documentation and dates are present and complete. Documentation and audit will be reviewed at the QA meeting.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Implemented (- 06/29/2023)

65c - Ancillary Staff Orientation

6. Requirements

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

Description of Violation

Ancillary staff person B, whose first day of work was [redacted]22, did not have a general orientation to his/her specific job functions unti[redacted]23.

Ancillary staff person D, whose first day of work was [redacted]/23, did not have a general orientation to his/her specific job functions until [redacted]/23.

Plan of Correction ***Accept ([redacted] - 06/13/2023)***

Ancillary staff person B started working in the home on [redacted]22, did not have general orientation to [redacted] specific job unctions until [redacted]/23. Ancillary staff person D, whose first day of work was [redacted]/23, did not have general orientation to [redacted] specific job functions unti [redacted]/23. Immediately the Administrator reviewed hiring process with managers who assist with orientation. (See document #1) First with interviewing, if there is a potential candidate a background check will be done. The candidate will be asked if they have a diploma or GED and will provide documentation of diploma/GED. All caregiver applicants will be required to take 6 hour DPW Direct care test. Once all required paperwork, Diploma/GED, background check, and DPW course/test (when applicable) completed, employee will attend orientation and complete first 40 hours of required trainings as per regulation 2600.65c. First topic that is always first is fire safety, by Security Manager who is certified. All state required trainings will be completed upon first 2 days of hire as per regulation 2600.65c. Day 3 through first 2 weeks of employment, all new associates will shadow mentor with in their department, on all 3 shifts. The DOW will meet with employees during orientation to assess progress. These steps of the hiring process is stressed by the Administrator through observation of new employees. Once orientation is complete, associate's orientation paperwork will be given to Administrator for review. Once verified that all required training and paperwork is complete, Administrator will file accordingly.

Licensee's Proposed Overall Completion Date: *05/25/2023*

Implemented ([redacted] - 06/29/2023)

81b - Resident Personal Equipment

7. Requirements

2600.
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 5/4/23 at 3:23 p.m., there was an uncovered enabler bar present on resident #4's bed, with an opening measuring approximately 10 1/2" wide and 6 1/2" high, posing a potential entrapment hazard.

Plan of Correction ***Accept ([redacted] - 06/13/2023)***

Safety comes first and is one of the most important subjects to HSL Care LLC and Fair Oaks. The enabler of resident #4 was covered with a nylon/net covering to prevent potential entrapment wit the device. (See attached picture #1) The caregiver assigned will be responsible check the enabler and covering is secure. If the cover is off or the enabler becomes loose the caregiver will report it to the DOW who will immediately replace enabler cover. During rounds, Security Manager will ensure compliance. Documentation will be reviewed a the QA meetings. Beginning June, a brochure will be included in all new resident contracts, offering all new residents the bed cane system which is an

81b - Resident Personal Equipment (continued)

enabling device that comes with a cover. Families will sign paperwork indicating if they are interested in bed cane system. If interested, PT screening will be conducted to determine if appropriate. (See brochure #2) (See paperwork for family if interested in enabler #3)

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented ([redacted] - 06/29/2023)

85e - Trash Outside Home

8. 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 5/3/23 at 8:59 a.m., the right dumpster in the home's parking lot was overflowing with trash bags, could not fully close, and remained partially open until approximately 2:05 p.m.

Plan of Correction ***Accept ([redacted] - 06/13/2023)***

Fair Oaks receives garbage pick up on Monday, Wednesday, and Friday. It is picked up by a company called Biggs in Pittsburgh, PA. There are two dumpsters and the one dumpster's lid would not close. To prevent the dumpster from being overloaded, the Security Manager and /or maintenance Assistant will audit during daily rounds to ensure that the trash is emptied. If a dumpster becomes close to being full, the Security manager will notify Biggs for an extra pick up. Documentation will be kept and will be reviewed in the QA meetings.

Licensee's Proposed Overall Completion Date: *05/25/2023*

Implemented ([redacted] - 06/29/2023)

88a - Surfaces

9. 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 5/3/23 at 9:00 a.m., there were 7 ceiling tiles in the Lemon Room with dry water damage and one with a circular damp spot that measured 11" across its center.

Plan of Correction ***Directed ([redacted] - 06/21/2023)***

The Lemon Room had water damage ceiling tiles. A work order was put in and Maintenance/Designee replaced the ceiling tile. Ceiling tiles were ordered and after checking that there was no further leakage, all the ceiling tiles will be replaced. The Security Manager will inspect ceiling tiles in disrepair. Tiles will be repaired/replaced within 24 hours. Documentation will be kept and reviewed at the QA meetings.(Picture #1,2,3)

The Lemon Room had water damage ceiling tiles. A work order was put in and Maintenance/Designee replaced the ceiling tile on June 15th. In addition, the Administrator/designee will conduct weekly environmental rounds to ensure all areas are clean, in good repair and free from hazards; all areas of concern will be immediately reported to Security Manager.

DIRECTED

88a - Surfaces (continued)

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the requirements of Regulation 2600.88(a). Documentation of education shall be kept. 6/21/23 [redacted]

Directed Completion Date: *06/20/2023*

Implemented ([redacted] - 06/29/2023)

130e Hearing Impairment

10. Requirements

2600.
130.e. If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

Description of Violation

Resident #7 is unable to hear the fire alarm system. The home does not have a signaling device, approved by a fire safety expert and tested to ensure that resident #7 is alerted in the event of a fire.

Plan of Correction ***Directed ([redacted] - 06/21/2023)***

HSC Care LLC and Fair Oaks realize that the utmost importance is safety of the residents. A strobe light was ordered and immediately and was installed in room [redacted] by Fire Fighters and tested for the [redacted] resident. Procedures were explained to the resident regarding the function of the strobe light, and the resident verbalized understanding. Resident's RASP updated to reflect strobe light system. Documentation will be maintained and reviewed a the QA meetings.

HSC Care LLC and Fair Oaks realize that the utmost importance is to the safety of the residents. A strobe Light was ordered and immediately installed in room [redacted] by Fire Fighters and tested for the [redacted] resident. Procedures were explained to the resident regarding the function of the strobe light, and the resident verbalized understanding. The resident's RASP updated to reflect strobe light system. In addition, the Security Manager will test the strobe light system during all fire drills to ensure strobe light is functioning properly.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall contact the home's fire safety expert and obtain the fire safety expert's written approval for the use of the device for resident #7 and ensure that resident #7 is alerted to a fire alarm at all times when in the home. 6/21/23 JK

Directed Completion Date: *06/20/2023*

Implemented ([redacted] - 06/29/2023)

141a Medical Evaluation

11. Requirements

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

Description of Violation

Resident #8's initial medical evaluation, dated [redacted]/23, does not include the medical professional license number of the licensed professional who completed the evaluation. This section of the form is blank.

141a - Medical Evaluation (continued)

REPEAT VIOLATION: 11/15/2022 et al.; 6/23/2022 et al.

Plan of Correction ***Accept (- 06/13/2023)***

mmediately, the DOW called the physician to obtain his license number and DME corrected. Moving forward; An Admission Checklist has been created to include the DME. The Marketing Director will be responsible to ensure all areas of the Check list are completed and will give all completed paperwork the DOW. The DOW and DOW Assistant will audit all forms, including the DME, to ensure all areas have been addressed and no blanks are noted. The completed checklist will be given to the Administrator, who will complete a final audit to ensure compliance. Once all areas have been confirmed as complete, the DMR will be given to the DOW to file. The signed admission checklist will be put in the front of the resident's chart in a plastic cover. The DOW and Administrator will audit 5 charts monthly to ensure compliance. Documentation will be kept and will be reviewed in the QA meetings. Documentation #1)

Licensee's Proposed Overall Completion Date: *05/25/2023*

Implemented (- 06/29/2023)

144b - Policy on Smoking

12. Requirements

2600.
144.b. The home rules shall specify whether the home is designated as smoking or nonsmoking.

Description of Violation

The home rules in resident #7's contract, dated 22, indicate, "This is a non-smoking facility. If an employee, visitor, or resident wishes to smoke, that individual must leave the premises to smoke offsite." However, on 5/3/23 at approximately noon and 5:00 p.m., resident #7 was observed smoking along the pathway from the home's front entrance to the visitor parking lot. Also, the home has a designated smoking area on the premises, which is located up the hill in the back of the building.

Plan of Correction ***Directed (- 06/21/2023)***

Resident #7 was observed smoking along the pathway from the home's front entrance to the visitor's parking lot. The home has developed a new home rule specifying that smoking will only be permitted outdoors in the designated area.. If an employee, visitor, or resident wishes to smoke, he/she must smoke in the designated area. Smoking is not permitted in the building.(Document #1) it was explained to Resident #7 that must smoke in the designated area, and that a designated staff member must accompany to the area, and stay with while smokes for safety purposes. (Document#1)

Resident #7 was observed smoking along the pathway from the home's front entrance to the visitor' parking lot. The home has developed a new home rule specifying the smoking will only be permitted outdoors in the designated area. f an employee, visitor, or resident wishes to smoke he/she must smoke in the designated area. Smoking is not permitted in the building. It was explained to resident #7 that must smoke in the designated area and that a designated staff member must accompany to the area and stay with while smokes for safety purposes. In addition, all residents and families were educated June 19, 20, 2023, on the change of smoking policy; Administrator/designee will monitor the smoking area during daily rounds to ensure compliance.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction the administrator shall audit the home weekly

144b - Policy on Smoking (continued)

to ensure the home's smoking policy and procedures are followed. 6/21/23

Directed Completion Date: *06/20/2023*

Implemented (- 06/29/2023)

183b - Meds and Syringes Locked

14. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 5/3/23 at 11:04 a.m., there were (2) partially used 4-ounce tubes of r cream, unlocked, unattended, and accessible, in resident #9's bathroom.

On 5/3/23 at 11:37 a.m. there was a 1/3-full bottle of , unlocked, unattended, and accessible, in resident #10's bedroom.

On 5/3/23 at 12:14 p.m. there was a 2-ounce tube of found unlocked, unattended, and accessible, sitting on the sink resident #8's bathroom.

On 5/3/23 at 12:36 p.m., there was a half-full 4-ounce tube of cream, unlocked, unattended, and accessible at the sink in resident #11's bathroom.

REPEAT VIOLATION: 11/15/2022 et al.; 6/23/2022 et al.

Plan of Correction ***Accept (- 06/21/2023)***

All medication from resident 8,9,10, 11 was immediately removed from the room. On May 8, 2023, the Administrator Marketer, and Security Manager conducted a community search and found no other medications, ointments, or salves. (See Document #1). A letter was sent to the families on May 12, 2023 regarding OTC ointments and medications which explained proper procedures for bringing in OTC meds and that all OTC medications/treatments/etc. must be given to the DOW or Administrator, who will verify approval of items. (See Document #2).All Hospices and Home Health were also tonified that all OTC meds and treatments must not be left n resident bathrooms. (See Document#3) All med techs, caregivers and housekeepers were re-educated on May 9, 10, 11 to look for any unsecured medications when they are in resident's rooms and if discovered, retrieve and give it to the DOW. (See Document #4)

n addition, the DOW/designee will conduct weekly room audits x 4 weeks, then ongoing to ensure compliance.

Licensee's Proposed Overall Completion Date: *06/20/2023*

Implemented (- 06/29/2023)

183d - Prescription Current

15. Requirements

183d - Prescription Current *(continued)*

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

Description of Violation

On 5/3/23 at 11:04 a.m., there was a 3/4 full 4-ounce tube of [redacted] cream at the sink in resident #9's bathroom; however, the resident does not have a current order for the medication.

On 5/3/23 at 12:36 p.m., there was a half-full 4-ounce tube of [redacted] cream at the sink in resident #11's bathroom; however, the resident does not have a current order for the medication.

Resident #4's [redacted] was discontinued on 5/3/23; however, the medication was stored on medication cart #3 and #4 on 5/4/23 at 12:57 p.m.

On 5/4/23, multiple medications for resident #12 that were discontinued on 4/28/23 were stored on medication cart #2, including:

- *[redacted] 75mcg*
- *[redacted] 40mg*
- *[redacted] 4% patch*
- *[redacted] CL ER 15mg*

Plan of Correction ***Accept ([redacted] - 06/13/2023)***

Resident #10 is prescribed 1 to 2 drops of [redacted] into affected eye as needed [redacted] however, medication was originally dispensed on [redacted]21. Upon discovery on 5/3/23, the Med Cart was checked to see if resident had another bottle and when it was opened. Then the MAR was checked to see if it has been given, the resident's chart was reviewed to verify current order and order was compared to bottle. That was discovered in med cart. All MedTech's were Inservice on 5/15/23 on regulation 2600.183e, to include that only current prescriptions may be kept in the home, this includes OTS, sample and CAM meds. All expired meds must be disposed of timely and properly, and that all medications are to be dated once opened. The DOW or Assistant will inspect medications during weekly med cart inspections, and will monitor Med techs monthly, to ensure that medications are dated when opened and expired medications are immediately disposed of. Audit sheet will be completed. (Document #1) Document #2)

Licensee's Proposed Overall Completion Date: *06/15/2023*

Implemented ([redacted] - 06/29/2023)

183e - Storing Medications

16. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 5/3/23 at 11:37 a.m. there was a 1/3 full bottle of [redacted] in resident #10's bedroom. The medication was undated when opened, originally dispensed on [redacted]21, and expires 30 days after opening in accordance with the manufacturer's instructions; however, the medication was still present in the home.

183e - Storing Medications *(continued)*

Plan of Correction ***Accept (JK - 06/13/2023)***

n resident #10 room there was 1/3 bottle of [redacted] discovered. The medication was opened and undated. Drops were originally dispensed on [redacted]21 and would expire 30 days after opening in accordance with manufacture's instructions. However, the medication was still present in the home. The medication was immediately removed from the resident's room upon discovery. Immediately on 5/3/23, the med cart was inspected for expired meds, and dates for opened bottles. A complete med audit was completed for resident #10) to ensure all current orders match the MAR and medications/treatments stored in the med cart. No further discrepancies/issues noted. All med techs were Inservice on regulation 2600.183e, on 5/9, 10, 11/23, with specifics attention to the importance of dating all medications upon opening, checking expiration dates, and disposing of all expired/discontinued medications in a timely mannered as per protocol. DOW or DOW Assistant will inspect medications during weekly med cart inspections, to ensure all opened medications are dated properly and no expired med/treatments are left in med carts. Med Techs will be monitored monthly to ensure compliance with dates and disposal of expired medications. Documentation of audits will be maintained.(Document #1) (Document #2)(Document#3)

Licensee's Proposed Overall Completion Date: *06/08/2023*

Implemented ([redacted] - 06/29/2023)

185a - Implement Storage Procedures

17. 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

The home's policy titled, Control of Medications, indicates that the control sheet for each controlled medication prescription must indicate:

- *Name and strength of the drug*
- *Number on hand*
- *Name of physician*
- *Prescription number*
- *Date and time received*

On 5/4/23, resident #12's control sheet for [redacted] indicated there were 3 pills remaining; however, there were only 2 pills remaining in the medication blister pack. Also, the control sheet did not indicate the name of the medication, the date and time it was received, and the prescription number.

Plan of Correction ***Accept ([redacted] - 06/13/2023)***

The issue of violation is that the Med Tech gave the narcotic but did not sign the MAR that it was given, nor did [redacted] fill out the narcotic sheet for the medication, and no following the policy.
Med Techs will be re-educated on the narcotic administration policy by May 31, 2023.The Administrator or Designee shall audit staff administering controlled substance and documentation weekly for 3 months to ensure the home's policies and procedures are being followed and for accuracy and completion. (Document #1) Monthly MAR audits to be conducted by the DOW/ Designee (Document#2) DOW/Designee will do Monthly cart audits and document Document #3). Leechburg Pharmacy will do monthly audits of the med carts and will give results to DOW. It will be the responsibility of the DOW to maintain documentation and ensure compliance is met. Documentation of audits will be kept and reviewed at the QA meetings.

Licensee's Proposed Overall Completion Date: *05/31/2023*

185a - Implement Storage Procedures *(continued)*

Implemented (JK - 06/29/2023)

187a - Medication Record

18. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
8. Frequency of administration.
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #13 is prescribed [redacted] -Take 2 puffs every 4 hours as needed. However, the resident's April 2023 and May 2023 medication administration record (MAR) indicate-Take 2 puffs every 6 hours as needed.

Plan of Correction ***Accept (JK - 06/21/2023)***

For resident #13, the doctor's order was reviewed in the chart and pharmacy was called to verify the order. The frequency of the medication was corrected at the pharmacy and on the MAR. A MAR audit was completed May22, 2023 to ensure accuracy of orders medication frequency. The DOW will re-train all Med Techs in the 5 rights and focus on the order written in the MAR matches the order on the bottle by June 8. In addition to DOW training , on arious days throughout the month of June, Med Techs will be required to provide verbal training of proper medication administration procedures to fellow Med Techs, to demonstrate understanding of regulations 2600.187a, n the presence of the DOW. This will continue until all Med Techs have reiterated this practicum. Documentation will be kept and reviewed at QA meeting. Document #1) (Document #2)

n addition, the DOW/Designee will conduct weekly audits of 25 MARS x 4 weeks then monthly ongoing to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/06/2023*

Implemented (- 06/29/2023)

187b - Date/Time of Medication Admin.

19. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #12 is prescribed [redacted] Take 1 tablet by mouth 2 times a day; however, the resident's May 2023 MAR was not initialed by the staff member who administered the medication on 5/3/23 at 8:00 p.m.

Resident #14 is ordered [redacted] 40mg tablet-Take 1 tablet by mouth once a day in the morning. However, the resident's May 2023 MAR was not initialed by the staff member who administered the medication on 5/2/23 at 8:00 a.m.

187b - Date/Time of Medication Admin. (continued)

Resident #14 is ordered [redacted] -Take 1 capsule by mouth once daily in the morning. However, the resident's May 2023 MAR was not initialed by the staff member who administered the medication on 5/3/23 at 8:00 a.m.

Resident #14 is ordered [redacted] -Take 1 by mouth at bedtime. However, the resident's May 2023 MAR was not initialed by the staff member who administered the medication on 5/3/23 at 8:00 p.m.

Resident #15 is ordered [redacted] -Take 1 tablet by mouth once a day in the morning. However, the resident's May 2023 MAR was not initialed by the staff member who administered the medication on 5/4/23 at 6:00 a.m.

Resident #16 is prescribed multiple medications to be administered daily at 8:00 p.m., including the following, which were not initialed on the resident's May 2023 MAR by the staff person who administered the medications on 5/3/23 at 8:00 p.m.:

- *[redacted] 10-100*
- *[redacted] 2.5mg*
- *[redacted] 2mg/ml*
- *[redacted] 20mg*
- *[redacted] Ointment*
- *[redacted] 8.6mg*

Plan of Correction ***Accept (JK - 06/13/2023)***

Resident #12,#14,#15, #16 all received their medication 5/3/23 and 5/4/23. However, the issue is that the Med Tech did not initial that [redacted] had given the med. Effective immediately, the DOW is monitoring the proper recording of medications by overseeing the Med Tech's med passes twice weekly x1 month, then weekly x1 month, then monthly on-going. (See Document #1) All Med Techs will be re-trained on regulation 2600.187b, by June 1. (See Document #2) All Med Techs are now required to review their MAR at the completion of their shift until there is 100% compliance for three consecutive months. Med Techs will be required to document completion of their MAR audits. Audits will be give to the DOW to review and file. (See Document #3) The DOW will randomly spot check the MARs and re-evaluate as needed. The DOW/Designee will be responsible to maintain compliance through re-training, audits, and spot checking the MARs. Documentation will be presented and reviewed at the QA meetings.

Licensee's Proposed Overall Completion Date: *06/01/2023*

Implemented ([redacted] - 06/29/2023)

187d Follow Prescriber's Orders

20. Requirements

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

Description of Violation

Resident #14 was prescribed [redacted] Take 1 tablet by mouth once a day on Monday, Wednesday, and Friday; however, the medication was not administered to the resident on Wednesday, 5/3/23 at 9:00 a.m.

REPEAT VIOLATION: 6/23/2022 et al.

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

Plan of Correction ***Accept (06/21/2023)***

All Med Techs will be re-trained on regulation 2600.187d (Document#1) Documentation of attendance will be maintained. DOW/Designee will conduct monthly audits of the MARs and Med Carts. (Document #2) (Document #3). Pharmacy will conduct Med Cart audits and will assist with re-training Med Techs on proper medication administration, with specie attention on documentation of medication administration, matching the medication with e MAR< dosage and time, checking expiration dates during med passes, and proper disposal of expired meds mmediately upon discovery. All Med techs will be tested on proper medication administration procedures, which will be all citation related to medications. The DOW will be responsible for maintaining compliance. All documents will be signed by Administrator. All tests, in-services agendas and in-service attendance will be maintained by the DOW. All documentation will be kept and reviewed at the QA meetings.

n addition, the DOW/Designee will conduct weekly audit of 25 MARS x 4 weeks then monthly ongoing to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/06/2023*

Implemented (- 06/29/2023)

225a - Assessment 15 Days

21. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #7's initial assessment, dated /22, indicates that has no sensory hearing needs, and mobility assessment indicates that is independent in mobility and "can evacuate the community during an emergency by however, the resident is deaf and uses a hearing aide during the day.

REPEAT VIOLATION: 11/15/2022 et al.; 6/23/2022 et al.

Plan of Correction ***Accept (06/13/2023)***

Resident #7 assessment was immediately updated in reference to having a hearing deficit , wearing hearing aids, strobe light placed in room in case of fire, and smoking. The Administrator will provide training on RASP to DOW, DOW Assistant, and direct staff on 5/30/23. (See Document #1) DOW , DOW Assistant and Administrator will audit all RASPS and DMEs by June 20th to ensure compliance. 10 RASPS will be audited weekly x 2 months. (Document #2) 3 RASPS will then be audited weekly ongoing to ensure compliance. Any deficiencies/issues found will be corrected immediately. Any deficiencies/issues will be addressed with department managers during morning meeting. Documentation will be kept and reviewed at the QA meetings.

Licensee's Proposed Overall Completion Date: *07/26/2023*

Implemented (- 06/29/2023)

227c - Support Plan Revision

22. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Resident #4 uses a bed enabler for assistance with turning and positioning in bed; however, the use of an enabler is not addressed in the resident's most recent support plan, dated [redacted]/23.

Resident #9 began receiving [redacted] on [redacted]22; however, the resident's most recent support plan, dated [redacted]22, does not indicate the care and services or frequency of services that are being provided [redacted].

Resident #10 began receiving [redacted] on [redacted]/22; however, the resident's most recent support plan, dated [redacted]/22, does not indicate the care and services or frequency of services that are being provided [redacted]

Plan of Correction ***Accept ([redacted] - 06/13/2023)***

Resident #4 uses a bed enabler for assistance with turning and positioning in [redacted] bed, however, the use of an enabler s not addressed in the resident's most recent support plan. The DOW immediately updated resident #4 support plan to include enable. Resident #9 receiving [redacted] on 5/3/23 however, the resident's most recent support plan, dated [redacted]/22 does not indicate the care and services or frequency of services that are being provided [redacted]. The DOW reviewed chart and spoke with the resident#9 [redacted]. The support plan was then updated. resident #10 began [redacted] on [redacted]/22; but the resident's most recent support plan, dated [redacted]22, does not indicate the care and services or frequency of services that are being provided [redacted]. The DOW called [redacted] to find out the details of taking care of this resident, then the support plan was updated. Going forward the DOW, Assistant DOW and the Administrator will review 10 support plans a week for 2 months, then ongoing to 3 support plans weekly , to ensure focus on hospice residents, details of care, and changes in the resident's care needs. (Document #1)

Licensee's Proposed Overall Completion Date: *07/25/2023*

Implemented (JK - 06/29/2023)