pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **NORTHEAST PC OPERATIONS LLC**
LEGAL ENTITY

To operate **BRYN MAWR VILLAGE**
NAME OF FACILITY OR AGENCY

Located at **773 EAST HAVERFORD ROAD, BRYN MAWR, PA 19010**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **33**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 25**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **February 22, 2024** until **August 22, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **148341**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: FEBRUARY 22, 2024

[redacted]
President
Northeast PC Operations, LLC
773 East Haverford Road
Bryn Mawr, Pennsylvania 19010

RE: Bryn Mawr Village
License #: 148341

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection May 18, 2023 and October 17, 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 February 22, 2024 to August 22, 2024.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

[redacted]

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
62	2	23	$5	$115	5 calendar days from mailing date of this letter
65a	2	23	$5	$115	5 calendar days from mailing date of this letter
65b	2	23	$5	$115	5 calendar days from mailing date of this letter
65d	2	23	$5	$115	5 calendar days from mailing date of this letter
96a	2	23	$5	$115	5 calendar days from mailing date of this letter
233c	2	23	$5	$115	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.

[redacted]

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.

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

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

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

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *BRYN MAWR VILLAGE* **License #:** *14834* **License Expiration:** *03/29/2023*

Address: *773 EAST HAVERFORD ROAD, BRYN MAWR, PA 19010*

County: *DELAWARE* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *NORTHEAST PC OPERATIONS LLC*

Address: *773 EAST HAVERFORD ROAD, BRYN MAWR, PA, 19010*

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

Certificate(s) of Occupancy

Type: *I-2* **Date:** *09/03/2014* **Issued By:** *Haverford Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *30* **Waking Staff:** *23*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *05/18/2023*

Inspection Dates and Department Representative

05/18/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *33* **Residents Served:** *17*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Impressions* **Capacity:** *25* **Residents Served:** *12*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *17*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *13*

Have Physical Disability: *0*

Inspections / Reviews

05/18/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/12/2023*

Inspections / Reviews *(continued)*

02/02/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/14/2023*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

16b - Incident Policies

1. Requirements

2600.
16.b. The home shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

Description of Violation

The home does not have a written policy on the prevention, reporting, notification, investigation and management of reportable incidents.

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

Plan of Correction: The home does have a current written policy on the prevention, reporting, notification, investigation and management of reportable incidents, however the PCHA could not locate the document at the time of Inspection. PCHA will have a copy of the policy placed in a binder & easily assessable at all times; the document was recovered on 5/18/23.

Licensee's Proposed Overall Completion Date: *06/12/2023*

Implemented (02/02/2024)

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

Residents 1 and 2 did not receive any prescribed medications on the evening of 5/14/23. The home did not report these medication errors to the department.

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: PCHA and/or LPN Supervisor will provide in-service trainings to all Direct Care Staff on how to accurately document and report incidents/conditions to Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department on a monthly basis; trainings will be signed off on and certificate of completion presented to staff member. PCHA will provide copy of the completion certificate to the HR Director and a copy will be kept on file with the PCHA.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *The LPN supervisor will contact residents #1 and #2's physicians to advised them the residents did not receive their medications.*
2. *The PCHA and or LPN supervisor will provide a training on the importance of submitting an incident report, acceptable documentation and contacting the resident physicians when medications are missed by 7/20/23.*
3. *The PCHA and or LPN supervisor will audit all resident MAR's at least monthly to ensure all medications are administered timely, starting 7/12/23.*
4. *The LPN supervisor or Practicum observer will observe med techs administering medications and doumentation at least bi-annually, starting immediately.*
5. *The LPN supervisor will train the staff on peer to peer auditing of the MAR's at the end of each shift, by 7/20/23.*
6. *Documentation of trainings on incident reporting, auditing and per to peer auditing training will be maintained for the Departments review.*

16c - Written Incident Report *(continued)*

Directed Completion Date: *07/25/2023*

Not Implemented ([redacted] 02/02/2024)

25b - Contract Signatures

3. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted], for resident 1 was not signed by the resident.

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Correction: While the resident's contract was not signed by the resident, it was signed by the resident's agreed upon designated person.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *The administrator or business manager will discuss the contract with resident #1 and obtain their signature, by 7/20/23. If the resident refuses to sign the contract, at least two attempts are made to obtain the signature and document the attempts.*
2. *The business manager will audit all resident contracts to ensure the contracts have been signed by all residents by 7/25/23 and obtain the required signature.*
3. *The administrator will develop a checklist for all new admission documents to ensure compliance is maintained for all new admissions, by 7/25/23.*
4. *The administrator will review all new admission documents within 24 hours of admission to the home to ensure the required signature is completed, starting 7/20/23.*

Directed Completion Date: *07/25/2023*

Not Implemented ([redacted] 02/02/2024)

25b SOPa - Rent Rebate: Contract

4. Requirements

2600.
25b.a. The resident-home contract is to include whether the home collects a portion of a resident's rent rebate under § 2600.25(d) (relating to resident-home contract).

Description of Violation

The resident-home contract, dated [redacted] for Resident 1 does not indicate whether the home collects a portion of the resident's rent rebate benefit.

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Correction: Admissions Coordinator will update contract to include the Rent Rebate specifications.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *The admissions coordinator will update resident #1's contract to include the Rent Rebate specifications by 7/20/23.*
2. *The administrator will provide training to the admissions coordinator on the requirement all residents must sign the Resident Rights and complaint procedures upon admission, and why it is important for the resident to sign, by 7/25/23.*
3. *The admissions coordinator will audit all resident contracts to ensure the contracts have been signed by all*

25b SOPa - Rent Rebate: Contract (continued)

residents by 7/25/23 and the contract addresses the rent rebates.

4. *The administrator will develop a checklist for all new admission documents, and the contracts to ensure compiance is maintained for all new admissions, by 7/25/23.*
5. *The administrator will review all new admission documents within 24 hours of admission to the home to ensure the required signature is completed, starting 7/20/23.*

Directed Completion Date: *07/25/2023*

Not Implemented ([redacted] 02/02/2024)

26a - Quality Management Plan

5. Requirements

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

Description of Violation

The home does not have a quality management plan.

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

Plan of Correction: The home does have a current Quality Mgmt Plan, however the PCHA could not locate the document at the time of Inspection. PCHA will have a copy of the plan easily assessable at all times; the document was recovered on 5/18/23.

Licensee's Proposed Overall Completion Date: *06/14/2023*

Implemented ([redacted] 02/02/2024)

41e - Signed Statement

6. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident 1's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Correction: While the resident did not sign the statement acknowledging receipt of a copy of the resident rights and complaint procedures, the resident's agreed upon designated person signed the document.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *The administrator or admissions coordinator will explain the Resident Rights and complaint procedures to resident #1 by 7/20/23 and obtain the residents signature.*
2. *The administrator will provide training to the admissions coordinator on the requirement all residents must sign the Resident Rights and complaint procedures upon admission, and why it is important for the resident to sign, by 7/25/23.*
3. *The admissions coordinator will audit all resident contracts to ensure the Resident Rights and complaint procedures have been signed by all residents by 7/25/23 and obtain the required signature.*
4. *The administrator will develop a checklist for all new admission documents to ensure compiance is maintained for all new admissions, by 7/25/23.*
5. *The administrator will review all new admission documents within 24 hours of admission to the home to*

41e - Signed Statement (continued)

ensure the required signature is completed, starting 7/20/23.

Directed Completion Date: *07/25/2023* Not Implemented (02/02/2024)

42s - Privacy

7. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

There is a camera in the common area on the personal care side. There is no sign indicating video surveillance.

Plan of Correction ***Accept (- 07/12/2023)***

Plan of Correction: While there was a camera in the Personal Care common area during the inspection, it was inoperable and not in use. The PCHA will place a sign indicating video surveillance; matter was immediately remedied on 5/18/23. Maintenace Director or Maintenace Staff will remove defunct camera from Personal Care common room; matter was remedied on 6/12/23.

Licensee's Proposed Overall Completion Date: *06/12/2023* Implemented (02/02/2024)

51 - Criminal Background Check

8. 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 person A was hired on /23. The criminal background check was completed on /23.

Staff person B does not have a criminal background check.

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: HR Director will obtain all required clearances prior to employee Start Date; if employee is Agency Staff, HR Director will obtain copy of clearances from hiring agency prior to employee reporting to the facility.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *HR Director will obtain all required clearances prior to employee Start Date; if employee is Agency Staff, HR Director will obtain copy of clearances from hiring agency prior to employee reporting to the facility, starting 7/1/2/23.*
2. *The PCHA or HR Director will develop and implement a checklist to include all requred new employee documentation, including criminal background checks, to assist in the timely completion of required new staff documents, by 7/25/23.*
3. *The HR Director will review the new staff documents prior to their 1st day on the job, to ensure the required documents have been completed, starting 7/25/23.*
4. *The PCHA will conduct periodic checks, at least bi-monthly, of the new staff documents for compliance, starting 7/25/23.*

51 - Criminal Background Check (continued)

5. *The HR Director will conduct an audit of all staff criminal backgrounds to ensure they are all completed by 7/30/23.*
6. *The PCHA will maintain documents for the Departments review.*

Directed Completion Date: *07/25/2023*

Not Implemented (02/02/2024)

62 - Contact List

9. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

The home does not have a complete list of staff, including substitute personnel.

Repeat Violation: 2/7/23.

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

Plan of Correction: List of agency staff was in located another binder, however at the time of the inspection, the Scheduling Manager was not available to provide the documents. PCHA will coordinate with Scheduling Manager and HR Director to continue update, review and file new hires records as needed. PCHA, HR Director and Scheduling Manager will retain files of active agency and staff employees. HR Director will retain files of non-active employees.

Licensee's Proposed Overall Completion Date: *06/12/2023*

Not Implemented (02/02/2024)

64a - Admin Training

10. Requirements

2600.
64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:
1. An orientation program approved and administered by the Department.
2. A 100-hour standardized Department-approved administrator training course.
3. A Department-approved competency-based training test with a passing score.

Description of Violation

Staff person who is the home's administrator, has not successfully completed the following:
(1) An orientation program approved and administered by the Department.
(2) A 100-hour standardized Department-approved administrator training course.
(3) A Department-approved competency-based training test with a passing score.

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

Plan of Correction: Staff person did successfully complete PCHA Orientation, Training Course & Training Test in 2011, in addition to supplemental, refresher courses & trainings following; the original documents were destroyed due to natural flood disaster & could not be electronically retrieved from Norristown State Hospital or PA DHS. Staff Person was directed to retake all necessary courses & requirements. Orientation course on successfully completed on 6/8/23; PCHA 100 Training Course will operate from July 7-29, 2023; PCHA Exam will follow upon completion of course.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented (02/02/2024)

65a - FS Orientation 1st Day

11. 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:

Description of Violation

Staff persons A, B, and C did not receive orientation on the following topics:
(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.

Repeat Violation Date: 7/25/22

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Correction: HR Director in conjunction with the Maintenace Director will update, complete, implement & facilitate New Hire Orientation to include 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.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *The HR Director will conduct the required first day orientation on fire safety to staff A, B and C by 7/25/23.*
2. *The PCHA or HR Director will develop and implement a checklist to include all requred new employee documentation, including criminal background checks and orientation, to assist in the timely completion of required new staff documents, by 7/25/23.*
3. *The HR Director will review the new staff documents prior to their 1st day on the job, to ensure the required documents have been completed, starting 7/25/23.*
4. *The PCHA will conduct periodic checks, at least bi-monthly, of the new staff documents for compliance, starting 7/25/23.*
5. *The HR Director will conduct an audit of all staff orientation training to ensure they are all completed by 7/30/23.*
6. *The PCHA will maintain documents for the Departments review.*

65a - FS Orientation 1st Day (continued)

Directed Completion Date: *07/25/2023*

Not Implemented ([redacted] 02/02/2024)

65b - Rights/Abuse 40 Hours

12. 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:

Description of Violation

Staff persons A, B, and C 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.

Repeat Violation Date: 7/25/23

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Correction: Staff Persons A, B, C completed General Orientation training, which was signed & dated w/in the first 3 days of employment. PCHA will retain copies of these documents in addition to Human Resources filing the original for their record keeping.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *The HR Director will conduct the required 40 hour Resident Rights, Abuse, Incident Reporting orientation to staff A, B and C by 7/25/23.*
2. *The PCHA or HR Director will develop and implement a checklist to include all requred new employee documentation, including criminal background checks and orientation, to assist in the timely completion of required new staff documents, by 7/25/23.*
3. *The HR Director will review the new staff documents prior to their 1st day on the job and immediately following the 40 hour time frame, to ensure the required training has been completed, starting 7/25/23.*
4. *The PCHA will conduct periodic checks, at least bi-monthly, of the new staff documents for compliance, starting 7/25/23.*
5. *The HR Director will conduct an audit of all staff orientation training to ensure they are all completed by 7/30/23.*
6. *The PCHA will maintain documents for the Departments review.*

Directed Completion Date: *07/30/2023*

Not Implemented ([redacted] 02/02/2024)

65d - Initial Direct Care Training

13. 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 B did not complete and pass the Department-approved direct care training course and pass the competency test.

Repeat Violation Date: 7/25/22

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: Staff Person B is an agency staff member & did not receive their training in-house, but with an external provider.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *The HR Director will conduct the required direct care training to staff B by 7/25/23.*
2. *The PCHA or HR Director will develop and implement a checklist to include all requred new employee documentation, including criminal background checks, orientation, and required direct care training to assist in the timely completion of required new staff documents, by 7/25/23.*
3. *The HR Director will review the new staff documents prior to their 1st day providing unsupervised care to residents, to ensure the required training has been completed, starting 7/25/23.*
4. *The PCHA will conduct periodic checks, at least bi-monthly, of the new staff documents for compliance, starting 7/25/23.*
5. *The HR Director will conduct an audit of all direct care staff training to ensure they are all completed by 7/30/23.*
6. *The PCHA will maintain documents for the Departments review.*

Directed Completion Date: *07/30/2023* Not Implemented (02/02/2024)

14. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
3. Initial direct care staff person training to include the following:
i. Safe management techniques.
ii. ADLs and IADLs
iii. Personal hygiene.
iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
vi. Implementation of the initial assessment, annual assessment and support plan.
vii. Nutrition, food handling and sanitation.

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

viii. Recreation, socialization, community resources, social services and activities in the community.
ix. Gerontology.
x. Staff person supervision, if applicable.
xi. Care and needs of residents with special emphasis on the residents being served in the home.
xii. Safety management and hazard prevention.
xiii. Universal precautions.
xiv. The requirements of this chapter.
xv. Infection control.
xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person B did not complete the following initial direct care staff person training:
(i) Safe management techniques.
(ii) ADLs and IADLs.
(iii) Personal hygiene.
(iv) Care of residents with dementia, mental illness, cognitive impairments, mental retardation and other mental disabilities.
(v) The normal aging-cognitive, psychological and functional abilities of individuals who are older.
(vi) Implementation of the initial assessment, annual assessment and support plan.
(vii) Nutrition, food handling and sanitation.
(viii) Recreation, socialization, community resources, social services and activities in the community.
(ix) Gerontology.
(x) Staff person supervision, if applicable.
(xi) Care and needs of residents with special emphasis on the residents being served in the home.
(xii) Safety management and hazard prevention.
(xiii) Universal precautions.
(xiv) The requirements of this chapter.
(xv) Infection control.
(xvi) Care for individuals with mobility needs, such as prevention of decubitus ulcers (bed sores), incontinence, malnutrition and dehydration, if applicable to the residents served in the home

Repeat Violation: 7/25/22.

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Correction: Staff Person B is an agency staff member & did not receive their training in-house, but with an external provider.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *The HR Director will conduct the required direct care in-house training to staff B by 7/25/23.*
2. *The PCHA or HR Director will develop and implement a checklist to include all requred new employee documentation, including criminal background checks, orientation, and required direct care training to assist in the timely completion of required new staff documents, by 7/25/23.*
3. *The HR Director will review the new staff documents prior to their 1st day providing unsupervised care to*

65d - Initial Direct Care Training (continued)

residents, to ensure the required training has been completed, starting 7/25/23.

4. *The PCHA will conduct periodic checks, at least bi-monthly, of the new staff documents for compliance, starting 7/25/23.*
5. *The HR Director will conduct an audit of all direct care staff training to ensure they are all completed by 7/30/23.*
6. *The PCHA will maintain documents for the Departments review.*

Directed Completion Date: *07/30/2023* Not Implemented (02/02/2024)

65i - Training Record

15. 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

The home's record of direct care staff training does not include the name, date, source, content, and length of training.

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: PCHA and HR Director will accurately document name, date, source, content, and length of training for all Direct Care Staff trainings. The original training record document will be filed with Human Resources & PCHA will file a copy of the document in an easily accessible binder.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *The PCHA and/or HR Director will review the staff training documents to ensure all of the required elements are included in all training documents, starting 7/12/23.*
2. *The HR Director will audit all staff training documents and update the documents to include the required elements, initially by 7/25/23 and monthly thereafter for the next six months.*
3. *The PCHA will conduct periodic review of staff training documents, at least bi-annually, to ensure the required elements are noted on all training documents, starting 7/25/23.*

Directed Completion Date: *07/30/2023* Not Implemented (02/02/2024)

66a - Staff Training Plan

16. 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 ***Directed (- 07/12/2023)***

Plan of Correction: PCHA & HR Director will develop, implement & enforce Annual Staff Training Plan.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *The HR Director will develop an annual staff training plan for 2023, by 7/20/23 to include all of the required trainings in 2600.65f and 65g for all staff plus specialized training in Dementia for the direct care staff*

66a - Staff Training Plan (continued)

working in the SDCU and specialized skills for anxcillary staff.

2. *The HR Director will ensure the annual staff training plan is developed and implement by January 1st of each year, starting 1/1/24.*
3. *The HR Director will ensure the plan includes the name, position and duties of each direct care staff person and anxcillary staff; plus include the dats, times and locations of the scheduled trainings.*
4. *The PCHA will review the annual training training plan with the HR Director at least bi-annually to add any additional trainings needed to improved knowlege and skills of the staff, starting 7/12/23.*

Directed Completion Date: *07/30/2023*

Not Implemented ([redacted] 02/02/2024)

82c - Locking Poisonous Materials

17. Requirements

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

Description of Violation

At the kitchen sink in Impressions, there were three bottles of Gel Rite hand sanitizer that were unlocked, unattended, and accessible to residents. They each had a label that read, "In case of accidental ingestion, contact physician or Poison Control Center right away." Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Freshscent roll on antiperspirant and Paradontax were unlocked, unattended, and accessible in the bathroom in room 120 which is located in Impressions. Both have labels that read "if swallowed, contact a physician or Poison Control Center right away." Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Suave antiperspirant and Freshscent roll on antiperspirant were unlocked, unattended, and accessible in the bathroom in room 107 which is located in Impressions. Both have labels that read "if swallowed, contact a physician or Poison Control Center right away." Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Correction: PCHA, LPN Supervisor will provide inhouse training to all Direct Care Staff in regard to securing poisonous materials after care is provided; PCHA/LPN Supervisor will in-service staff members by 6/26/23. Maintenance Director or Maintenance Staff will install hand sanitizer unit in Impressions kitchen. LPN Supervisor will conduct rounds during shift to ensure that poisonous materials are secured in a locked cabinet. Additionally, PCHA will conduct random weekly rounds to check that poisonous materials are locked & inaccessible in residents' rooms.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *The PCHA, LPN Supervisor will provide inhouse training to all Direct Care Staff in regard to securing poisonous materials after care is provided; PCHA/LPN Supervisor will in-service staff members by 6/26/23.*
2. *Maintenance Director or Maintenance Staff will install hand sanitizer unit in Impressions kitchen. LPN Supervisor will conduct rounds during shift to ensure that poisonous materials are secured in a locked cabinet, by 7/20/23.*
3. *PCHA will conduct random weekly rounds to check that poisonous materials are locked & inaccessible in residents' rooms, starting 7/20/23.*

82c - Locking Poisonous Materials (continued)

4. The LPN Supervisor removed all poisonous materials upon discovery on the day of the inspection.

Directed Completion Date: *07/30/2023*

Not Implemented ([redacted] 02/02/2024)

85a - Sanitary Conditions

18. Requirements

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

Description of Violation

The facility only has two residents who are currently prescribed to have glucose checks completed. As reported by staff of the home, one glucometer is shared between residents 2 and 3. The glucometers found in the home are not labeled with any residents name.

At 10:25 am, there was a white substance spilled in the bottom of the Impressions freezer.

There is no method of hand drying in the bathrooms in rooms 107 and 120.

At 11:23 am, there was a purple substance spilled in the crisper bins of the refrigerator in personal care.

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Correction: Direct Care Staff will provide fresh hand towels or disposable paper towels to each resident for bathroom hand-drying use as needed; the matter was remedied immediately as every resident was provided with fresh hand towels on 5/18/23. Direct Care Staff & Housekeeping Staff will sanitize interior & exteriors or refrigerator and freezer on a daily basis. PCHA will conduct weekly random checks to ensure that refrigerators & freezers are clean of spills/debris; the matter was remedied immediately as Direct Care Staff sanitized the Personal Care refrigerator and Impressions freezer on 5/18/23.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *The LPN Supervisor will order new glucometers for residents 2 and 3, by 7/15/23.*
2. *The LPN Supervisor will audit all residents who use glucometers to ensure the staff are not sharing between residents by 7/15/23.*
3. *The LPN Supervisor will conduct a training to all licensed staff and med techs on the importance of not sharing glucometers, by 7/20/23.*
4. *The LPN Supervisor will conduct periodic, at least monthly for the next six months, a hands on check of all resident glucometers against the MAR documentation to ensure the glucometers are not being shared, starting 7/20/23.*
5. *The PCHA will conduct bi-annual review of glucometers to ensure they are not being shared and are correctly calibrated, starting 7/20/23.*
6. *Direct Care Staff will provide fresh hand towels or disposable paper towels to each resident for bathroom hand-drying use as needed; the matter was remedied immediately as every resident was provided with fresh hand towels on 5/18/23.*
7. *Direct Care Staff & Housekeeping Staff will sanitize interior & exteriors or refrigerator and freezer on a daily basis.*

85a - Sanitary Conditions (continued)

8. *PCHA will conduct weekly random checks to ensure that refrigerators & freezers are clean of spills/debris; the matter was remedied immediately as Direct Care Staff sanitized the Personal Care refrigerator and Impressions freezer on 5/18/23.*
9. *The Maintenance Director or housekeeping aides will conduct daily rounds for cleanliness of the home starting 7/20/23.*

Directed Completion Date: *06/12/2023* Not Implemented ([redacted] 02/02/2024)

85d - Trash Receptacles

19. Requirements

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

Description of Violation

There were 3 uncovered, unattended trash cans in the main kitchen.

Plan of Correction ***Accept ([redacted] - 07/12/2023)***

Plan of Correction; The 3 trash receptacles in the main kitchen were not covered during the inspection as they were about to be used to dispose waste from the lunch meal; the issue was immediately remedied on 5/18/23. The Dietary Manager & Dietary Staff will ensure that the main kitchen trash receptacles will be covered & closed properly when not in use by checking after each prepared meal, starting 5/18/23.

Licensee's Proposed Overall Completion Date: *06/12/2023* Implemented ([redacted] 02/02/2024)

88a - Surfaces

20. 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

In room 4B, there is a missing ceiling tile in the bathroom above the toilet. The tile next to the opening in the ceiling has a brown stain that appears to be water damage.

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Correction: Maintenace Director and/or Maintenace Staff will replace/repair ceiling tiles; matter was remedied on 5/23/23 (there was no evidence of leak or water damage within the bathroom ceiling).

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *Maintenance Director and/or Maintenance Staff will replace/repair ceiling tiles; matter was remedied on 5/23/23 (there was no evidence of leak or water damage within the bathroom ceiling).*
2. *The Maintenance Director will conduct a training with the direct care and housekeeping staff on how to alert the maintenance department when a repair is required, by 7/30/23. Documentation of the training will be maintained for the Departments review.*
3. *Maintenance Director and/or Maintenance Staff will conduct daily physical site inspections of the home to ensure everything is in good operating order, starting 7/20/23.*
4. *The LPN Supervisor will conduct weekly physical site inspections of the home to ensure all areas of the home are in good working order, starting 7/20/23.*
5. *The PCHA will conduct monthly physical site inspections of the home to ensure all areas of the home are in*

88a - Surfaces (continued)

good working order, starting 7/20/23, for the next six months.

Directed Completion Date: *07/30/2023*

Not Implemented (02/02/2024)

91 - Telephone Numbers

21. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in the personal care kitchenette.

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: Emergency Telephone Numbers were not posted in the Personal Care Kitchenette during the inspection; the matter was immediately remedied on 5/18/23. PCHA will ensure that emergency numbers are updated and posted by all telephones with an outside line connection.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *The PCHA posted the Emergency Telephone Numbers in the Personal Care Kitchenette during the inspection; the matter was immediately remedied on 5/18/23.*
2. *The PCHA will ensure that emergency numbers are updated and posted by all telephones with an outside line connection by conducting physical site inspections, at least monthly, starting 7/20/23.*
3. *The PCHA will discuss the importance of posting of emergency numbers by all telephones with an outside line connection at monthly staff meetings for the next six months, starting 7/12/23.*

Directed Completion Date: *07/25/2023*

Not Implemented (02/02/2024)

96a - First Aid Kit

22. 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 Impressions does not include scissors, gauze, eye covering, and tape.

The first aid kit on the personal care side only has bandages.

Repeat Violation Date: 7/25/22

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: The missing items were located in the Supply Station but were not placed in the First Aid Kit; the matter was immediately remedied on 5/18/23. PCHA and/or LPN Supervisor will refresh the First Aid Kits as needed. PCHA will also perform biweekly audit of First Aid kit to ensure that it is fully stocked with all required materials.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *The missing items were located in the Supply Station but were not placed in the First Aid Kit; the matter was*

96a - First Aid Kit (continued)

immediately remedied on 5/18/23 by the LPN Supervisor.

2. *PCHA and/or LPN Supervisor will refresh the First Aid Kits as needed, starting 7/20/23 by the PCHA will also performing biweekly audit of First Aid kit to ensure that it is fully stocked with all required materials.*
3. *The direct care staff will check the contents of the First Aid kit after each monthly fire drill to ensure the required materials are contained in the First Aid kit, starting 7/20/23.*

Directed Completion Date: *07/25/2023*

Not Implemented ([redacted] 02/02/2024)

103e - Left Overs

23. 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

In the Impressions refrigerator, there was a box of leftover donuts and two plastic bags with food. All were not labeled and dated.

In the Impressions freezer, there was a pack of partially eaten Reese's cups that was not labeled and dated.

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Action: Direct Care Staff, Activities Coordinator will not store any personal food items in Impressions fridge/freezer: Direct Care Staff will label & date any leftover food items belonging to residents that need to be placed in the fridge/freezer. PCHA will conduct weekly checks of the fridge/freezer to ensure that the only food will be that belonging to residents, which must be labeled & dated.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *The LPN supervisor will conduct a training with all Direct Care Staff, and the Activities Coordinator on understanding the importance of dating and labeling any food items in Impressions fridge/freezer by 7/20/23.*
2. *Direct Care Staff will label & date any leftover food items belonging to residents that need to be placed in the fridge/freezer, starting 7/12/23.*
3. *PCHA will conduct weekly checks of the fridge/freezer to ensure that the only food will be that belonging to residents, which must be labeled & dated, starting 7/20/23 for one month, they every month for the next six months.*

Directed Completion Date: *07/20/2023*

Not Implemented ([redacted] 02/02/2024)

103f - Refrigerator/Freezer Temps

24. 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

At 10:25 am, the temperature in the Impressions refrigerator was 42°F and the temperature in the freezer was 6°F.

103f - Refrigerator/Freezer Temps *(continued)*

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: Although there was a thermometer in the freezer during the inspection, it was found that the thermometer was outdated & therefore not accurate. PCHA ordered replacement freezer thermometers on 5/25/23; once received, PCHA will place new thermometer in the freezer. PCHA will perform weekly audits of refrigerator/freezer to ensure temperature regulations.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *The thermometer in the freezer during the inspection, was outdated & therefore not accurate and the PCHA ordered a replacement freezer thermometers on 5/25/23.*
2. *The PCHA will place new thermometer in the freezer by 7/12/23.*
3. *PCHA will perform weekly audits of refrigerator/freezer to ensure temperature regulations, starting 7/20/23, for four weeks, then monthly thereafter for the next six months.*

Directed Completion Date: *07/20/2023*

25. Requirements Not Implemented (02/02/2024)

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 in the personal care kitchenette.

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: PCHA ordered replacement fridge thermometers on 5/25/23; once received, PCHA will place new thermometer in the fridge. PCHA will perform weekly audits of refrigerator/freezer to ensure temperature regulations.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *The PCHA ordered a replacement freezer thermometers on 5/25/23.*
2. *The PCHA will place new thermometer in the freezer by 7/12/23.*
3. *PCHA will perform weekly audits of refrigerator/freezer to ensure temperature regulations, starting 7/20/23, for four weeks, then monthly thereafter for the next six months.*

Directed Completion Date: *07/20/2023*

Not Implemented (02/02/2024)

103g - Storing Food

26. Requirements

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

Description of Violation

In the Impressions freezer, there was a pack of partially eaten Reese's cups that was not sealed.

In the main kitchen, in refrigerator 3, there was a stick of butter and a pack of waffles not sealed.

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Action: Direct Care Staff, Activities Coordinator will not store any personal food items in Impressions fridge/freezer. Direct Care Staff will label & date any leftover food or stored food items belonging to residents that

103g - Storing Food (continued)

need to be placed in the fridge/freezer. PCHA will conduct weekly checks of the Impressions fridge/freezer to ensure that the only food will be that belonging to residents, which must be labeled, properly sealed & dated. Dietary Manager & Dietary Staff will refrain from placing or storing any personal food items in the main kitchen refrigerator/freezer. Dietary Manager & Dietary Staff will label, date and properly seal any leftover food, opened food or stored food items. PCHA in conjunction with Dietary Manager will conduct weekly checks of main kitchen fridge/freezer to ensure compliance of this regulation.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *The unlabeled and undated left over food was removed immediately during the inspection by the Dietary Manager.*
2. *The Dietary Manager will conduct a training with Direct Care Staff, and Activities Coordinator on the importance of labeling and dating any stored personal food items in Impressions fridge/freezer, by 7/20/23.*
3. *Direct Care Staff will label & date any leftover food or stored food items belonging to residents that need to be placed in the fridge/freezer, starting 7/15/23.*
4. *PCHA will conduct weekly checks of the Impressions fridge/freezer to ensure that the only food will be that belonging to residents, which must be labeled, properly sealed & dated.*
5. *Dietary Manager & Dietary Staff will refrain from placing or storing any personal food items in the main kitchen refrigerator/freezer, starting 7/15/23.*
6. *Dietary Manager & Dietary Staff will label, date and properly seal any leftover food, opened food or stored food items, starting 7/12/23.*
7. *PCHA in conjunction with Dietary Manager will conduct weekly checks of main kitchen fridge/freezer to ensure compliance of this regulation, for four weeks, then monthly thereafter for six months, starting 7/12/23.*

Directed Completion Date: *07/25/2023*

Not Implemented ([redacted] 02/02/2024)

103i - Outdated Food

27. Requirements

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

Description of Violation

In the walk-in refrigerator, there was a bag of shredded cheese, loaf of sliced cheese, and a tray of meat all not labeled and not dated.

In refrigerator 2, there were 3 2 Liter bottles of Pepsi and Iced Tea that were not dated.

In refrigerator 3, there were slices of cheese wrapped in plastic, a stick of butter, and a bag of waffles not labeled and not dated.

In refrigerator 4, there were 2 trays of Butterscotch pudding not labeled and dated.

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Correction; Dietary Manager & Dietary Staff will refrain from placing or storing any personal food items in

103i - Outdated Food (continued)

the main kitchen refrigerator/freezer. Dietary Manager & Dietary Staff will discard of any outdated/spoiled food appropriately. Dietary Manager & Dietary Staff will accurately label and date any opened food items. PCHA in conjunction with Dietary Manager will conduct weekly checks of main kitchen fridge/freezer to ensure compliance of this regulation.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *The unlabeled and undated left over food was removed immediately during the inspection by the Dietary Manager.*
2. *The Dietary Manager will conduct a training with Direct Care Staff, and Activities Coordinator on the importance of labeling and dating any stored personal food items in Impressions fridge/freezer, by 7/20/23.*
3. *Direct Care Staff will label & date any leftover food or stored food items belonging to residents that need to be placed in the fridge/freezer, starting 7/15/23.*
4. *PCHA will conduct weekly checks of the Impressions fridge/freezer to ensure that the only food will be that belonging to residents, which must be labeled, properly sealed & dated.*
5. *Dietary Manager & Dietary Staff will refrain from placing or storing any personal food items in the main kitchen refrigerator/freezer, starting 7/15/23.*
6. *Dietary Manager & Dietary Staff will label, date and properly seal any leftover food, opened food or stored food items, starting 7/12/23.*
7. *PCHA in conjunction with Dietary Manager will conduct weekly checks of main kitchen fridge/freezer to ensure compliance of this regulation, for four weeks, then monthly thereafter for six months, starting 7/12/23.*

Directed Completion Date: *06/13/2023* Not Implemented ([redacted] 02/02/2024)

107d - Procedure Emergency Management Agency Submission

28. Requirements

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

Description of Violation

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

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Correction: Maintenance Director will create & submit Emergency Mgmt Procedures to local Emergency Mgmt Agency,

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *The Maintenance Director will develop and submit the homes Emergency Procedures to the local Emergency Management Agency by 7/25/23.*
2. *Documentation of the submission of the Emergency Procedures will be maintained for the Departments review by the PCHA, starting 7/25/23.*
3. *The Maintenance Director will ensure the Emergency Procedures are updated and submitted to the local Emergency Management agency annually, as required, starting 7/2024.*
4. *The PCHA will review the Emergency Procedures to ensure they are complete and submitted to the local Emergency Management agency by 7/25/23 and annually thereafter.*
5. *The HR Director will provide training on the updated Emergency Procedures, at least, annually, starting*

107d - Procedure Emergency Management Agency Submission (continued)

7/25/23. Copies of the sign in sheets of the training will be maintained by the Department.

6. *The Maintenance Director will ensure the Emergency Procedures are posted in a conspicuous place in the home, by 7/25/23.*

Directed Completion Date: *07/25/2023* Not Implemented ([redacted] 02/02/2024)

121a - Unobstructed Egress

29. 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 5/18/23 the exit from Impressions is obstructed by a chair and a cart from the inside. From the outside, the same exit is obstructed by a patio chair.

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Correction: All exits/entrances will be unobstructed at all times. PCHA, Direct Care Staff, LPN Supervisor, Activities Coordinator will refrain from placing obstructions in entrance/exits paths and will remove obstructions if noticed, as needed.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *The Maintenance Director removed the chair from the exit on the day of the inspection.*
2. *All exits/entrances will be unobstructed at all times. PCHA, Direct Care Staff, LPN Supervisor, Activities Coordinator will refrain from placing obstructions in entrance/exits paths and will remove obstructions if noticed, starting 7/12/23.*
3. *The Maintenance Director and or maintenance staff will conduct daily physical site inspection of all exit doors to ensure they are not obstructed, starting 7/20/23.*
4. *The PCHA will conduct monthly physical site inspections of the home to ensure all exits are free and clear from obstructions, starting 7/20/23.*
5. *The PCHA will discuss the importance of not obstructing exits, in any manor, at the monthly staff meetings for the next six months, starting 7/20/23. The agenda and staff sign in will be maintained for the Departments review.*

Directed Completion Date: *07/25/2023*

Not Implemented ([redacted] 02/02/2024)

124 - Notice to Fire Department

30. Requirements

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

Description of Violation

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

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Correction: Maintenance Director will create, implement & submit documentation of written notification to

124 - Notice to Fire Department (continued)

the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency. Maintenace Director will provide a copy of this document to the PCHA and HR Director for record keeping purposes.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *Maintenance Director will create, implement & submit documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency BY 7/20/23.*
2. *Maintenance Director will provide a copy of this document to the PCHA and HR Director for record keeping purposes, by 7/20/23.*
3. *The PCHA will review the written notification to the local fire department, at least annually, starting 7/20/23.*

Directed Completion Date: *07/20/2023*

Not Implemented ([redacted] 02/02/2024)

132a - Monthly Fire Drill

31. Requirements

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

Description of Violation

An unannounced fire drill was not held during the following months: July 2022, Aug 2022, and April 2023.

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Action: Maintenace Director will conduct unannounced, monthly fire drills; a fire drill was conducted on 5/31/2023.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *Maintenance Director will conduct unannounced, monthly fire drills; a fire drill was conducted on 5/31/2023.*
2. *The PCHA will review the fire drill records, at least monthly, starting 7/20/23, to ensure fire drills are conducted and unannounced.*

Directed Completion Date: *07/25/2023*

Not Implemented ([redacted] 02/02/2024)

132b - Safety Inspection/Fire Drill

32. Requirements

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

Description of Violation

There was no fire safety inspection and no supervised fire drill for the Impressions area. Impressions is on a different floor from the personal care unit and on the opposite side of the building.

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

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: Maintenance Director will coordinate with local Fire Department (Fire Safety Expert) to complete facility Fire Safety Inspection & Fire Drill; the local Fire Chief is scheduled to report to the facility on 6/20/23 at 10:30am.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *Maintenance Director will coordinate with local Fire Department (Fire Safety Expert) to complete facility Fire Safety Inspection & Fire Drill; the local Fire Chief is scheduled to report to the facility on 6/20/23 at 10:30am.*
2. *The Maintenance Director will schedule the annual fire safety and fire drill inspections in advance of next July, 2024 to ensure the inspection and drill are completed timely.*
3. *The PCHA will review the annual fire safety drill to ensure all staff have attended and/or been educated on the fire drill procedures, starting 7/20/23.*
4. *The HR Director will add the annual fire safety drill to the annual staff training, to ensure all staff attend the drill in 2023 and 2024, by 7/20/23.*

Directed Completion Date: *07/25/2023*

Not Implemented (02/02/2024)

132c - Fire Drill Records

33. Requirements

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

Description of Violation

The fire drill record for the drill conducted on 9/30 does not include the year. None of the fire drill records include the number of residents in the home at the time of the drill and do not indicate which side of the building the drill is taken place. The personal care unit and the Secured Dementia Care Unit (SDCU) are located on opposites sides of the building and on different floors.

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: Maintenace Director will conduct, accurately document and record monthly, unannounced Fire Drills; an unannounced fire drill was conducted on the Secured Dementia Care Unit on 5/31/2023. Maintenace Director will document fire drills & provide a copy of the Fire Drill Record to the PCHA for record keeping.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *Maintenance Director will conduct, accurately document and record monthly, unannounced Fire Drills; an unannounced fire drill was conducted on the Secured Dementia Care Unit on 5/31/2023.*
2. *Maintenance Director will document fire drills & provide a copy of the Fire Drill Record to the PCHA for record keeping and review starting 7/20/23.*
3. *The PCHA will ensure that both the PCH and the SDCU have monthly fire drills and the drills are recorded with all of the required elements by checking the fire drill record, starting 7/20/23.*

Directed Completion Date: *07/25/2023*

Not Implemented (02/02/2024)

132d - Evacuation

34. 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 has a maximum safe evacuation time of 3 minutes and 30 seconds specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 3 minutes 30 seconds during the following drills: September 2022, November 2022, December 2022, January 2023, February 2023, and March 2023.

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: PCHA, LPN Supervisor, Direct Care Staff and Activities Coordinator will assist residents during evacuations procedures to ensure that evacuation time is not exceeded during fire drills.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *All staff on duty during the time of the unannounced fire drill, will provide evacuation assistance, as needed, starting 7/12/23.*
2. *The PCHA will review the staffing schedule and resident evacuation needs to ensure there are adequate staff to meet the needs of the residents during an emergency evacuation, starting 7/12/23.*
3. *In accordance with the local Fire Chief and the Maintenance Director, the staff will be trained on the proper evacuation techniques needed to assist the residents to the fire safe area within the time permitted for an extended evacuation time, by 7/25/23.*
4. *The LPN Supervisor will meet with the residents to explain the importance of timely evacuation during fire drills by 7/25/23.*
5. *The PCHA will discuss the emergency evacuation techniques at monthly staff meetings for the next six months, starting 7//12/23.*
6. *Documentation of the trainings and staff meetings will be maintained for the Departments review.*

Directed Completion Date: *07/25/2023* Not Implemented (02/02/2024)

141a - Medical Evaluation

35. 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 4 did not have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department.

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: Resident 4 had a medical evaluation conducted by in-house physician on at ; evaluation was recorded electronically.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *The LPN Supervisor scheduled Resident 4's medical evaluation with an in-house physician on at*

141a - Medical Evaluation (continued)

[redacted] *evaluation was recorded electronically and will be on the Departments required DME form.*

2. *The PCHA and/or LPN Supervisor will develop and utilize a tickler system to ensure all annual DME's are conducted annually as required, by 7/25/23.*
3. *The LPN supervisor will audit all resident annual DME's to ensure they are completed timely, by 7/30/23.*
4. *The PCHA will conduct a periodic review, at least bi-annually, of all resident DME's to ensure they are conducted annually starting 7/30/23.*

Directed Completion Date: *07/30/2023*

Not Implemented ([redacted] - 02/02/2024)

141a 1-10 Medical Evaluation Information

36. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 1's medical evaluation did not include a list of the resident's medications.

Plan of Correction ***Directed ([redacted] - 07/12/2023)***

Plan of Correction: Resident 1 had medical evaluation conducted by in house physician on [redacted] at [redacted]; evaluation was recorded electronically & resident's medications were listed.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *The LPN supervisor scheduled Resident 1's medical evaluation conducted by in house physician on [redacted] at [redacted] evaluation was recorded electronically & resident's medications were listed.*
2. *The LPN supervisor will provide representatives of the Department electronically signed by the physician upon request, starting 7/12/23.*
3. *The LPN supervisor will review all electronically completed DME's to ensure they include all of the required elements of this regulation, including a list of current medications, starting 7/20/23.*
4. *The PCHA will conduct a monthly review of, at least 10% of resident, electronic DME's to ensure they include all required elements of this regulation, starting 7/25/23.*

Directed Completion Date: *07/25/2023*

Not Implemented ([redacted] - 02/02/2024)

162c - Menus Posted

37. Requirements

2600.

162c - Menus Posted *(continued)*

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

The only menu posted in the home was a daily menu for Thursday. There was no weekly menu and no advanced weekly menu posted.

Plan of Correction ***Accept (- 07/12/2023)***

Plan of Correction: Dietary Manager will provide updated & accurate copies of the Weekly & Advanced Weekly Menu to PCHA or Activities Coordinator; menus will be displayed in a common & easily assessable area and also be available or residents at request. The current Weekly & Advance Weekly menu were posted in the Impressions & Personal Care common area bulletin boards on 5/18/23.

Licensee's Proposed Overall Completion Date: *06/12/2023* Not Implemented (- 02/02/2024)

183e - Storing Medications

39. 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 5/18/23, the Admelog insulin pen, which belongs to resident 2, did not have an open date. According to manufacturers instructions, unused portions of Admelog insulin must be used within 28 days of first opening.

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: LPN Supervisor will ensure that all 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. PCHA will conduct weekly checks to ensure that prescribed medications are used, stored, labeled & dated appropriately,

DIRECTED PLAN OF CORRECTION (7/12/23

1. *Resident #1's insulin pen will be discarded by 7/20/23 since it was not dated upon opening.*
2. *The LPN supervisor will provide training to all licensed staff and all med techs on the required dating of medications, upon opening, according to manufacture's instructions by 7/25/23.*
3. *The LPN supervisor or med tech will audit all open medications requiring dating to ensure they are properly dated or discard those not dated, by 7/25/23.*
4. *The PCHA will conduct a random audit of all open medications requiring dating, according to manufactures reequipments, at least monthly, starting 8/1/23.*
5. *Documentation of the trainings and audit will be maintained for the Departments review by the PCHA.*

Directed Completion Date: *07/30/2023* Not Implemented (- 02/02/2024)

185a - Implement Storage Procedures

40. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

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 glucometer on the Impressions med cart is not labeled with anyone's name.

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: All resident glucometers will be individually contained and labeled with the resident's name; the matter was immediately remedied on 5/18/23.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *The LPN supervisor ensured all resident glucometers will be individually contained and labeled with the resident's name; the matter was immediately remedied on 5/18/23 by the purchase of new glucometers.*
2. *The LPN Supervisor will audit all residents who use glucometers to ensure the staff are not sharing between residents by 7/15/23.*
3. *The LPN Supervisor will conduct a training to all licensed staff and med techs on the importance of not sharing glucometers, by 7/20/23.*
4. *The LPN Supervisor will conduct periodic, at least monthly for the next six months, a hands on check of all resident glucometers against the MAR documentation to ensure the glucometers are not being shared, starting 7/20/23.*
5. *The PCHA will conduct bi-annual review of glucometers to ensure they are not being shared and are correctly calibrated, starting 7/20/23.*

Directed Completion Date: *07/25/2023*

Not Implemented (- 02/02/2024)

41. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident 1 is prescribed Milk of Magnesia as needed. On 5/18/23 the medication was not available in the home.

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: The home did have the medication prescribed available in the home; however the medication was locked in the Supply Station. PCHA & LPN Supervisor will ensure that all prescribed medications are made available and are accessible to be administered.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *Resident #1's prescription of Milk of Magnesium will be made available at all times, starting 7/20/23.*
2. *The LPN supervisor will conduct a training of all med tech's to make them aware of the supply station of hours medications, by 7/20/23.*
3. *The LPN supervisor or med tech will conduct an audit of the supply stations medications to ensure they are available for administration at all times, initially and monthly thereafter, starting 7/25/23.*
4. *The PCHA will conduct an audit of house medications to ensure there is an adequate supply for all residents prescribed medications, starting 7/25/23.*
5. *Documentation of the trainings will be maintained for review by the HR Director, starting immediately.*

Directed Completion Date: *07/25/2023*

Not Implemented (- 02/02/2024)

187d - Follow Prescriber's Orders

42. Requirements

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

Description of Violation

Residents 1 and 2 did not receive any prescribed medications on the evening of 5/14/23.

Plan of Correction ***Directed (- 07/12/2023)***

Plan of Correction: In the event that a regularly scheduled dose of medication is withheld or refused, the LPN Supervisor's initial will be circled in the appropriate place in the Medication Administration Record Form (MAR) and a statement will be made on the back of the MAR & also documented in the Resident Progress Notes regarding the reason for the action. in the event that a medication is not available for administration to a resident, the pharmacy shall be notified to obtain the medication; the notification will be documented in the Resident Progress Notes.

DIRECTED PLAN OF CORRECTION (7/12/23

Directed Completion Date: *06/13/2023* Not Implemented (- 02/02/2024)

188b - Medication Error Reporting

43. Requirements

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

Description of Violation

Residents 1 and 2 did not receive any prescribed medications on the evening of 5/14/23. These medication error was not reported to the residents, the residents' designated persons and the prescribers.

Plan of Correction ***Directed (- 07/13/2023)***

Plan of Correction: In the event that a regularly scheduled dose of medication is withheld or refused, the LPN Supervisor's initial will be circled in the appropriate place in the Medication Administration Record Form (MAR) and a statement will be made on the back of the MAR & also documented in the Resident Progress Notes regarding the reason for the action. in the event that a medication is not available for administration to a resident, the pharmacy shall be notified to obtain the medication; the notification will be documented in the Resident Progress Notes. Additionally, the LPN Supervisor will immediately report the medication error to the resident, the resident's designated person and the prescriber and PCHA as well as document the occurrence in the Resident Progress Notes.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *In the event that a regularly scheduled dose of medication is withheld or refused, the LPN Supervisor's initial will be circled in the appropriate place in the Medication Administration Record Form (MAR) and a statement will be made on the back of the MAR & also documented in the Resident Progress Notes regarding the reason for the action. in the event that a medication is not available for administration to a resident, the pharmacy shall be notified to obtain the medication; the notification will be documented in the Resident Progress Notes. Additionally, the LPN Supervisor will immediately report the medication error to the resident, the resident's designated person and the prescriber and PCHA as well as document the occurrence in the Resident Progress Notes, starting 7/15/23.*
2. *The LPN Supervisor will provide a training on the identification of medication errors and the reporting process to all licensed staff and med techs, by 7/25/23. Documentation of the training will be maintained for the*

188b - Medication Error Reporting (continued)

Departments review.

3. *The LPN Supervisor or med tech will audit 10% of resident MAR's, monthly, to ensure all medication errors have been reported as required, starting 7/25/23. Documentation of the audit will be maintained for the Department review.*
4. *The PCHA will conduct a random MAR audit at least bi-monthly to ensure med errors are reported as required, starting 8/25/23.*

Directed Completion Date: *07/25/2023*

Not Implemented ([redacted] - 02/02/2024)

191 - Resident Right to Refuse

47. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident 1, admitted [redacted], has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Directed ([redacted] - 07/13/2023)***

Plan of Correction: The resident and [redacted] agreed upon designated person was presented with & also signed a copy of Resident Rights which notes a "Resident Right to Refuse" (page 20).

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *The administrator or business manager will discuss the residents right to refuse medications if they believe it is in error with resident #1 and obtain their signature, by 7/20/23.*
2. *If the resident refuses to sign the right to refuse document, at least two attempts are made to obtain the signature and document the attempts.*
3. *The business manager will audit all resident contracts to ensure the right to refuse medications has been signed by all residents by 7/25/23 and obtain the required signature.*
4. *The administrator will develop a checklist for all new admission documents to ensure compliance is maintained for all new admissions, by 7/25/23.*
5. *The administrator will review all new admission documents within 24 hours of admission to the home to ensure the required signature is completed, starting 7/20/23.*

Directed Completion Date: *07/25/2023*

Not Implemented ([redacted] - 02/02/2024)

224a - Preadmission Screen Form

48. Requirements

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

Description of Violation

Residents 1 and 4 do not have preadmission screening forms.

Plan of Correction ***Directed ([redacted] - 07/13/2023)***

Plan of Correction: PCHA and LPN Supervisor will conduct & document Preadmission Screen Form within 30 days

224a - Preadmission Screen Form (continued)

of a resident's admission; information will be recorded & stored electronically,

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *PCHA and LPN Supervisor will conduct & document Preadmission Screen Form within 30 days prior of a resident's admission; information will be recorded & stored electronically, starting 7/25/23.*
2. *The LPN Supervisor will complete a preadmission form for residents #1 and #4, using the current date as part of the plan of correction., by 7/25/23.*
3. *The PCHA and/or LPN Supervisor will conduct an audit of all resident preadmission records to ensure they have been completed, by 7/30/25.*
4. *The Admission Coordinator will receive training by the PCHA on the importance of ensuring the completed preadmission form is included in the admission packet, by 7/20/23.*
5. *The PCHA and Admissions Coordinator will develop and implement a checklist to include all required admission documents by 7/30/23.*
6. *The PCHA will review all new resident admission packets within 24 hours of admission to ensure all required documents are completed, starting 7/30/23.*
7. *The PCHA will conduct a random audit of all resident records at least bi-annually, starting 7/30/25.*

Directed Completion Date: *07/30/2023*

Not Implemented ([redacted] - 02/02/2024)

225a - Assessment 15 Days

49. Requirements

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

Description of Violation

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

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

Plan of Correction ***Directed ([redacted] - 07/13/2023)***

Plan of Correction: Resident 1 had an assessment conducted on [redacted] at [redacted], the assessment was recorded electronically. Resident 4 had an assessment conducted on [redacted] at [redacted]; the assessment was recorded electronically.

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *Resident 1 had an assessment conducted on [redacted] at [redacted] the assessment was recorded electronically. Resident 4 had an assessment conducted on [redacted] at [redacted]; the assessment was recorded electronically but was not available for the Departments review at the time of the inspection by the PCHA. A copy of the signed and completed assessments will be provided to the Department for review.*
2. *The LPN Supervisor will conduct an audit of all resident RASP's to ensure they are completed within 15 days of admission and updated annually, starting 7/20/23.*
3. *The PCHA and/or LPN Supervisor will develop and implement a tickler form to support the timely completion of new admission and annual completion of RASPs by 7/30/23.*
4. *The PCHA will develop and implement a checklist to include all resident documents as part of the admission packet or for the resident charts, by 7/30/23.*

225a - Assessment 15 Days (continued)

5. The PCHA will conduct bi-annual audit of at least 50% of all resident RASPs to ensure they are completed timely and complete, starting 8/30/23.

Directed Completion Date: *07/30/2023*

Not Implemented ([redacted] - 02/02/2024)

231c - Preadmission Screening

50. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident 1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident does not have a written cognitive preadmission screening.

Plan of Correction ***Directed ([redacted] - 07/13/2023)***

Plan of Correction: PCHA and LPN Supervisor will conduct & document Cognitive Preadmission Screening within 30 days of a resident's admission; information will be recorded & stored electronically,

DIRECTED PLAN OF CORRECTION (7/12/23 [redacted]

1. *PCHA and LPN Supervisor will conduct & document Cognitive Preadmission Screening within 30 days of a resident's admission; information will be recorded & stored electronically, starting 7/15/23.*
2. *The Geriatric Assessment team or the Resident #1s physician will complete the cognitive portion of the preadmission screening form by 7/25/23.*
3. *The LPN Supervisor will conduct an audit of all resident cognitive screens to ensure they are completed within 72 hours of admission. to the SDCU, starting 7/25/23.*
4. *The PCHA and/or LPN Supervisor will develop and implement a tickler form to support the timely completion of new admission and annual completion of RASPs by 7/30/23.*
5. *The PCHA will develop and implement a checklist to include all resident documents as part of the admission packet or for the resident charts, by 7/30/23.*
6. *The PCHA will conduct bi-annual audit of at least 50% of all resident preadmissions and cognitive screens for SDCU residents are completed timely and complete, starting 8/30/23.*

Directed Completion Date: *07/25/2023*

Not Implemented ([redacted] - 02/02/2024)

233b - Lock Manufacturer Statement

51. Requirements

2600.
233.b. A home shall have a statement from the manufacturer, specific to that home, verifying that the electronic or magnetic locking system will shut down, and that all doors will open easily and immediately when one of more of the following occurs:
1. Upon a signal from an activated fire alarm system, heat or smoke detector.
2. Power failure to the home.
3. Overriding the electronic or magnetic locking system by use of a key pad or other lock-releasing device.

233b - Lock Manufacturer Statement *(continued)*

Description of Violation

The home does not have a statement from the manufacturer of the locks on the exit doors in the Secure Dementia Care Unit verifying that the locks will release when the fire alarm system is activated, the home's power fails, and when the lock releasing device is operated.

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

Plan of Correction: Maintenace Director will contact the Lock Manufacturer to obtain necessary statement; once revived Maintenance Director will provide PCHA with a copy of the document, the original will be kept by the Maintenace Director in a labeled and easily assessable binder.

Licensee's Proposed Overall Completion Date: *06/12/2023*

Implemented (- 02/02/2024)

233c - Key-Locking Devices

52. 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 the door to the patio exit in the Secure Dementia Care Unit (SDCU). From the patio, the gate that exits the home also has no instructions for the locking mechanism. Repeat Violation Date: 7/25/22

Plan of Correction ***Directed (- 07/13/2023)***

Plan of Correction: The Secure Dementia Care Unit Patio Exit Instructions were not posted at the time of inspection; PCHA posted the required information on 5/18/23. However, the Patio Exit Gate Instructions were posted at the time of inspection.

DIRECTED PLAN OF CORRECTION (7/12/23

1. *The Secure Dementia Care Unit Patio Exit Instructions were not posted at the time of inspection; PCHA posted the required information on 5/18/23. However, the Patio Exit Gate Instructions were posted at the time of inspection.*
2. *The Maintenance Director of SDCU coordinator will conduct a monthly check of all entrances and exits to the SDCU to ensure directions to enter/exit are posted, starting 7/25/23.*
3. *The PCHA or LPN Supervisor will conduct periodic checks of the directions at the SDCU entrances and exits, at least bi-monthly, to ensure the directions are posted, starting 8/1/23.*

Directed Completion Date: *08/01/2023*

Not Implemented (- 02/02/2024)

234a - Admission Support Plan

53. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident 1 was admitted to the Secure Dementia Care Unit (SDCU) on . However, the resident's initial support plan was not completed.

234a - Admission Support Plan *(continued)*

Plan of Correction ***Directed (- 07/13/2023)***

Plan of Correction: PCHA will conduct & document Admission Support Plan within 72 hours of a resident's admission or within 72 hours prior to the resident's admission to the secured dementia care unit; information gathered will be recorded & stored electronically,

DIRECTED PLAN OF CORRECTION (7/12/23

1. *PCHA will conduct & document Admission Support Plan within 72 hours of a resident's admission or within 72 hours prior to the resident's admission to the secured dementia care unit; information gathered will be recorded & stored electronically,, STARTING 7/20/23.*
2. *Resident #1's RASP will be completed by 7/20/23, by the LPN supervisor as part of this plan of correction.*
3. *The LPN Supervisor will conduct an audit of all resident RASP's to ensure they are completed within 15 days of admission and updated annually, starting 7/20/23.*
4. *The PCHA and/or LPN Supervisor will develop and implement a tickler form to support the timely completion of new admission and annual completion of RASPs by 7/30/23.*
5. *The PCHA will develop and implement a checklist to include all resident documents as part of the admission packet or for the resident charts, by 7/30/23.*
6. *The PCHA will conduct bi-annual audit of at least 50% of all resident RASPs to ensure they are completed timely and complete, starting 8/30/23.*

Directed Completion Date: *07/25/2023*

Not Implemented (- 02/02/2024)

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

Facility Information

Name: *BRYN MAWR VILLAGE* **License #:** *14834* **License Expiration:** *03/29/2023*

Address: *773 EAST HAVERFORD ROAD, BRYN MAWR, PA 19010*

County: *DELAWARE* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *NORTHEAST PC OPERATIONS LLC*

Address: *773 EAST HAVERFORD ROAD, BRYN MAWR, PA, 19010*

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

Certificate(s) of Occupancy

Type: *I-2* **Date:** *09/03/2014* **Issued By:** *Haverford Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *41* **Waking Staff:** *31*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *10/17/2023*

Inspection Dates and Department Representative

10/17/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *33* **Residents Served:** *23*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Impressions* **Capacity:** *25* **Residents Served:** *15*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *23*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *18*

Have Physical Disability: *1*

Inspections / Reviews

10/17/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/11/2023*

Inspections / Reviews *(continued)*

11/13/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/31/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/18/2023*

11/27/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/31/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/27/2023*

02/02/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/31/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted], for Resident 1 was not signed by the resident.

Plan of Correction ***Accept ([redacted] - 11/13/2023)***

1. The Admissions Coordinator or PCHA will discuss the contract with resident and obtain their signature by 11/30/23. If the resident refuses to sign the contract, at least two attempts are made to obtain the signature and document the attempts.
2. The Admissions Coordinator or PCHA will audit all resident contracts to ensure the contracts have been signed by all residents by 11/30/23 and obtain the required signature.
3. The Admissions Coordinator and PCHA will develop a checklist for all new admission documents to ensure compliance is maintained for all new admissions, by 11/30/23.
4. The PCHA will review all new admission documents within 72 hours of admission to the home to ensure the required signature is completed, starting 11/1/23.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented ([redacted] - 02/02/2024)

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

Staff person A, whose first day of work was [redacted]/23, did not have a criminal background check completed prior to their first day of work. The background check on file was completed on [redacted]23.

Plan of Correction ***Accept ([redacted] - 11/13/2023)***

1. HR Director will obtain all required clearances prior to employee Start Date; if employee is Agency Staff, HR Director will obtain copy of clearances from hiring agency prior to employee reporting to the facility, starting 11/1/23.
2. HR Director will develop and implement a checklist to include all required new employee documentation, including criminal background checks, to assist in the timely completion of required new staff documents, by 11/30/23.
3. The HR Director will review the new staff documents prior to their 1st day on the job, to ensure the required documents have been completed, starting 11/1/23.
4. The HR Director will conduct an audit of all staff criminal backgrounds to ensure they are all completed by11/30/23.

51 - Criminal Background Check *(continued)*

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented ([redacted] - 02/02/2024)

65b - Rights/Abuse 40 Hours

3. 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 7/26/23. Staff person B completed [redacted] 40th scheduled work hour on 8/8/23. However, these staff persons did not complete training in the reporting of reportable incidents and conditions.

Repeat Violation Date: 7/25/22

Plan of Correction ***Accept ([redacted] - 11/13/2023)***

1. The HR Director will conduct the required 40-hour Resident Rights, Abuse, Incident Reporting orientation to staff by 11/30/23.
2. HR Director will develop and implement a checklist to include all required new employee documentation, including orientation & trainings, to assist in the timely completion of required new staff documents, by 11/30/23.
3. The HR Director will review the new staff documents prior to their 1st day on the job and immediately following the 40-hour time frame, to ensure the required training has been completed, starting 11/1/23.
4. The HR Director will conduct an audit of all staff orientation training to ensure they are all completed by 11/30/23.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented ([redacted] - 02/02/2024)

82c - Locking Poisonous Materials

4. Requirements

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

Description of Violation

A bottle of Listerine Ultra Clean, a tube of Crest Pro Health toothpaste, a tube of Crest Plus toothpaste, and an Old Spice deodorant, all with a manufacture's label indicating "If swallowed, get medical help or contact a Poison Control Center immediately," were unlocked, unattended, and accessible to Resident 2's bathroom sink and cabinet. Not all the residents of the home, including Resident 2, have been assessed capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials (continued)

Two bottles of Freshscent roll-on deodorants and a tube of Freshmint toothpaste, all with a manufacture's label indicating "If swallowed, get medical help or contact a Poison Control Center immediately," were unlocked, unattended, and accessible to Resident 3's bathroom sink. Not all the residents of the home, including Resident 3, have been assessed capable of recognizing and using poisons safely.

A bottle of Freshscent roll-on deodorant, a Secret deodorant, a tube of DawnMist Fluoride toothpaste, and a tube of Freshmint toothpaste, all with a manufacture's label indicating "If swallowed, get medical help or contact a Poison Control Center immediately," were unlocked, unattended, and accessible to Resident 4's bathroom sink. Not all the residents of the home, including Resident 4, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept (- 11/13/2023)***

1. The PCHA, LPN Supervisor will provide inhouse training to all Direct Care Staff in regard to securing poisonous materials after care is provided; PCHA/LPN Supervisor will in-service staff members by 11/30/23.
2. PCHA will conduct random weekly rounds to check that poisonous materials are locked & inaccessible in residents' rooms, starting 11/1/23.
3. The PCHA removed all poisonous materials upon discovery on the day of the inspection.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented (- 02/02/2024)

96a - First Aid Kit

5. 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 nurses station does not include eye coverings.

Plan of Correction ***Directed (- 11/27/2023)***

1. A box of Disposable Face Shields (eye coverings) are always available and were available at the time of survey; face shields are located near the First Aid Kit which is located in the Nurses' Station.
2. Disposable Plastic Eye Sheilds were purchased on 11/16/2023 and placed inside of the First Aides Kits to ensure availability.

Repeat Violation Date: 7/25/22
DIRECTED PLAN OF CORRECTION:
In addition to the above plan of correction the administrator or designee shall complete a monthly audit of the first aid kits in the home by the 15th of every month for the next 3 months, then quarterly thereafter.

Directed Completion Date: *11/20/2023*

Not Implemented (- 02/02/2024)

103e - Left Overs

6. 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.

103e - Left Overs *(continued)*

Description of Violation

There was an unlabeled, undated leftover sandwich in the refrigerator #2 in the main kitchen.

There were two pitchers of juice and half a cup of applesauce that were unlabeled and undated in the memory care kitchen refrigerator.

There was an unlabeled, undated cup of orange slice in the second-floor kitchenette refrigerator.

Plan of Correction ***Accept ([redacted] - 11/13/2023)***

1. The LPN supervisor will conduct a training with all Direct Care Staff, and the Activities Coordinator on understanding the importance of dating and labeling any food items in Impressions fridge/freezer by 11/30/23.
2. Direct Care Staff and Activities Coordinator will label & date any leftover food items belonging to residents that need to be placed in the fridge/freezer, starting 11/1/23.
3. PCHA will conduct weekly checks of the fridge/freezer to ensure that the only food will be that belonging to residents, which must be labeled & dated, starting 11/1/23.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented ([redacted] - 02/02/2024)

103f - Refrigerator/Freezer Temps

7. 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 10/17/23 at 9:50am, the temperature in the memory care refrigerator was 42 degrees Fahrenheit.

On 10/17/23 at 2:35pm, the temperature in the second-floor kitchenette refrigerator was 45 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 11/27/2023)***

1. PCHA will perform weekly audits of refrigerator/freezer to ensure temperature regulations, starting 11/1/23, for eight weeks, then monthly thereafter for the next six months.
2. PCHA adjusted temperature control setting of the refrigerator/freezer and placed it on the coldest setting to ensure that temperature remains within regulation standards.

Proposed Overall Completion Date: 11/20/2023

Licensee's Proposed Overall Completion Date: *11/20/2023*

Not Implemented ([redacted] - 02/02/2024)

132b - Safety Inspection/Fire Drill

8. Requirements

2600.

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

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

Description of Violation

The last fire safety inspection observed by a fire safety expert was conducted on 8/3/22.

Plan of Correction ***Accept ([redacted] - 11/13/2023)***

1. Maintenance Director will coordinate with local Fire Department (Fire Safety Expert) to complete facility Fire Inspection & Fire Drill.
2. The Maintenance Director will schedule the annual fire safety and fire drill in Inspections in advance of next July 2024 to ensure the inspection and drill are completed timely.
3. The Maintenance Director will review the annual fire safety drill to ensure all staff have attended and/or been educated on the fire drill procedures, starting 11/1/23.
4. The HR Director will add the annual fire safety drill to the annual staff training, to ensure all staff attend the drill in 2023 and 2024, by 11/30/23.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented ([redacted] - 02/02/2024)

132d - Evacuation

9. 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 has a maximum safe evacuation time of 3 minutes and 30 seconds specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 3 minutes 30 seconds during the following drills: 5/31/23 at 1:15pm, 7/27/23 at 9:48pm, and 9/28/23 at 6:40am.

Plan of Correction ***Accept ([redacted] - 11/13/2023)***

1. All staff on duty during the time of the unannounced fire drill, will provide evacuation assistance, as needed, starting 11/1/23.
2. The PCHA will review the staffing schedule and resident evacuation needs to ensure there are adequate staff to meet the needs of the residents during an emergency evacuation, starting 11/1/23.
3. In accordance with the local Fire Chief and the Maintenance Director, the staff will be trained on the proper evacuation techniques needed to assist the residents to the fire safe area within the time permitted for an extended evacuation time, by 11/30/23.
4. The LPN Supervisor will meet with the residents to explain the importance of timely evacuation during fire drills by 11/30/23.
5. The PCHA will discuss the emergency evacuation techniques at monthly staff meetings for the next six months, starting 11/1/23.
6. Documentation of the trainings and staff meetings will be maintained for the Departments review.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented ([redacted] - 02/02/2024)

132g - Fire Drills Days/Times

10. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills on the last week of the month as evidenced by the following drills on 5/31/23, 6/28/23, 7/27/23, 8/30/23, and 9/28/23.

Plan of Correction ***Accept (- 11/27/2023)***

1. Maintenance Director will conduct monthly fire drills during various days of the week, at various times of day & night beginning 11/1/23.
2. Maintenance Director in conjunction with PCHA will review fire drills records quarterly, beginning 12/1/2023.

Licensee's Proposed Overall Completion Date: *11/20/2023*

Not Implemented (- 02/02/2024)

162c - Menus Posted

11. 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

The home's current weeks menu was not posted in a conspicuous and public place in the home, additionally there was no future weeks menu posted in the home.

Plan of Correction ***Accept (- 11/27/2023)***

1. Dietary Director will provide updated & accurate copies of the Weekly & Advanced Weekly Menu to PCHA or Activities Coordinator; menus will be displayed in a common & easily assessable area and also be available or residents at request beginning 11/1/23,
2. Dietary Director immediately posted the current Weekly & Advance Weekly menu in the Impressions & Personal Care common area bulletin boards.
3. Dietary Directory will provide in-service training to Dietary staff by 11/30/23, to ensure regulatory standards are upheld.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented (- 02/02/2024)

183b - Meds and Syringes Locked

12. 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 10/17/23 at 9:35am, three tubes of PeriGuard Ointment were unlocked, unattended, and accessible in Resident

183b - Meds and Syringes Locked (continued)

3's bathroom sink in memory care.

On at 9:40am, five tubes of PeriGuard Ointment were unlocked, unattended, and accessible in Resident 4's bathroom sink and cabinet in memory care.

Plan of Correction ***Accept (- 11/13/2023)***

1. The PCHA, LPN Supervisor will provide inhouse training to all Direct Care Staff in regard to securing OTC medication creams after care is provided; PCHA/LPN Supervisor will in-service staff members by 11/30/23.
2. PCHA will conduct random weekly rounds to check that OTC medication creams are locked & inaccessible in residents' rooms, starting 11/1/23.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented (- 02/02/2024)

183e - Storing Medications

13. 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 10/17/23 at 10:15am, there were two loose, round, pink pills in the second drawer of the medication cart in memory care.

On 10/17/23, the Humalog KwikPen, which belongs to Resident 5, did not have an open date. According to the manufacturer's instructions, it must be thrown away 28 days after the first use.

Plan of Correction ***Accept (- 11/27/2023)***

1. The LPN supervisor will audit all open medications requiring dating to ensure they are properly dated or discard those not dated, by 11/1/23.
2. The PCHA will conduct a random audit of all open medications requiring dating, according to manufactures reequipments, at least monthly, starting 11/1/23.
3. The LPN Supervisor will conduct weekly audit of medication cart to ensure that all medications are properly stored and accounted for, starting 11/1/23.
4. PCHA will provide in-service training to all Nursing staff by 11/30/23 to ensure regulations standards are followed appropriately.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented (- 02/02/2024)

185a - Implement Storage Procedures

14. 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 10/8/23 at 5:31pm, Resident 5's blood glucose reading was 152. However, it was documented as 150 on

185a - Implement Storage Procedures (continued)

the Medication Administration Record.

On 10/8/23 at 5:31pm, Resident 5's blood glucose reading was 212. However, it was documented as 229 on the Medication Administration Record.

On 10/10/23 at 7:10pm, Resident 5's blood glucose reading was 106. However, it was documented as 108 on the Medication Administration Record.

On 10/11/23 at 11:37am, Resident 5's blood glucose reading was 163. However, it was documented as 169 on the Medication Administration Record.

On 10/12/23 at 8:59pm, Resident 5's blood glucose reading was 248. However, it was documented as 258 on the Medication Administration Record.

On 10/15/23 at 6:05pm, Resident 5's blood glucose reading was 154. However, it was not documented on the Medication Administration Record.

On 10/17/23 at 1:58pm, Resident 5's glucometer was not calibrated to the correct time. The glucometer was set to 10/17/23 at 11:52am.

Resident 5 is prescribed the following medications where were not available in the home on 10/17/23:

- Dulcolax Rectal Suppository, insert 1 suppository rectally every 24 hours as needed for constipation
- Fleet Enema Rectal Enema, insert 1 application rectally every 24 hours as needed for constipation
- Guaifenesin Liquid 100mg/5ml, give 10 milliliters by mouth every 4 hours as needed for cough
- Hydralazine HCl Oral tablet 25mg, give 1 tablet by mouth every 24 hours as needed for essential hypertension
- Loperamide HCl Capsule 2mg, give 1 capsule by mouth every 10 hours as needed for diarrhea.

Plan of Correction ***Accept ([redacted] - 11/27/2023)***

1. The LPN Supervisor will conduct bi-weekly review of glucometers to ensure they are correctly calibrated, starting 11/1/23.
2. The LPN supervisor will conduct an audit of the supply stations medications to ensure they are available for administration at all times, initially and monthly thereafter, starting 11/1/23.
3. The PCHA will conduct a monthly audit of house medications to ensure there is an adequate supply for all residents prescribed medications, starting 11/1/23.
4. PCHA will provide in-service training to all Nursing staff by 11/30/23 to ensure regulations standards are followed appropriately.

Licensee's Proposed Overall Completion Date: 11/30/2023

Not Implemented ([redacted] - 02/02/2024)

187d - Follow Prescriber's Orders

15. Requirements

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

Description of Violation

On 10/2/23 at 5:40pm, Resident 5's glucometer did not register a reading. However, a blood glucose level of 222 was documented on the Medication Administration Record.

On 10/4/23 at 6:17pm, Resident 5's glucometer did not register a reading. However, a blood glucose level of 115 was documented on the Medication Administration Record.

On 10/6/23 at 11:34am, Resident 5's glucometer did not register a reading. However, a blood glucose level of 177 was documented on the Medication Administration Record.

On 10/6/23 at 8:12pm, Resident 5's glucometer did not register a reading. However, a blood glucose level of 182 was documented on the Medication Administration Record.

On 10/7/23 at 8:41pm, Resident 5's glucometer did not register a reading. However, a blood glucose level of 115 was documented on the Medication Administration Record.

On 10/13/23 at 12:08pm, Resident 5's glucometer did not register a reading. However, a blood glucose level of 148 was documented on the Medication Administration Record.

Plan of Correction ***Directed ([redacted] - 11/27/2023)***

1. The LPN Supervisor will conduct bi-weekly review of glucometers to ensure they are correctly calibrated, starting 11/1/23.
2. PCHA will provide in-service training to all Nursing staff by 11/30/23 to ensure regulations standards are followed appropriately.

DIRECTED PLAN OF CORRECTION:
In addition to the above plan, the LPN supervisor or designee shall audit glucometer readings and compare the readings to the recorded information on the residents glucose logs. The audits shall be completed weekly for 1 month then twice monthly for 3 months. Any areas of non-compliance identified during these audits will prompt the LPN supervisor or designee to conduct an immediate in-service training with the staff responsible. Audits and in-service trainings shall be documented.

Directed Completion Date: *11/30/2023*

Not Implemented ([redacted] - 02/02/2024)

231c - Preadmission Screening

16. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

231c - Preadmission Screening *(continued)*

Description of Violation

Resident 1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's written cognitive preadmission screening was completed on [redacted]

Resident 6 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's written cognitive preadmission screening was completed on [redacted].

Resident 7 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's written cognitive preadmission screening was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 11/13/2023)***

1. PCHA will conduct & document Cognitive Preadmission Screening within 72 hours of a SDU resident's admission; information will be recorded & stored electronically, starting 11/1/23.
2. PCHA will complete the cognitive portion of the preadmission screening form starting 11/1/23.
3. The LPN Supervisor will conduct an audit of SDU resident cognitive screens to ensure they are completed within 72 hours of admission starting 11/1/23.
4. The PCHA will develop and implement a checklist to include all resident documents as part of the admission packet or for the resident charts, by 11/30/23.
5. The PCHA will conduct bi-annual audit of at least 50% of all SDU resident preadmissions and cognitive screens are completed timely and complete, starting 11/1/23.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented ([redacted] - 02/02/2024)

234a - Admission Support Plan

17. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident 1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was completed on [redacted].

Resident 6 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] However, the resident's initial support plan was completed on [redacted]

Resident 7 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's initial support plan was completed on [redacted].

Plan of Correction ***Accept ([redacted] - 11/13/2023)***

1. PCHA or LPN Supervisor will conduct & document Admission Support Plan within 72 hours of a resident's admission or within 72 hours prior to the resident's admission to the secured dementia care unit; information gathered will be recorded & stored electronically, starting 11/1/23.
2. The LPN Supervisor will conduct an audit of all SDU resident RASPs to ensure they are completed within 72

234a - Admission Support Plan (continued)

hours of admission and updated annually, starting 11/1/23.
3. The PCHA will develop and implement a checklist to include all resident documents as part of the admission packet or for the resident charts, by 11/30/23.
4. The PCHA will conduct bi-annual audit of at least 50% of all resident RASPs to ensure they are completed timely and complete, starting 11/1/23.

Licensee's Proposed Overall Completion Date:

Not Implemented (- 02/02/2024)