pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **NEW LIFE PERSONAL CARE HOME, INC.**
LEGAL ENTITY

To operate **NEW LIFE PERSONAL CARE**
NAME OF FACILITY OR AGENCY

Located at **2521 VERSAILLES AVENUE, MCKEESPORT, PA 15132**
(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 **18**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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 **November 28, 2023** until **May 28, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **431212**

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:
NOVEMBER 28, 2023

[redacted] Administrator
New Life Personal Care Home, Inc.
2521 Versailles Avenue
McKeesport, Pennsylvania 15132

RE: New Life Personal Care Home
License/COC #: 431212

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on June 15, 2023, and August 28, 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 issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND 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) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from November 28, 2023 to May 28, 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)
103(f)	II	13	$5	$65	5 calendar days from mailing date of this letter
141(b)(1)	II	13	$5	$65	5 calendar days from mailing date of this letter
144(c)(1)	II	13	$5	$65	5 calendar days from mailing date of this letter
183(b)	II	13	$5	$65	5 calendar days from mailing date of this letter
187(b)	II	13	$5	$65	5 calendar days from mailing date of this letter
187(d)	II	13	$5	$65	5 calendar days from mailing date of this letter
225(c)	II	13	$5	$65	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], 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
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: *NEW LIFE PERSONAL CARE* **License #:** *43121* **License Expiration:** *09/23/2023*

Address: *2521 VERSAILLES AVENUE, MCKEESPORT, PA 15132*

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

Administrator

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

Legal Entity

Name: *NEW LIFE PERSONAL CARE HOME, INC.*

Address: *2521 VERSAILLES AVENUE, MCKEESPORT, PA, 15132*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *08/24/1990* **Issued By:** *PA Dept L&I*

Type: *Other* **Date:** *11/20/1996* **Issued By:** *City of McKeesport*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *12* **Waking Staff:** *9*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date:** *06/15/2023*

Inspection Dates and Department Representative

06/15/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *18* **Residents Served:** *12*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *11* **Are 60 Years of Age or Older:** *9*

Diagnosed with Mental Illness: *11* **Diagnosed with Intellectual Disability:** *1*

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

Inspections / Reviews

06/15/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/09/2023*

07/10/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/01/2023*

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

07/21/2023 - POC Submission

Submitted By [redacted] **Date Submitted:** *08/01/2023*

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

10/19/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/01/2023*

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

At 9:35 a.m., the Resident Privacy Coding documents for the 12/28/22 and 9/7/22 licensing inspections summaries were posted on the accessible bulletin board on the first floor in the hall near the bathroom. The privacy documents included the names of several residents to include residents #1, #2, #3, and #4.

Repeat violation 9/7/22

Plan of Correction ***Directed (- 07/17/2023)***

The staff was trained on confidentiality of residents by the admin on 6/17/23

1. The staff will check the last assessment for confidentiality of others.

2. When inappropriates are found they will be removed and discussed with the admin.

3. The admin will check monthly for follow up behind staff for prevention this was implemented on 6/17/23.

DIRECTED

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit the home weekly to ensure resident records are confidential, and, except in emergencies, are not 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. Documentation of weekly audits shall be kept. 2/21/23

Directed Completion Date: *07/22/2023*

Implemented - 10/19/2023)

18 - Compliance With Laws

2. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

At 11:30 a.m., the home's boiler certificate had an expiration date of 9/28/22. There was no documentation that an inspection of the home's boiler had been completed since then.

Plan of Correction ***Directed 07/17/2023)***

Boiler maintenance will be done by staff.

1. Staff will check all certificates for expiration dates.

2. The boiler inspection on 6/15/23 was done to check complete annual inspection automatically on an annual basis. As of 6/15/23 annual checks scheduled by admin.

3. Boiler inspection will start and complete annually with a sign off of completion of inspection.

4. The admin will receive inspection tag place in boiler room annually to meet 2600 reg.

18 - Compliance With Laws (continued)

5. The boiler room will be checked by admin every 6 months for prevention.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall provide the documentation of the home's boiler certificate of operation or schedule a boiler inspection by an authorized boiler inspector. Documentation of the boiler certificate shall be kept and available to the Department upon request. 7/21/23 [redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit the boiler inspection expiration dates monthly to ensure the boiler certificate of operation does not expire. Documentation of monthly audits shall be kept. 7/21/23

Directed Completion Date: *07/22/2023* *Not Implemented* [redacted] *- 10/10/23*

20b1 - Financial Records

3. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
1. The home shall keep a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance.

Description of Violation

The home is representative payee for resident #1. However, the home does not have documentation of financial transactions that include the dates, amounts of [income] deposits and amounts of withdrawals. The home only documents the amount of the personal needs allowance (PNA) provided to the resident.

Plan of Correction ***Directed*** [redacted] ***- 07/17/2023)***

The home is not rep payee for resident #1 only. A quarterly financial summary is created for the others by the finance department who are going to check the records quarterly as of 6/16/23. The admin will monitor every three months as of 6/16/23. Moving forward the financial staff will be educated about the importance of record keeping of their finances.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit resident #1's financial records and document the resident's financial transaction from 1/1/23 through the current date. The documentation shall include a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance. The documentation shall be kept in the resident's record. 7/21/23 [redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall complete an initial audit all residents who receive assistance with financial management to ensure the home is maintaining a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance. The documentation shall be kept in the resident's record. 7/21/23 [redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall complete a monthly audit all residents who receive assistance with financial management to ensure the home is maintaining a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the

20b1 - Financial Records (continued)

current balance. The documentation shall be kept in the resident's record. Documentation of monthly audits shall be kept. 7/21/23[redacted]

Directed Completion Date: *07/22/2023*

Not Implemented[redacted] *10/10/23*

20b8 - Quarterly Account

4. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

The home is representative payee for resident #1. However, there is no documentation that an itemized list of financial transactions made on the resident's behalf has been provided to the resident on a quarterly basis.

Plan of Correction ***Directed***[redacted] ***07/17/2023)***

The home is not resident #1 rep payee. The admin has created financial sheets for the residents that we do represent.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit resident #1's financial records and provide the resident and the resident's designated person an itemized account of financial transactions made on the resident's behalf on a quarterly basis from 1/1/23 through the current date. The documentation shall be kept in the resident's record. 7/21/23[redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall complete an initial audit all residents who receive assistance with financial management to ensure the home is and provide the resident and the resident's designated person an itemized account of financial transactions made on the resident's behalf on a quarterly basis. The documentation shall be kept in the resident's record. 7/21/23[redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall complete a monthly audit all residents who receive assistance with financial management to ensure the home is and provide the resident and the resident's designated person an itemized account of financial transactions made on the resident's behalf on a quarterly basis The documentation shall be kept in the resident's record. Documentation of monthly audits shall be kept. 7/21/23[redacted]

Not Implemented[redacted]- 10/10/23

Directed Completion Date: *07/22/2023*

25b - Contract Signatures

5. 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 contract for resident #5 was updated on[redacted]*23 but was not signed by the resident or administrator with the updated cost of room and board and bed hold amount. The contract signature was dated*[redacted]*14.*

25b - Contract Signatures *(continued)*

Plan of Correction ***Directed [redacted] - 07/17/2023)***

The contract will be signed by the resident. The admin will present the document to the resident on 6/15/23.
The financial staff will be educated on contract agreements with consumers by the admin starting 6/16/23 completed 6/16/23 by admin.
The admin will assess all contracts every 6 months to prevent this from reoccurring.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all newly completed or updated contracts to ensure all applicable signatures are obtained. 7/21/23[redacted]

Directed Completion Date: *07/22/2023*

Implemented [redacted] 10/19/2023)

64c - Annual Training

6. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person[redacted] the home's administrator, only had 12 hours of annual training in the training year 1/1/22-12/31/22.

Plan of Correction ***Directed [redacted] - 07/17/2023)***

The annual training has been started online on 6/18/23. The training will be completed in September 2023.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall develop and implement a 2023 schedule of training for administrator[redacted] which includes a total of 36 hours of training to be completed by 12/31/23 (24 hours for 2023 and 12 hours for 2022.) A total of 12 hours shall be completed by October 1, 2023. The 2023 training schedule shall be submitted to the attention of [redacted] at the BSHL Western Regional Office. The training schedule shall include: course title, date, time, location, number of approved hours.

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall develop and implement an annual staff training plan for the administrator which includes 24 hours of Department-approved training. 7/21/23[redacted]

Directed Completion Date: *12/31/2023*

Not Implemented[redacted] 10/10/23

65e - 12 Hours Annual Training

7. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.

Description of Violation

Direct care staff person B, hired[redacted] 2010, only completed 11 hours of annual training during the 1/1/22 – 12/31/22

65e - 12 Hours Annual Training (continued)

staff training year.

Plan of Correction ***Directed [redacted] - 07/20/2023)***

The annual training has been started online on 6/18/23. The training will be completed in September 2023

DIRECTED
The administrator indicates direct care staff person B is no longer employed at the home. 7/21/23 [redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all staff training for the 2022 training year to ensure all direct care staff persons have completed at least 12 hours of training and documentation is in accordance with Regulation 2600.65(i). 7/21/23 [redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all staff training during the quality management review to ensure all direct care staff persons have completed at least 12 hours of annual training during the home's training year. 7/21/23 [redacted]

Directed Completion Date: *07/22/2023* *Not Implemented [redacted] - 10/10/23*

65f - Training Topics

8. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Description of Violation

Direct care staff person B, hired [redacted] 2010, did not receive training in (1) Medication self-administration and (2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during the 1/1/22 - 12/31/22 staff training year.

Plan of Correction ***Directed [redacted] - 07/20/2023)***

The annual training has been started online on 6/18/23. The training will be completed in September 2023

DIRECTED
The administrator indicates direct care staff person B is no longer employed at the home. 7/21/23 [redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all staff training for the 2022 training year to ensure all direct care staff persons have completed training in all of the required training topics in accordance with Regulation 260065(f) and documentation is in accordance with Regulation 2600.65(i). 7/21/23 [redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all staff training during the quality management review to ensure all direct care staff persons have completed training in all of the required training topics in accordance with Regulation 260065(f) during the home's training year. 7/21/23 [redacted]

Directed Completion Date: *07/22/2023* *Not Implemented [redacted] 10/10/23*

65g - Annual Training Content

9. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Direct care staff person B, hired [redacted] 2010, did not receive fire safety training completed by a fire safety expert during the 1/1/22 – 12/31/22 staff training year.

Plan of Correction ***Directed [redacted] - 07/20/2023)***

This staff person B no longer works for us. The admin will schedule fire training as of 6/15/23. We are implementing retraining sessions for whoever missed the class. The admin will be involved in all fire drills as of 6/15/23. There is an annual staff training plan available.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all staff training for the 2022 training year to ensure all direct care staff persons have completed training in all of the required training topics in accordance with Regulation 260065(g) and documentation is in accordance with Regulation 2600.65(i). 7/21/23[redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all staff training during the quality management review to ensure all direct care staff persons have completed training in all of the required training topics in accordance with Regulation 260065(g) during the home's training year. 7/21/23 [redacted]

Directed Completion Date: *07/22/2023* *Not Implemented [redacted] 10/10/23*

66a - Staff Training Plan

10. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

There is no documentation of a staff training plan for the 1/1/23 – 12/31/23 staff training year.

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

The healthcare agency has created an annual training plan for the staff for the year. The administrator will make sure of a staff training plan to be developed annually by the healthcare agency as of 6/18/23

Licensee's Proposed Overall Completion Date: *07/07/2023* *Not Implemented [redacted] 10/10/23*

85a - Sanitary Conditions

11. Requirements

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

Description of Violation

At 11:05 a.m., there was an accumulation of more than 100 cigarette butts on the ground between the end of the ramp leading to the emergency egress door from room #2 on the first floor and the bottom of the second-floor fire escape.

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Directed [redacted] - 07/20/2023)***

The maintenance team cleaned the area 6/17/23. The maintenance team cleaned the area on 6/17/23. The maintenance staff will monitor the area weekly starting 6/17/23. The admin will receive confirmation from maintenance every 3 weeks. This will be ongoing starting on 6/17/23.

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the requirements of Regulation 2600.85(a). Documentation of education shall be kept in accordance with Regulation 260065(i). 7/21/23[redacted]

Directed Completion Date: *07/26/2023* *Not Implemented[redacted] 10/10/23*

92 - Windows

12. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

At approximately 11:00 a.m., there was a one-half inch gap between the bottom of the screen and the window frame of the open window on the right side of resident bedroom #1 on the first floor when entering from the living room.

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

The screen was too short for the window casing. About a half inch was exposed at the bottom. The maintenance man placed a spacer greater than a half inch to fill the gap at the bottom of the screen. Housekeeping neglected to notice the screen and report it to the administrator. The admin inspected all windows in facility and everything was appropriate. We will do annual inspections on window integrity as of 6/15/23.

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

Implemented [redacted] 10/19/2023)

96a - First Aid Kit

13. 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

At 11:40 a.m., there was no complete first aid kit in the home. The first aid kit in the nook in the second-floor hall did not include nonporous disposable gloves, adhesive bandages, adhesive tape, or a thermometer. The first aid kit located in the home's kitchen did not include disposable gloves, or a CPR breathing shield.

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

The first aid kits were neglected, lacked some items. So the old kits were disposed of and new kits were purchased. Inspections have been done on the kits and they are complete. They will be locked in the med cart on the first floor as of 6/18/23. The lead staff will inspect the kits every 3 months for deficiencies.

Licensee's Proposed Overall Completion Date: *07/07/2023* *Not Implemented[redacted] - 10/10/23*

101j3 - Bed/Linens/Pillows/Blankets

14. 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

The white fitted sheet on the bed to the left when entering the second-floor front bedroom had a hole approximately 1.5" in diameter midway along the side of the mattress.

Plan of Correction ***Directed [redacted] 07/20/2023)***

On 6/11/23 the house keeping department had a training on the subject of appropriate linen. The linen supply was refreshed with new linen that was completed by admin as of 6/16/23. The housekeeping department will assess linen closet monthly, and all info will be relayed to admin. Monthly check completed on 7/1/23 and monitored by admin.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall replace the fitted sheet cited in the regulation. 7/21/23[redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all resident beds monthly to ensure compliance with Regulation 2600.103(j)(3). Documentation of audits shall be kept. 7/21/23[redacted]

Directed Completion Date: *07/22/2023*

Implemented [redacted] 10/19/2023)

103f - Refrigerator/Freezer Temps

15. 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 11:12 a.m., the temperature of the upright freezer in the home's basement measured 10 degrees Fahrenheit.

At 11:14 a.m., the temperature of the freezer compartment of the stainless-steel refrigerator/freezer in the home's basement measured five degrees Fahrenheit.

Repeat violation 9/7/22

Plan of Correction ***Directed [redacted] 07/20/2023)***

The freezer will be checked daily by all staff as of 6/15/23. The appliance repair man will be called 6/16/23. The repair man checked all appliances. Recommended a fan for circulation. As of 6/18/23 the admin installed a fan and monitors daily.

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the Requirements of Regulation 2600.103(f). Documentation of education shall be kept in accordance with Regulation 260065(i). 7/21/23[redacted]

103f - Refrigerator/Freezer Temps (continued)

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit the refrigerators and freezers in the home at least twice a week to ensure food requiring refrigeration is be stored at or below 40°F, frozen food is kept at or below 0°F, and thermometers are in refrigerators and freezers. Documentation of audits shall be kept. 7/21/23 [redacted]

Directed Completion Date: *07/22/2023*

Not Implemented [redacted] *10/10/23*

103g - Storing Food

16. Requirements

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

Description of Violation

At 11:15 a.m., there was an approximately half full unsealed four-pound bag of Domino granulated sugar setting on a shelf in the dry storage area of the home's basement.

Plan of Correction ***Directed*** [redacted] ***- 07/20/2023)***

As of 6/16/23 left over food was placed in sealed containers. As of 6/16/23 open containers will be disposed of by admin. As of 6/16/23 education was given to all staff by admin. The pantry and kitchen shelves will be checked for unsealed containers by all staff and admin.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all food storage areas, at least weekly, to ensure all food is stored in closed and sealed containers. Documentation of audits shall be kept. 7/21/23 [redacted]

Directed Completion Date: *07/22/2023*

Not Implemented JK- 10/10/23

107a - Emergency Preparedness

17. Requirements

2600.
107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

The home's administrator did not have a copy of the emergency preparedness plan for the City of McKeesport in which the home is located.

Plan of Correction ***Directed*** [redacted] ***- 07/20/2023)***

the city preparedness plan was available as of 6/15/23. The plan and other plans are now in a common place in dining room by admin as of 6/16/23. Completed by admin on 6/16/23.

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit the emergency management plan for the municipality monthly to ensure the plan is in the home. Documentation of audits shall be kept. 7/21/23 [redacted]

Directed Completion Date: *07/15/2023*

Not Implemented [redacted] *10/10/23*

123b - Emergency Procedures Posted

18. Requirements

123b - Emergency Procedures Posted *(continued)*

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

At 3:45 p.m. the home's emergency procedures plan was located in the basement of the home which is not a public and conspicuous place.

Plan of Correction ***Directed [redacted] - 07/20/2023)***

As of 6/15/23 the homes emergency procedures plan has been relocated to the dining room which is a more public and conspicuous place. Copies of the plan will be posted on each floor.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit the home weekly to ensure copies of the emergency procedures as specified in §2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept. Documentation of audits shall be kept. 7/21/23[redacted]

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the location of the home's and municipal emergency plans. Documentation of education shall be kept in accordance with Regulation 260065(i). 7/21/23[redacted]

Directed Completion Date: *07/26/2023*

Implemented ([redacted] - 10/19/2023)

132c - Fire Drill Records

19. 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 home's fire drill records for 9/15/22 through 5/10/23 do not specify the number of residents evacuated or the exit routes used for each of the fire drills.

Plan of Correction ***Directed [redacted] - 07/20/2023)***

as of 6/15/23 a fire drill log was created and will include date, time, evacuation time, the exit routes used, number of participants that were in the building before during and after the drill, number of staff persons participating, any problems that occurred and whether the fire alarm or smoke detector was operative or not. Log will be monitored and updated monthly by admin.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit the home's fire drill record monthly to ensure all required documentation in accordance with Regulation 2600.132(c) is documented in the home's fire drill record. Documentation of audits shall be kept. 7/21/23[redacted]

Directed Completion Date: *07/22/2023*

132c - Fire Drill Records *(continued)*

Implemented [redacted] - 10/19/2023)

132g - Fire Drills Days/Times

20. 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's fire drill records for 9/15/22 through 5/10/23 indicates that the "No. of staff members" participating was 2. However, according to the staffing schedule provided by the home, only one staff person is scheduled per shift.

Plan of Correction ***Directed [redacted] - 07/20/2023)***

As of 6/17/23 fire drills will be held on different days of the week and at different times of the day and night. Fire drills will be scheduled with more than one staff person in attendance. As of 6/15/23 more than one staff person is on the schedule. Admin will monitor staffing coverage for all fire drills.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall conduct fire drills 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. This includes conducting fire drills with only the number of staff scheduled.

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit the home's fire drill record monthly to ensure compliance with Regulation 2600.132(g). Documentation of audits shall be kept. 7/21/23
[redacted]

Directed Completion Date: *07/15/2023*

Not Implemented [redacted] - 10/10/23

141a 1-10 Medical Evaluation Information

21. 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 completed [redacted]/22 for resident #1, admitted [redacted]/22, indicates in Section 7 Medication

141a 1-10 Medical Evaluation Information (continued)

Addendum "see attached." However, there was nothing attached.

The medical evaluation completed [redacted]/22 for resident #6 admitted [redacted]22, did not include the resident's date of birth and mobility needs. These areas are blank.

Plan of Correction ***Directed [redacted]- 07/20/2023)***

before leaving for doctor appointments resident #1 will carry a copy of [redacted]medication list. The staff was trained on 6/17/23 by admin for preparation. The staff training will include DME purpose and completion of the form. Also included will be med log attached to the eval. Training was completed on 6/17/23. Once returned the admin will review the entire visit with the staff person and review the documents for corrections. This plan will include the weekly folder assessment. Plan implemented on 7/5/23. After doctor visits all documents will be reviewed by admin upon returning to facility. The admin will review for errors and other folders weekly as of 7/5/23.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall return resident #1's and resident #6's medical evaluation documentation to the medical professional who completed the medical evaluation to have the documentation corrected or the residents shall have a new medical evaluation completed and documented. 7/21/23[redacted]

Directed Completion Date: *07/22/2023*

Not Implemented [redacted] *10/10/23*

141b1 - Annual Medical Evaluation

22. Requirements

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

Description of Violation

The most recent medical evaluation (DME) for resident #2, admitted [redacted]05, was completed [redacted]/23 but did not include the resident's height, weight, medications and body positioning needs. These areas were blank. The resident's previous DME was completed was completed [redacted]22.

The most recent DME for resident #5 was completed on [redacted]/22. However, the resident's previous DME was completed [redacted]20.

Repeat violation 9/7/22, 12/28/22

Plan of Correction ***Directed [redacted]- 07/20/2023)***

Training was completed by admin on the importance of the annual evaluation and its completion. The staff was trained and educated on where to review all medical documents for resident #2 are. All staff persons will review all assessments with doctor and that all assessments are completed with medication list attached. Upon residents return admin will review all documents for accuracy and completeness. Admin will check resident files weekly starting 6/20/23. This process will be ongoing by admin until further notice.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall return resident #2's medical evaluation documentation to the medical professional who completed the medical evaluation to have the documentation corrected or the resident shall have a new medical evaluation completed and documented. 7/21/23
[redacted]

141b1 - Annual Medical Evaluation (continued)

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall develop and implement a written policy and procedure which includes the monthly monitoring of resident medical evaluation dates and scheduling annual medical evaluations.

Directed Completion Date: *07/22/2023*

Not Implemented [redacted] - 10/10/23

144c1 - Smoking Area Guidelines

23. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home does not permit smoking inside of the home. The designated smoking area is on the front porch of the home and along the ramp to the emergency exit from room #2. However, at approximately 10:55 a.m., there was an accumulation of chunks of cigarette ashes on resident #7's dresser in resident room #2 on the first floor. According to resident #7, [redacted] sometimes comes into [redacted] room from the outside ramp through the emergency exit door to [redacted] room before finishing [redacted] cigarettes and sets them on the dresser. There were also burn marks in the top of the dresser under the ashes, and there were multiple pieces of paper on the dresser.

Repeat violation 9/7/22

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

The house keeper will inspect all rooms and dispose of debris chemical or physical from dressers starting 6/16/23 and ongoing until further notice. The housekeeper will salvage all debris chemical and physical as of 6/17/23. The housekeeper will report find to staff. The staff will report to the admin as needed. The staff will document the incident. Staff will monitor resident #7 for repeat behavior and will report to admin who will monitor twice weekly. Plan was implemented on 6/16/23. Training implemented on 6/16/23 by admin to make sure this does not happen again to stay in 2600 compliance.

DIRECTED

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall update resident #7's support plan regarding the smoking issue including the level of supervision required to protect the resident and other residents in the home. 7/21/23 [redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall educate all residents on the home's policy and procedures for smoking. 7/21/23 [redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator, housekeeper, or other staff person shall audit resident #7 room daily to ensure the resident is following the home's policy and procedures for smoking. Documentation of audits shall be kept. 7/21/23 [redacted]

Directed Completion Date: *07/22/2023*

Not Implemented [redacted] 10/10/23

183b - Meds and Syringes Locked

24. 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

At approximately 10:55 a.m., there was a red gel capsule medication setting on resident #7's dresser in room #2 on the first floor. According to staff person A it is resident #7's Colace 100 mg.

Repeat violation 9/7/22

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

As of 6/15/23 each resident will be administered their medications in the appropriate area. House keeper will inspect all rooms and dispose of debris chemical or physical from dressers starting 6/16/23 and ongoing until further notice. The housekeeper will salvage all lose, found medications as of 6/17/23. The housekeeper will report find to med staff. The med staff will report to the admin as needed. The med staff will document the incident. Med staff will monitor resident #7 for repeat behavior and will report to admin who will monitor twice weekly. Plan was implemented on 6/16/23. Training implemented on 6/16/23 by admin to make sure this does not happen again to stay in 2600 compliance.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall remove and dispose the medication cited in the violation if not already done. 7/21/23[redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit the home weekly to ensure prescription medications, OTC medications, CAM and syringes are kept in an area or container that is locked. Documentation of audits shall be kept. 7/21/23[redacted]

Directed Completion Date: *07/22/2023* *Not Implemented[redacted] 10/10/23*

184a - Resident's Meds Labeled

25. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #1 is ordered Carvedilol 3.125mg – take 1 tablet by mouth 2 times daily. However, the pharmacy label for this medication indicates Carvedilol 3.125mg tablet – take 1 tablet by mouth once a day for blood pressure.

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

on 6/15/23 med staff called the pharmacy for the correct order. The med staff will be trained on documentation. The med staff will review all medications against the MAR. The med trainer will do the trainings for med staff. Medication log and medications will be monitored daily by the admin. This will start on 6/15/23 and continue for the foreseeable future. The admin will call pharmacy on 6/15/23. The pharmacy will reprint the order directly from doctor script completed on 6/18/23. The med staff and admin will review the meds and MAR daily to make current.

DIRECTED

184a - Resident's Meds Labeled (continued)

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall complete a monthly audit of prescriptions, the MAR and the medication labels to ensure accuracy and completeness. Documentation of audits shall be kept. 7/21/23[redacted]

Directed Completion Date: *07/22/2023* *Not Implemented*[redacted] *- 10/10/23*

187a - Medication Record

26. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
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

Resident #1 is ordered Cyanocobalamin 500mcg tab – take one tablet by mouth daily for vitamin B-12 supplement. However, the resident's June 2023 medication administration record (MAR) indicates Cyanocobalamin 1000mcg – take by mouth one daily.

Resident #1 is ordered Melatonin 3mg capsule – take 1 by mouth at bedtime as needed. This medication is not on the resident's June 2023 MAR. However, according to staff person C and the resident, resident #1 is administered this medication every night.

Resident #1 is ordered acetaminophen 325mg – take three tablets by mouth three times a day as needed for pain. However, the only entry for acetaminophen on the resident's June 2023 MAR is for Tylenol Arthritis 650mg caplet ER – take two tablets by mouth twice daily.

Resident #1 is ordered Fluticasone 500/salmeterol 50mcg inhl disk – inhale 1 puff orally every 12 hours. However, this medication is not on the resident's June 2023 MAR.

There is an entry on resident #1's June 2023 MAR that indicates Thiamine B1 100mg – take by mouth 1 tablet daily. However, this medication was discontinued on 11/8/22.

Resident #5 is ordered escitalopram oxalate 20mg tab – take one-half tablet by mouth daily for anxiety. However, the resident's June 2023 MAR had an entry that indicated Escitalopram oxalate 20mg tab - take 1 tab by mouth daily.

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

The med staff will be trained on documentation of meds by the med trainer in July until then the pharmacy will be contacted on 6/16/23 to send out a updated medication list which was completed on 6/18/23. That med list on 6/18/23 was sent to another pharmacy to print an accurate list and was sent back to the facility on 6/18/23. It is

187a - Medication Record (continued)

now being used. The med staff will monitor the MAR and meds daily. The admin will review all meds and MAR twice weekly for 30 days as things become consistent, then monthly from then on. Plan implemented as of 6/18/23 and an incident report has been filed with DHS on the med error of documentation.

Licensee's Proposed Overall Completion Date: *07/15/2023* *Not Implemented [redacted] 10/10/23*

187b - Date/Time of Medication Admin.

27. 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 #1 is ordered Melatonin 3mg capsule – take 1 by mouth at bedtime as needed. At 2:40 p.m., this medication was not on the resident's June 2023 medication administration record (MAR). However, according to staff person C and the resident, resident #1 is administered this medication every night but is not signed off as being administered.

At 2:37 p.m., there was an entry on resident #1's June 2023 MAR that indicates Thiamine B1 100mg – take by mouth 1 tablet daily that has been signed off as being administered 6/1/23 – 6/15/23. However, this medication was last filled by the pharmacy on 10/16/22 and discontinued on 11/8/22.

Repeat violation 9/7/22, 12/28/22

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

Whenever resident #1 has doctor visits [redacted] will be accompanied by staff during the doctors visit. The staff will verify discontinued medications and current medications at that time with the doctor. Staff person will bring the current medication list to the facility for the med staff. The med staff will document the medication exactly from the label to the MAR. The admin will follow up with med staff for accuracy. Plan was initiated on 6/16/23 and will continue indefinitely.
The pharmacy was contacted on resident #1 to get a complete and current medication list which was initiated by admin on 6/16/23. On 6/17/23 the pharmacy sent over a copy of resident #1 current medication list to the admin. The medication list will be copied accordingly to the MAR by the admin as of 6/17/23. The MAR will be monitored daily by the med staff upon administering medication as of 6/17/23. The admin will monitor the label and the MAR twice weekly for a month and then monthly initiated 6/17/23 by admin.

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons qualified to administer medications on the requirements of Regulation 2600.187(b). Documentation shall be kept in accordance with Regulation 2600,65(i). 7/31/23 [redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all resident MARs at least twice weekly to ensure the documentation of medication administration is accurate and complete. Documentation of audits shall be kept. 7/21/23 [redacted]

Directed Completion Date: *07/26/2023* *Not Implemented [redacted] - 10/10/23*

187d - Follow Prescriber's Orders

28. Requirements

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

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

Description of Violation

Resident #1 is ordered acetaminophen 325mg – take three tablets by mouth three times a day as needed for pain. However, at 2:40 p.m., the only entry on the resident's June 2023 MAR indicates Tylenol arthritis 650mg caplet ER – take two tablets by mouth twice daily which is signed off on when the ordered medication is administered which has only been twice daily from 6/1/23 – 6/14/23.

Resident #1 is ordered Fluticasone 500/salmeterol 50 inhl disk – inhale 1 puff orally every 12 hours. However, at 2:45 p.m., this medication was not on the resident's June 2023 MAR and staff person C stated that this medication has not been administered since resident was admitted on [redacted]22.

Repeat violation 8/7/22, 12/28/22

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

As of 6/16/23 whenever medications are refused the med staff will contact admin and give notification of refusal and the admin will then contact the doctor immediately. Once a response has been received from the doctor the med staff will follow doctors instructions.

The pharmacy was contacted on resident #1 to get a complete and current medication list which was initiated by admin on 6/16/23. On 6/17/23 the pharmacy sent over a copy of resident #1 current medication list to the admin. The medication list will be copied accordingly to the MAR by the admin as of 6/17/23. The MAR will be monitored daily by the med staff upon administering medication as of 6/17/23. The admin will monitor the label and the MAR twice weekly for a month and then monthly. Initiated 6/17/23 by admin.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall notify resident #1's prescriber of the medication errors and the refusal of medications and update the resident's refusal of the medications on the MAR. Documentation shall be kept in the resident's record 7/21/23 [redacted]

Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons qualified to administer medications on the requirements or Regulation 2600.187(d) and the home's policy and procedures for medication administration. Documentation of education shall be kept in accordance with Regulation 2600.65(i). 7/21/23[redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all resident MARs at least twice weekly to ensure the directions of the prescriber are followed. Documentation of audits shall be kept. 7/21/23[redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall only initiate the discharge of a resident in accordance with Regulation 2600.228. 7/21/23 [redacted]

Directed Completion Date: *07/26/2023* *Not Implemented [redacted]- 10/10/23*

223a - Description of Service

29. Requirements

223a - Description of Service *(continued)*

2600.
223.a. The home shall have a current written description of services and activities that the home provides including the following:
1. The scope and general description of the services and activities that the home provides.
2. The criteria for admission and discharge.
3. Specific services that the home does not provide, but will arrange or coordinate.

Description of Violation

The administrator was not able to produce a copy of the home's description of services.

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

The home already has a descriptive plan of service. At that time and at that condition the administrator did not understand what the inspectors were looking for. The plan is now posted in an obvious open place as of 6/19/23.

Licensee's Proposed Overall Completion Date: *07/07/2023* *Not Implemented [redacted] 10/10/23*

224a - Preadmission Screen Form

30. 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

The preadmission screening for resident #1, admitted [redacted]/22, was not completed until [redacted]/22. The screening does not indicate if the resident can safely use and avoid poisonous materials.

Repeat violation 9/7/22

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

The pre admission screening will be closely read and completed by the admin as of 6/16/23. The pre admission screening will be followed up by the administrators assistant, and then reviewed by the admin for completion as of 6/16/23.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall update resident #1's preadmission screening. 7/21/23[redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all current resident records to ensure a preadmission screening has been completed in its entirety and is in each resident record. 7/21/23 [redacted]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit all newly completed preadmission screening documents prior to the resident's admission for accuracy and completeness. 7/21/23 [redacted]

Directed Completion Date: *07/22/2023*

Implemented [redacted] 10/19/2023)

225c - Additional Assessment

31. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

The most recent assessment for resident #2, admitted [redacted]/05, was completed [redacted]/16.

The most recent assessment for resident #5 was completed [redacted]/22. However, the resident's previous assessment was completed [redacted]/20.

Repeat violation 9/7/22

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

Resident #2 and #5 annual assessments will be logged and marked on residents folder of the month of the assessment by admin on 6/19/23. The assessments of all residents will be monitored and reviewed by the admissions staff and admin on a monthly basis as of 6/19/23.

Licensee's Proposed Overall Completion Date: *07/16/2023* *Not Implemented [redacted] 10/10/23*

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *NEW LIFE PERSONAL CARE* **License #:** *43121* **License Expiration:** *09/23/2023*

Address: *2521 VERSAILLES AVENUE, MCKEESPORT, PA 15132*

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

Administrator

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

Legal Entity

Name: *NEW LIFE PERSONAL CARE HOME, INC.*

Address: *2521 VERSAILLES AVENUE, MCKEESPORT, PA, 15132*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *08/29/1982* **Issued By:** *PA Dept L&I*

Type: *I-1* **Date:** *06/02/2000* **Issued By:** *City of McKeesport*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *13* **Waking Staff:** *10*

Inspection Information

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

Reason: *Complaint, Interim* **Exit Conference Date:** *08/29/2023*

Inspection Dates and Department Representative

08/28/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *18* **Residents Served:** *13*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *10* **Are 60 Years of Age or Older:** *10*

Diagnosed with Mental Illness: *12* **Diagnosed with Intellectual Disability:** *1*

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

Inspections / Reviews

08/28/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/30/2023*

10/05/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/16/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/12/2023*

10/11/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/16/2023*

Reviewer [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/18/2023*

10/19/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/16/2023*

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

20b1 - Financial Records

1. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
1. The home shall keep a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance.

Description of Violation

The home is representative payee for resident #1. However, the "Money Count Verification" form for resident #1 only indicates the amount of cash disbursed to the resident each month. It does not include the dates and amounts of deposits of the resident's income and withdrawals for the resident's monthly rent.

The home is representative payee for resident #2. However, the "Money Count Verification" form for resident #2 only indicates the amount of cash disbursed to the resident each month. It does not include the dates and amounts of deposits of the resident's income and withdrawals for the resident's monthly rent.

The home is representative payee for resident #3. However, the "Money Count Verification" form for resident #3 only indicates the amount of cash disbursed to the resident each month. It does not include the dates and amounts of deposits of the resident's income and withdrawals for the resident's monthly rent.

Plan of Correction ***Accept [redacted] 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/29/2023 by the Admin to Residents 1,2 and 3 financial records were updated. Process began on 9/29/2023.

To enhance the currently compliant operations, on 09/29/2023 the admin will will monitor contracts. Expense allowances will reflect the income of the resident, spending allowance and rent, with a completion date of 10/08/2023.

Effective 09/29/2023 the admin will perform monthly review through 10/08/2023 to maintain ongoing compliance with keeping a record of financial transactions with residents, including the dates, amounts of deposits, amounts of withdrawals and the current balance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *10/08/2023* *Not Implemented [redacted] 10/10/23*

20b8 - Quarterly Account

2. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

The home is representative payee for resident #1. However, the resident and the resident's designated person have not been given an itemized account of financial transactions made on the resident's behalf on a quarterly basis. The

20b8 - Quarterly Account (continued)

"Money Count Verification" form for resident #1 only indicates the amount of cash disbursed to the resident each month.

The home is representative payee for resident #2. However, the resident and the resident's designated person have not been given an itemized account of financial transactions made on the resident's behalf on a quarterly basis. The "Money Count Verification" form for resident #2 only indicates the amount of cash disbursed to the resident each month.

The home is representative payee for resident #3. However, the resident and the resident's designated person have not been given an itemized account of financial transactions made on the resident's behalf on a quarterly basis. The "Money Count Verification" form for resident #3 only indicates the amount of cash disbursed to the resident each month.

Plan of Correction ***Directed [redacted] - 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/29/2023 by the admin to Audit began on 9/29/2023. The quarterly audit will have a sign sheet to ensure the frequency.

To enhance the currently compliant operations, on 09/29/2023 the admin will do quarterly audits and will have a log sheet to ensure the frequency, with a completion date of 10/08/2023.

Effective 09/29/2023 the admin will perform quarterly audits through 10/08/2023 to maintain ongoing compliance with giving residents and residents' designated persons, an itemized account of financial transactions made on residents' behalf on a quarterly basis. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall provide Residents #1, #2, and #3 with an itemized account of financial transactions made on the resident's behalf since 1/1/23.[redacted]10/11/23

Directed Completion Date: *10/12/2023* *Not Implemented[redacted] 10/10/23*

27a - SSI Benefits

3. Requirements

2600.
27.a. If a home agrees to admit a resident eligible for SSI benefits, the home's charges for actual rent and other services may not exceed the SSI resident's actual current monthly income reduced by the current personal needs allowance.

Description of Violation

Resident #3 receives Supplemental Security Income (SSI) of which the 2023 federal and state combined rate is $1,553.30. However, resident #3's contract dated [redacted]/23 indicates the cost of [redacted]room and meals is $1,500.00/month as clarified by staff person A. However, the maximum charge for room and meals can only be $1,468.30/month after $85.00 is deducted for the personal needs allowance (PNA).

27a - SSI Benefits *(continued)*

Plan of Correction ***Directed [redacted] - 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/03/2023 by the admin, contract was updated and reflects correct amounts for room, meals and PNA.

To enhance the currently compliant operations, on 09/03/2023 the Admin will check quarterly reports for all. Will have log sheet signed and dated to ensure delivery on a quarterly basis, with a completion date of 10/08/2023.

Effective 09/03/2023 the Admin will perform monthly checks through 10/08/2023 to maintain ongoing compliance with charging for actual rent and other services, and not to exceed the SSI resident's actual current monthly income reduced by the current personal needs allowance, if a resident is eligible for SSI benefits and is admitted. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall complete an audit of the funds paid by resident #3 and that a refund, if, applicable will be paid to the resident. [redacted] 10/11/23

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall complete an of all current resident contracts and payments to ensure compliance with Regulation 2600.27(a). [redacted] 10/11/23

Directed Completion Date: *10/12/2023* *Not Implemented [redacted] 10/10/23*

65e - 12 Hours Annual Training

4. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.

Description of Violation

Staff person A only received 11 hours of annual training for the 1/1/22-12/31/22 staff training year.

Staff person B received zero hours of annual training for the 1/1/22-12/31/22 staff training year.

Plan of Correction ***Accept [redacted] - 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/03/2023 by the admin to Staff was informed and training was conducted immediately.

To enhance the currently compliant operations, on 09/03/2023 the Admin will Admin will monitor the current training on a monthly basis with a log sheet, with a completion date of 10/08/2023.

Effective 09/03/2023 the admin will perform monthly monitor through 10/08/2023 to maintain ongoing compliance with ensuring direct care staff persons A and B have at least 12 hours of annual training relating to their job duties, and ensuring all Staff persons orientation is included in the 12 hours of training for the first year of employment. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

65e - 12 Hours Annual Training *(continued)*

Licensee's Proposed Overall Completion Date: *10/08/2023* *Not Implemented* [redacted] *10/10/23*

65f - Training Topics

5. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A, hired [redacted]19, did not receive training in medication self-administration for the 1/1/22-12/31/22 staff training year.

Direct staff person B, hired [redacted]/11, did not receive annual training in any of the required topics for the 1/1/22-12/31/22 staff training year.

Plan of Correction ***Accept [redacted] 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/10/2023 by the Admin to Training was conducted immediately. Training was done on 9/12/2023 by landmark.

To enhance the currently compliant operations, on 09/10/2023 the Admin will Will ensure monthly staff training are completed by a signature of completion by admin and DCS, admin will audit all current staff records on a monthly basis with corrective action included if staff records are not current, with a completion date of 10/08/2023.

Effective 09/10/2023 the Admin will perform monthly audit through 10/08/2023 to maintain ongoing compliance with ensuring training topics for the annual training for direct care staff persons include, including medication self-administration training, and instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, and care for residents with dementia and cognitive impairments, and infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, and personal care service needs of the resident, and safe management techniques, and care for residents with mental illness or an intellectual disability, or both, if the population is served in the home. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *10/08/2023* *Not Implemented* [redacted] *10/10/23*

65g - Annual Training Content

6. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Violation

Direct care staff person A, hired [redacted]/19, did not receive training in (1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during the 1/1/22-12/31/22 staff training year.

Direct care staff person B, hired [redacted]22, did not receive training in (1) Fire safety completed by a fire safety expert, (2) Emergency preparedness, (3) Resident rights, (4) The Older Adult Protective Services Act, and (5) Falls and accident prevention during the 1/1/22 – 12/31/22 staff training year.

Plan of Correction ***Accept[redacted] - 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/10/2023 by the admin to Fire safety and all missing trainings were conducted immediately. Fire safety training was completed in March at 10 a.m approximately.

To enhance the currently compliant operations, on 09/12/2023 the Admin will a monthly audit of all training signed by DCS and admin will be performed, with a completion date of 10/08/2023.

Effective 09/10/2023 the admin will perform monthly audit through 10/08/2023 to maintain ongoing compliance with ensuring direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers are trained annually in, including fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, or videos prepared by a fire safety expert and accompanied by an onsite staff person trained by a fire safety expert, and emergency preparedness procedures and recognition and response to crises and emergency situations, and resident rights, and the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), and falls and accident prevention, and fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, or videos prepared by a fire safety expert and accompanied by an onsite staff person trained by a fire safety expert, and emergency preparedness procedures and recognition and response to crises and emergency situations, and resident rights, and the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), and falls and accident prevention. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *10/08/2023* *Not Implemented[redacted] 10/10/23*

85a - Sanitary Conditions

7. Requirements

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

85a - Sanitary Conditions *(continued)*

Description of Violation

At 10:33 a.m., there were approximately 30 cigarette butts on the cement pad between the top of the ramp leading to the emergency egress door from room #2 on the first floor and the bottom of the second-floor fire escape. There was also an accumulation of cigarette butts strewn about the landscaping stones off of the front porch smoking area.

At 12:38 p.m., there was a large, wet, darkened area measuring approximately 8"X14" of what appeared to be mold on the floor surrounding the toilet in the second-floor common bathroom.

Plan of Correction ***Accept [redacted] - 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/10/2023 by the Admin to The mold area was located, cleaned and sanitized with commercial bleach and tile-x. cleaning started on 9/10/23 and ended on 9/11/23.

To enhance the currently compliant operations, on 09/10/2023 the admin and DCS will perform daily monitoring of the outside of the building for cigarette butts, and inside the building for any water stains and or mold like stains to maintain sanitary conditions, with a completion date of 10/08/2023.

Effective 09/10/2023 the admin will perform daily monitor through 10/08/2023 to maintain ongoing compliance with maintaining sanitary conditions. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *10/08/2023* *Not Implemented [redacted] 10/10/23*

96a - First Aid Kit

8. 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

On 8/28/23, the home's only first aid kit in the kitchen did not include a thermometer and disposable gloves.

Plan of Correction ***Accept [redacted] - 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/10/2023 by the Admin to The missing items were replaced by pharmacy immediately after they were contacted.

To enhance the currently compliant operations, on 09/10/2023 the admin and DCS will training was conducted and completed on 10/7/23 by admin. All staff were made aware of the first aid contents and when items need replaced to call pharmacy, with a completion date of 10/08/2023.

Effective 09/10/2023 the Admin and DCS will perform monthly monitor through 10/08/2023 to maintain ongoing compliance with having a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

96a - First Aid Kit *(continued)*

Licensee's Proposed Overall Completion Date: *10/08/2023* *Not Implemented [redacted] - 10/10/23*

101r - Bedroom - shades/drapes/window covering

9. Requirements

2600.
101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

At 9:25 a.m., there were no drapes, shades, curtains, blinds or shutters on the windows on either of the side windows in the second floor front bedroom off of the television room.

Plan of Correction ***Accept [redacted] - 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/13/2023 by the DCS to replaced curtains on 9/13/2023 for the privacy of of the residents.

To enhance the currently compliant operations, on 09/13/2023 the Admin and DCS will Staff training was done on 9/13/23 by admin and completed on 9/13/23, with a completion date of 10/08/2023.

Effective 09/13/2023 the admin and DCS will perform weekly monitor through 10/08/2023 to maintain ongoing compliance with ensuring there are drapes, shades, curtains, blinds or shutters on the bedroom windows, and window coverings are clean, in good repair, provide privacy and cover the entire window when drawn. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *10/08/2023* *Not Implemented [redacted] 10/10/23*

103f - Refrigerator/Freezer Temps

10. 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 11:36 a.m., the Philco upright freezer in the home's basement measured 22 degrees Fahrenheit.

At 11:38 a.m., the freezer compartment of the white refrigerator/freezer measured 12 degrees Fahrenheit.

REPEAT VIOLATION 9/7/22

Plan of Correction ***Accept [redacted] - 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/10/2023 by the Admin and DCS to Fans were installed at the rear of the refrigerator in order to give equipment airflow and circulation.

To enhance the currently compliant operations, on 09/10/2023 the admin and dcs will Staff were trained on 9/10/23 by admin on food safety temperature controls the training was was completed on 9/10/23, with a completion date of 10/08/2023.

103f - Refrigerator/Freezer Temps (continued)

Effective 09/10/2023 the admin and DCS will perform daily then monthly monitor through 10/08/2023 to maintain ongoing compliance with ensuring food requiring refrigeration is stored at or below 40°F, and frozen food is kept at or below 0°F, and thermometers are present in refrigerators and freezers. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *10/08/2023* *Not Implemented* [redacted] *10/10/23*

132g - Fire Drills Days/Times

11. 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's fire drill record for the fire drill conducted on 6/16/23 at 5:19 p.m. indicates that two staff persons participated in the evacuations of residents. However, the home only has one staff person working in the home.

The home's fire drill record for the fire drill conducted on 7/30/23 at 9:15 p.m. indicates that two staff persons participated in the evacuations of residents. However, the home only has one staff person working in the home.

Plan of Correction ***Directed ([redacted] 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/01/2023 by the admin to made corrections to the schedule on 9/3/23.

To enhance the currently compliant operations, on 09/01/2023 the Admin will monitor the employee schedule and coordinate it with the fire drill on the same date, day and time, with a completion date of 10/08/2023.

Effective 09/01/2023 the admin will perform monthly monitor through 10/08/2023 to maintain ongoing compliance with ensuring fire drills are held on different days of the week, at different times of the day and night. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit the fire drill record to ensure compliance with Regulation 2600.132(g) specifically that fire drills are not conducted when additional staff persons are present and not routinely held at times when resident attendance is low. [redacted] 10/11/23

Directed Completion Date: *10/08/2023* *Not Implemented* [redacted] *10/10/23*

141b1 - Annual Medical Evaluation

12. Requirements

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

141b1 - Annual Medical Evaluation *(continued)*

Description of Violation

Resident #2's most recent annual medical evaluation (DME) was completed [redacted]/22. However, the resident's previous DME was completed [redacted]/21.

Resident #3's most recent annual medical evaluation (DME) completed [redacted]/22 did not include the resident's height, weight, pulse rate, blood pressure, temperature or body and positioning/movement. These areas were blank.

Repeat violation 9/7/22; 12/28/22

Plan of Correction ***Accept [redacted]- 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/09/2023 by the admin to errors were discovered with resident #2 and #3 DME and was immediately corrected by MD on 9/9/23.

To enhance the currently compliant operations, on 09/09/2023 the admin will will conduct bi-weekly audits on DME's of all residents to ensure accuracy and timeliness, with a completion date of 10/08/2023.

Effective 09/10/2023 the admin will perform biweekly monitor through 10/08/2023 to maintain ongoing compliance with ensuring each resident has a medical evaluation at least annually. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *10/08/2023* *Not Implemented [redacted] 10/10/23*

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

At 2:05 p.m., there was a box with pharmacy label for resident #4 containing a Wixela inhaler of fluticasone propionate and salmeterol that indicated an expiration of "Jul-2023."

Plan of Correction ***Accept [redacted]- 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 09/03/2023 by the admin and med techs to All old meds were referred to pharmacy on 9/14/23. Expired meds were corrected and properly disposed of expired medications.

To enhance the currently compliant operations, on 09/03/2023 the admin and med techs will Expired meds were gathered on 9/3/23 and the D/c's facilitated the returns on 9/4/23. Training was conducted with DCS by admin on 9/3/23, with a completion date of 10/08/2023.

183e - Storing Medications (continued)

Effective 09/03/2023 the admin and med techs will perform biweekly monitor through 10/08/2023 to maintain ongoing compliance with ensuring prescription medications, OTC medications and CAM will be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *10/08/2023* *Not Implemented [redacted] 10/10/23*

184a - Resident's Meds Labeled

14. Requirements

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

Description of Violation

At 2:05 p.m., there was an albuterol sulfate inhaler that staff person A indicated belongs to resident #4. The inhaler was not labeled with a pharmacy label or the resident's name.

Plan of Correction ***Accept ([redacted] - 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 08/29/2023 by the admin and med techs to admin was made aware of medications without labels. The pharmacy was notified and a corrected label was sent.

To enhance the currently compliant operations, on 08/29/2023 the admin and med techs will med cart will be monitored daily by admin and med techs for medications that are not properly stored in their packaging. Training by admin was conducted and completed with med staff on 8/29/23, with a completion date of 10/08/2023.

Effective 08/29/2023 the admin and med techs will perform daily monitor through 10/08/2023 to maintain ongoing compliance with ensuring the original container for prescription medications will be labeled with a pharmacy label that includes. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *10/08/2023* *Not Implemented [redacted] 10/10/23*

187a - Medication Record

15. Requirements

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

Description of Violation

At 2:05 p.m., there was an entry on resident #4's August 2023 medication administration record (MAR) for Tylenol arthritis 650mg – Take 2 tablets twice daily. As of 6/15/23 this medication is not prescribed for the resident.

Plan of Correction ***Accept [redacted] - 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 08/29/2023 by the admin and med techs to MAR had medications that were not prescribed for the resident so the MAR was verified and corrected for the appropriate medications for that specific resident.

187a - Medication Record (continued)

To enhance the currently compliant operations, on 08/29/2023 the admin and med techs will The med staff was trained on medical records on 8/29/23 by admin and completed on 8/29/23. At each doctor visit staff will do a review of current medications with physician for accuracy. All adjustments will be made at that time, with a completion date of 10/08/2023.

Effective 08/29/2023 the admin and med techs will perform at each doctor visit verify through 10/08/2023 to maintain ongoing compliance with keeping a medication record, for each resident for whom medications are administered, that includes. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *10/08/2023* *Not Implemented [redacted] - 10/10/23*

187b - Date/Time of Medication Admin.

16. 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

At 2:05 p.m., there was an entry on resident #4's August 2023 medication administration record (MAR) for Tylenol arthritis 650mg – Take 2 tablets twice daily. As of 6/15/23 this medication is not prescribed for the resident. However, the medication was signed off as administered from 8/1/23 through 8/7/23 at 8:00 a.m. and 8:00 p.m.

Resident #4 is ordered Thera M (beta carotene) – Take by mouth 1 tablet daily. At 2:01p.m., the medication was not available on the medication cart. Staff person A stated that [redacted] finished the medication on 8/27/23 in the evening and discarded the bottle. However, staff person C, the home's administrator, signed the resident's medication administration record (MAR) on 8/28/23 at 8:00 a.m. as having administered the medication.

The August 2023 MAR for resident #5 included a second page duplicating all of the resident's straight order medications to include: Thera-M (Beta-carotene) tablet – Take by mouth 1 tablet daily, Risperdal 3mg tablet – Take by mouth 1 tablet twice daily, Lithium carbonate 300mg capsule – Take by mouth 2 capsules twice daily, Cogentin 1mg tablet – Take by mouth 1 tablet twice daily, Lexapro 20mg tablet – Take by mouth ½ tablet daily; Propranolol 10 mg tablet – Take by mouth 2 tablet three times daily. Each of these medications was signed off as having been administered twice at each dosing time from 8/1/23 through 8/27/23.

REPEAT VIOLATION: 9/7/22; 12/28/22

Plan of Correction ***Accept [redacted] - 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 08/09/2023 by the admin and med techs to on 8/30/23 admin conducted a medication review discussing the 5 rights of medication administration to med techs resolved on 8/30/23.

To enhance the currently compliant operations, on 08/09/2023 the admin and med techs will The admin on 8/30/23 did a thorough training on medication time, dose, route, medicine, person. Training was completed on 8/30/23 the med staff completed training. Admin and med techs will inspect MAR daily and reviewed every other day by admin, with a completion date of 10/08/2023.

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

Effective 08/09/2023 the admin and med techs will perform daily review through 10/08/2023 to maintain ongoing compliance with ensuring the information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *10/08/2023* *Not Implemented* [redacted] *10/10/23*

225c - Additional Assessment

17. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

The most recent annual assessment for resident #2 was completed [redacted]/22. However, the resident's previous assessment was completed [redacted]/21.

The most recent annual assessment for resident #8 was completed [redacted]/23. However, the resident's previous assessment was completed [redacted]/22.

REPEAT VIOLATION: 9/7/22

Plan of Correction ***Accept [redacted] - 10/11/2023)***

In response to the violation on 10/05/2023 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 08/30/2023 by the admin to All annual assessments will be scheduled on proper designated times.

To enhance the currently compliant operations, on 08/30/2023 the admin will monitor times and dates. Annual DME will be scheduled whether MD is on vacation or at the appropriate time by CNP, so assessments can be done at appropriate times. Upon returning admin will review all DME's. Admin will audit resident assessments which was completed on 9/3/23. The audit began on 9/1/23 by admin, with a completion date of 10/08/2023.

Effective 08/30/2023 the Admin will perform annual audit through 10/08/2023 to maintain ongoing compliance with ensuring each resident has additional assessments, including annually. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *10/08/2023* *Not Implemented* [redacted] *10/10/23*