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

July 7, 2023

[redacted], OWNER/ADMINISTRATOR
CORNERSTONE OF CLAYSBURG LLC
[redacted]

RE: CORNERSTONE OF CLAYSBURG
969 BEDFORD STREET
CLAYSBURG, PA, 16625
LICENSE/COC#: 33327

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/23/2023, 03/24/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *CORNERSTONE OF CLAYSBURG* **Licen e #**: *33327* **Licen e Expiration**: *06/06/2023*

Address: *969 BEDFORD STREET, CLAYSBURG, PA 16625*

County: *BLAIR* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *CORNERSTONE OF CLAYSBURG LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *03/14/1984* **I ued By**: *Department of Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *20* **Waking Staff**: *15*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *03/24/2023*

Inspection Dates and Department Representative

03/23/2023 On Site [redacted]

03/24/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* **Residents Served**: *20*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older**: *17*

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

Have Mobility Need: *0* **Have Physical Disability**: *2*

Inspections / Reviews

03/23/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/16/2023*

Inspections / Reviews *(continued)*

04/18/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/15/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/26/2023*

05/04/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/15/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/12/2023*

07/06/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/15/2023*

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

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

The home does not have a copy of the most recent license inspection summary issued by the Departement dated 9/27/22 posted in the home.

Plan of Correction ***Accept ([redacted] - 05/01/2023)***

The most recent inspection report (from 9/27/22) was copied and posted on the main bulletin board on 3/23/2023 by the Administrator. After each annual inspection and approved plan of correction, the Administrator will copy and post the inspection/POC the day it is approved A copy of the most recent license is also posted by the front door and on 2 other bulletin boards located within the Home. The Administrator will post the most recent inspection report and plan of correction by 4/28/2023.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented ([redacted] - 05/23/2023)

26a - Quality Management Plan

2. Requirements

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

Description of Violation

The home has not established and implemented a quality management plan since 2019.

Plan of Correction ***Directed ([redacted] - 05/01/2023)***

The Quality Management Team was established in January 2020 to establish, implement and review the quality of services we offer and to ensure we are meeting the needs of our residents in the Home. Once a year, the policies and procedures are reviewed (in January) and necessary changes are made and/or implemented. A core group of staff now make up the "team" consisting of myself (the Administrator), the Director of Resident Services and our House Manager. Others are asked to participate on an as-needed basis such as our former nurse, pharmacist, fire safety expert. The Quality Team meets once a month on the 3rd Monday at 1:30. A lot of times, this is a stand-up meeting , residents are discussed, jobs are assigned and tasks are completed. Documentation has not been properly kept for these meetings. The next meeting of the quality management team meetings will be held on April 17, May 15, and June 19, 2023. The Administrator will be responsible for making any changes to the plan with the help of the staff. The Administrator will start to take minutes for the monthly meetings starting in May. The corrective actions are discussed and delegated among the staff at the monthly staff meetings.

Directed)

- *The administrator established the Quality Management Team in January 2020.*
- *The administrator will establish the Quality Management Plan by 3/23/23, to include the elements outlined in this regulation. The Quality Team meets once a month on the 3rd Monday at 1:30. The next meeting of the quality management team meetings will be held on 4/17/23, 5/15/23, and 6/19/23. S*
- *Starting 5/15/23, the administrator will ensure the Quality Management Plan is kept in the home,*
- *Starting 12/15/23, the administrator will review the policies and procedures to ensure the Quality*

26a - Quality Management Plan (continued)

Management plan is properly implemented and up to date for next year.

Directed Completion Date: *05/15/2023*

Implemented [redacted] - 07/06/2023)

26b - Quality Management Plan Content

3. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:

Description of Violation

The home's quality management review dated 3/16/23 does not address the periodic review and evaluation of the following topics
(1) The reportable incident and condition reporting procedures.
(2) Complaint procedures.
(3) Staff person training.
(4) Licensing violations and plans of correction, if applicable.
(5) Resident or family councils, or both, if applicable.

Plan of Correction ***Directed [redacted] - 05/01/2023)***

On the 3rd Monday of every month, we will have a Quality Management meeting with minutes taken. Currently on the 3rd or 4th Wednesday of every month, we conduct a staff meeting, now to be linked up with an hour-long training topic. Currently on the 3rd or 4th Thursday of every month we hold a Resident Council meeting at the home. The resident council meetings are conducted by the Administrator, sometimes by the Director, and sometimes by the Hose Manager in my absence. The Administrator conducts the staff meetings - for the one being held on May 17, I will be assisted by Stacy Parks, or Ombudsman for the training topic of Resident Rights.

Directed)

- *Starting 4/20/23, the administrator will ensure the Resident Council Meetings are conducted monthly and meeting minutes are completed and kept in the home.*
- *The administrator will establish the Quality Management Plan by 3/23/23, to address the periodic review and evaluation of this regulation.*
- *Starting 4/17/23, the administrator will hold Quality Management Meetings every month, to include the reportable incident and condition reporting and complaint procedures, staff person training, and Licensing iolations and plans of correction.*
- *On 5/17/23, the administrator will conduct a Staff Meeting to discuss resident rights.*
- *Starting 5/17/23, the administrator will ensure Quality Management Meeting Minutes are taken and kept in the home.*

Directed Completion Date: *05/17/2023*

Implemented [redacted] - 07/06/2023)

63a - First Aid/CPR Training

4. Requirements

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

Description of Violation

The home had a census of 20 residents on the dates listed below and required at least one staff member certified in CPR and First Aid. However, Staff Member A was scheduled alone during the following dates and shifts and is not certified in CPR and First Aid:
On 03/02/23 from 10:00pm to 6:00am
On 03/03/23 from 08:00pm to 6:00am
On 03/04/23 from 08:00pm to 6:00am
On 03/05/23 from 08:00pm to 6:00am

Repeated Violation - 9/27/22, 5/24/22, 2/10/22, et al

Plan of Correction ***Directed ([redacted] - 05/01/2023)***

All staff were trained/re-trained last on June 26, 2022 in CPR and first aid. At the time 8 staff members were trained but as of this date only 3 of those staff members are still employed as Aides. The Administrator schedules the staff for the CPR and first aid classes when they are hired, or on an as needed basis. The Administrator can provide training n CPR and first aid for current staff for training or annual updates as needed. Scheduled CPR and first aid training will be held on May 31, 2023 and taught by the Administrator (a certified Instructor.) New hires will be trained in CPR and first aid when they are hired, either by going to a community class, or by the Administrator.

Directed)

- *The administrator scheduled CPR/First Aid training for Staff Person A on 4/22/23*
- *The administrator will obtain CPR/First Aid training, as appropriate, for all Staff Persons and obtain copies of their cards showing their qualifications no later than one week following the certification. The certification cards will be placed in the staff persons' individual records.*
- *The administrator will develop and implement a new hire checklist by 5/15/23 to ensure that new direct care staff are trained in CPR/First Aid before providing direct care.*
- *The administrator will audit the staff schedule daily beginning 5/15/23 to ensure that trained and qualified staff are scheduled in the required ratio for each shift.*

Directed Completion Date: *05/15/2023*

Implemented [redacted] - 07/06/2023)

64c - Annual Training

5. 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.

64c - Annual Training *(continued)*

Description of Violation

Staff Member B, [redacted], completed only 6 hours of Department-approved training in training year 2022.

Plan of Correction ***Directed [redacted] - 05/01/2023)***

All staff will have un update on Residents Rights and Responsibilities by our local Ombudsman on May 17, 2023. The [redacted] training for the remaining 18 hours needed will take place every month depending on topics and what is offered by the state and online. I have an ongoing relationship with another Administrator and reached out to [redacted] on 3/24/23 to discuss a training plan, and to get some ideas. I will be responsible for ensuring my own training. I decided that at least 3 hours a month was the goal, certainly dependent on staffing and other responsibilities. The Administrator will take a look at ALL staff training no later than November 1, and schedule additional training and classes as need to ensure compliance for the year.

Directed Plan)

- *Starting 5/15/23, the administrator will begin the required 24 hours of annual training related to job duties.*
- *Starting 5/15/23, the administrator will identify training offerings via DHS, other accredited college or university or other applicable courses outlined in this regulation.*
- *Starting 5/15/23, the administrator will complete 4 hours each of the required training monthly until training s completed by 10/2023.*
- *Starting 5/15/23, the administrator will ensure the 24 hours required training is completed annually based on the administrator training year.*
- *Starting 5/15/23, the administrator will place trainings in the administrator's record.*

Directed Completion Date: *05/15/2023*

Implemented [redacted] - 07/06/2023)

65d - Initial Direct Care Training

6. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
3. Initial direct care staff person training to include the following:

Description of Violation

Direct Care Staff Member A hired [redacted] and Staff Member C hired [redacted], began providing unsupervised ADL services since their dates of hire. However, the two staff members did not complete the initial direct care staff person training.

Repeated Violation-5/24/22, et al

Plan of Correction ***Directed ([redacted] - 05/01/2023)***

DHS provided the link through several emails to PCH's, although WE were not able to access it on several occasions and the website seemed to not be running properly, I did call DHS directly and received an email with the link, and Casey tried on several occasions to access it, even contacting customer service through the Temple website. All of

65d - Initial Direct Care Training (continued)

this was around the end of February, beginning of March because we had a new hire and we knew it needed completed. Staff member C is no longer one of our employees and staff member A will complete the training/testing by the April 30, 2023. As of April 1, 2023, the Administrator will ensure that all new direct care staff complete the training and testing for competency by utilizing the new program through Temple University.

Directed)

- *On approximately 2/28/23, the administrator contacted DHS, via email and telephone. The administrator was provided with links to complete training.*
- *The Administrator will ensure the initial direct care staff person training is completed for Staff Member A by 4/30/23.*
- *Starting 3/30/23, the administrator will ensure the initial direct care staff person training and testing is completed at the time of hire by utilizing the new program through Temple University.*
- *Starting 5/15/23, The administrator will audit staff records quarterly. The administrator will development an auditing form to document the findings.*
- *Starting 5/15/23, the administrator will place the training in the staff persons individual records.*

Directed Completion Date: *05/15/2023*

Implemented [redacted] - 05/23/2023)

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.

Description of Violation

Direct care Staff Member D and Staff Member E did not complete the 12 hours of required annual training in training year 2022.

Plan of Correction ***Directed [redacted] - 05/01/2023)***

The Administrator updated the 2023 staff training plan on 3/24/23. The Administrator contacted the necessary providers to request their services for training/updates and the times projected during the last week of March 2023. The Administrator will offer staff training at least once a month according to the training plan to ensure compliance for direct care Aides to have 12 hours of required training.

Directed)

- *The administrator will ensure the annual 12 hours training is completed for Staff Member D and E by 5/15/23.*
- *Starting 3/30/23, the Administrator will offer staff training at least once a month according to the training plan to ensure compliance for Direct Care Staff persons.*
- *Starting 3/30/23, the administrator will ensure the 12 Hours annual training is completed annually accordance with the staff training plan developed.*
- *Starting 5/15/23, The administrator will audit staff records quarterly. The administrator will development an auditing form to document the findings and will schedule any required trainings within one week of the findings.*
- *Starting 5/15/23, the administrator will place trainings in the staff persons individual records.*

Directed Completion Date: *05/15/2023*

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

Implemented [redacted] 07/06/2023)

65f - Training Topics

8. Requirements

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

Description of Violation

Direct care Staff Member D and Staff Member E did not receive training in following topics during training year 2022:
1. Medication self administration
2.Instruction on meeting the needs (DME & RASP)
3. Care for residents w/dementia & cognitive impair.
4. Infection control/cleanliness/immobility concerns
5. Personal care service needs of the resident
6. Safe management techniques
7. Care for residents with MH or ID, if served

Plan of Correction ***Directed ([redacted] - 05/01/2023)***

The new staff training plan will be implemented immediately by the Administrator and topics to be discussed will be noted to include the above mentioned topics as well, and signed off by staff and the trainer as they are completed. The training plan will be reviewed and discussed and corrections made though the quality management meetings held on the 3rd Monday of each month starting April 17, 2023. The Administrator is responsible for ensuring the staff are trained throughout the year in the topics required by DHS. As of April 2023, staff meetings will be held once a month to cover the following topics:
1. Medication self-administration
2. Instruction on meeting the needs (DME & RASP)
3. Care for residents w/dementia & cognitive impair.
4. Infection control/cleanliness/immobility concerns
5. Personal care service needs of the resident
6. Safe management techniques
7. Care for residents with MH or ID, if served .
The Administrator will review staff files by November 1, 2023 at the latest to make sure all staff are compliant with the training topics required by DHS for the year.

Directed)

- *The administrator will ensure the annual training outlined in this regulation is completed for Staff Member D and E by 5/15/23.*
- *Starting 3/30/23, the Administrator will offer staff training at least once a month according to the training plan to ensure annual training compliance for Direct Care Staff persons.*
- *Starting 5/15/23, the administrator will audit staff records quarterly. The administrator will development an auditing form to document the findings and will schedule any required trainings within one week of the findings.*
- *Starting 5/15/23, the administrator will place trainings in the staff persons individual records.*

65f - Training Topics (continued)

Directed Completion Date: *05/15/2023*

Implemented [redacted] - 07/06/2023)

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:

Description of Violation

Direct Care Staff Member D and Staff Member E did not receive training in following topics during training year 2022 to 2023:

1. Fire safety by a fire safety expert or staff trained by FSE
2. Emergency preparedness procedures
3. Resident rights
4. Older Adult Protective Services Act (OAPSA)
5. Falls and accident prevention
6. New population groups (if applicable)

Plan of Correction [redacted] ***05/01/2023)***

Although the proper documentation was not in these employee's files, I can assure you the training was completed in most of these topics during monthly scheduled staff meetings throughout 2022. The Administrator is responsible for ensuring the staff are trained on these topics each year. The training plan has been updated to include these topics and is being implemented through monthly staff meetings and other training hours throughout the year to make sure all topics are covered. Documentation will be kept by the administrator and in each of the employees files. The Administrator will review the files no later than November 1, 2023 to make sure the staff is receiving the training they need and have the proper documentation.

Directed)

- *The administrator will ensure the annual training outlined in this regulation is completed for Staff Member D and E by 5/15/23.*
- *Starting 3/30/23, the Administrator will offer staff training at least once a month according to the training plan to ensure annual training compliance for Direct Care Staff persons.*
- *Starting 5/15/23, the administrator will audit staff records quarterly. The administrator will development an auditing form to document the findings and will schedule any required trainings within one week of the findings.*
- *Starting 5/15/23, the administrator will place trainings in the staff persons' individual records.*

Directed Completion Date: *05/15/2023*

Implemented [redacted] - 07/06/2023)

66a Staff Training Plan

10. Requirements

2600.

66a - Staff Training Plan *(continued)*

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

Description of Violation

The home does not have a staff training plan for 2022 or 2023.

Plan of Correction ***Directed [redacted] - 05/01/2023)***

The staff training plan was developed on 3/23/23 by the Administrator for the calendar year 2023 and is attached. Going forward, the next years training plan will be updated and submitted at the end of the current year annually by the Administrator. The topics will be discussed by the staff as a whole and training will continue on a monthly basis as outlined in the training plan. Checklists and training records will be kept in the employees files by the Administrator. The training plan will be completed and submitted by the Administrator no later than December 15 for the following calendar year.

Directed)

- *On 3/23/23, the administrator developed the annual Staff Training Plan for Training Year 2023.*
- *Starting 3/30/23, the administrator will provide staff training monthly.*
- *The administrator will develop and complete the Staff Training plan for training year 2024 by 12/15/23.*
- *The administrator will ensure a copy of the annual staff training plan is kept in the home.*

Directed Completion Date: *12/15/2023*

Implemented ([redacted] - 05/23/2023)

85a - Sanitary Conditions

11. Requirements

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

Description of Violation

On 3/23/23 at approximately 11:00am the full bathroom located on the 1st floor had a strong odor deriving from the base of commode which was also observed showing dark-colored ring around the bottom.

Plan of Correction ***Directed [redacted] - 05/01/2023)***

The toilet was removed, the main pipe was cleared of debris, the floor was scrubbed and a new rubber ring was nstalled at the base of the toilet as well as new bolts to the f oor. The work to the back bathroom was done by the [redacted] on Thursday, April 13, 2023. The bathrooms are spot checked and cleaned (if needed) on every shift by the Aide on duty. All 5 bathrooms are thoroughly cleaned every nights by our 3rd shift Aide as part of their staff duties. Any clogs or drainage issues are immediately dealt with when they occur. If there is an issue that cannot be immediately corrected, it is reported to [redacted] and [redacted] will fix it, usually by the following day at the latest.

(Directed)

85a - Sanitary Conditions (continued)

- *On 4/13/23, the Director of Resident Services removed the toilet, cleared the main pipe of debris, scrubbed the floor, installed a new rubber ring at the base of the toilet and installed new bolts to the floor.*
- *Starting 4/13/23, bathrooms are spot checked and cleaned on every shift by the Resident Aide on duty.*
- *Starting 4/13/23, all 5 bathrooms are thoroughly cleaned every night by the 3rd shift Resident Aide scheduled. Duties will include immediately addressing clogs or drainage issues.*
- *Starting 4/13/23, if Resident Aides who are unable to resolve the issue, the issue will be immediately reported to the Director of Resident Services who w ll address the issue by the following day of discovery.*
- *Starting 5/15/23, the administrator will ensure a walkthrough of the home is conducted weekly. The administrator will develop an auditing form by 5/15/23 to document findings and address any issues within one week of discovery.*

Directed Completion Date: *05/15/2023*

Implemented ([redacted] 05/25/2023)

86b - Bathroom

12. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The full bathroom on the 2nd floor, near room 25, has a ventilation fan that is inoperable and there is no window in the bathroom.

Plan of Correction ***Directed ([redacted] - 05/01/2023)***

The ventilation fan has been repaired and is operable in the bathroom on the 2nd floor. There was a loose wire in the ventilation fan in the bathroom. No one mentioned that it had not been working. [redacted] looked at the fan 4/13/23, removed the cover, adjusted the wire, cleaned off some debris around the fan cover and the fan is now working. Each shift the Aide on duty will check each bathroom to make sure they are all clean and maintained. The Aide on third shift is responsible for thoroughly cleaning the bathrooms and making sure everything is functioning properly. If there is an issue that cannot be immediately corrected, it is reported to [redacted] and [redacted] will fix it, usually by the following day at the latest.

Directed)

- *On 4/13/23, Director of Resident Services repaired a loose wire in the ventilation fan in the 2nd floor bathroom.*
- *Starting 4/13/23, the Resident Aide will check each bathroom to ensure each are clean and maintained.*
- *Starting 4/13/23, the Resident Aide on the 3rd shift will thoroughly clean bathrooms to ensure each are clean, maintained and ensure each are functioning properly.*
- *Starting 4/13/23, if Resident Aides who are unable to resolve the issue, the issue will be immediately reported to the Director of Resident Services who w ll address the issue by the following day of discovery.*
- *Starting 5/15/23, the administrator will ensure a walkthrough of the home is conducted weekly. The administrator will develop an auditing form by 5/15/23 to document findings and address any issues within one week of discovery.*

86b - Bathroom *(continued)*

Directed Completion Date: *05/15/2023*

Implemented (- 05/25/2023)

88a - Surfaces

13. Requirements

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

Description of Violation

The ceiling located in the sitting room is missing two ceiling tile squares.

The hard-wired smoke detector installed in resident room 26 is missing the cover.

An extension cord was observed taped across the floor in resident room 23, this poses a potential fall hazard to the residents residing in the room.

Plan of Correction ***Directed - 05/01/2023)***

A pack of new ceiling tiles was purchased in the fall of 2022 by Casey, for the house and have been in the basement as needed. In March, installed new ceiling fans in the sitting room and planned to reinstall the new tiles, once the fans were operational. The (new) ceiling tiles were put up into the ceiling on 4/25/23 by . The extension cord was purchased on 4/11/23 by the Administrator on ebay and arrived on 4/23/23. It was installed on 4/25/23 by The Administrator found the missing cover in the closet of the resident's room on 4/9/23 and it was replaced on 4/23/23.

Directed)

- *On 09/2022 the Director of Resident Services purchased the ceiling tiles for the home to have as needed.*
- *On 4/25/23, the Director of Resident Services installed the missing ceiling tiles.*
- *On 4/9/23, the Administrator located the missing smoke detector cover in the closet of the resident's bedroom.*
- *On 4/23/23, the administrator placed the cover on the smoke detector.*
- *On 4/11/23, the administrator purchased the extension cord which arrived 4/25/23.*
- *On 4/25/23, the Director of Resident Services installed the Extension Cord.*
- *Starting 5/15/23, the administrator will ensure a walkthrough of the home is conducted weekly. The administrator will develop an auditing form by 5/15/23 to document findings and address any issues within one week of discovery.*

Directed Completion Date: *05/15/2023*

Implemented (- 05/25/2023)

95 - Furniture and Equipment

14. Requirements

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

95 - Furniture and Equipment *(continued)*

Description of Violation

The toilet on the ground floor in the "back hall bathroom" is loose and rotates on its base about 1 inch. The back of the toilet is propped up by two blackened wooden shims; and the grab rail attached to the wall near the toilet is loose.

Plan of Correction ***Directed (- 05/01/2023)***

The toilet was removed, the main pipe was cleared of debris, the floor was scrubbed and a new rubber ring was nstalled at the base of the toilet as well as new bolts into the floor. New, longer screws were attached to the grab rail beside the toilet to secure it. The work to the back bathroom was done by on Thursday, April 13, 2023. The bathrooms are spot checked and cleaned (if needed) on every shift by the Aide on duty. All 5 bathrooms are thoroughly cleaned every nights by our 3rd shift Aide as part of their staff duties. Any clogs or drainage issues are mmediately dealt with when they occur. If there is an issue that cannot be immediately corrected, it is reported to and will fix it, usually by the following day at the latest.

Directed)

- *On 4/13/23, the Director of Resident Services removed the toilet, cleared the main pipe of debris, scrubbed the floor, installed a new rubber ring at the base of the toilet and new were bolts added to the floor.*
- *On 4/13/23, the Director of Resident Services attached new longer screws to the grab rail beside the toilet to secure it.*
- *Starting 4/13/23, bathrooms are spot checked and cleaned on every shift by the Resident Aide on duty.*
- *Starting 4/13/23, all 5 bathrooms are thoroughly cleaned every night by the 3rd shift Resident Aide scheduled. Duties will include immediately addressing clogs or drainage issues.*
- *Starting 4/13/23, if Resident Aides are unable to resolve the issue, the issue will be immediately reported to the Director of Resident Services who will address the issue by the following day of discovery.*
- *Starting 5/15/23, the administrator will ensure a walkthrough of the home is conducted weekly. The administrator will develop an auditing form by 5/15/23 to document findings and address any issues within one week of discovery.*

Directed Completion Date: *05/15/2023*

Implemented - 07/06/2023)

97 - Elevators/Lifting Devices

15. Requirements

2600.
97. Elevators and Stair Glides - Each elevator and stair glide must have a certificate of operation from the Department of Labor and Industry or the appropriate local building authority in accordance with 34 Pa. Code Chapter 405 (relating to elevators and other lifting devices).

Description of Violation

The home's chairlift does not have a current certificate of operation from the Department of Labor and Industry or appropriate local building authority. The chairlift was last inspected 09/17/21.

Plan of Correction ***Accept (- 05/01/2023)***

The Department of Labor and Industry was contacted on April 3, 2023 by the Administrator and the chair lift was nspected on April 10. 2023. In the past, the Inspector has shown up for inspection in September - was last here in September of 2021. The home has not used the chair lift actively since the beginning of 2022 and it was simply overlooked by the Administrator. The Administrator will contact the Department of Labor and Industry each year by March 15 to schedule an inspection of the chair lift by April 10 (the current inspection date.)

97 - Elevators/Lifting Devices *(continued)*

Licensee's Proposed Overall Completion Date: *04/20/2023*

Implemented (NN - 05/25/2023)

101j2 - Bedroom Chairs

16. Requirements

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

Description of Violation

Bedroom 21 is occupied by 2 residents; however, there is only 1 chair in the room.

Bedroom 23 is occupied by 3 residents; however, there is only 1 chair in the room.

Plan of Correction ***Directed ([redacted] - 05/01/2023)***

New steel folding chairs were purchased on 4/13/23 by the Administrator at walmart. One chair was placed under the bed for one resident in room 21 and 2 chairs were placed under each bed for 2 residents in bedroom 23 by the Administrator on 4/13/23. The Administrator will make sure there is at least 1 chair per resident in each bedroom and double-check to make sure the chair is accessible and in good shape twice a year, when the staff (on duty) perform our yearly fall cleaning at the facility in September and spring cleaning in April.

Directed)

- *On 4/13/23, new steel folding chairs were purchased by the Administrator. One chair was placed under the bed for one resident in room 21 and 2 chairs were placed under each bed for 2 residents in bedroom 23 by the Administrator.*
- *Starting 4/13/2023, the Administrator will make sure there is at least 1 chair per resident in each bedroom and double-check to make sure the chair is accessible and in good shape twice a year.*
- *Starting 04/2023, the staff (on duty) will perform yearly spring cleaning in April and fall cleaning in September.*
- *Starting 5/15/23, the administrator will ensure a review of the home is conducted weekly. The administrator will develop an auditing form by 5/15/23 to document findings and address any issues within one week of discovery.*

Directed Completion Date: *05/15/2023*

Implemented ([redacted] - 05/25/2023)

101j7 - Lighting/Operable Lamp

17. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident 1 and Resident 2 do not have access to a source of light that can be turned on/off at their bedsides.

101j7 - Lighting/Operable Lamp *(continued)*

Plan of Correction ***Directed (NN 05/01/2023)***

A lamp was placed on the bedside table for resident 1. There was already a lamp in resident 2's bedroom, but she chose to take it off of the table and set it on the floor. That lamp was cleaned off and put back on her bedside table for lighting in her room. The Administrator added a lamp on the bedside tables of the two residents on 3/24/23. New bulbs were added and the lamp was tested to make sure it was operable. The Administrator will make sure there is at least 1 lamp per resident in each bedroom and double-check to make sure the lamp is accessible and in good shape twice a year, when the staff (on duty) perform our yearly fall cleaning at the facility in September and spring cleaning in April.

(Directed)

- *On 3/24/23, A lamp was placed on the bedside table for resident 1; Resident 2's lamp which was already in the room was placed on the bedside table. New light bulbs were added, and the lamps were tested to make sure it was operable.*
- *Starting 04/13/2023, the Administrator will make sure there is at least 1 lamp per resident in each bedroom and double-check to make sure the lamp is accessible and in good shape twice a year.*
- *Starting 04/2023, the staff (on duty) will perform yearly spring cleaning in April and fall cleaning in September.*
- *Starting 5/15/23, the administrator will ensure a review of the home is conducted weekly. The administrator will develop an auditing form by 5/15/23 to document findings and address any issues within one week of discovery.*

Directed Completion Date: *05/15/2023*

Implemented ([redacted] - 05/25/2023)

102i Soap Dispenser

18. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

There was an unlabeled used bar of soap in the shared second floor bathroom across from bedroom 21.

Plan of Correction ***Directed [redacted] 05/01/2023)***

The unlabeled bar of soap found in the second floor bathroom shower stall was immediately thrown in the trash. There is a soap dispenser within reach of the sink for every resident and staff in all 5 bathrooms in the home as well as near the kitchen and laundry room sinks. Any resident who uses bar soap is provided with a plastic container for storage with their initials clearly marked on the container. The Administrator discarded the bar soap when the Inspectors were on site. The Home has plastic storage containers in the supply closet and they are labeled and given when someone requests bar soap. All 5 bathrooms are thoroughly cleaned every nights by our 3rd shift Aide as part of their staff duties. Any messes or issues are immediately dealt with when they occur. Soap dispensers are filled each night or as needed throughout the day by the Aides. If there is an issue that cannot be immediately corrected, it is reported to [redacted] [redacted] will fix it, usually by the following day at the latest.

102i - Soap Dispenser (continued)

(Directed)

- *On 3/23/23, the administrator threw the unlabeled bar soap found in the 2nd floor bathroom in the trash.*
- *Starting 3/23/23, the administrator will ensure any resident who uses bar soap is provided with a plastic container for storage with their initials clearly marked on the container.*
- *Starting 4/13/23, bathrooms are spot checked and cleaned on every shift by the Resident Aide on duty. Soap dispensers are filled each night or as needed throughout the day by the Resident Aides.*
- *Starting 4/13/23, all 5 bathrooms are thoroughly cleaned every night by the 3rd shift Resident Aide scheduled. Duties will include immediately addressing clogs or drainage issues.*
- *Starting 4/13/23, if Resident Aides are unable to resolve the issue, the issue will be immediately reported to the Director of Resident Services who will address the issue by the following day of discovery.*
- *Starting 5/15/23, the administrator will ensure a walkthrough of the home is conducted weekly. The administrator will develop an auditing form by 5/15/23 to document findings and address any issues within one week of discovery.*

Directed Completion Date: *05/15/2023*

Implemented ([redacted] - 05/25/2023)

103f - Refrigerator/Freezer Temps

19. 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

There were no thermometers found in the upright freezer and in the chest freezer located in the basement.

Plan of Correction ***Directed [redacted] - 05/01/2023)***

The thermometer located in the chest freezer had fallen under the food in that freezer. The home uses 3 upright refrigerator/freezers with an additional 2 refrigerator/freezers and 2 chest freezers in the basement. All refrigerators and freezers have a thermometer in each one for safe temperature management. The thermometers were found by the Administrator and immediately put back to be visible in the freezers on 3/27/23. The Administrator will make sure there is at least 1 thermometer in each refrigerator and freezer and double-check to make sure it is visible and in good shape twice a year, when the staff (on duty) perform our yearly fall cleaning at the facility in September and spring cleaning in April.

(Directed)

- *On 3/27/23, the administrator located the thermometers in the upright and chest freezers.*
- *On 3/27/23, the administrator placed each thermometer visible in the freezers.*
- *Starting 3/27/23, the administrator will make sure there is at least 1 thermometer in each refrigerator and freezer and double-check to make sure it is visible and in good shape twice a year, the staff (on duty) will perform yearly spring cleaning in April and fall cleaning in September.*
- *Starting 5/15/23, the administrator will ensure a walkthrough of the home is conducted weekly. The administrator will develop an auditing form by 5/15/23 to document findings and address any issues within one week of discovery.*

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

Directed Completion Date: *05/15/2023*

Implemented [redacted] - 07/06/2023)

103i Outdated Food

20. Requirements

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

Description of Violation

There were four packages of chicken sealed in Ziploc bags, that were not labeled with a date in the upright freezer in the basement.

Plan of Correction ***Directed [redacted] - 05/01/2023)***

The 4 packages of frozen chicken that were not dated were immediately discarded on 3/24/23 by the Administrator. All packaged food placed in the freezer is labeled and dated. As of 3/24/23, and going forward all food placed in the freezer for future meals will continue to be labeled and dated by the staff who puts it there. The Administrator will double check to make sure all the food in the freezer is labeled and dated on a monthly basis.

(Directed)

- *On 3/24/23, the administrator discarded the 4 packages of frozen chicken.*
- *Starting 3/24/23, the administrator will ensure all foods placed in the freezers are labeled and dated by staff member placing the food in the freezer.*
- *Starting 5/15/23, the administrator will ensure a walkthrough of the home is conducted weekly. The administrator will develop an auditing form by 5/15/23 to document findings and address any issues within one week of discovery.*

Directed Completion Date: *05/15/2023*

Implemented [redacted] - 07/06/2023)

109b - Rabies Vaccination

21. Requirements

2600.
109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On 3/22/23, the home's dog was observed in the home. The home does not have a current certificate of rabies vaccination for the pet. The rabies vaccination was last given 10/22/20.

Plan of Correction ***Accept ([redacted] - 04/28/2023)***

[redacted] immediately called for an appointment to [redacted] veterinarian for an updated rabies vaccine when the inspectors were here. [redacted] is scheduled at the vet for [redacted] updated shot on May 15th at 1 pm. Until then, [redacted] will not be permitted to be in the Home. The veterinarian is [redacted] in Ebensburg. [redacted] was contacted by [redacted] who is [redacted] owner when the inspectors were on site, 3/23/23 and the soonest they could get [redacted] scheduled was May 15, 2023.

109b - Rabies Vaccination (continued)

Kelz has not been allowed inside the Home since 3/23/23. Every year, the Administrator will schedule Kelz for [redacted] rabies vaccine before May and keep a copy on file at the Home.

Licensee's Proposed Overall Completion Date: *04/20/2023*

Implemented ([redacted] - 05/25/2023)

132d Evacuation

22. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety e pert. For purposes of this subsection, the fire safety e pert may not be a staff person of the home.

Description of Violation

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the drill conducted on 2/23/23 at 3:30am, which took a total 2 minutes 52 seconds to evacuate all residents.

Plan of Correction ***Accept [redacted] 05/01/2023)***

The Administrator contacted the fire safety expert who completed the fire safety inspection on April 9, 2023 listing the safe evacuation time of 3 minutes. The Administrator is responsible for contacting the fire safety expert every year in September for the supervised fire drill and fire safety inspection, annually in October. Every year in September, the Administrator will arrange for the fire safety expert to come to the home for inspection and training and to make sure there are 2 forms completed to include the acceptable evacuation time each year.

Licensee's Proposed Overall Completion Date: *04/25/2023*

Implemented ([redacted] - 05/25/2023)

162c - Menus Posted

23. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menu for the week of 3/20 through 3/26/23 was posted. However, the home did not have future menus posted.

Plan of Correction ***Directed ([redacted] 05/01/2023)***

The Director is responsible for printing the menus from the computer and posting them on the bulletin board for the upcoming weeks at the end of each month. Menus are done for a month in advance and were finalized and posted for the following 4 weeks while the inspectors were here on 3/24/23 by [redacted].

Directed)

- *On 3/24/23, the Director of Resident Services posted 4 weeks of Menus for the month of April 2023.*

162c - Menus Posted (continued)

- *Starting 3/24/23, the administrator will print menus and post menus at the end of each month.*

Directed Completion Date: *05/02/2023*

Implemented (- 05/25/2023)

164a - Withholding Meals

24. Requirements

2600.
164.a. A home may not withhold meals, beverages, snacks or desserts as punishment. Food and beverages may be withheld in accordance with prescribed medical or dental procedures.

Description of Violation

On 03/23/23 at approximately 3:00pm, Staff Member B stated Resident 3 was previously informed dessert would be withheld from Resident 1 for refusing medications.

Plan of Correction ***Directed (- 05/01/2023)***

The Administrator is responsible for contacting the resident's doctor when refuses to take medications. The doctor has been contacted on 12/13/22 and again on 2/28/23 - each time with no change to medications, just that we need to make sure takes them and schedule for a routine appointment. All meals (food and drinks), second helpings, and own snacks have never been withheld from the resident. The resident is on a low-sugar diet for diabetes, and desserts are not given to when blood sugars are high to be in compliance with doctor's orders. The Administrator will ensure the resident is following his doctor's orders and following a well balanced, low sugar diet starting /23.

Directed)

- *The administrator contacted resident 3's physician on 12/13/22 and 2/3/23, no changes to medications were ordered by physician.*
- *Starting 3/23/23, the administrator will ensure Resident 3 is not being informed meals or desserts will be withheld due to Resident 3 refusing to take medications.*
- *All staff will be educated by 5/15/23 that they cannot withhold meals, desserts or snacks from any resident who refuses medications.*

Directed Completion Date: *05/15/2023*

Implemented 05/25/2023)

183b - Meds and Syringes Locked

25. Requirements

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

Description of Violation

On 3/23/23 at approximately 11:00am a white pill labeled with the number 5 was found unlocked, unattended, and accessible lying on the floor in Bedroom Number 3.

183b - Meds and Syringes Locked (continued)

On 3/24/23 at 10:36am, the [redacted] is prescribed to Resident 4 was found unlocked, unattended, and accessible in home's refrigerator located in the kitchen.

*On 3/24/23 at 10:36am, the [redacted] **Self Administers is prescribed to Resident 5 was found unlocked, unattended, and accessible in home's refrigerator located in the kitchen.*

Plan of Correction ***Directed ([redacted] 05/01/2023)***

The white pill found on the floor in the residents bedroom was an accident. It belonged to the resident in bedroom 3 but there was no way to tell how long it had been lying there. It had fallen near the recliner. We assumed it fell from [redacted] pocket or somehow [redacted] missed [redacted] mouth at some point while attempting to take the medication. The pill was mmediately destroyed by the Administrator on 3/23/23.

The 2 insulin pens found in the refrigerator belonged to resident 4 and resident 5. There is a locked box kept in the refrigerator that houses insulin pens for the residents who use them. Each pen is labeled and dated and locked in the box until it is needed for use. The night before the inspection, 2 boxes of new insulin pens were delivered - the lantus for resident 4 and the humalog for resident 5. Since the box seemed full, the staff member on duty simply put the pens behind the locked box on the same shelf in the refrigerator. The following morning when the inspectors were there, the violation was corrected by the Administrator and the prescription insulin pens were placed inside the box and locked as is our procedure. The Administrator placed the lantus and humalog in the lockbox and made sure it was locked on 3/23/23. The Administrator will purchase a larger lockbox to accommodate more quick pens by 5/1/23.

Directed)

- *The identified medication found on the floor in resident bedroom 3 was destroyed by the administrator on 3/23/23.*
- *The administrator will train all direct care staff who administer medications on the 5 Rights of administering medications. This training will occur by 5/9/23.*
- *On 3/24/23 the administrator placed the medication for Resident 4 and Resident 5 in the lockbox.*
- *Starting 5/1/23, the administrator will purchase a larger lockbox to accommodate more quick pens.*
- *A medication cart and medication refrigerator audit will be conducted by the Administrator by 05/15/23 and monthly thereafter.*
- *Starting 5/15/23, the administrator will develop an audit form to document findings and make any corrections within one week of discovery.*

Directed Completion Date: *05/15/2023*

Implemented ([redacted] - 06/02/2023)

187d Follow Prescriber's Orders

26. Requirements

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

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

Description of Violation

Resident 3 is prescribed [redacted] Take one tablet by mouth every day [redacted] and [redacted]. However, resident 3 did not receive this medication on [redacted].

Resident 6 is prescribed [redacted].
However, resident 6 did not receive this medication on [redacted]
Resident 6 is prescribed [redacted]. However,
resident 6 did not receive this medication on [redacted].
Resident 6 is prescribed [redacted].
However, resident 6 did not receive this medication on [redacted].

Plan of Correction ***Directed ([redacted] - 05/01/2023)***

After talking to the staff member on duty at the time of these mistakes, she informed me that the medications in question were administered and taken by the resident(s). The staff member who gave the medication and failed to record it at the time was Kimberly Eaton. She informed me of the mistake after it had occurred as we discuss details of the weekend every Monday with the House Manager that discussion took place on 3/20/23. Staff members are advised on a ongoing basis about the accuracy of their input and making sure they are in compliance with administering and recording medications. The House Manager [redacted] is scheduled every Monday starting at 6 am. The Director of Resident Services [redacted], and the Administrator have a stand up meeting with her regarding the weekend report each Monday. These meeting have been going on since January 30, 2023 and will continue until further notice. The Administrator is ultimately responsible for all medication administration and any errors that may occur during the process. The errors will be documented when they occur (or when they are noticed) and reported to the Administrator every Monday, unless such an error results in emergency action, then the Administrator would be notified immediately.

(Directed)

- *On 3/24/23, the administrator determined after speaking with staff the medication in question was administered to Resident 3 and Resident 6 but was not recorded by the Med Tech, Staff Member.*
- *Starting 3/24/23, the administrator advised the staff members that on an ongoing basis, the medications must be accurately inputted and recorded onto the residents MAR.*
- *On 3/24/23 the administrator placed the medication for Resident 4 and Resident 5 in the refrigerator lockbox.*
- *Starting 01/30/23, the Director of Resident Services, and the Administrator have a scheduled meeting each*

187d - Follow Prescriber's Orders (continued)

Monday with the Med Tech, staff member to discuss the weekend report.

- *A medication cart and medication refrigerator audit will be conducted by the Administrator by 05/15/23 and monthly thereafter.*
- *A MAR audit will be conducted by the Administrator by 5/15/23 and monthly thereafter.*
- *Starting 5/15/23, the administrator will develop an audit form to document findings and make any applicable corrections within one week of discovery.*

Directed Completion Date: *05/15/2023*

Implemented ([redacted] - 07/06/2023)