



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: DECEMBER 26, 2023

[REDACTED], Owner
ET 141 Operations LLC

[REDACTED]


RE: Emerald Personal Care
320 Market Street
Elizabethtown, PA 17022
License #: 338860

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on July 12, 2023 and November 14, 2023 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (338810) dated June 7, 2023 to June 7, 2024 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code §20.71(a)(2);(4);(5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed.

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. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:


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.

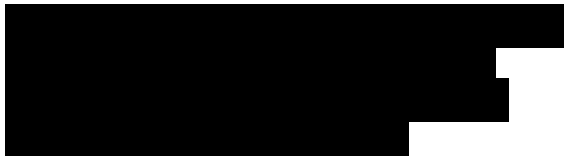
Sincerely,



Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summaries

cc:



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

Facility Information

Name: EMERALD PERSONAL CARE License #: 33886 License Expiration: 06/07/2024
Address: 320 MARKET STREET, ELIZABETHTOWN, PA 17022
County: LANCASTER Region: CENTRAL

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: ER 320 OPERATIONS LLC
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-1 Date: 05/20/1996 Issued By: DOH

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 18 Waking Staff: 14

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Interim Exit Conference Date: 07/12/2023

Inspection Dates and Department Representative

07/12/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 26 Residents Served: 18

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 17
Diagnosed with Mental Illness: 2 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 0 Have Physical Disability: 0

Inspections / Reviews

07/12/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 08/14/2023

Inspections / Reviews (*continued*)

08/18/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/23/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 08/24/2023

12/13/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/23/2023

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

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

On 7/12/23, the home's most recent license inspection summary (LIS), dated 03/22/2023, was not posted in a conspicuous and public place in the home.

Plan of Correction

Directed (████ - 08/16/2023)

Administrator posted the 03/22/2023.

Administrator/Designee will complete a monthly audit for 2 months to ensure required postings are in place.

[Directed]

- Administrator will post the most recent license inspection summary (LIS) in a conspicuous place by 9/1/23.*
- Starting 9/1/23, the Administrator will complete a monthly audit of all postings in the home for 6 months to ensure compliance. Documentation of audits will be kept.*

Directed Completion Date: 09/15/2023

Implemented (████ - 12/13/2023)

15a - Resident Abuse Report

2. Requirements

2600.

- 15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

There were no Act 13 forms completed and filed with the local Area Agency on Aging regarding the incidents of on-going verbal abuse occurring between Resident 1, Resident 2 and Resident 3.

Plan of Correction

Directed (████ - 08/14/2023)

Administrator reported on 7-12-23 Residents concern for receiving insults from another Residents.

7-13-23 Clinical Director interviewed each resident to determine if they have any concerns or any situation to feel uncomfortable.

7-13-23 residents as violating The House Rules were educated signed house rules and given a copy of expectations. House Rules were reviewed at Resident Council. Three residents agreed to speak with behavioral council, one continues on weekly support with Pych services and new medication.

Education was completed by Administrator and team to define abuse and reporting requirements.

15a - Resident Abuse Report (continued)

Audit will be completed weekly for 3 months to ensure any suspected incident of abuse was immediately reported.

[Directed]

- Administrator reported incidents to the local Area Agency on Aging on 7/12/23.
- Administrator will educate all staff on reporting abuse requirements by 9/15/23.
- Starting 9/15/23, staff are to immediately report any concerns of abuse to the Administrator and/or the Clinical Director. Administrator and/or Clinical Director will complete an Act 13 form and send into Aging within 24 hours of incident. Copies of the completed Act 13 forms will be kept.
- Starting 9/15/23, incidents will be reviewed at the home's quality management meetings to ensure the appropriate reports were made to the appropriate agencies.

Directed Completion Date: 09/15/2023

Implemented (████) - 12/13/2023)

16c - Written Incident Report

3. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

The home has not reported the incidents of on-going verbal abuse between Resident 1, Resident 2 and Resident 3 to the Department.

Plan of Correction

Directed (████) - 08/14/2023)

Education was completed by Administrator and team to define abuse and reporting requirements.

Audit will be completed weekly for 3 months to ensure any suspected incident of abuse was immediately reported.

[Directed]

- Administrator will complete a reportable incident form and send to the Department by 9/1/23.
- Administrator will educate all staff on reporting abuse requirements by 9/15/23.
- Starting 9/15/23, staff are to immediately report any concerns of abuse to the Administrator and/or the Clinical Director. Administrator and/or Clinical Director will complete a reportable incident form and send to the Department within 24 hours of incident. Copies of completed reportable incident forms will be kept.
- Starting 9/15/23, incidents will be reviewed at the home's quality management meetings to ensure the appropriate reports were made to the appropriate agencies.

Directed Completion Date: 09/15/2023

Implemented (████) 12/13/2023)

20b5 - No Commingling

4. Requirements

2600.

20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:

5. Commingling of resident funds and home funds is prohibited.

Description of Violation

The Personal Care Home utilizes a monetary service for several residents (8 Personal Care Residents) through a company called RFMA (Resident Fund Management Service). Each Resident has an interest-bearing sub account under a main account. However, this main account is under the Personal Care Home's name.

Plan of Correction**Directed (████ - 08/14/2023)**

Resident Account has been set up for account to be under Resident Name/Account number.

Education was completed.

Monthly Audit will be completed.

[Directed]

- Administrator will set up a separate account for each resident under each resident's name by 9/15/23.*
- Administrator will educate all staff handling resident finances on this violation by 9/15/23.*
- Starting 9/1/23, Administrator or designee will complete a monthly audit to ensure all residents have their own, separate accounts. Documentation of audits will be kept.*

Directed Completion Date: 09/15/2023

Implemented (████ 12/13/2023)

25a - Written Contract and Review

5. Requirements

2600.

25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident 6 has an admission date of █████/2023. The resident's contract also states the move in date as █████/2023. However, the resident's Power of Attorney (POA) and Administrator did not sign the contract till █████/2023, 5 days after admission.

Plan of Correction**Directed (████ - 08/14/2023)**

Education was completed by Administrator and Clinical Director on the requirements to complete the Admission Contract. Resident 6, POA received contract via email in the 24 hour requirement; however, failed to return and date until after 24 hours.

Audit will be completed weekly for 3 months to ensure all Admission contracts are compliant.

25a - Written Contract and Review (continued)

[Directed]

- Administrator and Clinical Director were educated about this violation on 7/12/2023 by Inspectors.
- Administrator and/or Clinical Director will audit all current resident contracts for compliance by 9/15/23. Documentation of audit will be kept.
- Starting 9/15/23, Administrator and/or Clinical Director will review contracts on a resident's move-in day to ensure completion.

Directed Completion Date: 09/15/2023

Implemented [redacted] - 12/13/2023)

42b - Abuse

6. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident 2 and Resident 3 have emotionally and verbally abused Resident 1 multiple times per week over the last several months, including offensive name-calling that resulted in Resident 1 feeling hurt, embarrassed, degraded and belittled.

Plan of Correction

Directed [redacted] - 08/16/2023)

Administrator reported on 7-12-23 Residents concern for receiving insults from another Residents.

7-13-23 Clinical Director interviewed each resident to determine if they have any concerns or any situation to feel uncomfortable.

7-13-23 residents as violating The House Rules were educated signed house rules and given a copy of expectations. House Rules were reviewed at Resident Council. Three residents agreed to speak with behavioral council, one continues on weekly support with Pych services and new medication.

Education was completed by Administrator and team to define abuse and reporting requirements.

Audit will be completed weekly for 3 months to ensure any suspected incident of abuse was immediately reported.

[Directed]

- On 7/13/23, Administrator reviewed the home rules with Residents 1, 2 and 3. Residents signed the home rules and were given a copy. Residents agreed to behavioral counseling. Administrator and/or Clinical Director will complete referrals for behavioral counseling for the residents by 9/15/23.
- On 7/13/23, Clinical Director interviewed the other residents in the home to ensure residents feel safe.
- Administrator and/or Clinical Director will educate all staff on defining abuse, reporting abuse and safe-management techniques by 9/15/23.
- Starting 9/1/23, Administrator and/or Clinical Director will complete monthly check-ins with residents to ensure residents continue to feel safe in the home.

Directed Completion Date: 09/15/2023

42b - Abuse (continued)

Implemented [redacted] - 12/13/2023)

65a - FS Orientation 1st Day

7. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Staff person A, hired [redacted] /2023, and Staff Person B, hired [redacted] /2023, did not receive orientation on the following topics:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Plan of Correction

Directed [redacted] - 08/16/2023)

Employee A and B have completed education per regulation.

Administrator and Clinical Director were educated.

Monthly Audit will be completed.

[Directed]

- Staff Person A and B will complete first day orientation trainings by 9/15/23.
- Administrator and Clinical Director were educated on the violation by Inspectors on 7/12/23.
- Administrator and/or Clinical Director will implement a new-hire check list, including the required first-day trainings, by 9/15/23.
- Administrator and/or Clinical Director will complete an audit of all current staff records to ensure compliance. Audit will be completed by 9/15/23. Documentation of audit will be kept.
- Starting 9/1/23, Administrator and/or Clinical Director will complete monthly audits of new-hire staff records to ensure compliance. Documentation of audits will be kept.

Directed Completion Date: 09/15/2023

Not Implemented [redacted] - 12/13/2023)

65b - Rights/Abuse 40 Hours

8. Requirements

2600.

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

Description of Violation

Staff person A, hired [REDACTED]/2023, and Staff Person B, hired [REDACTED]/2023, did not complete training in the following topics as part of the first 40-hour trainings:

- 2. Emergency medical plan.
- 4. Reporting of reportable incidents and conditions.

Plan of Correction

Directed [REDACTED] - 08/16/2023)

Employee A and B have completed education per regulation.

Administrator and Clinical Director were educated.

Monthly Audit will be completed.

[Directed]

- Staff Person A and B will complete first day orientation trainings by 9/15/23.
- Administrator and Clinical Director were educated on the violation by Inspectors on 7/12/23.
- Administrator and/or Clinical Director will implement a new-hire check list, including the required first 40-hour trainings, by 9/15/23.
- Administrator and Clinical Director will complete an audit of all current staff records to ensure compliance. Audit will be completed by 9/15/23. Documentation of audit will be kept.
- Starting 9/1/23, Administrator and/or Clinical Director will complete monthly audits of new-hire staff records to ensure compliance.

Directed Completion Date: 09/15/2023

Not Implemented ([REDACTED] - 12/11/2023)

65d - Initial Direct Care Training

9. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

- 2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, hired on [REDACTED]/2023, and direct care staff person B, hired on [REDACTED]/2023, did not complete

65d - Initial Direct Care Training (continued)

and pass the Department-approved direct care training course and pass the competency test. Staff person A and staff person B have been providing unsupervised care to residents.

Plan of Correction

Directed [REDACTED] - 08/16/2023)

Employee A and B have completed education per regulation.

Administrator and Clinical Director were educated.

Monthly Audit will be completed.

[Directed]

- Staff Person A and B will complete first day orientation trainings by 9/15/23.
- Administrator and Clinical Director were educated on the violation by Inspectors on 7/12/23.
- Administrator and Clinical Director will complete an audit of all current staff records to ensure compliance. Audit will be completed by 9/15/23. Documentation of audit will be kept.
- Administrator and/or Clinical Director will implement a new-hire check list, including the required direct care competency test, by 9/15/23.
- Starting 9/1/23, Administrator and/or Clinical Director will complete monthly audits of new-hire staff records to ensure compliance. Documentation of audits will be kept.

Directed Completion Date: 09/15/2023

Implemented [REDACTED] - 12/13/2023)

85a - Sanitary Conditions

10. Requirements

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

Description of Violation

On 07/12/2023, several vine type plants were observed growing through the windowpanes of the windows located in the home's activity room. This has caused the windows to create an opening which has led to various types of insects entering the home as evidence of the deceased insects located in the windowsills.

Plan of Correction

Directed [REDACTED] - 08/16/2023)

Vines were groomed to maintain appropriate height to ensure window is sealed.

85a - Sanitary Conditions (continued)

Admin/Designee will audit windows weekly for 2 weeks, then monthly for 2 weeks to ensure sanitary conditions are maintained.

[Directed]

- Maintenance Director or designee will trim vines, clean up the dead insects surrounding the area and ensure window is sealed by 9/1/23.
- Maintenance Director or designee will review the other windows in the building to ensure there are no other areas of concern by 9/1/23.
- Starting 9/15/23, Administrator or designee will audit the windows in the building monthly for the next 6 months. Documentation of audits will be kept.

Directed Completion Date: 09/15/2023

Implemented (████) - 12/13/2023)

85d - Trash Receptacles

11. Requirements

2600.

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

Description of Violation

On 07/12/2023 at 2:30pm, there were full, uncovered, unattended trash cans in the kitchen.

Plan of Correction

Directed (████) - 08/16/2023)

On 07/12/2023 Dietary staff placed lids on the trash cans in the kitchen.

Dietary Manager educated staff on requirement to keep trash covered.

Daily audits will be completed by the Dietary Manager for 14 days , then weekly audits for 4 weeks.

[Directed]

- On 07/12/23, dietary staff placed lids on the trash cans in the kitchen.
- Dietary manager will educate dietary staff on this regulation by 9/15/23.
- Starting 9/15/23, Dietary Manager will complete daily audit of the kitchen trash cans daily for 14 days then weekly audits for 4 weeks. Documentation of audits will be kept.

Directed Completion Date: 09/15/2023

Implemented (████) - 12/13/2023)

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

Upon inspection of the bathroom in Resident Room 19, the exhaust fan/ vent was inoperable and not producing any air flow. It is also noted that there is no window in Resident 19's bathroom.

86b - Bathroom (continued)

Plan of Correction**Directed** [REDACTED] - 08/16/2023)

Residents bathroom 19 will repair inoperable exhaust fan/vent.

Maintenance Director and Clinical Care Director educated on the requirements of 2600.86.b.

Weekly audit will be completed by the Clinical Care Director/Designee to ensure compliance.

[Directed]

- Maintenance Director or designee will repair the exhaust fan in bathroom 19 by 9/1/23.
- Maintenance Director or designee will complete an audit all the exhaust fans to ensure all exhaust fans are operable by 9/1/23. Documentation of audit will be kept.
- Administrator will educate Maintenance Director and Clinical Care Director on the violation by 8/25/23.
- Starting 9/1/23, Clinical Care Director or designee will complete weekly audits of exhaust fans to ensure compliance. Documentation of audits to be kept.

Directed Completion Date: 09/15/2023

Implemented [REDACTED] - 12/13/2023)

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

On 07/12/2023, there were multiple ceiling tiles with very heavy water staining in the dining room and outside the medical records office.

There were also missing ceiling tiles over the door to the medical records office.

The carpet on the 2nd floor is dirty and stained.

Plan of Correction**Directed** [REDACTED] - 08/16/2023)

New product purchased and carpets cleaned on the 2nd floor.

Ceiling tiles in dining room and outside the medical records office were replaced.

Weekly audits by Admin/Designee will be done for 2 months.

[Directed]

- Maintenance Director or designee will purchase and replace carpets on the 2nd floor by 9/1/23.
- Maintenance Director or designee will replace the ceiling tiles in the dining room and outside of the medical

88a - Surfaces (continued)

records office by 9/1/23.

- Administrator was educated on this violation by Inspectors on 7/12/23. Administrator will educate Maintenance Director and Clinical Director on this violation by 8/25/23.
- Starting 9/1/23, Administrator or designee will complete weekly audits of the building to ensure compliance. Documentation of audits will be kept.

Directed Completion Date: 09/15/2023

Implemented [redacted] - 12/13/2023)

89b - Hot Water Temperature

14. Requirements

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 07/12/2023, the hot water temperature in resident room 19 measured 127.8 degrees Fahrenheit.

On 07/12/2023, the hot water temperature in resident room 59 measured 124.2 degrees Fahrenheit.

Plan of Correction

Directed [redacted] - 08/16/2023)

On 07/13/2023 Maintenance Director resolved and reset hot water to ensure it did not exceed 120 degrees.

Admin and Maintenance Director logged water temps at varied parts of personal care to audit compliance. Audits will be done 3x weekly for a month. Ongoing water temp checks will be completed weekly.

[Directed]

- On 07/13/23, Maintenance Director resolved and reset the hot water to ensure it did not exceed 120 degrees.
- Administrator was educated on this violation by Inspectors on 7/12/23.
- Administrator and Maintenance Director will complete an audit of water temperatures throughout the building by 9/1/23 to ensure compliance. Documentation of audit will be kept.
- Starting 9/1/23, Administrator and/or Maintenance Director will complete an audit of water temperatures 3 times a week for a month then once a week on-going. Documentation of audits will be kept.

Directed Completion Date: 09/15/2023

Implemented [redacted] - 12/13/2023)

103f - Refrigerator/Freezer Temps

15. Requirements

2600.

103f - Refrigerator/Freezer Temps (continued)

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 07/12/2023, the refrigerator located in the dining room measured 44 degrees Fahrenheit. The freezer located in the dining room measured 5 degrees Fahrenheit.

Plan of Correction

Directed (████) - 08/16/2023)

Clinical Director adjusted temperature to ensure refrigeration is at 40 degrees/below and Frozen food at below zero.

Staff were educated on the requirements of 2600.103.f

Clinical Director/Designee will audit to ensure compliance daily for a week, then weekly for 2 months to ensure compliance.

[Directed]

- Clinical Director will adjust temperature in the refrigerator in the dining room by 8/25/23 or replace the thermometer if required.
- Clinical Director or designee will complete an audit of all refrigerators and freezers in the home to ensure compliance by 9/1/23. Documentation of audit will be kept.
- Administrator or Clinical Director will educate all staff on this violation by 9/1/23.
- Starting 9/1/23, Clinical Director or designee will complete an audit of all refrigerator and freezer temperatures daily for a week then weekly for 2 months to ensure compliance. Documentation of audits will be kept.

Directed Completion Date: 09/15/2023

Implemented (████) - 12/13/2023)

105g - Lint Removal and Duct Cleaning

16. Requirements

2600.

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

Description of Violation

On 07/12/2023 there was a thick film of dryer lint in the lint trap of the dryer labeled "Dryer 1" in the 1st floor laundry room. There were no clothes in the dryer at the time.

Plan of Correction

Directed (████) - 08/16/2023)

On 07/12/2023 lint was removed from the dryer.

Education was provided to staff on 2600.105.g.

Audits were completed daily 5x a week for a week by the Maintenance Director.

Weekly audits will be completed for 2 months.

105g - Lint Removal and Duct Cleaning (continued)

[Directed]

- On 07/12/2023, lint was removed from the dryer.
- Administrator will educate staff on this regulation by 9/1/23.
- Starting 9/1/23, Maintenance Director will complete audits of the home's dryers 5 times during the first week then weekly audits for 2 months to ensure compliance. Documentation of audits will be kept.

Directed Completion Date: 09/15/2023

Implemented (█) - 12/13/2023)

132f - Alternate Exit Routes

17. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The fire drills conducted on 3/23/2023, 4/28/2023, 5/3/2023, and 6/6/2023 used the same exit routes labeled "back door entrance" and "PC Porch entrance".

Plan of Correction

Directed (█) - 08/16/2023)

Residents and staff have been educated on options to exit based on the locaton of the fire.

Firedrill will rotate locations to provide evacuation training based on location of the fire.

Audit will be completed quarterly by the Maintenance Director.

[Directed]

- Administrator will educate all residents and staff on this violation as well as exit route options available based on the location of the fire. Education will be provided by 9/1/23.
- Starting 9/1/23, Maintenance Director or designee will rotate the fire locations to ensure staff are utilizing alternative exit routes.
- Starting 9/1/23, Maintenance Director or designee will review the exit routes used by staff and residents immediately following a fire drill to ensure compliance.
- Starting 9/1/23, Administrator or designee will audit the fire drill documentation after each monthly fire drill to ensure compliance. Documentation of these audits will be kept.

Directed Completion Date: 09/12/2023

Implemented (█) - 12/13/2023)

141a 1-10 Medical Evaluation Information

18. Requirements

2600.

141a 1-10 Medical Evaluation Information (continued)

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

Description of Violation

Resident 5’s medical evaluation, dated [REDACTED]/2023, does not include an evaluation of the resident’s ability to safely use or avoid poisonous materials.

Plan of Correction

Directed [REDACTED] - 08/16/2023)

Clinical Care Director fixed Resident 5’s medical evaluation dated [REDACTED]/2023 to include an evaluation of the resident’s ability to safely use or avoid poisonous materials.

Clinical Care Director was educated on requirements of 2600.141.a

Clinical Care Director audited all residents to ensure evaluation of the resident’s ability to safely use avoid poisonous materials.

[Directed]

- Clinical Care Director will revise Resident 5’s medical evaluation, dated [REDACTED]/2023, to include an evaluation of the resident’s ability to safely use or avoid poisonous materials by 9/15/23.
- Administrator will educate Clinical Care Director on this violation by 9/1/23.
- Clinical Care Director will complete an audit of all current resident medical evaluations to ensure completion by 9/15/23. Documentation of audit will be kept.
- Starting 9/15/23, Clinical Care Director will complete an audit of all current resident medical evaluations quarterly to ensure compliance. Documentation of audits will be kept.

Directed Completion Date: 09/12/2023

Implemented [REDACTED] - 12/13/2023)

144c1 - Smoking Area Guidelines

19. 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:

144c1 - Smoking Area Guidelines (continued)

- 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 exterior smoking area has two cigarette receptacles. However, on 07/12/2023, there were 7 cigarette butts observed scattered in and around the smoking area.

The smoking area also contains two metal-framed chairs with upholstered seat and back cushions which do not have labels indicating resistance to fire.

Plan of Correction

Directed [redacted] - 08/16/2023)

Smoking area has cleaned up scattered butts NOT in the receptacle. two chairs with upholstered seats have been removed.

Smoking staff have been educated on requirements of 2600.144c

Daily Audits for one week will be completed, then weekly audits for one month to ensure compliance.

[Directed]

- Maintenance Director or designee will clean up smoking area and remove all fire hazards from the smoking area by 9/1/23.
- Administrator will educate all staff and residents on the violation by 9/15/23.
- Starting 9/15/23, Maintenance Director or designee will complete weekly audits of the smoking area for a month to ensure compliance. Documentation of audits will be kept.

Directed Completion Date: 09/12/2023

Not Implemented ([redacted] 12/11/2023)

183b - Meds and Syringes Locked

20. 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

One of the medication carts located in the personal care activity room was unlocked and had various expired medications inside of it, including: Breo Ellipta INH 200mcg/25mcg for a resident located in skilled nursing, a 16fl oz bottle of Geri-Tussin (Guaifenesin Oral Solution USP), two 17.9oz containers of Goodsense ClearLax (Polyethylene Glycol 3350 powder solution), a spray bottle of StingFree Liquid Skin Prep & Sheild, a 12fl oz bottle of Phillip's Milk of Magnesia Original, and an open 200 count box of Pressure activated Safety Lancets.

183b - Meds and Syringes Locked (continued)

Plan of Correction

Directed [redacted] - 08/16/2023)

Carts were locked 7-12-23

Clinical Care Director educated on requirements of 2600.183.b

Weekly audits for one week, then monthly audits for two months to ensure compliance.

[Directed]

- Med carts were secured on 7/12/23 while inspectors were on-site.*
- Administrator will educate Clinical Care Director and med techs on this violation by 9/15/23.*
- Clinical Care Director or designee will complete audits on all med carts for expired medications by 9/15/23. Documentation of audit will be kept.*
- Starting 9/15/23, Clinical Care Director will complete monthly audits on all medication carts for expired medications. Documentation of audits will be kept.*

Directed Completion Date: 09/15/2023

Implemented [redacted] - 12/13/2023)

185a - Implement Storage Procedures

21. Requirements

2600.

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

Description of Violation

Resident 4's glucometer is not programmed with the correct time, at 2:50 pm it states that the time is 10:13 am.

Resident 6's glucometer is not programmed with the correct time, at 3:08 pm it states that the time is 6:39 pm.

Plan of Correction

Directed [redacted] - 08/16/2023)

Root cause determined a transcription error.

Education provided to educate on the 5 rights/documentation.

Clinical Director Designee will audit weekly for 2 months.

185a - Implement Storage Procedures (continued)

[Directed]

- Clinical Director will calibrate Resident 4 and 6's glucometers by 9/1/23.
- Administrator or Clinical Director will educate med techs on this violation by 9/15/23.
- Clinical Director will audit all current glucometers for compliance by 9/15/23. Documentation of audit will be kept.
- Starting 9/15/23, Clinical Director or designee will audit all current glucometers monthly for compliance. Documentation of audits will be kept.

Directed Completion Date: 09/12/2023

Implemented [redacted] - 12/13/2023)

187a - Medication Record

22. 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

Resident 4 is prescribed Vilazodone HCL 20 MG, take 1 tablet by mouth daily. The medication administration record (MAR) lists the strength of the medication as 40 MG when the physician's order is for 20 MG.

Plan of Correction

Directed [redacted] - 08/16/2023)

Root cause determined a transcription error.

Education provided to educate on the 5 rights/documentation.

Clinical Director Designee will audit weekly for 2 months.

[Directed]

- Clinical Director will revise Resident 4's MAR to reflect the correct dosage for Vilazodone by 9/1/23.
- Clinical Director will complete an audit of all current resident MARs for accuracy by 9/15/23. Documentation of this audit will be kept.
- Administrator or Clinical Director will provide education to med techs on this violation by 9/15/23.
- Starting 9/15/23, Clinical Director will complete monthly audits of all current resident MARs for accuracy for 6 months. Documentation of audits will be kept.

Directed Completion Date: 09/15/2023

Not Implemented [redacted] - 12/11/2023)

191 - Resident Right to Refuse

23. Requirements

2600.

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

191 - Resident Right to Refuse (*continued*)**Description of Violation**

The contracts for Resident 4, 5 and 6 do not include documentation that the residents were educated on their right to refuse medication if they believe the medication has been given in error.

Plan of Correction

Directed ([REDACTED]) - 08/16/2023)

Residents 3, 5 and 6 will be educated on right to refuse medication if the resident believe that there may be a medication error.

Staff education on 2600.191

Clinical Director Designee will audit weekly .

[Directed]

- Administrator or Clinical Director will educate Residents 3, 5 and 6 on their right to refuse medication if the resident believes that there may be a medication error by 9/15/23. Documentation of this education will be kept in the residents' files.*
- Administrator or Clinical Director will educate all staff on this violation by 9/15/23.*
- Clinical Director will conduct an audit of all current resident files to ensure documentation all residents have received education on their right to refuse medication of the resident believes that there may be a medication error. This audit will be completed by 9/15/23. Documentation of audit will be kept.*
- Starting 9/15/23, Clinical Director will complete a quarterly audit of resident records to ensure compliance. Documentation of audits will be kept.*

Directed Completion Date: 09/15/2023

Implemented ([REDACTED]) 12/13/2023)

224a - Preadmission Screen Form

24. 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

Preadmission Screening forms were not completed for Residents 4, 5 and 6.

Plan of Correction

Directed ([REDACTED]) - 08/16/2023)

Preadmission Screening forms were completed for Residents 4, 5 and 6

Staff education has been completed.

Clinical Director Designee will audit weekly.

224a - Preadmission Screen Form (continued)

[Directed]

- Administrator will educate Clinical Director on violation by 8/25/23.
- Clinical Director will complete preadmission screenings for Residents 4, 5 and 6 by 9/15/23.
- Clinical Director will complete an audit of all current resident preadmission screenings for compliance by 9/15/23. Documentation of audit will be kept.
- Starting 9/15/23, Clinical Director or designee will implement a new admission checklist, which includes a pre-admission screening, to utilize for all new residents.
- Starting 9/15/23, Clinical Director or designee will schedule an appointment with resident within 30 days prior to resident moving into the home to complete a preadmission screening.
- Starting 9/15/23, Clinical Director or designee will complete a quarterly audit of resident records to ensure compliance. Documentation of these audits will be kept.

Directed Completion Date: 09/15/2023

Not Implemented [redacted] - 12/11/2023)

225a - Assessment 15 Days

25. Requirements

2600.

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

Description of Violation

Resident 5 was admitted to the home on [redacted]/2023. However, the resident's assessment was not completed until [redacted]/2023.

Plan of Correction

Directed [redacted] - 08/17/2023)

Administrator educated Clinical Director on 2600.225.

Audit will be completed weekly to determine compliance.

[Directed]

- Administrator will educate Clinical Director on violation by 8/25/23.
- Clinical Director will complete an audit of all current resident records for compliance by 9/15/23. Documentation of audit will be kept.
- Starting 9/15/23, Clinical Director or designee will implement a new admission checklist, which includes an initial assessment, to utilize for all new residents.
- Starting 9/15/23, Clinical Director or designee will schedule an appointment with resident within 72 hours of resident moving into the home to complete an initial assessment.
- Starting 9/15/23, Clinical Director or designee will complete a quarterly audit of resident records to ensure compliance. Documentation of these audits will be kept.

Directed Completion Date: 09/15/2023

225a - Assessment 15 Days (continued)

Implemented [REDACTED] - 12/13/2023)

226a - Mobility Assessment

26. Requirements

2600.

226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Residents 5 and 6 utilize a walker for mobility, however, the assessments for these residents (dated [REDACTED]/23 and [REDACTED]/23, respectively) indicate that they are independent with ambulation.

Plan of Correction

Directed [REDACTED] - 08/17/2023)

Residents 5 and 6 have been corrected to reflect utilization of a walker for mobility.

Education was completed.

Audit of all residents will be completed to ensure correct documentation on the resident's assessment.

[Directed]

- Administrator will educate Clinical Director on the violation by 9/1/23.
- Clinical Director or designee will update Resident 5 and 6's assessments to include residents' utilization of a walker by 9/15/23.
- Clinical Director or designee will complete an audit of all current resident assessments to ensure compliance by 9/15/23. Documentation of audit will be kept.
- Starting 9/15/23, Clinical Director or designee will complete a quarterly audit of all resident assessments to ensure compliance. Documentation of audit will be kept.

Directed Completion Date: 09/12/2023

Implemented [REDACTED] - 12/13/2023)

252 - Record Content

27. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

Resident 4's record does not include identifying marks, height, weight, hair color, eye color, religion, photo of resident and language spoken.

Resident 5's record does not include identifying marks, hair color and eye color.

Resident 6's record does not include identifying marks, hair color and eye color.

252 - Record Content (continued)

Plan of Correction

Directed (█ - 08/17/2023)

Resident's 4,5 and 6 have been corrected to reflect utilization of a walker for mobility.

Education was completed.

Audit of all residents will be completed to ensure correct documentation on the resident's assessment.

[Directed]

- Administrator will provide education to Clinical Director and all admission staff on the violation by 9/1/23.
- Clinical Director or designee will update Resident 4, 5 and 6's records to include the missing content by 9/15/23.
- Clinical Director or designee will complete an audit of all current resident records to ensure compliance by 9/15/23. Documentation of audit will be kept.
- Starting 9/15/23, Clinical Director or designee will implement a new admission checklist, which includes obtaining and reviewing record content, to utilize for all new residents.
- Starting 9/15/23, Clinical Director or designee will complete a quarterly audit of resident records to ensure compliance. Documentation of these audits will be kept.

Directed Completion Date: 09/12/2023

Implemented (█ - 12/13/2023)

254a - Records Discharge/Active

28. Requirements

2600.

254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 07/12/2023, the following items were found unsecured, unattended and accessible on the counter in the Dining room: Resident 4's prescription bottle for Vitamin D2 1/25 mcg, a handwritten note with Resident 7's last name and Novolog beside the Resident's name, and Resident 8's first name with Lantus written beside it. There were also various binders with additional Resident protected health information such as Resident first and last names with Blood thinners and Aspirin prescriptions with dosage that were found unsecured, unattended and accessible in the cabinets above

254a - Records Discharge/Active (continued)

the counter.

Plan of Correction**Directed ([REDACTED] - 08/17/2023)**

Administrator educated Clinical Director and team on 2600.225.

Audit will be completed daily for one week, then weekly for two months to determine compliance.

[Directed]

- Items were secured by staff while Inspectors were on-site on 7/12/23.
- Administrator will educate all staff on violation by 9/15/23.
- Starting 9/15/23, Administrator or designee will complete weekly walk-through audits of the home to ensure compliance. Documentation of audits are to be kept.

Directed Completion Date: 09/12/2023

Implemented ([REDACTED] - 12/13/2023)

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

Facility Information

Name: EMERALD PERSONAL CARE License #: 33886 License Expiration: 06/07/2024
Address: 320 MARKET STREET, ELIZABETHTOWN, PA 17022
County: LANCASTER Region: CENTRAL

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: ER 320 OPERATIONS LLC
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-1 Date: 05/20/1996 Issued By: Dept of Health

Staffing Hours

Resident Support Staff: Total Daily Staff: 22 Waking Staff: 17

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Complaint, Incident, Interim Exit Conference Date: 11/14/2023

Inspection Dates and Department Representative

11/14/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 26 Residents Served: 22

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: Unknown Are 60 Years of Age or Older: 22
Diagnosed with Mental Illness: 14 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 0 Have Physical Disability: 0

Inspections / Reviews

11/14/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 12/09/2023

Inspections / Reviews (*continued*)

12/13/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/09/2023

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

65a - FS Orientation 1st Day

1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was [REDACTED]/2023, did not receive orientation on the following topics:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Plan of Correction

Directed [REDACTED] - 12/11/2023)

Staff members have signe the orientation form.

Proposed Overall Completion Date: 12/09/2023

[Directed]

- Administrator will have Staff Person A complete and sign off on first day trainings by 1/15/24.
- Administrator will complete an audit of all current staff records to ensure all staff had their first day trainings. Audit will be completed by 1/15/24. Documentation of audit will be kept and available for review by the Department.
- Administrator will create a new hire checklist, including first day trainings. This will be created and implemented by 1/15/24.
- Starting 1/15/24, Administrator will complete quarterly reviews of new staff records to ensure compliance with trainings.

Directed Completion Date: 01/15/2024

65b - Rights/Abuse 40 Hours

2. Requirements

2600.

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

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

Description of Violation

Staff person A, whose first day of work was [REDACTED]/2023, did not complete training in the following topics:

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

Plan of Correction

Directed [REDACTED] - 12/11/2023)

Staff members have signed the orientation form.

Proposed Overall Completion Date: 12/09/2023

[Directed]

- Administrator will have Staff Person A complete and sign off on first 40-hour trainings by 1/15/24.
- Administrator will complete an audit of all current staff records to ensure all staff had their first 40-hour trainings. Audit will be completed by 1/15/24. Documentation of audit will be kept and available for review by the Department.
- Administrator will create a new hire checklist, including first 40-hour trainings. This will be created and implemented by 1/15/24.
- Starting 1/15/24, administrator will complete quarterly reviews of new staff records to ensure compliance with trainings.

Directed Completion Date: 01/15/2024

82a - Poisonous Materials

3. Requirements

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 11/14/2023, a spray bottle labeled "(Resident's name) Clean" was observed in Resident 1's bathroom. There was an unknown cleaning liquid in this spray bottle, and there was no manufacture label on the bottle.

82a - Poisonous Materials (continued)**Plan of Correction****Directed (█ - 12/11/2023)**

The unlabeled bottle was removed from the residents room. Residents and staff were educated on not using chemicals in unlabeled bottles.

Proposed Overall Completion Date: 12/09/2023

[Directed]

- Administrator will educate staff and residents on not using chemicals in unlabeled bottles by 1/15/24. Documentation of this education will be kept and available for review by the Department.*
- Administrator will complete an audit of the home to ensure all poisonous materials are in their original, labeled containers. This audit will be completed by 1/15/24. Documentation of audit will be kept and available for review by the Department.*
- Starting 1/15/24, administrator will complete a weekly walkthrough of the home to review all poisonous materials for compliance. Documentation of these walkthroughs will be kept and available for review by the Department.*

Directed Completion Date: 01/15/2024

144c1 - Smoking Area Guidelines**4. 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

On 11/14/2023, the smoking area located near the recycling dumpsters had multiple cigarette butts scattered on the ground amongst dried leaves.

The smoking area also contained two metal-framed chairs with upholstered seat and back cushions which do not have labels indicating they are fire resistant.

Plan of Correction**Directed (█ - 12/11/2023)**

The chairs were removed from the smoking area and disposed of. As of January 2024 the building will become smoke free and the smoking area will no longer exist.

Proposed Overall Completion Date: 12/09/2023

[Directed]

- Administrator and/or designee will clean out designated smoking area by 1/15/24 as the home is becoming a smoke-free facility.*
- Administrator will educate staff and residents regarding the home becoming a smoke-free facility by*

144c1 - Smoking Area Guidelines (continued)

1/15/24. Documentation of education will be kept and available for review by the Department.

- Starting 1/15/24, administrator and/or designee will complete a weekly walk around the outside of the building, including previous designated smoking area to ensure compliance. Documentation these reviews of the outside areas will be kept and available for review by the Department.

Directed Completion Date: 01/15/2024

187a - Medication Record**5. Requirements**

2600.

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

6. Dose.

Description of Violation

Resident 2 is prescribed Levemir. The prescription label on medications states "Administer 20 units in AM and 30 units at Bedtime". However, Resident 2's medication administration record (MAR) states "Administer 25 units in AM and 30 units at Bedtime".

Plan of Correction

Directed [REDACTED] - 12/11/2023)

The prescription label of the medication and the MAR now match. Random audits of the residents MAR and resident's prescription label will be completed to assure accuracy.

Proposed Overall Completion Date: 12/09/2023

[Directed]

- Administrator will educate all med techs on medication administration records (MAR) and prescription labels needing to match by 1/15/24. Documentation of education will be kept and available for review by the Department.
- Administrator will complete an audit of all current MARs and prescription labels to ensure compliance. This audit will be completed by 1/15/24. Documentation of audit will be kept and available for review by the Department.
- Starting 1/15/24, administrator will complete a monthly audit of a sample of MARs and prescription labels to ensure compliance. Documentation of audits will be kept and available for review by the Department.

Directed Completion Date: 01/15/2024

190a - Completion Medication Course**6. Requirements**

2600.

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

Description of Violation

Staff Person B, who administers medication regularly to residents, has not had a medication administration review or medication administration observation in the past 6 months. Last review and observation were on 04/19/2023.

190a - Completion Medication Course (continued)**Plan of Correction****Directed (█) - 12/11/2023)**

Staff members to have regularly scheduled Med Tech observations. Med Tech observation scheduled for the week of 12/11/23.

Proposed Overall Completion Date: 12/09/2023

[Directed]

- Administrator will complete an audit of medication administration certifications for all current med techs. This audit will be completed by 1/15/24.
- Administrator will create a master list of the last dates med techs last had a medication administration review and a medication administration observation. Administrator will use these dates to schedule the next medication administration reviews and medication administration observations. Administrator will create and implement this list by 1/15/24.

Directed Completion Date: 12/09/2023

191 - Resident Right to Refuse**7. Requirements**

2600.

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

Description of Violation

There is no documentation Resident 3, admitted to the home on █/2023, has been educated on the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction**Directed (█) - 12/11/2023)**

Residents were educated on the right to refuse medications and it was added to the contract for new admissions. Going forward all contracts will state the updated rights and education will be provided at resident council meetings.

Proposed Overall Completion Date: 12/09/2023

[Directed]

- Administrator will update the home's contract by 1/15/24, to include residents are educated on the right to refuse medication if they feel there is a medication error.
- Administrator will educate all residents on the right to refuse medication if they feel there is a medication error by 1/15/24. Documentation of this education will be kept in each resident's record and available for review by the Department.
- Administrator will create a new admission checklist, including a resident's right to refuse medication if they feel there is a med error. This checklist will be created and implemented by 1/15/24.

Directed Completion Date: 12/09/2023

224a - Preadmission Screen Form**8. Requirements**

2600.

224a - Preadmission Screen Form (*continued*)

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

Resident 2 was admitted to the home on [REDACTED]/2023; however, the resident's preadmission screening form was completed on [REDACTED]/2023.

Resident 3 was admitted to the home on [REDACTED]/2023; however, the resident's preadmission screening form was completed on 08/02/2023.

Plan of Correction

Directed ([REDACTED] - 12/11/2023)

Pre-admission screening forms will be completed prior to resident's being admitted. Staff were educated on need to complete pre-admission prior to admit date.

Proposed Overall Completion Date: 12/09/2023

[Directed]

- Administrator will create a new admission checklist, including a preadmission screening form is completed. This checklist will be created and implemented by 1/15/24.
- Administrator will complete an audit of all current resident records to ensure each resident has a completed preadmission screening. Audit will be completed by 1/15/24. Documentation of this audit will be kept and available for review by the Department.
- Administrator will educate staff involved in the new admission process regarding a preadmission screening needing to be completed within 30 days prior to admission. Staff will be educated by 1/15/24. Documentation of this education will be kept and available for review by the Department.
- Starting 1/15/24, administrator will review all new resident records quarterly to ensure compliance. Documentation of these audits will be kept and available for review by the Department.

Directed Completion Date: 12/09/2023