



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: FEBRUARY 13, 2024

██████████
President
Chestnut Manor, LLC
4926 Chestnut Street
Philadelphia, Pennsylvania 19139

RE: Chestnut Manor
License #: 101881

Dear ██████████

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection July 18, 2023 and November 16, 2023 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 101880 dated June 9, 2023 to June 9, 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. The license dated June 9, 2023 to June 9, 2024 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(4) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from February 13, 2024 to August 13, 2024..

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

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

[REDACTED]

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

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

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

Sincerely,



Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

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

Facility Information

Name: CHESTNUT MANOR License #: 10188 License Expiration: 06/09/2024
Address: 4926 CHESTNUT STREET, PHILADELPHIA, PA 19139
County: PHILADELPHIA Region: SOUTHEAST

Administrator

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

Legal Entity

Name: CHESTNUT MANOR LLC
Address: 4926 CHESTNUT STREET, PHILADELPHIA, PA, 19139
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: Other Date: 05/06/2011 Issued By: City of Phila L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 6 Waking Staff: 5

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal Exit Conference Date: 07/18/2023

Inspection Dates and Department Representative

07/18/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 13 Residents Served: 6

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 6 Are 60 Years of Age or Older: 0
Diagnosed with Mental Illness: 6 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 0 Have Physical Disability: 0

Inspections / Reviews

07/18/2023 - Full

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 08/10/2023

08/15/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/29/2023

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 08/20/2023

09/01/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/29/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 09/29/2023

02/02/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/29/2023

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

18 - Compliance With Laws

1. Requirements

2600.

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

Description of Violation

Personal care homes are considered "public places" under the Clean Indoor Air Act (35 P.S. § 637.1 – 637.11) and thus are subject to those regulations as well. According to the Act, personal care homes must post a sign at each entrance that states "Smoking Permitted in Designated Areas Only". On 7/18/23, the home did not have any signs posted in the designated smoking area.

Plan of Correction

Accepted [redacted] - 08/15/2023)

The home now has posted "Smoking Permitted in Designated Areas Only" signs at each entrance. As part of the daily checklist, the staff on duty will check to ensure they remain in place.

Licensee's Proposed Overall Completion Date: 08/09/2023

Implemented [redacted] - 02/02/2024)

53a - Qualifications

2. Requirements

2600.

53.a. The administrator shall have one of the following qualifications:

1. A license as a registered nurse from the Department of State.
2. An associate's degree or 60 credit hours from an accredited college or university.
3. A license as a licensed practical nurse from the Department of State and 1 year of work experience in a related field.
4. A license as a nursing home administrator from the Department of State.
5. For a home serving 8 or fewer residents, a general education development diploma or high school diploma and 2 years direct care or administrative experience in the human services field.

Description of Violation

On 7/18/23, the home was serving 6 residents. Staff person [redacted], the administrator, does not have any of the required qualifications listed.

Plan of Correction

Directed [redacted] - 09/01/2023)

Due to the fire that caused the loss of the administrator documents a plan method was started on 08-16-2023 to prevent this violation from recurring. All residents are now handing over all their cigarettes, tobacco, and matches to staff on duty before going upstairs. Cigarettes and matches are handed back to residents upon request as they make their way to the smoking area outside of the building. Additionally, a cigarette and tobacco tracking chart has been created. For all staff on duty to monitor the building on an hourly basis continuously for compliance.

Directed Plan of Correction:

- The administrator or designee shall keep a file containing all relevant documents on file in the home. The administrator or designee shall audit the admin file on a quarterly basis beginning in October 2023 to ensure that all required qualifications/documents are available for the Department's review.

Directed Completion Date: 08/22/2023

Implemented [redacted] - 02/02/2024)

64c - Annual Training

3. Requirements

2600.

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

Description of Violation

Staff person [REDACTED], the home's administrator, completed only 19 hours of Department-approved training in training year 2022.

Plan of Correction

Accept ([REDACTED] - 08/15/2023)

Staff person [REDACTED] has been registered with Temple University for continuing education: "Understanding the impact of stress" and "How to achieve self-preservation". A staff training plan has been constructed and will be followed as layed out in the plan to ensure present and future compliance.

Licensee's Proposed Overall Completion Date: 09/27/2023

Implemented ([REDACTED] - 02/02/2024)

65f - Training Topics

4. Requirements

2600.

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

- 1. Medication self-administration training.

Description of Violation

Direct care staff person B did not receive training in medication self-administration during training year 2022.

Plan of Correction

Accept ([REDACTED] - 09/01/2023)

The above-referenced training information was located subsequent to the inspection and was found to have been satisfied on 3-11-23 for the medication training requirements. The administrator will inspect all staff folders on a quarterly basis for completeness starting 08/09/2023 to ensure future compliance.

Licensee's Proposed Overall Completion Date: 08/09/2023

The quarterly start date and audit is 08/09/2023

Licensee's Proposed Overall Completion Date: 08/22/2023

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

65g - Annual Training Content

5. 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:

- 3. Resident rights.
- 4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
- 5. Falls and accident prevention.

Description of Violation

Staff person B did not receive training in Residents Rights, the Older Adult Protective Services Act, and Falls and Accident Prevention during training year 2022.

Plan of Correction

Accept ([REDACTED] - 09/01/2023)

Staff person B's required annual training record was already in their file folder. For some unknown reason, it was

65g - Annual Training Content (continued)

overlooked. In the future, the Administrator will double-check all staff folders on a monthly basis, starting on 08/10/2023 to ensure that all necessary documents are visible and in place, to ensure future compliance.
Licensee's Proposed Overall Completion Date: 08/10/2023
Update: 08/15/2023

Licensee's Proposed Overall Completion Date: 08/22/2023

Not Implemented (████ - 02/02/2024)

66a - Staff Training Plan

6. Requirements

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

Description of Violation

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

Plan of Correction

Accept (████ - 08/15/2023)

The home has now developed a staff training plan for the 2023 calendar year. Since then, the Administrator has made the development of an annual training plan as part of our yearly checklist to ensure continued and future compliance.

Licensee's Proposed Overall Completion Date: 08/10/2023

Not Implemented (████ - 02/02/2024)

85a - Sanitary Conditions

7. Requirements

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

Description of Violation

On 7/18/23, there was an unlabeled toothbrush in the second floor bathroom.

Both bathrooms had shower mats in the tub that are shared by all residents.

There was frozen juice spilled in the bottom of the freezer.

Plan of Correction

Accept (████ - 09/01/2023)

The home has removed the toothbrush, shower mats, and spilled juice. Staff will check daily as part of a daily checklist starting on 08/09/2023 to maintain compliance with regulations. The residents were reminded on 08/09/2023 not to leave any personal items in the bathrooms such as bar soap, toothbrushes, towels, and any other personal effects.

Licensee's Proposed Overall Completion Date: 08/09/2023

Licensee's Proposed Overall Completion Date: 08/22/2023

Implemented (████ - 02/02/2024)

88a - Surfaces

8. 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

There was a brown, mold-like substance on the ceiling in the first floor bathroom above the tub.

There were several dark brown spots/substance on the pantry ceiling.

Plan of Correction

Accept (████ - 09/01/2023)

The home has cleaned and sanitized the areas in question on 08/09/2023. Staff will monitor these and other areas to ensure future compliance on a daily basis. The administrator will also check behind staff members starting on 08/09/2023 to ensure compliance.

Licensee's Proposed Overall Completion Date: 08/09/2023

Licensee's Proposed Overall Completion Date: 08/22/2023

Implemented (████ - 02/02/2024)

100a - Exterior - Free of Hazards

9. Requirements

2600.

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

Description of Violation

On 7/18/23 there is a broken bicycle wheel, a tarp spread out on the ground, and a stack of scaffolding leaning against the the fire escape stairs in the back yard of the home.

Plan of Correction

Accept (████ - 09/01/2023)

The home has removed all items mentioned in the backyard. Staff on duty, as part of the daily checklist beginning on 08/09/2023, will walk the exterior to identify any potential hazards and will report to the administrator to remove them to ensure future compliance.

Licensee's Proposed Overall Completion Date: 08/09/2023

Licensee's Proposed Overall Completion Date: 08/22/2023

Implemented (████ - 02/02/2024)

103f - Refrigerator/Freezer Temps

10. Requirements

2600.

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

Description of Violation

On 7/18/23, the temperature in the basement freezer was 10 degrees Fahrenheit.

On 7/18/23, the temperature in the dining room freezer was 10 degrees Fahrenheit.

Plan of Correction

Accept (████ - 09/01/2023)

The temperature settings on the freezer have been adjusted on 08/09/2023 to bring it within specifications. Staff

103f - Refrigerator/Freezer Temps (continued)

members, as part of the daily checklist which starts on 08/09/2023, will check freezer temperature to ensure ongoing compliance and will inform the administrator of any changes.

Licensee's Proposed Overall Completion Date: 08/09/2023

Licensee's Proposed Overall Completion Date: 08/22/2023

Not Implemented (████) - 02/02/2024)

103i - Outdated Food

11. Requirements

2600.

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

Description of Violation

There was an unlabeled, undated pack of cheese in the refrigerator.

There was an unlabeled, undated box of dried herbs in the kitchen.

There was a can of tomato sauce in the kitchen with a use by date of 2/11/23.

There was a moldy hotdog bun in a bag in the kitchen.

Plan of Correction

Accept (████) - 09/01/2023)

The home has labeled and dated all required food items and also removed any outdated items. Staff will properly label, date, and organize food to be stored in their respective locations. The administrator will check immediately to be sure that instructions given to the staff are followed. Also, staff in-service training will take place on 08/17/2023 on proper food storage and food rotation. The administrator will check the food pantry starting on 08/17/2023 and every Monday for ongoing compliance.

Licensee's Proposed Overall Completion Date: 08/09/2023

Licensee's Proposed Overall Completion Date: 08/22/2023

Implemented (████) - 02/02/2024)

109b - Rabies Vaccination

12. 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 7/18/23, one cat was present at the home. The home does not have a current certificate of rabies vaccination for the cat.

Plan of Correction

Accept (████) - 08/15/2023)

An appointment for 8/17/23 has been set with the veterinarian for the cat to obtain current vaccination and certification. The administrator will review pet records on a semi-annual basis to ensure future compliance.

Licensee's Proposed Overall Completion Date: 08/17/2023

Implemented (████) - 02/02/2024)

124 - Notice to Fire Department

13. Requirements

2600.

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

Description of Violation

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

Plan of Correction

Accept (redacted) - 08/15/2023)

The home has now sent a written notification to the local fire department containing current information to satisfy the requirements of the regulation. The administrator will check semi-annually to coincide with the semi-annual overnight fire drill as an easy reminder and to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 08/09/2023

Implemented (redacted) - 02/02/2024)

131f - Fire Extinguisher Inspection

14. Requirements

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The all of the fire extinguishers in the home have not been inspected by a fire safety expert.

Plan of Correction

Accept (redacted) - 09/01/2023)

The brand-new fire extinguishers have now been inspected and labeled on 08/10/2023 by a fire safety expert to comply with the above regulation. To ensure future compliance, the administrator will note that even though new, they should be inspected to be in compliance with the annual safety inspection.

Licensee's Proposed Overall Completion Date: 08/10/2023

Licensee's Proposed Overall Completion Date: 08/22/2023

Implemented (redacted) - 02/02/2024)

162e - Menu Changes

15. Requirements

2600.

162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On 7/18/23, hamburger, french fries, salad, Swedish meatballs, noodles, and broccoli were listed on the menu for the lunch meal. Tuna salad sandwiches with juice were served instead. No notice was provided to the residents in advance of the meal.

Plan of Correction

Accept (redacted) - 09/01/2023)

Future menu changes will be posted on the bulletin board alongside the menu before the meal. Staff in-service

162e - Menu Changes (continued)

training on general food handling, food menu, food safety, food rotation, and food storage began on 08/17/2023. The administrator and staff will monitor daily to maintain continued compliance. Licensee's Proposed Overall Completion Date: 08/09/2023

Licensee's Proposed Overall Completion Date: 08/22/2023

Implemented (████) - 02/02/2024)

183e - Storing Medications

16. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

████ prescribed to resident 1 did not have an open date. According to the manufacturer's instructions this medication must be discarded one year after opening.

████ prescribed to resident 1 did not have an open date. According to the manufacturer's instructions this medication must be discarded three months after opening.

Plan of Correction

Accept (████) - 09/01/2023)

The home has now dated █████. The administrator will monitor the start date and label as new █████ are received to ensure future compliance.

Licensee's Proposed Overall Completion Date: 08/09/2023. The administrator will conduct monthly medication staff-in-service reviews for a duration of 30 minutes each time for proper administration, documentation, and storage. The administrator will review monthly as new medication arrives from the pharmacy starting on 08/17/2023 for continue compliance.

Licensee's Proposed Overall Completion Date: 08/22/2023

Not Implemented (████) 02/02/2024)

224a - Preadmission Screen Form

17. 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

Resident 1 was admitted to the home on █████; however, the resident does not have a preadmission screening form.

Plan of Correction

Accept (████) - 08/15/2023)

The preadmission screening form was among those unrecoverable after the fire. To prevent future occurrences the home will hold and manage cigarettes, matches, and lighters. The home will be regulated, items controlled and residents reminded to smoke in designated smoking areas only.

Licensee's Proposed Overall Completion Date: 08/09/2023

Implemented (████) - 02/02/2024)

225a - Assessment 15 Days

18. 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 2's assessment does not include a date.

Plan of Correction

Accept (█ - 09/01/2023)

We are presently awaiting a response from Inspector █ regarding clarification on the above-referenced violation. After reviewing Resident 2's RASP, who was initially admitted on █, the finalization date for both the Assessment and Support Plans was noted as █. Resident 2 has not been with us for a year as of yet. therefore, there was no "date of last assessment" or "date of last support plan" noted/visible on the RASP. Resident #2 assessment has been dated and signed. Starting on 08/17/2023, the administrator will utilize an intake checklist to include the assessment and to make sure it is completed in its entirety. The administrator will review it at the end of each month and on a continuous basis to ensure further compliance.

Licensee's Proposed Overall Completion Date: 08/22/2023

Not Implemented (█ - 02/02/2024)

252 - Record Content

19. Requirements

2600.

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

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.

Description of Violation

Resident 1's record does not include the following:

- 1) Gender, admission date, and Social Security number.*
- (2) Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.*
- (3) A photograph of the resident that is no more than 2 years old.*
- (4) Language or means of communication spoken or used by the resident.*
- (5) The name, address, telephone number, and relationship of a designated person to be contacted in case of an emergency*
- (7) The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.*
- (18) An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.*

252 - Record Content (continued)

Resident 2's record does not include a photograph of the resident that is no more than 2 years old.

Plan of Correction

Accept [REDACTED] - 09/01/2023)

The resident record was unrecoverable after the fire. We have taken steps to regulate the use of cigarettes, matches, and lighters by controlling access to them and having a designated smoking area. This will help to reduce the risk of fire in the future.

Since [REDACTED] resident #1 has moved away from Chestnut Manor. Due to the fire that caused the loss of resident #1 records. To prevent this violation from recurring as of 08/17/2023 the administrator has now secured all residents' records in a fire resistance storage container to ensure future compliance.

Licensee's Proposed Overall Completion Date: 08/09/2023

Licensee's Proposed Overall Completion Date: 08/22/2023

Not Implemented [REDACTED] - 02/02/2024)

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

Facility Information

Name: CHESTNUT MANOR License #: 10188 License Expiration: 06/09/2024
Address: 4926 CHESTNUT STREET, PHILADELPHIA, PA 19139
County: PHILADELPHIA Region: SOUTHEAST

Administrator

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

Legal Entity

Name: CHESTNUT MANOR LLC
Address: 4926 CHESTNUT STREET, PHILADELPHIA, PA, 19139
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: Other Date: 05/06/2011 Issued By: City of Phila / L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 8 Waking Staff: 6

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Monitoring Exit Conference Date: 11/16/2023

Inspection Dates and Department Representative

11/16/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 13 Residents Served: 8

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 8 Are 60 Years of Age or Older: 3
Diagnosed with Mental Illness: 8 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 0 Have Physical Disability: 0

Inspections / Reviews

11/16/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 12/07/2023

Inspections / Reviews (*continued*)

12/14/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/07/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 12/19/2023

12/20/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/07/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 01/05/2024

02/02/2024 - Document Submission

Submitted By: *Austin Virgo*

Date Submitted: 01/07/2024

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

25b - Contract Signatures

1. Requirements

2600.

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

Description of Violation

The resident-home contract, dated [REDACTED], for resident #1 was not signed by the administrator, and or administrator designee.

The resident-home contract, dated [REDACTED], for resident #2 was not signed by the administrator, and or administrator designee.

The resident-home contract, dated [REDACTED], for resident #3 was not signed by the administrator, and or administrator designee.

Plan of Correction

Directed [REDACTED] - 12/20/2023)

Immediately on 11/16/2023, the resident contract for residents #1, 2, and 3 was signed by the administrator. All other resident's records & contracts were checked for required signatures. To prevent the recurrence of this violation starting upon new admission, the administrator and staff member will double-check and review all resident records every month for compliance.

No specific training is warranted at this time. A monthly resident file checklist has been created and is attached to each resident file that will be reviewed by staff and administrator to indicate that all required documents are in place and completed within the specified time frame. Sign and dated for future accountability compliance.

Directed Plan of Correction:

In addition to the above plan of correction, the administrator or designee shall provide training to all staff of the home within 10 calendar days of the receipt of this plan of correction. The training shall include how and when to use the monthly resident file checklist, what staff are to do when they identify non-compliance issues, and how the form is to be documented and stored. Documentation of trainings, including signature logs, and completed checklists shall be kept for department review upon request.

Documentation of the completed trainings and completed daily checklists shall be submitted via Sanswrite for verification purposes.

Directed Completion Date: 01/05/2024

Not Implemented [REDACTED] - 02/02/2024)

85a - Sanitary Conditions

2. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 11/16/23, in the second-floor bedroom #3, there were clothes thrown on the floor and clothes for the two residents in the room were mixed together.

85a - Sanitary Conditions (continued)

The third-floor linen closet had bags of unlabeled clothes inside and not put away.

Plan of Correction

Directed (████) - 12/20/2023)

On 11/16/2023, the administrator met with both residents who occupy the second-floor bedroom #3 and had them straighten out their room by gathering each individual's belonging and putting things back in place as they were once was.

The third-floor linen closet was organized and items were properly labeled by the staff on duty. To prevent the recurrence of this violation starting 11/17/2023 daily, all bedrooms and linen closets will be checked by the staff on duty followed by the administration to make sure everything discussed is to stay in compliance.

No specific training is warranted at this time. Due to previous discussions with residents and staff. However, a daily bedroom and lining closet checklist has been created for documentation and to indicate countability for future compliance.

Directed Plan of Correction:

In addition to the above plan of correction, the administrator or designee shall provide training to all staff of the home within 10 calendar days of the receipt of this plan of correction. The training shall include how and when to use the daily checklist, what staff are to do when they identify non-compliance issues, and how the form is to be documented and stored. Documentation of trainings, including signature logs, and completed checklists shall be kept for department review upon request.

Documentation of the completed trainings and two weeks of completed daily checklists shall be submitted via Sanswrite for verification purposes.

Directed Completion Date: 01/05/2024

Implemented (████) - 02/02/2024)

85d - Trash Receptacles

3. 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 11/16/23 at 3pm there was a full, uncovered, unattended trash can in the 3rd floor bathroom.

Plan of Correction

Directed (████) - 12/20/2023)

On 11/16/2023 the scheduled bathroom cleaning was for 5 pm that evening, however, the trash can was filling up quicker than expected, were paper was sticking out from under the covered lid. The trash can was emptied immediately and then put back in place with a covered lid.

To prevent the recurrence of this violation starting 11/17/2023 the staff on duty will now check twice per day all the trash cans in the building and empty them as needed to stay in compliance.

No specific training is warranted at this time. A daily bathroom checklist has been created for documentation and to indicate accountability for future compliance.

85d - Trash Receptacles (continued)

Directed Plan of Correction:

In addition to the above plan of correction, the administrator or designee shall provide training to all staff of the home within 10 calendar days of the receipt of this plan of correction. The training shall include how and when to use the daily checklist, what staff are to do when they identify non-compliance issues, and how the form is to be documented and stored. Documentation of trainings, including signature logs, and completed checklists shall be kept for department review upon request.

Documentation of the completed trainings and two weeks of completed daily checklists shall be submitted via Sanswrite for verification purposes.

Directed Completion Date: 01/05/2024

Implemented (redacted) 02/02/2024)

131e - Accessible Extinguishers

4. Requirements

2600.

131.e. Fire extinguishers shall be accessible to staff persons. Fire extinguishers shall be kept locked if access to the extinguisher by a resident could cause a safety risk to the resident. If fire extinguishers are kept locked, each staff person shall be able to immediately unlock the fire extinguisher in the event of a fire emergency.

Description of Violation

The fire extinguisher on the first floor is stored on the floor and is not properly mounted for ease of accessibility.

Plan of Correction

Directed (redacted) - 12/20/2023)

On 11/17/2023The fire Extinguisher on the first floor was properly mounted on the wall by the administrator. To prevent the recurrence of this violation. Starting each year and after the inspection and service of the extinguishers the staff on duty followed by the administrator will check every month to make sure the extinguishers stay mounted.

No specific training is warranted at this time. A monthly fire inspection checklist has been created for monitoring and documentation to indicate accountability for future compliance.

Directed Plan of Correction:

In addition to the above plan of correction, the administrator or designee shall provide training to all staff of the home within 10 calendar days of the receipt of this plan of correction. The training shall include how and when to use the monthly checklist, what staff are to do when they identify non-compliance issues, and how the form is to be documented and stored. Documentation of trainings, including signature logs, and completed checklists shall be kept for department review upon request.

Documentation of the completed trainings and documentation of completed checklists shall be submitted via Sanswrite for verification purposes.

Directed Completion Date: 01/05/2024

Implemented (redacted) - 02/02/2024)

144c1 - Smoking Area Guidelines

5. Requirements

144c1 - Smoking Area Guidelines (continued)

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

In the home's designated smoking area, there is a tarp on the ground in the home's designated smoking area outside creating both a fire hazard and a tripping hazard.

Plan of Correction

Directed (█ - 12/20/2023)

On 11/16/2023 Immediate action was taken to remove the plastic tarp from the smoking area that one of the residents put there.

To prevent the recurrence of this violation, starting on 11/16/2023 the staff on duty will check the smoking areas followed by the administrator daily as to make sure the smoking area stays hazard-free.

No specific training is warranted at this time. However, a daily smoking area checklist has been created for documentation monitoring and to indicate accountability for future compliance.

Directed Plan of Correction:

In addition to the above plan of correction, the administrator or designee shall provide training to all staff of the home within 10 calendar days of the receipt of this plan of correction. The training shall include how and when to use the daily checklist, what staff are to do when they identify non-compliance issues, and how the form is to be documented and stored. Documentation of trainings, including signature logs, and completed checklists shall be kept for department review upon request.

Documentation of the completed trainings and two weeks of completed daily checklists shall be submitted via Sanswrite for verification purposes.

Directed Completion Date: 01/05/2024

Not Implemented (█ - 02/02/2024)

185a - Implement Storage Procedures

6. Requirements

2600.

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

Description of Violation

Resident #2 is prescribed █ On 11/16/23 this medication(s) was not available in the home.

Plan of Correction

Accept (█ - 12/20/2023)

On 11/16/2023 Resident #2 medication █ had fallen behind the drawer in the storage cabinet and was not available for inspection, after an intense search, the medication was found. The inspector was notified within two hours after leaving the facility █ instruction was followed as █ directed us.

185a - Implement Storage Procedures (continued)

To prevent the recurrence of this violation, starting immediately on 11/16/2023 the administrator has changed the medication storage location so as not to allow medication to be out of sight to ensure future compliance.

On November 29 2023 staff person A completed the medication course training. Given by a certified medication instructor, topics covered in the training include medication storage procedures, following the direction of the prescriber, and a resident's right to refuse or question their medication. Starting immediately on 11-29-2023 the administrator will perform weekly medication audits/reviews on an ongoing basis. A weekly medication audit list has been created for documentation to ensure future compliance

Proposed Overall Completion Date: 12/19/2023

Licensee's Proposed Overall Completion Date: 12/19/2023

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

187d - Follow Prescriber's Orders

7. Requirements

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

Description of Violation

Resident #2 is prescribed [redacted] [redacted] However, this medication was not available in the home.

Plan of Correction

Accept ([redacted] - 12/20/2023)

On 11/16/2023 Resident #2 medication that had fallen behind the drawer in the storage cabinet was recovered and was available in time. For a resident to receive their prescribed dose on time. To prevent the recurrence of this violation starting immediately on 11/16/2023 the administrator has changed the medication storage location so as not to allow medication again to be out of sight to ensure future compliance.

On November 29 2023 staff person A completed the medication course training. Given by a certified medication instructor, topics covered in the training include medication storage procedures, following the direction of the prescriber, and a resident's right to refuse or question their medication. Starting immediately on 11-29-2023 the administrator will perform weekly medication audits/reviews on an ongoing basis. A weekly medication audit list has been created for documentation to ensure future compliance

Licensee's Proposed Overall Completion Date: 12/19/2023

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

190a - Completion Medication Course

8. Requirements

- 2600.

190a - Completion Medication Course (continued)

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 A, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:

On 11/16/23 at 8am and 12pm, staff member A administered [redacted] to resident #1.

For the month of November, staff member A administered 8am, 8pm and PRN's medications to resident #2 to include [redacted]

For the month of November, staff member A administered 8am, 8pm and PRN's medications to resident #3 to include [redacted].

Plan of Correction

Accept [redacted] - 12/20/2023)

Staff person A did not acquire medication recertification in a timely manner. Staff member A is currently engaged in studies for the completion of medication administration training.

To prevent the recurrence of this violation starting 11/17/2023 the administrator will check and review quarterly all staff records and make sure all required documents are current and in place.

During the time that staff person A was obtaining their medication training immediately on 11/16/2023, the administrator who is qualified to do so took over to ensure that medication was administered to the residents to ensure continued compliance.

Proposed Overall Completion Date: 12/19/2023

Licensee's Proposed Overall Completion Date: 12/19/2023

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

191 - Resident Right to Refuse

9. Requirements

2600.

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

Description of Violation

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

Resident #2, admitted [redacted] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

191 - Resident Right to Refuse (continued)

Resident #3, admitted [REDACTED] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction

Accept ([REDACTED] - 12/20/2023)

On 11/16/2023 Residents 1, 2, and 3 have now been educated by the administrator of their right to question or refuse a medication if they believe there may be a medication error.

To prevent the recurrence of this violation starting upon new admission the administrator and staff will double-check and review all resident records every month for compliance.

On November 29 2023 staff person A completed the medication course training. Given by a certified medication instructor, topics covered in the training include medication storage procedures, following the direction of the prescriber, and a resident's right to refuse or question their medication. Starting immediately on 11-29-2023 the administrator will perform weekly medication audits/reviews on an ongoing basis. A weekly medication audit list has been created for documentation to ensure future compliance

Licensee's Proposed Overall Completion Date: 12/19/2023

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

225a - Assessment 15 Days

10. Requirements

2600.

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

Description of Violation

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

An assessment was not completed for resident #2, who was admitted to the home on [REDACTED]

An assessment was not completed for resident #3, who was admitted to the home on [REDACTED]

Plan of Correction

Directed ([REDACTED] - 12/20/2023)

An assessment for residents numbers 1,2, and 3 was completed within the specified time frame, however at the time of inspection due to misplacement we were unable to present the assessment. Since then we have located the assessment and is now placed in the resident record folder.

To prevent the recurrence of this violation starting in the future upon the completion of the resident assessment it will be placed right away in the resident file folder. The staff member and administrator will double-check and review all residents' records every month for compliance.

No specific training is warranted at this time. A monthly resident file checklist has been created and is attached to each resident file that will be reviewed by staff and administrator to indicate that all required documents are in place and completed within the specified time frame. Sign and dated for future accountability compliance.

Directed Plan of Correction:

225a - Assessment 15 Days (continued)

In addition to the above plan of correction, the administrator or designee shall provide training to all staff of the home within 10 calendar days of the receipt of this plan of correction. The training shall include how and when to use the monthly resident file checklist, what staff are to do when they identify non-compliance issues, and how the form is to be documented and stored. Documentation of trainings, including signature logs, and completed checklists shall be kept for department review upon request.

Documentation of the completed trainings and completed daily checklists shall be submitted via Sanswrite for verification purposes.

Directed Completion Date: 01/05/2024

Not Implemented () - 02/02/2024)

227a - Support Plan 30 Days

11. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #1 was admitted on [redacted]; however, the resident's initial support plan was not completed within 30 days of admission.

Resident #2 was admitted on [redacted]; however, the resident's initial support plan was not completed within 30 days of admission.

Plan of Correction

Directed () - 12/20/2023)

A support plan for residents number 1 and 2 was developed within the specified time frame, however at the time of the inspection it was not available due to the misplacement of the support plan record. Since then it has been located and it is now placed in the resident folder of records.

To prevent the recurrence of this violation starting in the future upon the completion of the resident support plan it will be placed right away in the resident file folder. The staff member and administrator will double-check and review all residents' records every month for compliance.

No specific training is warranted at this time. A monthly resident file checklist has been created and is attached to each resident file that will be reviewed by staff and administrator to indicate that all required documents are in place and completed within the specified time frame. Sign and dated for future accountability compliance.

Directed Plan of Correction:

In addition to the above plan of correction, the administrator or designee shall provide training to all staff of the home within 10 calendar days of the receipt of this plan of correction. The training shall include how and when to use the monthly resident file checklist, what staff are to do when they identify non-compliance issues, and how the form is to be documented and stored. Documentation of trainings, including signature logs, and completed checklists shall be kept for department review upon request.

Documentation of the completed trainings and completed daily checklists shall be submitted via Sanswrite for

227a - Support Plan 30 Days (continued)

verification purposes.

Directed Completion Date: 01/05/2024

Not Implemented (█) - 02/02/2024)

252 - Record Content

12. Requirements

2600.

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

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
14. A support plan.

Description of Violation

Resident 1's record does not include name, gender, admission date, birth date and Social Security number, race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks, a photograph of the resident that is no more than 2 years old, language or means of communication spoken or used by the resident, the name, address, telephone number and relationship of a designated person to be contacted in case of an emergency, the name, address and telephone number of the resident's physician or source of health care, and a support plan.

Resident 2's record does not include name, gender, admission date, birth date and Social Security number, race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks, a photograph of the resident that is no more than 2 years old, language or means of communication spoken or used by the resident, the name, address, telephone number and relationship of a designated person to be contacted in case of an emergency, the name, address and telephone number of the resident's physician or source of health care, and a support plan.

Resident 3's record does not include name, gender, admission date, birth date and Social Security number, race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks, a photograph of the resident that is no more than 2 years old, language or means of communication spoken or used by the resident, the name, address, telephone number and relationship of a designated person to be contacted in case of an emergency, the name, address and telephone number of the resident's physician or source of health care, and a support plan.

Plan of Correction

Directed (█) - 12/20/2023)

A resident record, for Residents 1,2, and 3 was completed but it was not available at the time of inspection, since then the record has been located and is now placed in the resident folder.

To prevent the recurrence of this violation starting in the future upon the completion of the resident record it will be placed right away in the resident file folder. The staff member and administrator will double-check and review all residents' records every month for compliance.

No specific training is warranted at this time. A monthly resident file checklist has been created and is attached to

252 - Record Content (continued)

each resident file that will be reviewed by staff and administrator to indicate that all required documents are in place and completed within the specified time frame. Sign and dated for future accountability compliance.

Directed Plan of Correction:

In addition to the above plan of correction, the administrator or designee shall provide training to all staff of the home within 10 calendar days of the receipt of this plan of correction. The training shall include how and when to use the monthly resident file checklist, what staff are to do when they identify non-compliance issues, and how the form is to be documented and stored. Documentation of trainings, including signature logs, and completed checklists shall be kept for department review upon request.

Documentation of the completed trainings and completed daily checklists shall be submitted via Sanswrite for verification purposes.

Directed Completion Date: 01/05/2024

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