pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **2618 E MARKET STREET OPERATING COMPANY LLC**
LEGAL ENTITY

To operate **AUTUMN HOUSE EAST**
NAME OF FACILITY OR AGENCY

Located at **2618 EAST MARKET STREET, YORK, PA 17402**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **150**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 32**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **November 21,** **2023** until **May 21,** **2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **338231**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: NOVEMBER 21, 2023

[redacted], Executive Vice President
2618 E. Market Street Operating Company, LLC
[redacted]

RE: Autumn House East
2618 East Market Street
York, Pennsylvania 17402
Certificate #: 338230

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 19, 2023 and August 25, 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 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) (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:

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

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

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summaries

cc: [redacted]

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

Facility Information

Name: *Autumn House East* **License #:** *33823* **License Expiration:**

Address: *2618 E. Market Street, York, PA 17402*

County: *YORK* **Region:** *CENTRAL*

Administrator

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

Legal Entity

Name: *2618 E. Market Street Operating Company, LLC*

Address: [redacted]

Phone: **Email:** [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *04/27/2004* **Issued By:** *Department of Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *172* **Waking Staff:** *129*

Inspection Information

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

Reason: *Complaint, Change Legal Entity* **Exit Conference Date:** *07/19/2023*

Inspection Dates and Department Representative

07/19/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: **Residents Served:** *115*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Laurel Court* **Capacity:** *32* **Residents Served:** *28*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *115*

Diagnosed with Mental Illness: *37*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *57*

Have Physical Disability: *2*

Inspections / Reviews

07/19/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/05/2023*

08/03/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/10/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/14/2023*

09/18/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/10/2023*

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

On 7/19/2023, the battery operated carbon monoxide alarms in the kitchen and basement were not labeled with the date of installation as per the Care Facility Carbon Monoxide Alarm Standards Act. Per Staff Member A, the batteries have not been changed within the past year.

On 7/19/2023, the home did not have a sign at each entrance stating "Smoking Permitted in Designated Areas Only" or "No Smoking" per The Clean Indoor Air Act. The home does permit smoking in designated areas.

Plan of Correction ***Accept [redacted] - 08/01/2023)***

Batteries in the carbon monoxide alarms were replaced and labeled on 8/1/2023. Maintenance Director to check and replace batteries according to regulations. Monthly check of batteries to be performed by Maintenance Director starting 8/1/2023. "Smoking in Designated Areas Only" signs to be put up at each entrance on 8/3/2023. Maintenance Director to check that all signs in place every month starting on 9/1/2023. Education and training on why we need the signs and who to report to if signs are no longer visible will be held at the all staff meeting on 8/8/2023.

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

Implemented [redacted] - 09/15/2023)

42b - Abuse

2. 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 #3 requires total physical assistance for personal hygiene surrounding the resident's incontinence. Resident #3 has been observed to have bowel on [redacted] body and bedding on 5/24/2023. Per staff and resident interview, Resident #3 refuses personal care, resulting in the resident remaining in soiled items.

Plan of Correction ***Directed [redacted] - 08/01/2023)***

The local Area of Aging office was contacted by the Director of Wellness to come out and do a level of care assessment on the resident to determine if the resident needs skilled placement on 7/20/2023. Resident is also on hospice, and they have advised the family on moving their loved one to a skilled facility. We are currently still awaiting a date for the AAA assessment. Resident was educated on the need to allow the staff to perform care on [redacted] as [redacted] is unable to perform the actions [redacted] [redacted] did voice understanding and stated that [redacted] will try and allow the staff to help [redacted] with [redacted] care as much as possible. Family was also notified and educated on the importance of allowing the staff to perform [redacted] care. Full staff education and training on how to deal with refusals and whom to report the refusals will be held at the staff meeting on 8/8/2023.

(Directed)

- *Resident was educated on the need to allow the staff to perform care on [redacted] as [redacted] is unable to perform the actions [redacted] on 7/28/2023 by the Administrator, DOW, ADOW and a social worker from hospice.*

42b - Abuse (continued)

- *Full staff education and training on how to deal with refusals and whom to report the refusals will be held at the staff meeting on 8/8/2023 by the Administrator and/or designee.*

Directed Completion Date: *08/08/2023*

Implemented [redacted] - 09/15/2023)

82c - Locking Poisonous Materials

3. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 7/19/2023 at approximately 10:00 AM, a 16.7oz container of Lysol wipes with a manufacturer's label indicating "call poison control center or doctor for treatment advice" as well as a 7oz aerosol can of Concentrated Room Deodorant with a manufacturer's label indicating "in the event of swallowing, contact a physician or poison control center" were unlocked, unattended, and accessible to residents in the Secured Dementia Care Unit's shared shower room in the F-Hall . The residents in the Secured Dementia Care Unit are not considered to be capable of recognizing and using poisons safely

Plan of Correction ***Directed ([redacted] - 08/01/2023)***

Doors to F hall shower to be locked at all times. Dementia Care Director and Memory Care Coordinator to ensure it is locked every day. Staff education and training on the importance of locked doors and poisonous materials to be done at the all staff meeting being held on 8/8/2023.

(Directed)

- *Staff education and training on the importance of locked doors and poisonous materials to be done at the all staff meeting being held on 8/8/2023 by the Administrator and/or designee.*
- *Dementia Care Director and/or Memory Care Coordinator will complete daily walkthroughs of the SDCU beginning 8/8/2023 to ensure the doors to the F hall shower room remain locked.*

Directed Completion Date: *08/08/2023*

Not Implemented [redacted] - 09/15/2023)

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

On 7/19/2023 at approximately 10:50 AM, the interior of the kitchen's ice machine was observed to have mold.

Plan of Correction ***Directed [redacted] - 08/01/2023)***

Mold was cleaned from the ice machine on 7/19/2023. Director of Dietary to ensure ice machine is mold-free weekly starting 7/31. Training to be provided to staff on proper daily cleaning of all surfaces and ice machines at the all staff meeting on 8/8/2023.

85a - Sanitary Conditions (continued)

(Directed)

- *Training to be provided to staff on proper daily cleaning of all surfaces and ice machines at the all staff meeting on 8/8/2023 by the Administrator and/or Designee.*
- *If during the weekly ice machine check mold is present, the ice machine will be emptied, cleaned and sanitized properly.*

Directed Completion Date: *08/08/2023*

Implemented ([redacted] - 09/15/2023)

86b - Bathroom

5. 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

On 7/19/2023, the exhaust fan in resident bathroom E8 was inoperable and there is no outside window in the bathroom.

On 7/19/2023, resident bathroom D10 was observed to be covered in a thick layer of dust with potential to prevent proper ventilation.

Plan of Correction ***Accept [redacted] - 08/01/2023)***

Exhaust fan in E8 was repaired and in working order on 7/20/2023. Fan in D10 was cleared of all dust on 7/20/2023. Maintenance Director will maintain and clean all fans as needed and weekly check will be performed to ensure all fans are working and cleaned properly starting on 8/1/2023. Education and training on cleaning and reporting issues with exhaust fans will be held at the staff meeting on 8/8/2023

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

Not Implemented [redacted] - 09/15/2023)

92 - Windows

6. Requirements

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

Description of Violation

On 7/19/2023, the screen to the door in the laundry room was in use and observed to have holes and tears.

Plan of Correction ***Directed ([redacted] - 08/01/2023)***

Screen door in laundry room was cleaned and repaired by Maintenance Director on 7/31/2023. Checks to be performed on door by Housekeeping Director and Maintenance Director weekly starting 8/1/2023. Training on proper upkeep of windows and doors. and how to report issues through our TELS service to be done at the staff meeting being held on 8/8/2023

92 - Windows (continued)

(Directed)

- *An initial audit of all screen windows and doors will be completed by the Administrator or designee by 8/14/2023.*
- *Training on proper upkeep of windows and doors. and how to report issues through our TELS service to be done at the staff meeting being held on 8/8/2023 by the Administrator or designee.*

Directed Completion Date: *08/14/2023*

Implemented [redacted] - 09/15/2023)

101j6 - Mirror

7. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
6. A mirror.

Description of Violation

On 7/19/2023, resident room A3 did not have a mirror.

Plan of Correction ***Directed [redacted] - 08/01/2023)***

The mirror in A6 was replaced on 7/20/2023. Maintenance Director to ensure that all rooms have everything required per state requirements every month. Education and training to be provided to all staff about what needs to be in each room and the proper way to report missing items at the staff meeting on 8/8/2023

(Directed)

- *An initial audit will be completed by the Administrator or designee to ensure each resident rooms contains a mirror by 8/14/2023. The Maintenance Director will ensure all rooms contain mirrors monthly following the initial audit.*
- *Education and training to be provided to all staff about what needs to be in each room and the proper way to report missing items at the staff meeting on 8/8/2023 by the Administrator or designee.*

Directed Completion Date: *08/14/2023*

Implemented [redacted] - 09/15/2023)

101j7 - Lighting/Operable Lamp

8. Requirements

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

Description of Violation

On 7/19/2023, Resident's #1 and #2 did not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept [redacted] - 08/01/2023)***

Light in Resident 1 and 2s room was moved closer to the bed per regualtion on 7/19/2023. All staff to check that all bedside lights are at the proper distance for easy access by all residents. Director of Wellness and Memory Care Coordinator to perform weekly checks of rooms to ensure that bedside lamps are easily accessible by all residents starting 8/1/2023. Education to provided to all staff at the staff meeting being held on 8/8/2023.

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

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

Implemented [redacted] - 09/15/2023)

102i - Soap Dispenser

9. Requirements

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

Description of Violation

On 7/19/2023, there was an unlabeled used bar of soap in the shared F-Hall shower room.

Plan of Correction ***Directed [redacted] - 08/01/2023)***

Unlabeled bar of soap was removed and disposed of. All soap in community bathrooms will be labeled properly. Checks to be performed weekly by Dementia Care Director and Memory Care Coordinator. Staff training on proper storage and labeling of bar soap in community bathrooms to be performed at the all staff meeting on 8/8/2023.

(Directed)

- *An audit will be completed in each shared bathroom by the Administrator or designee no later than 8/14/2023 to ensure bars of soap are labeled properly. Following the initial audit, weekly checks will be completed by the Administrator or designee in all shared bathrooms to ensure bars of soap remain labeled.*
- *Staff training on proper storage and labeling of bar soap in shared bathrooms to be performed at the all staff meeting on 8/8/2023 by the Administrator or designee.*

Directed Completion Date: *08/14/2023*

Not Implemented [redacted] - 09/15/2023)

107c - Food/Water 3 Day Supply

10. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 7/19/2023, the home served 115 residents, requiring 345 gallons of emergency drinking water. However, the home had only 300 gallons. The home does not have a contract with a local bottled water supplier.

Plan of Correction ***Directed [redacted] - 08/01/2023)***

45 gallons of water was purchased and stored with other emergency drinking supply. Maintenance Director to ensure that there is enough water per requirements and according to census at the end of every month.

(Directed)

- *On 7/20/2023, the Maintenance Assistance purchased 45 additional gallons of water and stored it with the rest of the emergency water supply.*
- *Monthly Audits will be completed beginning in August of 2023 to ensure emergency water is available per the current census by the Maintenance Director.*
- *Education will be provided to the Maintenance Director by the Administrator or Designee no later than*

107c - Food/Water 3 Day Supply (continued)

8/14/2023 on the requirements for emergency water supply.

Directed Completion Date: *08/14/2023*

Implemented [redacted] - 09/15/2023)

107d - Procedure Emergency Management Agency Submission

11. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been reviewed, updated or submitted to the local emergency management agency since 3/21/2022.

Plan of Correction ***Directed [redacted] - 08/01/2023)***

Emergency policies and procedures were sent to emergency management agency of 7/20/2023. Confirmation of receival and acceptance of procedures was sent back to us on 7/25/2023. Executive director to ensure that letter gets sent every year starting 3/1/2024.

(Directed)

- *Emergency policies and procedures were sent to emergency management agency of 7/20/2023 by the ADOW.*
- *The Executive Director or designee will add a tickler to a calendar to ensure the emergency procedures are reviewed and sent to local emergency management agency annually.*

Directed Completion Date: *08/01/2023*

Implemented [redacted] - 09/15/2023)

183b - Meds and Syringes Locked

12. Requirements

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

Description of Violation

On 7/19/2023 at approximately 10:20 AM, a 1.76oz container of Vick's Vapor Rub and a bottle of Safeway Loperamide 2mg tablets were in Resident #4's bathroom. Resident #4 cannot self-administer medications per Resident #4's Resident Assessment and Support Plan, dated 3/30/2023, and DME, dated 2/8/2023.

On 7/19/2023 at approximately 11:30 AM, a 1.76oz container of Vick's Vapor Rub was observed on Resident #3's bedroom nightstand. Resident #3 cannot self-administer medications per Resident #3's Resident Assessment and Support Plan, dated 11/15/2022 and DME, dated 11/8/2022.

Plan of Correction ***Directed [redacted] - 08/01/2023)***

Medications were removed from residents room and explanation given to residents and POAs on why the

183b - Meds and Syringes Locked (continued)

medications cannot be in the room without a self-administer order. Director of wellness to perform room checks of all residents to ensure no medications are in residents room without self-administer order every two weeks starting the week of 8/1/2023. Education and training on proper storage of medications and how to obtain self-administer order to be performed at all staff meeting on 8/8/2023.

(Directed)

- *Medications were removed from the resident's room on 7/19/2023 by the DOW.*
- *Education and training on proper storage of medications and how to obtain self-administer order to be performed at all staff meeting on 8/8/2023 by the Administrator or designee.*

Directed Completion Date: *08/08/2023*

Not Implemented [redacted] - 09/15/2023)

227d - Support Plan Medical/Dental

13. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #3 refuses personal care for incontinence. Resident #3's RASP, dated [redacted]/2022, does not include the resident's refusal of personal care or the home's plan to meet this service need.

Plan of Correction ***Directed ([redacted] - 08/01/2023)***

RASP for resident #3 was updated to include the frequent refusals. All other RASPs were checked and updated if necessary. Monthly audits on every resident to be performed by the Assistant Director of Wellness and the Memory Care Coordinator starting on 8/1/2023. Training and education on what is supposed to be in RASPs and when updating is necessary to be held at the staff meeting on 8/8/2023.

(Directed)

- *RASP for resident #3 was updated to include the frequent refusals on 7/28/2023 by the ADOW.*
- *An initial audit of all resident RASP's was completed by the ADOW on 8/1/2023.*
- *Training and education on what is supposed to be in RASPs and when updating is necessary to be held at the staff meeting on 8/8/2023 by the Administrator or designee.*

Directed Completion Date: *08/08/2023*

Not Implemented [redacted] - 09/15/2023)

233c - Key-Locking Devices

14. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

233c - Key-Locking Devices *(continued)*

Description of Violation

On 7/19/2023, the directions for operating the home's locking mechanism are not conspicuously posted near the Secure Dementia Care Unit (SDCU) exit from the enclosed courtyard.

Plan of Correction ***Accept (- 08/01/2023)***

Directions for exiting the SDCU and the courtyard were placed in a conspicuous manner near the locking devices on 7/20/2023. Memory Care Coordinator and Dementia Program Director will check all devices weekly to ensure directions are placed at each one starting 8/1/2023. Training and education on placement and necessity of directions will be held at the all staff meeting on 8/8/2023.

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

Not Implemented (- 09/15/2023)

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

Facility Information

Name: *AUTUMN HOUSE EAST* **License #:** *33823* **License Expiration:**

Address: *2618 E. Market Street, York, PA 17402*

County: *YORK* **Region:** *CENTRAL*

Administrator

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

Legal Entity

Name: *2618 E. Market Street Operating Company, LLC*

Address: [redacted]

Phone: **Email:** [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *04/27/2004* **Issued By:** *Department of Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *213* **Waking Staff:** *160*

Inspection Information

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

Reason: *Interim* **Exit Conference Date:** *08/25/2023*

Inspection Dates and Department Representative

08/25/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: **Residents Served:** *127*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Laurel Court* **Capacity:** *32* **Residents Served:** *29*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *127*

Diagnosed with Mental Illness: *35*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *86*

Have Physical Disability: *2*

Inspections / Reviews

08/25/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/08/2023*

09/05/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/13/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/12/2023*

09/08/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/13/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/14/2023*

09/18/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *09/13/2023*

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

On 8/25/2023, the battery-operated carbon monoxide alarms in the kitchen and basement were labeled with the date of installation of 10/19/2017. Per the Administrator of the home, the batteries have not been changed within the last year per the Care Facility Carbon Monoxide Alarm Standards Act.

Plan of Correction ***Accept [redacted] - 09/05/2023)***

Carbon Monoxide detector batteries were replaced and dated by Maintenance Director on 8/30/2023. Batteries will be replaced and dated yearly by maintenance staff. Audits to be done by Administrator every six months to maintain proper replacement and dating of all batteries. Maintenance Director and Administrator to have staff meeting to educate staff on Compliance with all Laws on 9/13/2023

Licensee's Proposed Overall Completion Date: *09/13/2023*

Implemented ([redacted] - 09/15/2023)

81b - Resident Personal Equipment

2. Requirements

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

Description of Violation

On 8/25/2023, Resident #1's bed contained an unsecured enabler with an uncovered open area measuring 6 1/2 inches high by 11 1/2 inches wide. The enabler's opening and lack of securement to the bed creates a potential hazard for entrapment.

On 8/25/2023, Resident #2's bed contained an uncovered enabler with an open area measuring 17 inches high by 11 inches wide. The enabler's opening creates a potential hazard for entrapment.

Plan of Correction ***Accept ([redacted] - 09/05/2023)***

Enabler for Resident #1 was secured properly to the bed by Maintenance Director on 8/25/2023 and covered properly. Enabler bar for Resident #2 was covered properly by the Dementia Care Programmer on 8/25/2023. Weekly audits to check all enabler bar placement, secureness, and coverage to be performed by Director of Wellness beginning on 9/4/2023. Administrator to perform follow-up audits monthly beginning on 10/1/2023. Education on enabler bar regulations (measurements, proper securing, and covering) to be done by the administrator at the all staff meeting being held on 9/13/2023.

Licensee's Proposed Overall Completion Date: *09/13/2023*

Not Implemented [redacted] - 09/15/2023)

81b - Resident Personal Equipment *(continued)*

82a - Poisonous Materials

3. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 8/25/2023 at 10:35 AM, a clear 26oz spray bottle with unidentified blue liquid was observed on the bottom food prep shelf in the home's main kitchen. According to the kitchen staff, the liquid substance contained in the spray bottle was US Chemical Sani-tabs. The original product labeling at the home says "if swallowed, call a poison control center". A manufacturer's label was not on the clear spray bottle.

Plan of Correction ***Accept [redacted] - 09/05/2023)***

Spray bottle was labeled with appropriate information by Dietary Manager on 8/25/23. Daily audits of all chemicals and cleaning substances to ensure proper labeling to be done by the Dietary Manager or the Cook on duty that day starting 8/28/23. Follow-up audits to be performed weekly by Administrator to ensure proper labeling as well. Education on proper labeling and storage of hazardous materials to be performed by the Administrator at the all staff meeting being held on 9/13/23.

Licensee's Proposed Overall Completion Date: *09/13/2023*

Not Implemented ([redacted] - 09/15/2023)

82b - Poisonous Material Storage

4. Requirements

2600.
82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation

On 8/25/2023 at 10:35 AM, a bottle of Purell Food Service Surface Cleaner Sanitizer was observed on the food preparation table directly next to four bowls of covered cookies in the main kitchen.

Plan of Correction ***Accept [redacted] 09/05/2023)***

Bottle of sanitizer was removed from the food preparation table on 8/25/28 by the cook on duty that day. Audits of the kitchen to be performed daily by the Dietary Manager and/or Cook on duty to ensure that all hazardous materials are stored properly starting 8/28/23. Administrator to perform weekly follow up audits of the kitchen beginning on 9/4/23. Education on proper storage and potential dangers of leaving hazardous materials near foods to be done by the administrator at the all staff meeting being held on 9/13/23.

Licensee's Proposed Overall Completion Date: *09/13/2023*

Not Implemented [redacted] - 09/15/2023)

82c - Locking Poisonous Materials

5. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

82c - Locking Poisonous Materials *(continued)*

Description of Violation

On 8/25/2023 at 9:55 AM, the following items were unlocked, unattended, and accessible to residents in the Secured Dementia Care Unit's shared shower room in the F-Hall. The residents in the Secured Dementia Care Unit are not considered to be capable of recognizing and using poisons safely:

- *4oz container of Remedyl Skin Repair Cream with manufacturer's label indicating "if swallowed, contact poison control right away"*
- *3.5oz Peri Guard Ointment with manufacturer's label indicating "if swallowed, contact poison control right away"*
- *7oz aerosol can of Concentrated Room Deodorant with a manufacturer's label indicating "in the event of swallowing, contact a physician or poison control center"*

Plan of Correction ***Accept [redacted] - 09/05/2023)***

Doorway to the shared shower room in F hall was locked by administrator on 8/25/2023 and sign placed on door stating that door must be locked at all times on the same day. Weekly audits of all doors that need to be locked at all times to be performed by Director of Wellness, Assistant Director of Wellness, and/or Dementia Care Programmer starting on 9/4/2023. Administrator to perform monthly follow up audits beginning on 10/1/2023. Education on proper storage of poisonous materials and keeping doors locked to be provided by Administrator at the all staff meeting on 9/13/2023.

Licensee's Proposed Overall Completion Date: *09/13/2023*

Not Implemented [redacted] - 09/15/2023)

86b - Bathroom

6. 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

On 8/25/2023, the shared bathroom hallway A was observed to have a window that is inoperable, and there is no exhaust fan for ventilation.

Plan of Correction ***Accept [redacted] - 09/05/2023)***

Window in the A hall bathroom was repaired by Maintenance Director on 8/30/23 and is operational. Maintenance Director to perform weekly audits on all bathrooms to ensure proper ventilation starting on 9/11/2023. Administrator to perform follow up audits monthly beginning on 10/1/2023. Education on operating windows and reporting any issues with windows to be performed at all staff meeting by Administrator and Maintenance Director on 9/13/2023.

Licensee's Proposed Overall Completion Date: *09/13/2023*

Not Implemented [redacted] - 09/15/2023)

88a - Surfaces

7. Requirements

88a - Surfaces *(continued)*

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 8/25/2023, the interior frame of the home's exit at the end of hallway D was observed to be in disrepair with pieces of drywall lifting away from the wall. Per the home's Administrator, the exit doors were replaced on 4/25/2023 which is when the damage to the interior frame occurred.

Plan of Correction ***Accept [redacted] - 09/05/2023)***

Interior frame of the exit door by D hall was repaired by Maintenance Director on 8/30/2023. Weekly audits to be done by maintenance director to ensure that building is free of hazards and in good repair beginning on 9/4/23. Administrator to perform monthly inspections of building starting on 10/1/23.

Licensee's Proposed Overall Completion Date: *09/04/2023*

Not Implemented [redacted] - 09/15/2023)

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

8. Requirements

2600.
102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

On 8/25/2023, the first-floor shared shower room in hallway C did not have a slip-resistant surface.

Plan of Correction ***Accept [redacted] - 09/08/2023)***

Non-slip mats were purchased by Assistant Director of Wellness and will be placed in all shower rooms upon arrival. Director of Wellness to perform weekly audits of shower rooms to ensure mats are placed properly starting after arrival of mats. Administrator will perform monthly audits of shower rooms beginning 10/1/2023. Education on necessity. placement, cleaning and reporting missing or damaged mats will be done at the all staff meeting on 9/13/2023 by Administrator.

Licensee's Proposed Overall Completion Date: *09/13/2023*

Not Implemented [redacted] - 09/15/2023)

102i - Soap Dispenser

9. Requirements

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

Description of Violation

On 8/25/2023 at approximately 9:45 AM, the shared bathroom "F8" contained an unlabeled used bar of soap on the bathroom sink and a second unlabeled used bar of soap sitting in a Styrofoam cup in the shower.

102i - Soap Dispenser (continued)

On 8/25/2023 at approximately 10:10 AM, the shared shower room in hallway C contained an unlabeled used bar of soap.

Plan of Correction ***Accept [redacted] - 09/08/2023)***

Unlabeled bars of soap were removed from the shared bathroom in F8 and the shower room in C hallway on 8/25/2023 by Director of Wellness. Weekly audits of all shared bathrooms and common shower rooms looking for unlabeled bars of soap to be performed by Director of Wellness beginning on 9/4/2023. Administrator will perform monthly audits of all shower rooms beginning on 10/1/2023. Education on proper labeling and storage of personal hygiene products for residents to be provided by administrator at the all staff meeting on 9/13/23.

Licensee's Proposed Overall Completion Date: *09/13/2023*

Not Implemented ([redacted] - 09/15/2023)

103c - Food Protected

10. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 8/25/2023 at approximately 10:25 AM, two bags of frozen foods were observed open and exposed to potential contamination in the deep freezer located in the home's kitchen storage area. One bag was a 64oz frozen bag of whole green beans that was previously opened and tied close with no identified date opened. The bag had a large hole next to the knot that tied the bag closed. The second bag was a 64oz frozen bag of blended peppers which was wrapped in cellophane; however, the frozen peppers were sitting freely in the cellophane which was not completely sealed.

Plan of Correction ***Accept [redacted] - 09/05/2023)***

Opened and unlabeled bags of food were disposed of by cook on 8/25/23. Daily audits of all kitchen storage areas to be done by Dietary Manager and/or cook on duty that day to ensure all food items are protected from contamination starting on 8/28/23. Follow-up weekly audits to be done by the administrator to ensure the same starting on 9/4/23. Education on proper storage, and labeling of food items to be done by the administrator at the all staff meeting being held on 9/13/23.

Licensee's Proposed Overall Completion Date: *10/13/2023*

Not Implemented [redacted] - 09/15/2023)

107c - Food/Water 3 Day Supply

11. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 8/25/2023, the home served 125 residents, requiring 375 gallons of emergency drinking water. However, the home had only 348 gallons. The home does not have a contract with a local bottled water supplier.

Plan of Correction ***Accept [redacted] - 09/08/2023)***

On 8/29/2024, seven cases of water, for a total of 42 more gallons, were ordered through [redacted] Food Service by

107c - Food/Water 3 Day Supply (continued)

Dietary manager. Water placed in warehouse with the rest of the emergency supply. Maintenance Director to ensure that supply of water is maintained via monthly audits beginning on 9/1. Emergency water count will be reviewed upon every new admission to maintain compliance by Maintenance Director beginning on 10/1/23. Administrator to perform follow-up audits starting on 9/8.

Licensee's Proposed Overall Completion Date: *09/13/2023*

Implemented ([redacted] - 09/15/2023)

130e - Hearing Impairment

12. Requirements

2600.
130.e. If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

Description of Violation

Resident #3 is unable to hear the fire alarm system. The home does not have a signaling device, approved by a fire safety expert and tested to ensure that Resident #3 is alerted in the event of a fire when the resident is in [redacted] bedroom.

Plan of Correction ***Accept ([redacted] - 09/08/2023)***

Maintenance Director and fire alarm security company are getting a wireless bed shaker for Resident #3s room that will be inspected by a fire safety expert and integrated into facility fire alarm system. Bed shaker to be purchased on 9/8/2023 and installed upon arrival. Maintenance Director to perform monthly checks on the device during fire drills starting the month of September. RASP to be updated to include use of device by Assistant Director of Wellness on 9/8/2023. Education on what the device is, the necessity of the device, and that the staff cannot alert resident in lieu of device and how it works to provided to resident and family by Administrator upon arrival. Same education also to be provided to the staff at the staff meeting on 9/13/23.

Licensee's Proposed Overall Completion Date: *09/13/2023*

Implemented [redacted] - 09/15/2023)

144c1 - Smoking Area Guidelines

13. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home permits smoking in designated areas outside of the home and the home's policy states, "smoking is prohibited in all interior areas". Per the home's resident progress notes, Resident #4 was observed smoking in the resident's bedroom on 8/6/2023.

144c1 - Smoking Area Guidelines (continued)

Plan of Correction ***Accept (- 09/08/2023)***

Resident and family have been re-educated on the smoking policies of the facility on 8/28/23. Family will no longer provide cigarettes to the resident as they will only be given to the administrator or Director of Wellness. Cigarettes will be stored in a locked med room and can only be given to the resident by designated staff. Resident will have access to cigarettes upon request. Facility is currently working on finding placement to a skilled nursing facility for the resident. Education to be provided to the staff on resident and employee smoking policy and how to distribute cigarettes to the resident. This education will be held at the staff meeting being held by the administrator on 9/13/23.

Licensee's Proposed Overall Completion Date: *09/13/2023*

Implemented - 09/15/2023)

183b - Meds and Syringes Locked

14. Requirements

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

Description of Violation

On 8/25/2023 at approximately 10:05 AM, a plastic medication cup containing 9 pills was observed on a table tray in Resident #5's bedroom. Resident #5 cannot self-administer medications per Resident Assessment and Support plan (RASP), dated /2022, and medical evaluation, dated 2022.

On 8/25/2023 at approximately 10:15 AM, 2 Fluticasone Propionate Nasal Spray bottles and a prescription bottle of Sodium Chloride was observed on a table in Resident #6's bedroom. Resident #6 cannot self-administer medications per RASP, dated /2023, and medical evaluation, dated 2023.

On 8/25/2023 at approximately 10:30 AM, a 1.76oz container of Vick's Vapor Rub was observed on Resident #4's bedroom nightstand. Resident #4 cannot self-administer medications per RASP, dated 2022, and medical evaluation, dated /2022.

Plan of Correction ***Accept (09/08/2023)***

All medications were removed from Residents 4, 5, 6, and 7s room on 8/25/2023 and stored in the medication cart. Initial room sweep audit to ensure no residents have medications in rooms without a self-administer order to be performed by Director of Wellness on 9/11/2023. Director of Wellness and Assistant Director of Wellness to perform weekly audits of resident's rooms and med carts to ensure no medications are in the room and that all medications are being used only for the resident they are prescribed to starting 9/11/2023. Administrator to perform monthly follow up audits beginning 10/1/2023. Education on proper process for medication administration which includes watching residents take their medication, not leaving medications unattended in resident's rooms that do not have a self-administer order, and for staff to look for and alert nursing management on any medications found in resident's rooms at the staff meeting on 9/13/23. Education to be provided by Administrator.

Licensee's Proposed Overall Completion Date: *09/13/2023*

Not Implemented (- 09/15/2023)

186b - Medication Used by Resident

15. Requirements

2600.
186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

On 8/25/2023 at approximately 10:15 AM, Resident #6 was observed to have a bottle of Sodium Chloride in the resident's bedroom. Resident #6 confirmed staff administer this medication to [redacted] However, the pharmacy label on the bottle states the treatment is prescribed for Resident #7. The information on the pharmacy label was crossed out in black marker including the prescription number and patient identifying information.

Plan of Correction ***Accept ([redacted] - 09/08/2023)***

All medications were removed from Resident 6s room on 8/25/2023 and stored in the medication cart. Initial audit of all medication carts to ensure medications are stored and labeled for the correct residents to be performed by Director of Wellness on 9/7/2023. Director of Wellness and Assistant Director of Wellness to perform monthly audits of residents' rooms and med carts to ensure no medications are in the room and that all medications are being used only for the resident they are prescribed to starting 9/11/2023. Administrator to perform monthly follow up audits to check pharmacy labels and orders beginning 10/1/2023. Education on proper usage, storage of medications and how to check the pharmacy label to ensure medications are given to the proper resident to be done by the administrator at the staff meeting on 9/13/2023.

Licensee's Proposed Overall Completion Date: *09/13/2023*

Not Implemented ([redacted] - 09/15/2023)

227d - Support Plan Medical/Dental

16. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment and support plan for Resident #1, dated [redacted]/2022, does not include the resident's use of an enabler when positioned in bed which was in use on 8/25/2023.

The assessment and support plan for Resident #3, dated 3/3/2023, indicates the resident is hard of hearing and does not have hearing aids. However, Resident #3 wears a hearing aid in [redacted] right ear. Resident #3's communicative methods include writing messages on a white board and reading lips which are not identified in the resident's RASP. Lastly, the assessment and support to evacuate safely during an emergency includes oral and physical assistance. However, per staff interviews, staff physically alert the resident to an emergency as the resident cannot hear the fire alarm.

Plan of Correction ***Accept [redacted] - 09/05/2023)***

Assistant Director of Wellness updated RASPs for residents #1 and #3. on 8/28/2023. Administrator and ADOW to perform audits of all RASPs monthly to ensure all needs are documented starting 9/11/2023. Education to be

227d - Support Plan Medical/Dental (continued)

provided on what needs to be documented in the RASPs and how to enter into RASPs by the administrator at the all staff meeting on 9/13/2023.

Licensee's Proposed Overall Completion Date: *09/13/2023*

Not Implemented (- 09/15/2023)

233c - Key-Locking Devices

17. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 8/25/2023, the directions for operating the home's locking mechanism were not conspicuously posted near the Secure Dementia Care Unit (SDCU) exit from the enclosed courtyard.

Plan of Correction ***Accept - 09/05/2023)***

Directions for operating the exit from the courtyard in the SDCU were posted on the device on 9/1/2023. Dementia Care Programmer and Memory Care Coordinator to perform weekly audits on all locked locations to ensure placement of all codes to operate door starting on 9/11/2023. Administrator to perform follow up audits monthly starting on 10/1 to ensure the same. Education to be provided to all staff on importance of codes being posted and proper reporting if codes are not visible during all staff meeting on 9/13/2023

Licensee's Proposed Overall Completion Date: *09/01/2023*

Not Implemented - 09/15/2023)