pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: SEPTEMBER 26, 2023

[redacted]
Ark Manor LLC
105 Sandra Drive
Delmont, Pennsylvania 15626

RE: Ark Manor
License/COC #: 446863

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on April 6, 2023, June 1, 2023, June 2, 2023, and June 5, 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), failure to submit an acceptable plan to correct noncompliance items, and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby REVOKES your certificate of compliance (license number 446862) dated March 17, 2023 – September 17, 2023, and issues you a THIRD PROVISIONAL license to operate the above facility. A THIRD 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) and 55 Pa. Code § 20.71(a)(2); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your THIRD PROVISIONAL license is enclosed and is valid from September 26, 2023 to March 26, 2024.

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

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
82(c)	II	35	$5	$175	5 calendar days from mailing date of this letter
85(a)	II	35	$5	$175	5 calendar days from mailing date of this letter
85(e)	II	35	$5	$175	5 calendar days from mailing date of this letter
88(a)	II	35	$5	$175	5 calendar days from mailing date of this letter
100(a)	II	35	$5	$175	5 calendar days from mailing date of this letter
141(a)	II	35	$5	$175	5 calendar days from mailing date of this letter
183(b)	II	35	$5	$175	5 calendar days from mailing date of this letter
185(a)	II	35	$5	$175	5 calendar days from mailing date of this letter
187(b)	II	35	$5	$175	5 calendar days from mailing date of this letter
187(d)	II	35	$5	$175	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not

been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a 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 PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

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

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

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: *ARK MANOR* **License #:** *44686* **License Expiration:** *09/17/2023*

Address: *105 SANDRA DRIVE, DELMONT, PA 15626*

County: *WESTMORELAND* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *ARK MANOR LLC*

Address: *105 SANDRA DRIVE, DELMONT, PA, 15626*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/23/2006* **Issued By:** *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *38* **Waking Staff:** *29*

Inspection Information

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

Reason: *Complaint, Provisional, Monitoring* **Exit Conference Date:** *06/05/2023*

Inspection Dates and Department Representative

06/01/2023 - On-Site: [redacted]
06/02/2023 - On-Site:
06/05/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *70* **Residents Served:** *35*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *17* **Are 60 Years of Age or Older:** *30*

Diagnosed with Mental Illness: *15* **Diagnosed with Intellectual Disability:** *4*

Have Mobility Need: *3* **Have Physical Disability:** *0*

Inspections / Reviews

06/01/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/03/2023*

07/10/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/28/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/17/2023*

07/21/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/28/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/28/2023*

08/03/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/28/2023*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 6/2/23, at approximately 12:40 p.m., the home's medication cart was left unattended, unlocked, and accessible in alcove area across from the dining room and to the doors to the resident's smoking area. The key to the narcotic drawer was in the lock and a set of keys on top of medication cart. The following documents were unsecured on top of the med cart, to include:

** The home's narcotic book, that included narcotic sheets for resident #1's Lorazepam 2mg and Methylphenidate 20mg.*

** Resident #2's DME and IDT discharge instructions.*

** Resident #3's physician orders.*

** A "Glucometer Readings" document, dated 6/2/23, with resident's blood glucose levels recorded for resident's #2, #4, #5, and #6 recorded on it.*

Repeat Violation: 11/8/22, et.al.

Plan of Correction ***Accept [redacted] - 07/10/2023)***

-Med Tech staff given a verbal re-education on 2600.17 immediately while inspectors were on site by assistant administrator.

-All staff will be retrained on 2600.17, record confidentiality. Staff re-training scheduled for July 10,2023. Documentation of retraining will be kept.

Administration will walk through the facility each day she is scheduled x 4 weeks beginning 7/11/2023 to ensure all records remain confidential. Documentation of checks will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023*

Implemented [redacted] 08/03/2023)

66a - Staff Training Plan

2. 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 the 2023 training year.

Plan of Correction ***Accept [redacted] 07/10/2023)***

Annual staff training plan was developed with assistant administrator and outside agency, Viaquest Hospice, on 6/6/2023. Staff education will be completed for 2023 with this developed plan. Documentaition of annual trainings will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023*

Implemented - [redacted] 8/3/23

81b - Resident Personal Equipment

3. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 6/1/23, at approximately 1:40 p.m., there were two portable oxygen tanks on the floor by the bookcases, not in a storage rack or carrying case, and not secured approximately 3' from the emergency exit door in the back sitting area in the green hall Wing 1. Staff indicated the resident who used the oxygen tanks was no longer in the home.

Plan of Correction ***Accept [redacted] - 07/10/2023)***

-On 6/1/23, when inspectors were on site, oxygen tanks were removed from the hallway area and placed into the medroom area. Oxygen provider contacted and equipment returned.
-Re-education on 2600.81.b is scheduled for 7/10/2023 for all staff.
-Administration will do a walk-through of the facility in entirety minimally of weekly, beginning on 7/11/2023 x4weeks to verify compliance with 2600.81.b- ensuring Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented - [redacted] 8/3/23

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

On 6/1/23, at approximately 10:20 a.m., the laundry room/shower room #413 door was open and unlocked. There were two full 170 FL oz. bottles of Ecos Pro Laundry Detergent on a small table with a manufacturer's label indicating "If swallowed or gets in mouth, drink a glassful of water to dilute and seek medical treatment call a poison control center or physician." The room was unattended and accessible to the residents.

On 6/1/23, at approximately 2:35 p.m., the following poisons were unlocked, unattended and accessible in the cabinet under the sink in the dining room, to include:
** A full one-gallon bottle of Array Germicide Bleach and Disinfectant with a manufactures label "Call Poison Control Center or doctor, if ingested*
** A full 1.12-gallon container of Pine Sole Multi Surface Cleaner with a manufactures label: Call Poison Control Center or doctor immediately if treatment advice if ingested. Have person sip a glassful of water if able to swallow. DO NOT induce vomiting unless told to do so b a poison control center or doctor.*
** A one-gallon container of Mr. Clean Professional Finish Floor Cleaner Liquid Concentrate with a manufactures label: If swallowed: Rinse mouth and drink a glass of water. Call a poison control center if you feel unwell. Do not induce vomiting unless they tell you to do so.*
** A 52 FL oz bottle of Array Citrus Spray and Wipe Cleaner with a manufactures label: "Call Poison Control Center or doctor if swallowed.*

Not all residents of the home, have been assessed capable of recognizing and using poisons safely, to include residents #7 and #8.

Repeat Violation: 11/8/22, et.al.

82c - Locking Poisonous Materials *(continued)*

Plan of Correction ***Accept [redacted] 07/10/2023)***

-on 6/5/2023- House Keeper, [redacted] re educated on 2600.82.c with assistant administrator, [redacted] Documentation of education will be kept. After re education, House keeper, [redacted] promptly checked all areas of the facility to ensure compliance with regulation 2600.82.c
-[redacted] will continue to do checks to ensure compliance each of her scheduled housekeeping days. Administration will also ensure compliance with walk throughs of the facility, minimally of 3 times per week x 4 weeks beginning 7/11/2023. Documentation will be kept.
-Staff will be re education on 2600.82.c onMonday 7/10/2023- documentation of education will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023*

Not Implemented - [redacted] 8/3/23

83a - Indoor Temperature

5. Requirements

2600.
83.a. The indoor temperature, in areas used by the residents, must be at least 70°F when residents are present in the home.

Description of Violation

On 6/5/23, at approximately, 12:22 p.m. temperature in bedroom #400 measured approximately 63.3 degrees Fahrenheit in the purple hall/Wing 4 that is shared with resident's #9 and #10. The two thermostats just before bedroom #400 indicated a temperature of 65 degrees on the left and on the right appeared to be set at 58 degrees Fahrenheit. There was condensation on the inside of the glass window of the emergency exit door. There are three other bedrooms and a total of four residents residing at that end of the hallway.

Plan of Correction ***Accept ([redacted] - 07/10/2023)***

-Maintenance notified of low temperatures when state inspectors were on site. Issue resolved same day.
-Staff re education on 2600.83.a, for all staff, scheduled for Monday 7/10/2023.
-Temperatures in all hallways will be checked daily x 4 weeks beginning 7/11/2023, if temperatures read below 70 degrees Fahrenheit, maintenance will be notified and expected to repair immediately. Documentation of these checks will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023*

Not Implemented - [redacted] 8/3/23

85a - Sanitary Conditions

6. Requirements

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

Description of Violation

On 6/1/23 at 10:15 a.m., there were the following unsanitary conditions in the shower room in Wing 4, to include dried fecal spatter over the inside rim of the toilet bowl in the Wing 4 shower room.

On 6/1/23, at approximately 10:40 a.m. the following unsanitary conditions were observed in the kitchen, as follows:
** Panasonic counter microwave- there is a dried reddish substance that appeared to be a tomato sauce, spattered over the entire interior of the microwave, including the interior of the door.*
** The lid to the large electric roaster next to the microwave, had a dried reddish substance along the lid edges.*

85a - Sanitary Conditions (continued)

** The two stainless tea kettles on the stove have a heavy residue of grease and food spatter over both tea kettles.*
** There is a heavy concentration of dirt, grease, food residue over the top of the stove and on the outside of the oven doors and handles.*
** There is a heavy concentration of dirt and food residue over the exterior side of the stainless-steel refrigerator's double doors.*
** There is a lunch tray in the refrigerator with assorted condiments to include, ketchup, mustard, syrup, along with nine plastic bottles with spouts containing assorted condiments to include, mayonnaise, tartar sauce, Italian salad dressing, French dressing, ranch dressing, barbecue sauce. The plastic bottles do not have lids over the openings. There are three bottles that have fallen over and leaked the contents over the tray and over the other bottles. There is residue from the condiment around the outside bottom of the cap that has discolored and crusted and over the top of the lids and crusted over the opening of the spouts.*
** There is a large puddle of a sticky maple color substance, that appears to be syrup with a one-gallon container of Log Cabin Syrup set on top of the puddle.*

On 6/1/23, at approximately 2:05 p.m., there was approximately 1/8" of dust/dirt on and inside the slats of the ceiling exhaust fan cover in the Jack and Jill bathroom shared with bedroom #103.

On 6/1/23, at approximately 2:35 p.m., there were no paper towels, mechanical air blower, individual cloth towels or other means of safe hand drying at the sink in the dining room.

On 6/1/23, there were the following unsanitary conditions noted in multiple areas of the exterior of the home, to include:
** There was a pile of dead dry leaves approximately 6' by 3' with approximately four cigarette butts laying throughout between Wing 4 and Wing 1 on the exterior of the home.*
** Along the sidewalk from the sunroom, cigarette butts noted along the edges of the sidewalk, on the ground under the shrubbery, in and around the gazebo*
** Multiple cigarette butts in and around the gazebo.*
** Four cigarette butts where the sidewalk meets the edge of the covered patio.*
** Approximately 100 or more cigarettes on the ground along the edge of the covered patio, in the landscaping along the covered patio and up around the grill on the patio.*
** On the ground around the chairs and along the garage of the staff smoking area was approximately 20 cigarette butts or more and assorted trash, to include: an empty small can of Shasta Cola, an empty pack of Cheyenne Cigarettes, an empty "Custer Monster" Vape Juice container.*

Repeat Violation: 2/13/23, 11/8/22, et.al.

Plan of Correction ***Accept [redacted] - 07/10/2023)***

Shower room located in wing 4 was cleaned promtly while inspectors were on site 6/1/23 at approx 10:25am.
Dietary staff cleaned the following areas in the kitchen promtly after inspection (6/5/23) all kitchen counters, the lid on the electric roaster, kettles, stove top, oven doors, the exterior of the fridge, Syrup containers cleaned. All condiement bottles disposed of and new (non reusable) bottles purchased and will continue to purchase non reusable condiment (bottles).
Housekeeping checked availabilty of paper towels in all restroom areas of the facility and will continue to do so minimally of every other day- documentation will be kept x 4 weeks
Maintenance assigned to ensure sanitary conditions [redacted] once per week- documentation will be kept x4weeks.
7/10/23 [redacted]

85a - Sanitary Conditions (continued)

Staff re education scheduled for 7/10/23. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023*

Not Implemented [redacted] 8/3/23

85b - Infestation

7. Requirements

2600.
85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On 6/1/23 at approximately 11:30 a.m., there were approximately 4 gnats observed on the walls and flying around in the pantry and kitchen. There were approximately four flies in the kitchen.

On 6/1/23, at approximately 2:40 p.m., the basement steps and floor had had an accumulation of dead drain flies present. There was the presence of live drain flies flying about too numerous to count. There were multiple fly strips hanging from the ceiling that were covered with dead drain flies. There were live drain flies present on the exterior of the hot water tank, the trash can and walls in the basement.

Repeat Violation: 11/8/22, et.al.

Plan of Correction ***Accept ([redacted] - 07/10/2023)***

-Ehrlich contacted and in for insect inspection/treatment on 6/2/2023. Verification of visit attached.
-Maintance re educated on 2600.85b, documentation will be kept.
-complete walk through of the facility in entirety will be done minimally of twice weekly by administration and/or maintanence to ensure no infestation of insects or rodents in the facility.

Licensee's Proposed Overall Completion Date: *07/03/2023*

Implemented [redacted] - 08/03/2023)

85d - Trash Receptacles

8. 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

On 6/1/23, at approximately 2:00 p.m., and 6/5/23, at approximately 11:37 a.m., there was no lid on the small trash can in the Jack & Jill bathroom shared with bedroom #103.

On 6/1/23, at approximately 2:40 p.m., there was no lid on the trash can in the shared bathroom with bedroom #301.

Plan of Correction ***Accept ([redacted] - 07/21/2023)***

Kitchen and bathroom areas all checked to ensure that all areas have a covered trash receptacles. New cans with lids provided in each area not in compliance, including the bathrooms of room 103 and 301.
All staff will be retrained on 2600.85.d. re education scheduled for 7/10/2023. documentation of re education will be kept. Beginning 7/11/2023 administration will do walk through of facility in entirety to ensure compliance with 2600.85.d. minimally of 3 times per week x 4 weeks. Documentation of weekly walk throughs will be kept.

Licensee's Proposed Overall Completion Date: *07/17/2023*

Not Implemented [redacted] 8/3/23

85e - Trash Outside Home

9. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 6/1/23, at approximately 2:55 p.m., there was a blue 30-gallon garbage can that had no lid and was approximately ¼ full of trash, to include: multiple empty plastic pop bottles, multiple food wrappers, multiple cigarette butts, and several plastic cups in the middle of the covered patio.

Repeat Violation: 11/8/22, et.al.

Plan of Correction ***Accept [redacted] 07/21/2023)***

Trash can located outside was replaced with new receptacle with lid.
All staff will be retrained on 2600.85.e. re education scheduled for 7/10/2023. documentation of re education will be kept. Beginning 7/11/2023 administration will check all outside receptacles to ensure they are covered and in compliance with 2600.85.d. minimally of 3 times per week x 4 weeks. Documentation of weekly walk throughs will be kept.

Licensee's Proposed Overall Completion Date: *07/17/2023* Not Implemented - [redacted] 8/3/23

88a - Surfaces

10. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 6/1/23, the emergency exit door at the end of the hall by bedroom #401 in Wing 4 (purple hall). There was a rope type grey caulking around the door and frame to close the opening; however, the caulking was peeling and falling off exposing the opening at the top of the door and the frame of approximately 1" from left side to almost the middle of the door.

On 6/1/23, at approximately 3:45 p.m., there was a 6" by 6" beige ceramic tile that was loose, not secured to the floor. In the alcove area in front of the med cart, is the 6th tile in from the outside wall.

Repeat Violation: 11/8/22, et.al.

Plan of Correction ***Accept [redacted] 07/10/2023)***

The exposed area above emergency exit door at the end of wing 4 repaired by maintenance. The loose, beige tile located in the alcove area was repaired by maintenance. Staff re education scheduled for 7/10/2023. During re education, all staff will be instructed to report any areas in need of repair to be reported to administration and/or maintenance immediately. Beginning 7/11/2023 administration and maintenance will conducted weekly walk throughs of the facility in entirety to ensure all floors, walls, ceilings, windows doors and other surfaces are clean, in good repair and free of hazards. Maintenance will be expected to complete any necessary repairs immediately upon discovery.

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented - [redacted] 8/3/23

89a - Water Pressure

11. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 6/5/23, at approximately 11:37 a.m., there was no hot water at the sink in the shared Jack and Jill bathroom with room #103. The hot water temperature measured 98.7 degrees Fahrenheit, after it was let run from 11:37 a.m. to 11:43 a.m. (almost 7 minutes).

On 6/5/23, at approximately 11:50 a.m., the hot water temperature at the sink in the shared Jack and Jill bathroom by bedroom #104, measured approximately 95.4 degrees Fahrenheit after letting run for approximately 5 minutes.

Plan of Correction ***Accept [redacted] 07/10/2023)***

Maintenance notified of low water temperatures when inspectors were on site and promptly tended to the water temperature issues. Maintenance will be retrained on 2600.89.a. Weekly water temperature checks will be conducted in 4 locations by maintenance or administration to ensure temperatures remain appropriate x 4 weeks. Documentation of checks will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented - [redacted] 8/3/23

95 - Furniture and Equipment

12. Requirements

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

Description of Violation

On 6/1/23, at approximately 10:40 a.m., two of the six knobs (2nd and 6th from the left) for the stove top burners are missing from the front of the stove.

On 6/1/23, the thermostat on the back right wall in the sunroom was not secured to the wall. It was pulled away from the wall hanging by the wiring.

On 6/1/23, there is a piece of metal measuring approximately 8" by 3" that is sticking out approximately, 2 ½" from the bottom of the white base board heater at the end of the entrance on the right closest to hall.

On 6/1/23, at approximately 1:25 p.m., there was a bulb missing from the four lighted ceiling fan in bedroom #101 in the green hall Wing 1. The light bulb socket was left open and exposed.

On 6/1/23, there is a large circular tear in the worn seat of the 2nd large black pleather chair, measuring approximately, 13" by 16" in the large living room by green hall. The material is still attached, laying over the open area like a flap; however, the padding and foam are still exposed.

Plan of Correction ***Accept ([redacted] - 07/10/2023)***

Staff re training on 2600.95 scheduled for 7/10/2023. During re education, all staff will be instructed to report any areas in need of repair to be reported to administration and/or maintenance immediately. Documentation of re education will be kept.
-Replacement knobs have been purchased. delivery and repair expected to be complete no later than 7/17/2023.
-Maintenance has repaired the thermostat on the sunroom wall.
-Maintenance has repaired the exposed metal near the baseboard near the front exit.

95 - Furniture and Equipment (continued)

-Administration replaced the missing lightbulb in bedroom #101 on 6/1/23.
-The reclining chair, that was in disrepair has been removed from the facility and disposed of.
-Maintenance or Administration will conduct complete walk through of the facility in entirety x 4 weeks to ensure all furniture and equipment are in good repair and clean and free of hazards. Documentation of walk throughs will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023*

Not Implemented - [redacted] 8/3/23

100a - Exterior - Free of Hazards

13. Requirements

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

Description of Violation

The grey composite decking in the back exterior of the home, off the living room is deteriorating, rotting and in disrepair. There are multiple areas on the deck where there are soft spots on the boards and bow, the decking screws have rusted and no longer secure the boards in place.

On 6/1/23, the exterior deck at the emergency exit door from the living room, the eighth board from the right lifts at either end approximately 2" when stepped on. Following the egress route on the long portion of the deck there are multiple boards when stepped on bow lower than the frame and appear soft and almost touch the ground below. The ends of several boards bow below the frame approximately 3". On the red hall side /Wing 3 by room #304, have multiple areas where the wood is soft bows, and the ends of the boards drop approximately 3" when stepped on.

Repeat Violation 11/8/22, et.al.

Plan of Correction ***Accept [redacted] 07/21/2023)***

Maintenance has started repair the outside deck, off the living room, repairs expect to be completed no later than 8/3/2023. In the event of repair delay, administration will notify DHS via email. Maintenance staff re education(2600.100.a.) scheduled on 7/10/2023. Beginning 7/11/2023 maintenance will conduct a complete evaluation of the exterior of the building to ensure the exterior of the building and the building grounds are in good repair and free of hazards. Exterior checks will be completed weekly x 4 weeks, Documentation will be kept. Anything in disrepair will be addressed and maintenanced immediately

Licensee's Proposed Overall Completion Date: *07/17/2023*

Not Implemented - [redacted] 8/3/23

101j1 - Mattress Fire Retardant

14. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

On 6/1/23, at approximately 2:00 p.m., resident #2's green vinyl mattress in bedroom #103 is in disrepair. There are multiple large cracks in the vinyl from the middle of the mattress to the bottom and going across the width of the mattress exposing some of the threading.

101j1 - Mattress Fire Retardant *(continued)*

Plan of Correction ***Accept ([redacted] 07/10/2023)***

Resident #2's mattress was discarded on 6/5/23 and replaced with a new mattress. Staff re education (101.j) scheduled for 7/10/23. Beginning 7/11/23, DCS will examine all resident's mattress minimally of once per week x 4 weeks to ensure compliance. A new mattress will be provided immediately if a resident is found to have a mattress that is in disrepair, unclean, or does not support the resident. Documentation of checks will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented - [redacted] 8/3/23

101j2 - Bedroom Chairs

15. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

On 6/1/23, there are two residents sharing bedroom #101 and only one chair.

On 6/1/23, at approximately 2:04 p.m., there are two resident sharing bedroom #104 and only one chair.

Plan of Correction ***Accept [redacted] 07/10/2023)***

Residents residing in bedroom 101 and 104 have been provided with a chair that meets their needs. Staff re education (2600.101.j) scheduled on 7/10/2023. Documentation of re education will be kept. Beginning 7/11/2023, DCS will be assigned to conduct checks to ensure each resident has a chair that meets the resident's needs in their bedroom. In the event that a chair is not in the room, a chair will be provided immediately. checks to be conducted weekly x 4 weeks. Documentation of checks will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented - [redacted] 8/3/23

101j3 - Bed/Linens/Pillows/Blankets

16. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

Description of Violation

On 6/1/23 at approximately 1:35 p.m., there were two pillows on resident #11's bed. The top pillow did not have a pillowcase and had dried blood stains covering more than half of the pillow. The bottom pillow had a pillowcase that was also covered in dried blood in multiple areas covering approximately half of the pillow. There were approximately four large, dried clumps of blood stuck to the lower section of the white blanket on resident #11's bed.

On 6/1/23, at approximately 2:04 p.m., there was no pillowcase resident #12's bed pillow in bedroom #[redacted]

Plan of Correction ***Accept [redacted] 07/10/2023)***

on 6/1/23 resident #11 soiled bed linens, including pillows, were replaced with new clean linens. Staff re education (2600.101.j) scheduled on 7/10/2023. Beginning 7/11/23 a DCS will be assigned each day to do a complete check of all residents bedding to ensure pillows, bed linens and blankets are clean and in good repair. Soiled linens will be replaced with clean linens immediately. DCS checks will be conducted daily x 4 weeks. Administration will do weekly checks x 4 weeks to ensure compliance. Documentation of all checks will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented - [redacted] 8/3/23

101j4 - Bedroom Storage Area

17. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
4. A storage area for clothing that includes a chest of drawers and a closet or wardrobe space with clothing racks or shelves accessible to the resident.

Description of Violation

On 6/1/23, there is no storage unit or dresser for resident #8. to store clothing in. The only dresser in the shared bedroom #[redacted] is used by resident #13 and not shared.

Plan of Correction ***Accept ([redacted] 07/10/2023)***

Both residents (#8 and #13) residing in bedroom [redacted] now have a storage area for clothing. Staff re education (2600.101.j) scheduled on 7/10/2023. Documentation of re education will be kept. Beginning 7/11/2023, DCS will be assigned to conduct checks to ensure each resident has a storage area for clothing that includes a chest of drawers and a closet or wardrobe space with clothing racks or shelves accessible to the resident. checks to be conducted weekly x 4 weeks. Documentation of checks will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented - [redacted] 8/3/23

102k - No Common Towel

18. Requirements

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

On 6/1/23, at approximately 2:07 p.m. there was an unlabeled folded grey bath towel on top of the paper towel dispenser on the wall in the Jack and Jill shared with bedroom #[redacted]

Plan of Correction ***Accept [redacted] 07/10/2023)***

The unused, unlabeled towel in the shared bathroom of room #[redacted] was removed promptly on 6/1/23. Staff re education (102k) scheduled for 7/10/23. Documentation will be kept. Beginning 7/11/23, first shift scheduled med tech will check all bathrooms and common shower areas to ensure no common towels are available or being used. Daily checks will be conducted x 4 weeks. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented - [redacted] 8/3/23

103e - Left Overs

19. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 6/1/23, at approximately, at approximately 10:48 a.m., the kitchen refrigerator contained the following unlabeled and undated items, to include:

** A one-gallon zip lock bag with yellow sliced American cheese. Approximately, 20 slices were hard and dark yellow.*

** A 6-quart container with a red lid, contained approximately 5.5 quarts of green bean casserole. There was an unidentified clear liquid substance over the top of the lid.*

** A 3lb. container of Gordan Choice Macaroni and Cheddar salad, approximately ½ full.*

103e - Left Overs (continued)

** A container with approximately 4 quarts of mashed potatoes.*
** An 8lb. container of Honey Dew Chunks approximately ½ full was open and unsealed.*
** A 6-quart container with approximately 4 quarts of sloppy joes, in an unlabeled and undated container.*
** A large industrial baking pan that was identified with a Mexican rice mixture. The pan was almost full and covered with aluminum foil that was torn in the one corner, exposing the food. The pan was also not labeled or dated.*

On 6/1/23, there were the following unlabeled and undated items in the pantry, to include:
** Two large plastic containers and two smaller plastic containers containing assorted cereals that were not in original packaging.*
** There was a large, approximately 25lb. bag of flour that was undated and torn open in the middle of the bag, exposing the food on the left side of the panty bottom shelf in the back.*

Plan of Correction ***Accept ([redacted] - 07/10/2023)***

on 6/1/23, while inspectors were on site, all unlabeled, undated food items in the refrigerator (yellow american cheese, green bean casserole, Macaroni salad, mashed potatoes, honey dew chunks, sloppy joe, and mexican rice) were disposed of. Staff re education (103e) scheduled on 7/10/2023. Documentation will be kept. Re education to include appointing scheduled dietary staff to check all refrigerated items daily to ensure all items in the refrigerator are labeled and not expired. dietary staff to check daily x 4 weeks, documentation will be kept. Administration will also conduct checks minimally of twice per week x 4 weeks to ensure compliance. documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023*

Implemented ([redacted] - 08/03/2023)

103f - Refrigerator/Freezer Temps

20. 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 6/1/23, the temperature of the stainless-steel double door refrigerator measured 44 degrees Fahrenheit. A recheck was conducted on 6/2/23 at 9:05 a.m., the temperature measured 44 degrees Fahrenheit.

Repeat Violation: 11/8/22, et. al.

Plan of Correction ***Accept [redacted] - 07/10/2023)***

VenTec refrigeration contacted and repair completed. Staff re education (103f) scheduled on 7/10/23. Documentation of re education will be kept. Beginning 7/11/23, scheduled dietary staff will conduct a temperature check daily to ensure refrigerator temperatures maintain appropriate degree. In the event that temperature is above 40 degrees, dietary staff to notify administration immediately to schedule prompt repair. Documentation of daily checks will be kept x 4 weeks.

Licensee's Proposed Overall Completion Date: *07/03/2023*

Implemented [redacted] - 08/03/2023)

103g - Storing Food

21. Requirements

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

Description of Violation

On 6/1/23, at approximately 10:48 a.m., there were the following open and unsealed items in multiple areas of the kitchen to include:
The double door refrigerator in the kitchen, to include:
** Two - 2lb. packages of Primo Gusto Hard salami slices – one package approximately ¾ remaining and the other package had approximately 15 slices that appeared, discolored, old both were also unlabeled and undated.*
** A 12oz package of Italian Style Combo pack meat slices. The original package was open and unsealed inside of a one-gallon zip lock bag that was also open and unsealed. The package was not dated when open.*

There were two loaves of white bread that were not sealed on a microwave cart in the kitchen. One loaf was ½ full and the other approximately ¼ loaf.

On 6/1/23, at approximately 11:30 a.m., the pantry contained the following open and unsealed items, to include:
** A large plastic container full of Cheerios cereal, with a blue lid that was not secured on the container. The one end of the lid popped up exposing the cereal and was not dated.*
** An open unsealed 1lb. 15oz. bag of Traditional Stuffing Mix.*
** A large, approximately 25 lb. bag of flour, with a large opening torn in the middle of the bag, exposing the flour, that was also undated.*

Plan of Correction ***Accept [redacted] - 07/10/2023)***

On 6/1/23 all items found to be unsealed were disposed of immediately. (Salami slices, combo meat slices, both loaves of bread, cheerios, stuffing mix and bag of flour) Staff re education (2600.103f) scheduled on 7/10/2023. Documentation of re education will be kept. Re education to include appointing scheduled dietary staff to check items daily to ensure all food items are stored are closed or sealed and labeled. dietary staff to check daily x 4 weeks, documentation will be kept. Administration will also conduct checks minimally of twice per week x 4 weeks to ensure compliance. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023*

Implemented [redacted] 08/03/2023)

103i - Outdated Food

22. Requirements

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

Description of Violation

On 6/1/23, at approximately, at approximately 10:48 a.m., the kitchen refrigerator contained the following items, to include:
** Two one-gallon zip loc bags one containing 6 peeled hard-boiled eggs in original package and the second bag had one peeled hardboiled egg; however, neither was dated.*
** A 6-quart container with approximately 15 hot dogs. Multiple hot dogs have mold over them.*
** A 6-quart container with approximately 3½ quarts of Tater Tots. There is mold covering the top layer of the tater tots.*

Plan of Correction ***Accept [redacted] - 07/21/2023)***

On 6/1/23, when inspectors were on site, the following was disposed of: hard boiled eggs, 15 hot dogs, container of tator tots.

103i - Outdated Food (continued)

Staff re education (2600.103.i.)scheduled for 7/10/23. documentation of re education will be kept. Re education to include appointing scheduled dietary staff to check all food items daily to ensure all items are not outdated, spoiled, or cans have dents. dietary staff to check daily x 4 weeks, documentation will be kept. Administration will also conduct checks minimally of twice per week x 4 weeks to ensure compliance. Documentation of checks will be kept.

Licensee's Proposed Overall Completion Date: *07/17/2023*

Implemented [redacted] - 08/03/2023)

104b - Dishes/Glassware/Utensils

23. Requirements

2600.
104.b. Dishes, glassware and utensils shall be provided for eating, drinking, preparing and serving food. These utensils must be clean, and free of chips and cracks. Plastic and paper plates, utensils and cups for meals may not be used on a regular basis.

Description of Violation

On 6/1/23 at approximately 10:35 a.m., Agents of the Department observed lunch trays stacked on two rolling carts in the kitchen that were being prepped for lunch meal. The trays had a Styrofoam hot cup and a black plastic fork and napkin. Staff person A and B reported the home uses disposable plates, bowls, cups, and plastic utensils on a regular basis for all meals. There were stacks of Styrofoam plates, bowls, and cups present on a microwave cart against wall across from a prepping station. The home currently serves 35 residents; however, after further inspection, staff person A reported having no silverware for the residents to eat with and a count of only 27 dinner plates in the dishwasher drying rack.

On 6/1/23, at approximately, 12:10 p.m. lunch was observed. The residents were served breaded chicken patties, French fries that appeared undercooked and fruit in a glass fruit dish, that was served on the 27 dinner plates, dessert and other size plates and bowls, with a black plastic fork. Drinks were served in regular coffee cups and glasses. Staff person B and cook indicated those residents that needed food cut up were put in bowls, "was actually easier for them to eat and less messy, didn't spill."

On 6/2/23, staff person A indicated having purchased dinnerware and silverware and assured there was more than enough for all residents plus extra. However, interviews conducted on 6/5/23, reported staff continued to provide plastic utensils for dinner on Sunday, 6/4/23, residents reported could not cut their ham and had to ask for a knife. On Monday, 6/5/23, interviews indicated at breakfast residents were provided a plastic spoon to eat cereal with.

Plan of Correction ***Accept ([redacted] - 07/10/2023)***

On 6/2/23 Inventory of kitchen dishes, glassware and utensils completed by staff member A. Additional dishes and utensils were purchased to ensure stock included more than enough dishes, glassware and utensils for all meals for the residents. Staff re education (2600.104.b) scheduled 7/10/23. Re education to include introduction of a sign off sheet for dietary staff to confirm no plastic/ throw products were used in serving residents each meal. Dietary to keep documentation for each meal daily x 4 weeks. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented - [redacted] 8/3/23

105g - Lint Removal and Duct Cleaning

24. Requirements

2600.

105g - Lint Removal and Duct Cleaning *(continued)*

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 6/1/23, at approximately 10:25 a.m., there was a thick layer of lint over the entire dryer vent screen, measuring approximately 1/8" thick. The inside of the dryer vent trap, there was a thick layer of lint over the grates and along the sides. A layer of lint had accumulated along the rubber on the interior side of the dryer door.

Plan of Correction ***Accept [redacted] - 07/10/2023)***

On 6/1/23, while inspectors were on site at approximately 10:35AM lint was throughly removed from areas on the dryer. Staff re education (2600.105.g.) scheduled on 7/10/23. Beginning 7/11/23, all staff will be expected to document lint removal after each load. Documentation of removal will be kept x 4 weeks. Administration will do sporadic checks to ensure lint is being removed after each load minimally of three times per week. Documentation of all checks will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented [redacted] 8/3/23

141a 1-10 Medical Evaluation Information

25. 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

The medical evaluation dated 9/5/22, for resident #3, does not indicate Body positioning/movement. The section (8) is blank.

Repeat Violation: 11/8/22, et. al.

Plan of Correction ***Accept [redacted] - 07/10/2023)***

Administration will have resident #3 seen by their PCP no later than 7/10/23. Administration will request resident's PCP re complete DME upon visit and will then ensure it is completed in entirety. Administration will review all other resident's medical evaluations by 8/7/23 to ensure completeness. Documentation of reviews will be kept. Because this is a repeat violation, after initial check is complete, Administration will continue to review 4 med evals per month for an additional 3 months to ensure compliance. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented [redacted] 8/3/23

183b - Meds and Syringes Locked

26. 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 6/2/23, at approximately 12:40 p.m., the home's medication cart was left unattended, unlocked, and accessible in the alcove area across between the main dining room and the door to residents' smoking area. There were no staff present. The key to the narcotic drawer was in the lock and a set of keys were on top of medication cart. The medication cart contained medications for all the 34 residents being served in the home, to include:
** Resident #2's Amlodipine Besylate 10mg Tablet and Lorazepam 0.5mg Tablet.*
** Resident #3's Quetiapine Fumarate 50mg Tablet and Oxycodone HCL 10mg tablet.*

Repeat Violation: 11/8/22, et.al.

Plan of Correction ***Directed [redacted] 07/21/2023)***

Staff notified by inspectors of the medication cart being unlocked, and unattended. Med tech on duty immediatly locked the medcart and removed the keys from the area.
Med Tech staff re education (2600.183.b) scheduled on 7/10/23. Documentation of re education will be kept. During re education, administration will advise med tech staff that failure to remain in compliance with regulation 2600.183.b will result in immediate repercussions. Beginning 7/11/23, administrator/ assistant will conduct minimally of 2 checks each day. Checks will be conducted each day the administrator/ assistant is scheduled in the facility. Documentation of checks will be kept.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The checks by the administrator/assistant will include checking the home to ensure prescription medications, OTC medications, CAM and syringes ar kept in an area or container that is locked. 7/21/23[redacted]

Directed Completion Date: *07/17/2023* Not Implemented - [redacted] 8/3/23

183e - Storing Medications

27. 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 6/2/23, at approximately 1:05 p.m., resident #14's Spiriva Respimat 2.5mcg/actuation inhaler was found in the medication cart with an expiration sticker, dated: 1/28/22. The home did not have a current physician order for the medication. There were two additional Spiriva Respimat 2.5mcg/actuation inhalers labeled with resident #14's name in the medication cart. The seals on both were broken and had no open date or expiration date. One indicated approximately 30 doses administered and the second one indicated approximately 58 doses administered.

Plan of Correction ***Accept ([redacted] 07/10/2023)***

Administrator/ Assistant will contact resident #14's PCP on 7/3/23 and will request medication order clarification, and medication reorder if necessary. Staff re education (2600.183.e) scheduled on 7/10/23. Documentation of re education will be kept. Administrator / assistant will participate in med cart audit with scheduled med tech to ensure compliance with 2600.183.e. Complete audit will be complete no later than 7/31/23. Administrator / assistant will continue to participate in complete monthly med cart audits x 3 months. Documentation of all audits will be kept.

183e - Storing Medications *(continued)*

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented - [redacted] 8/3/23

184a - Resident's Meds Labeled

28. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #14's most current physician order, dated 5/23/23, indicates the resident is prescribed Albuterol Sulfate HFA 90mcg, - Inhale 2 puffs every four hours. However, medication label indicates inhale 2 puffs six times a day and the residents June 2023 MAR indicates inhale 1 puff four times a day, separate puffs by 5 minutes.

Plan of Correction ***Accept ([redacted] - 07/10/2023)***

Administrator/ Assistant will contact resident #14's PCP and will request medication order clarification. Med Tech staff to be re educated (2600.84.a) on 7/10/23. Administrator / assistant will participate in med cart / MAR audit with scheduled med tech to ensure compliance with 2600.184.a. Complete audit will be complete no later than 7/31/23. Administrator / assistant will continue to participate in complete monthly med cart/ MAR audits x 3 months. Documentation of all audits will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented - [redacted] 8/3/23

185a - Implement Storage Procedures

29. Requirements

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

Description of Violation

Resident #2's June 2023 MAR indicates the resident is prescribed the following medications; however, on 6/2/23 the medication was not available in the med cart or home, to include:

** Bisacodyl Suppository 10 mg - unwrap and insert 1 suppository as needed not on the med cart.*

** Banophen 25 mg capsule - take 1 capsule by mouth at bedtime.*

** Loratadine 10 mg tablet - take 1 tablet by mouth every 12 hours.*

** Ondansetron 4 mg tablet - take every 6 hours as needed.*

Resident #3 is prescribed Phenobarbital 32.4mg tablet- take one tablet by mouth twice a day (8:00 a.m. & 8:00 p.m.). However, on 6/2/23, at 11:30 a.m., the medication was not available in the med cart or home.

Resident #3 is prescribed Oxycodone HCL (IR) 5 mg tablet – take one tablet every 6 hours routinely at 8:00 a.m., 12:00 p.m., 5:00 p.m. and 8:00 p.m. However, on 6/2/23, at 11:30 a.m., the medication was not available in the home for the 12:00 p.m. administration.

Repeat Violation: 11/8/22.

Plan of Correction ***Accept [redacted] - 07/21/2023)***

Med Tech staff was in contact with resident #2 and resident #3 ordering physician and all ordered medications were received for mentioned residents. Med Tech staff to be re educated (2600.185.a) on 7/10/23. Administrator / assistant will participate in med cart / MAR audit with scheduled med tech to ensure compliance with 2600.185.a. Complete

185a - Implement Storage Procedures (continued)

audit will be complete no later than 7/31/23. Administrator / assistant will continue to participate in complete monthly med cart/ MAR audits x 3 months. Documentation of all audits will be kept. During audits med tech staff and med techs will ensure that all prescribed medications are in house for scheduled administration.

Licensee's Proposed Overall Completion Date: *07/17/2023* Not Implemented - [redacted] 8/3/23

187a - Medication Record

30. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

On 6/2/23, at 11:01 a.m., the following medications were listed on resident #2's June 2023 MAR. However, a physician order, dated 5/25/23, indicates the following medication was discontinued, to include:
** Enema - Insert 1 application rectally as needed when the resident has not had a bowel movement in 12 hours after Dulcolax suppository.*
** Glucose 45 gel - Inject 1MG PRN.*
** Myrbetriq ER 25 mg take 1 by mouth once a day.*
** Milk of Magnesia Suspension – shake well, take 30ML by mouth as needed for [redacted] if no [redacted] movement in 3 days.*
On 6/2/23, the June 2023 MAR for resident #14 indicates the resident is prescribed Albuterol Inhaler HFA 90 mcg inhale one puff four times a day. Separate puffs by 5 minutes. The pharmacy label indicates Albuterol Inhaler HFA 90mcg- Inhale 2 puffs six times a day. Discard when 0 or after expiration date. However, the current order, dated 5/23/23, from the VA Hospital indicates resident #14 is prescribed, Albuterol Inhaler 90mcg- inhale 2 puffs every 4 hours, as needed.

Plan of Correction ***Accept [redacted] 7/21/2023)***

Assistant administrator contacted pharmacy in regards to the errors on the MAR for resident #2 and the errors were corrected 6/2/23. Administrator/ Assistant will contact resident #14's PCP on 7/3/23 and will request medication order clarification. Med Tech staff to be re educated (2600.187.a) on 7/10/23. Administrator / assistant will participate in med cart / MAR audit with scheduled med tech to ensure compliance with 2600.187.a. Complete audit will be complete no later than 7/31/23. Administrator / assistant will continue to participate in complete monthly med cart/ MAR audits x 3 months. Documentation of all audits will be kept. During audits med tech staff and med techs will ensure that all prescribed medications are in house for scheduled administration.

187a - Medication Record *(continued)*

Licensee's Proposed Overall Completion Date: *07/17/2023* Not Implemented - [redacted] 8/3/23

187b - Date/Time of Medication Admin.

31. Requirements

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

Description of Violation

Resident #2 is prescribed Lorazepam 1mg Tablet – take one tablet once daily. On 6/2/23, the pharmacy label indicates Lorazepam 1mg Tablet, give one tablet by mouth every evening at 9:00 p.m. However, the resident's June 2023 Medication Administration Record (MAR) indicates Lorazepam 1mg Tablet – Give one tablet once daily, with an administration time of 8:00 a.m. On 6/1/23, staff interviews indicated the medication is being administered at 9:00 p.m. as indicated on the label; however, staff are initialing in the June 2023 MAR administering at 8:00 a.m.

Repeat Violation: 11/8/22, et.al.

Plan of Correction ***Accept*** [redacted] ***07/10/2023)***

Administration contacted the pharmacy in regards to resident #2's Lorazepam 1mg lorazepam. All necessary changes made. after clarification with resident #2's PCP.
Med Tech staff to be re educated (2600.187.b) on 7/10/23. Administrator / assistant will participate in med cart / MAR audit with scheduled med tech to ensure compliance with 2600.187.b. Complete audit will be complete no later than 7/31/23. Administrator / assistant will continue to participate in complete monthly med cart/ MAR audits x 3 months. Documentation of all audits will be kept.

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented - [redacted] 8/3/23

187d - Follow Prescriber's Orders

32. Requirements

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

Description of Violation

Resident #2 is prescribed Banophen 25mg capsule – Take one capsule at bedtime. On 6/1/23 at 8:00 p.m., direct care staff person C incorrectly documented as "refused" in resident's June 2023 MAR; however, the medication was not available in the home to administer, and resident #2 was not administered the medication.

Resident #3 is prescribed Oxycodone HCL (IR) 5 mg tablet – take one tablet every 6 hours routinely at 8:00 a.m., 12:00 p.m., 5:00 p.m. and 8:00 p.m. However, on 6/2/23, at 11:30 a.m. the medication was not available in the home for administration, and resident #3 was not administered the medication.

Resident #4 is ordered Humalog insulin 100u/ml four times a day, with meals and at bedtime (8:00 a.m.,12:00 p.m.,5:00 p.m., and 8:00 p.m.) per sliding scale: 0-150=0U; 151-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; 351-400=10U; greater than >400 give10U and call MD. On 6/1/23 at 12:00 p.m., the resident #4's blood glucose level was 255, requiring 6 units of insulin. However, according to the resident's June 2023 MAR and the home's CBG Sheet, the resident was administered 8 units of insulin.

Repeat Violation: 11/8/22, et.al.

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

Plan of Correction ***Directed ([redacted] 07/21/2023)***

Med Tech staff re educated on 6/6/23 (2600.187.d) During re education violations as presented below regulation 2600.187.d were discussed. Administrator / assistant will conduct full med cart / MAR audit with scheduled med tech. Audit will be completed no later than 7/31/23. After initial audit is complete administrator / assistant will continue participating in complete med cart / MAR audits monthly x 3 months to ensure compliance. Documentation of all audits will be kept. During audits med tech staff and med techs will ensure that all prescribed medications are in house for scheduled administration. Med techs to administer medications as ordered by resident's physicians orders.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall notify the prescribers for resident #2, #3, and #4 of the medication errors. The administrator shall also notify the residents and the resident's designated persons of the medication errors. Documentation shall be kept in the resident's records. 7/21/23 [redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall file incident reports for the medication errors. 7/21/23 [redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall continue with monthly audits of all resident MARs to ensure compliance with Regulation 2600.187(d). Documentation of audits shall be kept. 7/21/23 [redacted]

Directed Completion Date: *07/22/2023*

Not Implemented [redacted] 8/3/23

190a - Completion Medication Course

33. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Direct care staff person D's most recent Medication Administration Certification is dated, 5/6/22. Direct care staff person D is not currently recertified and administered medications to the residents in the home on 5/28/23, at approximately 8:00 a.m., to include:
** Resident #2's Amlodipine Besylate 10mg tablet, Lorazepam 0.5mg tablet, Metformin HCL 1000 mg tablet.*
** Resident #4's Risperidone 0.25 mg tablet, Fluoxetine HCL 20mg capsule*
** Resident #14's Lisinopril 5 mg tablet, Omeprazole DR 20 mg capsule, Carvedilol 25mg tablet.*

Direct care staff person E's most recent Medication Administration Certification is dated, 2/23/23. However, the original certification is dated, 3/5/20 and no recertification was completed during the 2022 training year. The Annual Certification is not signed by a train-the-trainer or dated. Direct care staff person E administered medications to the residents in the home on 6/1/23 at approximately 8:00 a.m., to include:
** Resident #4's Amlodipine Besylate 5 mg tablet, Digoxin 0.125 mg tablet, Metoprolol Succ. 50 mg tablet.*
** Resident #6's Bupropion HCL SR 100 100 mg tablet, Furosemide 20 mg tablet, Lisinopril 2.5 mg tablet.*
**Resident #14's Carvedilol 25 mg tablet, Eliquis 5 mg tablet, Furosemide 20 mg tablet.*

Plan of Correction ***Accept ([redacted] 07/10/2023)***

Staff persons D and E were removed from the med tech schedule until necessary training per regulations is

190a - Completion Medication Course (continued)

complete. Administrator / assistant will produce a spreadsheet to easily review training expiration dates etc by 7/11/23. Administration / assistant will review spreadsheet minimally of monthly x 6 months to ensure compliance.

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented - [redacted] 8/3/23

226b - Mobility Requirements

34. Requirements

2600.
226.b. If a resident is determined to have mobility needs as part of the initial or annual assessment, specific requirements relating to the care, health and safety of the resident shall be met immediately.

Description of Violation

The assessment and support plan, dated 9/7/22, for resident #3 and medical evaluation, dated 9/5/22 includes a mobility assessment as having minimal mobility need. However, the resident was identified, as a 2-person assist, and interviews indicated the resident often requires the assist of two staff for transfers including transferring out of shower. However, the resident is often transferred with only one staff person.

Plan of Correction ***Accept*** [redacted] ***- 07/10/2023)***

Necessary updates made to resident #3 assessment and support plan and medical evaluation pertaining to mobility needs on 6/30/2023. Administrator / Assistant will check minimally of 3 resident's assessment and support plan and medical evaluation each week to ensure mobility needs are true, accurate and updated if needs change. Admin / assistant will keep documentation of checks x 8 weeks.

Licensee's Proposed Overall Completion Date: *07/03/2023* Not Implemented - [redacted] 8/3/23