





CERTIFIED MAIL – RETURN RECEIPT  
REQUESTED MAILING DATE: DECEMBER 8, 2023

[REDACTED], Owner  
Sterling Home LLC  
[REDACTED]

RE: Sterling Home  
1318 Arch Street  
McKeesport, Pennsylvania 15132  
License/COC #: 452692

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on August 10, 2023, August 25, 2023, and September 21, 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), mistreatment or abuse of residents, failure to submit an acceptable plan to correct noncompliance items and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby issues you a **SECOND PROVISIONAL** license to operate the above facility. A **SECOND PROVISIONAL** license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your **SECOND PROVISIONAL** license is enclosed and is valid from December 8, 2023 to June 8, 2024.

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

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
<b>Section:</b>					
17	II	32	\$5	\$160	5 calendar days from mailing date of this letter
42(b)	II	32	\$5	\$160	5 calendar days from mailing date of this letter
63(a)	II	32	\$5	\$160	5 calendar days from mailing date of this letter
65(d)	II	32	\$5	\$160	5 calendar days from mailing date of this letter
85(b)	II	32	\$5	\$160	5 calendar days from mailing date of this letter
89(b)	II	32	\$5	\$160	5 calendar days from mailing date of this letter
103(f)	II	32	\$5	\$160	5 calendar days from mailing date of this letter
144(c)(2)	II	32	\$5	\$160	5 calendar days from mailing date of this letter
225(c)	II	32	\$5	\$160	5 calendar days from mailing date of this letter
227(a)	II	32	\$5	\$160	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.



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

**Facility Information**

Name: *STERLING HOME* License #: *45269* License Expiration: *11/09/2023*  
Address: *1318 ARCH STREET, MCKEESPORT, PA 15132*  
County: *ALLEGHENY* Region: *WESTERN*

**Administrator**

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

**Legal Entity**

Name: *STERLING HOME LLC*  
Address: [REDACTED]  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *01/30/2023* Issued By: *L&I*  
Type: *C-2 LP* Date: *08/22/2001* Issued By: *L&I*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *32* Waking Staff: *24*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal, Complaint* Exit Conference Date: *08/25/2023*

**Inspection Dates and Department Representative**

08/10/2023 - On-Site: [REDACTED]  
08/25/2023 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *42* Residents Served: *31*

**Secured Dementia Care Unit**

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

**Hospice**

Current Residents: *1*

**Number of Residents Who:**

Receive Supplemental Security Income: *28* Are 60 Years of Age or Older: *23*  
Diagnosed with Mental Illness: *18* Diagnosed with Intellectual Disability: *2*  
Have Mobility Need: *1* Have Physical Disability: *0*

## Inspections / Reviews

08/10/2023 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *09/22/2023*

09/26/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *10/31/2023*

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *10/02/2023*

10/06/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *10/31/2023*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *10/31/2023*

11/08/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *10/31/2023*

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

3c - Post Current License

1. Requirements

2600.

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

Description of Violation

On 8/10/23, the following license inspection summaries were not posted in a public and conspicuous place in the home:

- license inspection summary, dated 3/8/23
- license inspection summary, dated 10/19/22, et. al.
- license inspection summary, dated 8/23/22, et. al.

On 8/10/23, the home's current Provisional license, dated 5/9/23-11/9/23, was not posted in a public and conspicuous place in the home. The license was posted behind a dresser in the hallway.

Plan of Correction

Accept (█ - 10/03/2023)

1. Reports posted on 8/10/2023. License was picked up and posted on the dresser on site. License is now nailed to the wall in the lobby.

2. All important signage is now secured to the wall. Once monthly a physical site review of the entire facility will be completed using created checklist; to guarantee all important signage is posted in a conspicuous area. Physical site review started on 9/1/2023.

Administrator will complete physical site checklist monthly to verify all important signage is posted in a conspicuous area. All documentation will be held on file in Administration office.

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

Not Implemented (█ - 11/08/2023)

17 - Record Confidentiality

2. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 8/10/23 at 2:45 PM, the 1st floor office was unlocked, open and unattended. Numerous resident medical documents were present in the unlocked office, to include the following resident medical evaluations:

- Resident #1's medical evaluation, dated █/█/23
- Resident #2's medical evaluation, dated █/█/22

17 - Record Confidentiality (continued)

- Resident #3's medical evaluation, dated [REDACTED]/22
- Resident #4's medical evaluation, dated [REDACTED]/23

REPEAT VIOLATION: 8/23/2022, et. al.

Plan of Correction

Directed [REDACTED] - 10/03/2023)

1. All medical evaluations were placed back inside resident charts and put away on site, 8/10/2023.

2. Meeting held with assistant administrator and nursing supervisor on 8/11/2023, re-educating them on HIPPA regulations and resident confidentiality. They were instructed to lock the door every time they leave the office. All Staff meeting held on 09/08/2023 to educate staff members to close the office door if they see no one is present to avoid any HIPPA violations for residents. Documentation of meeting will be kept in administration office.

3. Administrator posted a sign in the office next to the door to remind staff members to close the door behind them at all times when leaving. Assistant administrator was instructed to keep the office door closed at all times on 8/10/2023. During hourly rounds which have been implemented on 8/10/2023, staff members and Administrator will check the office door to make sure it is closed at all times

DIRECTED: Beginning on 10/9/23: The administrator/shift supervisor shall inspect the entire home at least daily to ensure all resident information is kept in an area that is locked. [REDACTED] 10/3/23

Directed Completion Date: 10/09/2023

Not Implemented [REDACTED] - 11/08/2023)

25b - Contract Signatures

3. 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

Resident #5's resident-home contract, dated [REDACTED]/23, is not signed by resident #5 or the administrator.

Plan of Correction

Accept [REDACTED] - 10/03/2023)

1. Contract was signed by Resident #5 and Administrator on 8/10/2023.

2. All resident contracts were reviewed by Administrator on 8/11/2023 to verify signatures were recorded on all resident contracts. Meeting held with assistant administrator on 9/1/2023 to go over new document and what needs to be in a resident file during admission process.

3. Policy in place, implemented on 8/10/2023 to sign off on new resident file document created on 9/1/2023 to ensure contract is completed and supporting documentation is completed on or before date of admissions. Resident checklist will be signed by administrator or assistant administrator on day of admission. All documentation will be placed in resident file. All resident contracts will be reviewed quarterly by Administrator starting 9/1/2023 and signed off in resident chart once completed. Documentation of review will be placed in administrative office.

25b - Contract Signatures (*continued*)

Licensee's Proposed Overall Completion Date: 09/29/2023

Not Implemented [REDACTED] - 11/08/2023)

## 41e - Signed Statement

## 4. Requirements

2600.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

## Description of Violation

*Resident #5's record does not include a statement signed by resident #5 acknowledging receipt of a copy of the resident rights and complaint procedures.*

## Plan of Correction

Accept [REDACTED] - 10/03/2023)

1. Resident rights document was signed by Resident #5 and on 8/10/2023.

2. All resident contracts were reviewed by Administrator on 8/11/2023 to verify signatures were recorded on all resident contracts. Meeting held with assistant administrator on 9/1/2023 to go over new document and what needs to be in a resident file during admission process.

3. Policy in place, implemented on 8/10/2023 to sign off on new resident file document created on 9/1/2023 to ensure contract is completed and supporting documentation is completed on or before date of admissions. Resident checklist will be signed by administrator or assistant administrator on day of admission. All documentation will be placed in resident file. All resident contracts will be reviewed quarterly by Administrator starting 9/1/2023 and signed off in resident chart once completed. Documentation of review will be placed in administrative office.

Licensee's Proposed Overall Completion Date: 09/29/2023

Implemented [REDACTED] - 11/08/2023)

## 42b - Abuse

## 5. 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

*On 8/10/23 at approximately 9:30 AM, resident #6 overturned the chair resident #1 was sitting in in the designated smoking area. As a result, resident #1 fell and struck [REDACTED] head on the ground. Resident #1 was transported to the hospital for evaluation. Also, numerous residents indicated that resident #1 frequently belittles resident #6, frequently calls resident #6 names and frequently yells at resident #6, which upsets resident #6.*

*REPEAT VIOLATION: 10/19/2022, et. al.*

## Plan of Correction

Directed [REDACTED] - 10/03/2023)

42b - Abuse (continued)

1. Resident #6 was escorted back to [redacted] room to calm down and regroup [redacted] Resident #6 and #1 were monitored every half hour for one week starting 8/10/2023.

2. Resident #1 and #6 were re-educated on resident rights on 8/11/2023. Both residents are aware they are not permitted to be outside together, they have to take turns for cigarettes. Staff meeting was held on 9/6/2023 to re-educate them on resident rights and enforce a new policy to monitor smoking area every hour to verify resident safety. Staff were also re-educated on 9/6/2023 to bring any change in status of a resident to the attention of a manager immediately. A resident council meeting was held on 9/8/2023 to re-educate residents on resident rights. Residents were re-educated on failure to adhere to the home rules or violation of any right will result in termination of their contract. Administrator will conduct at least 5 resident interviews per month starting 9/1/2023 to ensure residents feel safe and free from abuse. Documentation of interviews will be kept in resident file and administrative office.

3. Administrator and assistant administrator will continue to complete rounds through out the day on a daily basis to monitor residents safety and verify policy is being enforced and working. Administrator will continue to hold monthly staff meetings and monthly resident council meetings to clarify staff and residents are aware of policies and rules. Administrator contacted local ombudsman to hold a training for all residents and staff members regarding resident rights. Target date is scheduled for end of September or early October. As of 9/28/2023 Administrator is waiting on a phone call from [redacted] (ombudsman) for specific date. Administrator will notify DHS supervisor as soon as date is set. (DIRECTED: The Ombudsman resident rights training shall be completed for all staff persons by 10/31/23. Documentation of the education shall be kept in accordance with 2600.65i. [redacted] 10/5/23). Administrator will continue to have this training done with Ombudsman annually. Resident RASP's were updated on 9/15/2023 by DON to indicate behaviors. Resident RASP will be reviewed monthly and as needed by DON and Administrator starting 9/1/2023 to include any change in status.

DIRECTED: By 10/10/23: The administrator shall update residents #1 and #6's assessments and support plans to includes the resident's current behaviors and current supervision needs. Copies of residents #1 and #6's updated assessments and support plans shall be placed in their resident records and be made available to direct care staff persons at all times in accordance with 2600.227i. [redacted] 10/5/23

Directed Completion Date: 10/31/2023

Not Implemented [redacted] - 11/08/2023)

51 - Criminal Background Check

6. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Direct care staff person A's first day of work was [redacted]/23; however, direct care staff person A's Pennsylvania criminal background check was not completed until [redacted]/23.

51 - Criminal Background Check (continued)

No Pennsylvania criminal background check was completed for direct care staff person B, who's first day of work was [REDACTED]/23.

Staff person C's first day of work was [REDACTED] 23; however, staff person C's Pennsylvania criminal background check was not completed until [REDACTED]/23.

Plan of Correction

Directed ([REDACTED] 10/05/2023)

1. Administrator re-educated assistant administrator on OAPS guidelines and time frames for criminal background checks on 8/10/2023. (DIRECTED: Documentation of the education shall be kept in accordance with 2600.65i. [REDACTED] 10/5/23). Criminal background check for Staff person B was completed on [REDACTED]/2023 control # [REDACTED] (DIRECTED: By 10/8/23: A copy of staff person's B completed background check shall be placed in staff person B's record. [REDACTED] 10/5/23). Administrator had to redo criminal background check on 8/13/2023 when review of file didn't see paperwork and epatch records do not save that long.

2. Policy in place for Administrator to check all new hire paperwork prior to and during their first 40 hours of orientation to verify all documentation is completed and placed inside their file on 9/1/2023. Document created for all new hire's created for Administrator to sign once completed and checked. All employee files were reviewed on 8/13/2023 to clarify all current employees have the required paperwork.

3. Administrator will review all new employee files prior to filing away using new created document. Administrator will review all employee files quarterly to ensure all files are completed with necessary documents according to regulations. First quarterly review of all employee files were done on 8/13/2023.

Directed Completion Date: 10/08/2023

Not Implemented ([REDACTED] - 11/08/2023)

57b - 1 Hour/Day

7. Requirements

2600.

57.b. Direct care staff persons shall be available to provide at least 1 hour per day of personal care services to each mobile resident.

Description of Violation

The home is required to provide a minimum of 1 hour of personal care services for each mobile resident. On 8/6/23, there were 31 residents in the home, requiring a total minimum of 31 direct care hours. On this day, only 28 hours of direct care staffing were provided.

Plan of Correction

Accept ([REDACTED] - 10/05/2023)

1. Weekly schedule was reviewed and hours were calculated on 8/10/2023 by Administrator and DON

2. System in place for Administrator, assistant administrator and DON to check schedule daily starting 8/11/2023 to ensure personal care hours are calculated according to resident needs. one additional staff member will be placed

**57b - 1 Hour/Day (continued)**

*on the schedule for additional back up. an on call schedule has been implemented on 8/11/2023 in case a staff member calls off. A member of management must sign off on schedule daily to verify hours are within standards. Should there be short hours management is aware and educated they must cover the missing hours*

*3. Administrator, assistant administrator and DON will check DCS schedule daily starting 8/11/2023 to ensure hours are within standards. Management will sign off daily that hours are accounted for. Management is aware as of 8/10/2023 to cover shifts if staffing hours are under*

**Licensee's Proposed Overall Completion Date:** 09/29/2023

**Not Implemented** ( ) - 11/08/2023)

**57c - 2 Hours/Day****8. Requirements**

2600.

57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

**Description of Violation**

*The home is required to provide a minimum of 1 hour of personal care services for each mobile resident and 2 hours of personal care services for each resident with mobility needs. On 8/6/23, there were 31 residents in the home, including 1 resident with mobility needs, requiring a total minimum of 32 direct care hours. On this day, only 28 hours of direct care staffing were provided.*

**Plan of Correction**

**Accept** ( ) - 10/05/2023)

*1. Weekly schedule was reviewed and hours were calculated on 8/10/2023 by Administrator and DON*

*2. System in place for Administrator, assistant administrator and DON to check schedule daily starting 8/11/2023 to ensure personal care hours are calculated according to resident needs. one additional staff member will be placed on the schedule for additional back up. an on call schedule has been implemented on 8/11/2023 in case a staff member calls off. A member of management must sign off on schedule daily starting 8/11/2023 to verify hours are within standards. Should there be short hours management is aware and educated they must cover the missing hours*

*3. Administrator, assistant administrator and DON will check DCS schedule daily starting 8/11/2023 to ensure hours are within standards. Management will sign off daily that hours are accounted for. Management is aware as of 8/10/2023 to cover shifts if staffing hours are under. All schedules will be placed in file in administrative office.*

**Licensee's Proposed Overall Completion Date:** 09/29/2023

**Not Implemented** ( ) - 11/08/2023)

**57d - Waking Hours****9. Requirements**

**57d - Waking Hours (continued)**

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

**Description of Violation**

*The home is required to provide a minimum of 1 hour of personal care services for each mobile resident and 2 hours of personal care services for each resident with mobility needs. On 8/6/23, there were 31 residents in the home, including 1 resident with mobility needs, requiring a total minimum of 24 direct care staffing during waking hours. On this day, only 21 hours of direct care staffing were provided during waking hours.*

**Plan of Correction**

Accept (█ - 10/05/2023)

1. Weekly schedule was reviewed and hours were calculated on 8/10/2023 by Administrator and DON

2. System in place for Administrator, assistant administrator and DON to check schedule daily starting 8/11/2023 to ensure personal care hours are calculated according to resident needs. one additional staff member will be placed on the schedule for additional back up. an on call schedule has been implemented on 8/11/2023 in case a staff member calls off. A member of management must sign off on schedule daily starting 8/11/2023 to verify hours are within standards. Should there be short hours management is aware and educated they must cover the missing hours

3. Administrator, assistant administrator and DON will check DCS schedule daily starting 8/11/2023 to ensure hours are within standards. Management will sign off daily that hours are accounted for. Management is aware as of 8/10/2023 to cover shifts if staffing hours are under.

Licensee's Proposed Overall Completion Date: 09/29/2023

Not Implemented (█ - 11/08/2023)

**63a - First Aid/CPR Training****10. Requirements**

2600.

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

**Description of Violation**

*On numerous dates and times, to include the following, 31 residents were present in the home; however, there were no staff persons present in the home who were trained in first aid and certified in obstructed airway techniques and CPR:*

- *On 8/12/23 from approximately 4:00 PM through approximately 7:00 AM on 8/13/23*
- *On 8/11/23 from approximately 4:00 PM through 11:00 PM*
- *On 8/10/23 from approximately 4:00 PM through 11:00 PM*
- *On 8/7/23 from approximately 4:00 PM through 11:00 PM*

REPEAT VIOLATION: 8/23/2022, et. al.

## 63a - First Aid/CPR Training (continued)

**Plan of Correction****Directed** [REDACTED] - 10/05/2023)

1. Scheduled was reviewed on 8/10/2023. It was changed to reflect one staff person present in the home at all times who is CPR certified.

2. System in place for Administrator, assistant administrator and DON to check schedule daily starting 8/11/2023, to ensure at least one staff person is present inside the home who is CPR trained at all times. CPR has been scheduled for September 27th 2023 to train all staff members. (DIRECTED: Copies of the CPR/first aid cards shall be kept. [REDACTED] 10/5/23). Management is aware they must cover shifts until all staff members are trained. Administrator or designee will sign off schedule daily to ensure compliance. A tracking system has been created on 9/26/2023 in Tabula pro to track all certifications for all staff members. Tabula pro will give Administrator, assistant administrator and DON notification of those who need to complete certificates and those who are expiring soon. Administrator, assistant administrator and DON will ensure all certificates are completed within a timely manner. Administrator, assistant administrator and DON will review tabula pro daily starting 9/26/2023 to ensure all are in compliance with regulations and schedule classes accordingly.

3. Administrator, assistant administrator and DON will check DCS schedule daily starting 8/11/2023 to ensure compliance. Administrator, assistant administrator and DON will closely monitor staffing schedules daily starting 8/11/2023 to ensure compliance and plan accordingly. Administrator, assistant administrator and DON will monitor Tabula pro daily starting 9/26/2023 to review all staff certifications and staffing hours, schedule trainings as needed and change schedules to ensure compliance.

**Directed Completion Date:** 10/05/2023**Not Implemented** [REDACTED] - 11/08/2023)

## 64c - Annual Training

**12. 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 who was hired on [REDACTED]/20, only completed approximately 2 hours of annual training during the 2022 training year.

**Plan of Correction****Directed** [REDACTED] - 10/05/2023)

1. Administrator was re-educated on 64 C by DHS representative on 8/10/2023.

64c - Annual Training (continued)

2. Administrator is enrolled in 30 CEU hours from North Hampton University for fall 2023 to ensure [REDACTED] has at least 24 hours completed for annual training. training dates are as follows. Administrator will continue to search for CEU credits from DHS daily through email correspondence. As of 8/10/2023 Administrator has completed and is currently enrolled in the following classes.

- CRP/First Aide : 4/23/2023
- Diabetic Training : 12/8/2022
- Medication Administration: 1/8/2023

North Hampton University :

- 10/5/2023 9am-4pm
- 10/10/23 9am - 4pm
- 10/26/23 9am-4pm
- 11/2/23 1pm-4pm
- 11/9/23 9am-4pm
- 11/27/23 9a-4pm

3. Administrator will continue to enroll in more hours yearly to avoid not having the minimum hours needed to keep [REDACTED] licensure current. Administrator has now created a database in [REDACTED] computer to remind [REDACTED] of upcoming classes and current classes [REDACTED] is enrolled in to ensure [REDACTED] doesn't miss a class. Administrator will continue to enroll in more than 24 hours annually should something come up and [REDACTED] cannot attend class, there is a back up to complete the minimum requirements

DIRECTED: By 12/31/23: The administrator shall complete 46 hours of Department-approved training. Documentation of the completed trainings shall be kept in accordance with 2600.64f. [REDACTED] 10/5/23

DIRECTED: Beginning on 1/1/24: The administrator shall develop and implement a training plan to ensure the administrator completes at least 24 hours of Department-approved training during each training year. A copy of the staff training plan shall be kept and reviewed at least quarterly, as well as reviewed during the home's quality management meetings. Documentation of the reviews shall be kept.

Directed Completion Date: 09/29/2023

Not Implemented [REDACTED] - 11/08/2023)

64f - Record of Training

13. Requirements

2600.

64.f. A record of training including the individual trained, date, source, content, length of each course and copies of certificates received shall be kept.

Description of Violation

The record of training for staff person [REDACTED] diabetic training, conducted on 12/8/22, does not include the length of course. This section of the record of training is blank. Staff person [REDACTED] in the home's administrator.

64f - Record of Training (continued)

Plan of Correction

Accept ( ) - 10/06/2023)

- 1. Documentation was updated on 8/10/2023 to include length of course.
- 2. Policy in place for every employee training being done inside the home from an outside person, agency or in house, to be checked by Administrator , assistant administrator or DON to double check all documentation is completed before leaving the facility. All Diabetic, CPR training and staff training have been reviewed on 8/11/2023 dating back to January of 2022. Meeting held with assistant administrator and DON on 8/11/2023 to check all paperwork to ensure compliance. Documentation of training will be placed in administrative office. Policy has been implemented as of 8/11/2023
- 3. Starting 8/11/2023 Administrator will check all paperwork prior to filing away to clarify all records are filled out properly and there are no blank spaces before filing away

Licensee's Proposed Overall Completion Date: 09/29/2023

Not Implemented ( ) - 11/08/2023)

65a - FS Orientation 1st Day

14. Requirements

2600.

- 65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
  - 1. Evacuation procedures.
  - 2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
  - 3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
  - 4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
  - 5. The location and use of fire extinguishers.
  - 6. Smoke detectors and fire alarms.
  - 7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff person A's first day of work was /23; however, direct care staff person A did not receive orientation on any of the topics specified in 2600.65a.

Direct care staff person B's first day of work was /23; however, direct care staff person B did not receive orientation on any of the topics specified in 2600.65a.

Plan of Correction

Directed ( ) - 10/06/2023)

- 1. Staff person A is no longer employed at the facility. Staff person B started orientation on 8/11/2023. Staff person B has completed 40 hours of orientation and has signed off on document on 8/16/2023. (DIRECTED: By 10/10/23: Documentation of staff person B's training of all topics specified in 2600.65a shall be kept in staff person B's record. 10/6/23)
- 2. Assistant admin was re-educated on regulation 65.a. System in place on 8/11/2023 for Administrator to monitor newly hired employees during their first week of work to ensure employee's receive and complete their orientation

65a - FS Orientation 1st Day (continued)

within their first 40 hours. Orientation training will also be recorded on staffing schedule to verify they received their training, implemented 8/11/2023. Signature of completion from both employee and administrator will be kept in employee file. Administrator reviewed all employee files on 8/11/2023. All documentation has been placed in employee chart. Quality Management quarterly meetings will continue to be put in place. The next meeting is scheduled for November 2023. Administrator will continue to document all employee monthly trainings. Documentation of training will be kept in administrative office. Administrator will review trainings monthly to ensure compliance starting 8/11/2023, and continue to record monthly training and add new employee orientation trainings to QM starting 8/11/2023.

3. Administrator and employee will sign off on orientation training once completed. Orientation will be kept in employee file. Administrator will review employee files upon completion of training and quarterly to guarantee compliance starting 8/11/2023. Administrator will review all new employee files upon hire, sign off on documentation and place in employee file beginning 8/11/2023. Administrator will review all employee files quarterly starting 8/11/2023. Administrator will continue to monitor and record monthly trainings for employees and place documentation in administrative office. Administrator will review and record employee trainings and orientation during QM meetings quarterly. Administrator will now record all new hire orientation training to QM meetings starting 8/11/2023

DIRECTED: By 10/15/23: The administrator shall develop and implement a new hire checklist to ensure all newly-hired staff persons receive training on all topics specified in 2600.65a prior to or during their first workday. Copies of the completed checklists, as well as documentation of the training, shall be kept in each staff person's record. All staff persons involved in the hiring process shall be educated on the new checklist by 10/15/23. [REDACTED] 10/6/23

Directed Completion Date: 10/15/2023

Not Implemented ([REDACTED] - 11/08/2023)

65b - Rights/Abuse 40 Hours

15. Requirements

2600.

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

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

Description of Violation

Direct care staff person A's first day of work was [REDACTED]/23; however, direct care staff person A did not receive orientation on any of the topics specified in 2600.65b.

Direct care staff person B's first day of work was [REDACTED]/23; however, direct care staff person B did not receive orientation on any of the topics specified in 2600.65b.

Plan of Correction

Directed [REDACTED] - 10/06/2023)

1. Staff person A is no longer employed at the facility. Staff person B started orientation on 8/11/2023. Staff person B has completed [REDACTED] 40 hours of orientation and has signed off on document on 8/16/2023. (DIRECTED: By

65b - Rights/Abuse 40 Hours (continued)

10/10/23: Documentation of staff person B's training of all topics specified in 2600.65b shall be kept in staff person B's record. [REDACTED] 10/6/23)

2. Assistant admin was re-educated on regulation 65.b. System in place on 8/11/2023 for Administrator to monitor newly hired employees during their first week of work to ensure employee's receive and complete their orientation within their first 40 hours. Orientation training will also be recorded on staffing schedule to verify they received their training, implemented 8/11/2023. Signature of completion from both employee and administrator will be kept in employee file. Administrator reviewed all employee files on 8/11/2023. All documentation has been placed in employee chart. Quality Management quarterly meetings will continue to be put in place. The next meeting is scheduled for November 2023. Administrator will continue to document all employee monthly trainings. Documentation of training will be kept in administrative office. Administrator will review trainings monthly to ensure compliance starting 8/11/2023, and continue to record monthly training and add new employee orientation trainings to QM starting 8/11/2023.

3. Administrator and employee will sign off on orientation training once completed. Orientation will be kept in employee file. Administrator will review employee files upon completion of training and quarterly to guarantee compliance starting 8/11/2023. Administrator will review all new employee files upon hire, sign off on documentation and place in employee file beginning 8/11/2023. Administrator will review all employee files quarterly starting 8/11/2023. Administrator will continue to monitor and record monthly trainings for employees and place documentation in administrative office. Administrator will review and record employee trainings and orientation during QM meetings quarterly. Administrator will now record all new hire orientation training to QM meetings starting 8/11/2023

DIRECTED: By 10/15/23: The administrator shall develop and implement a new hire checklist to ensure all newly-hired staff persons receive training on all topics specified in 2600.65b within 40 scheduled working hours. Copies of the completed checklists, as well as documentation of the training, shall be kept in each staff person's record. All staff persons involved in the hiring process shall be educated on the new checklist by 10/15/23. [REDACTED] 10/6/23

Directed Completion Date: 10/15/2023

Not Implemented [REDACTED] 11/08/2023)

65d - Initial Direct Care Training

16. Requirements

2600.

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

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

Description of Violation

Direct care staff person A's first day of work was [REDACTED] 23; however, direct care staff person A has not successfully competed and passed the Department-approved direct care training course and passed the competency test.

REPEAT VIOLATION: 8/23/2022, et. al.

65d - Initial Direct Care Training (continued)

Plan of Correction

Directed (redacted) - 10/06/2023)

1. Staff person A is no longer employed at the facility. Staff person B started orientation on 8/11/2023. Staff person B has completed (redacted) 40 hours of orientation and has signed off on document on 8/16/2023.

DIRECTED: By 10/10/23: Staff person B shall successfully complete and pass the Department-approved direct care training course and pass of the competency test. A copy of the certificate shall be kept in staff person B's record. (redacted) 10/6/23

2. Assistant admin was re-educated on regulation 65.d. System in place on 8/11/2023 for Administrator to monitor newly hired employees during their first week of work to ensure employee's receive and complete their orientation within their first 40 hours. Orientation training will also be recorded on staffing schedule to verify they received their training, implemented 8/11/2023. Signature of completion from both employee and administrator will be kept in employee file. Administrator reviewed all employee files on 8/11/2023. All documentation has been placed in employee chart. Quality Management quarterly meetings will continue to be put in place. The next meeting is scheduled for November 2023. Administrator will continue to document all employee monthly trainings. Documentation of training will be kept in administrative office. Administrator will review trainings monthly to ensure compliance starting 8/11/2023, and continue to record monthly training and add new employee orientation trainings to QM starting 8/11/2023.

3. Administrator and employee will sign off on orientation training once completed. Orientation will be kept in employee file. Administrator will review employee files upon completion of training and quarterly to guarantee compliance starting 8/11/2023. Administrator will review all new employee files upon hire, sign off on documentation and place in employee file beginning 8/11/2023. Administrator will review all employee files quarterly starting 8/11/2023. Administrator will continue to monitor and record monthly trainings for employees and place documentation in administrative office. Administrator will review and record employee trainings and orientation during QM meetings quarterly. Administrator will now record all new hire orientation training to QM meetings starting 8/11/2023

DIRECTED: By 10/15/23: The administrator shall develop and implement a new hire checklist to ensure all newly-hired direct care staff persons successfully complete and pass the Department-approved direct care training course and pass of the competency test prior to performing unsupervised ADL services to residents. Copies of the completed checklists, as well as copies of the certificates, shall be kept in each staff person's record. All staff persons involved in the hiring process shall be educated on the new checklist by 10/15/23. (redacted) 10/6/23

Directed Completion Date: 10/15/2023

Not Implemented (redacted) - 11/08/2023)

65i - Training Record

17. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The record of training for diabetes training, conducted on 12/8/22, does not include the length of training or content of the course. These sections of the record of training are blank.

**65i - Training Record (continued)**

The record of training for diabetes training, conducted on 7/21/23, does not include the length of training, content of the course or the training source. These sections of the record of training are blank.

**Plan of Correction**

Accept (█) - 10/06/2023)

1. Training record blanks were filled in on 8/10/2023 by DON.

2. System in place starting 8/11/2023 for all trainings that are done in house or an outside agency to be checked by both DON and Administrator to verify all proper documentation is completed on the 65.i training form. prior to being filed away. Administrator and DON reviewed all trainings dating back to January 2023 on 8/11/2023 to ensure all signage is completed. Documentation of file review is placed in administrative office. Once Monthly administrator and DON will review all employee trainings and document review starting 8/11/2023.

3. Administrator and DON will review all documentation prior to filing away. During quarterly QM meetings which is scheduled for November 2023 Administrator and DON will review all monthly training records to ensure all documentation is filled out completely, implemented on 8/11/2023. Documentation of training review and QM will be placed in administrative office

Licensee's Proposed Overall Completion Date: 09/30/2023

Not Implemented (█) - 11/08/2023)

**85b - Infestation****18. Requirements**

2600.

85.b. There may be no evidence of infestation of insects or rodents in the home.

**Description of Violation**

On 8/10/23, numerous flies were present in the living area and hallway near bedroom #7.

REPEAT VIOLATION: 3/8/2023; 8/23/2022, et. al.

**Plan of Correction**

Accept (█) - 10/06/2023)

1. Smoking section door near bedroom #7 was closed on site 8/10/2023.

2. Resident council meeting was held on 9/8/2023 discussing that all doors need to be closed after they exit to avoid infestation. Staff meeting held on 9/6/2023 re-educating them on the importance of having the doors closed, checked during rounds and educating residents to close doors behind them. Daily rounds continue to be implemented since 8/10/2023 to check that all doors are closed and not propped open for convenience. Pestco continues to come once monthly and as needed to control any infestation in the home. Last visit was 9/1/2023. Next visit is scheduled for 10/3/2023. Documentation of service will continue to be filed away in administrative office.

3. Administrator, assistant administrator and care staff will continue to do hourly and daily rounds beginning 8/10/2023 of all doors inside the home to ensure they are closed. Should insects become an issue Administrator will contact Pestco to control problem. All documentation will be placed in administrative office

Licensee's Proposed Overall Completion Date: 09/30/2023

85b - Infestation (continued)

Not Implemented (████ - 11/08/2023)

85e - Trash Outside Home

19. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 8/10/23 at 12:12 PM, the lid to the home's dumpster was open and the dumpster was approximately 1/2 full of trash.

Plan of Correction

Directed (████ - 10/06/2023)

1. Trash lids were closed on site 8/10/2023.

2. Staff meeting was held on 9/8/2023 re-educating staff to keep dumpster lids closed at all times. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. █████ 10/6/23). A sign has been posted 8/11/2023 on exit door to remind staff members to close lid when taking out trash. During daily rounds implemented on 8/11/2023 dumpsters will be checked by administrator or assistant to verify they're closed. Should dumpster become overflowed at any time Administrator will call trash removal company to remove trash to ensure lid can be closed.

3. Daily rounds will be conducted by administrator or assistant administrator starting 8/11/2023 to ensure dumpster lids are closed. monthly physical site checklist created 8/11/2023 will continue to be implemented, signed off and stored away in administrative office. Documentation of any additional phone calls to trash removal company will be documented.

Directed Completion Date: 10/06/2023

Not Implemented (████ - 11/08/2023)

89b - Hot Water Temperature

20. Requirements

2600.

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

Description of Violation

On 8/10/23 at 9:14 AM, the hot water temperature at the bathroom sink across from bedroom #20 was 127.2 degrees Fahrenheit.

On 8/10/23 at 12:11 PM, the hot water temperature at the bathroom sink near bedroom #11 was 124.3 degrees Fahrenheit.

On 8/10/23 at 12:15 PM, the hot water temperature at the bathroom sink near bedroom #9 was 126.3 degrees Fahrenheit.

REPEAT VIOLATION: 8/23/2022, et. al.

## 89b - Hot Water Temperature (continued)

**Plan of Correction**

Accept [REDACTED] - 10/06/2023)

1. all three hot water heaters were turned down on site and re checked at 4:30pm reading 115-117 degrees
2. Daily temperature checks have been implemented on 9/26/2023 to check at least two sources from each hot water tank for one month, then weekly thereafter. Administrator, Assisant administrator and maintenance director will check temps daily for a week and monthly there after starting 9/26/2023. All documentation including date, source and temperature readings will be filed in administrative office.
3. Maintenance director, Administrator or assistant administrator will record all readings on document created and implemented on 9/26/2023 weekly for one month and monthly. Documentation of date, source and temperatures will be recorded on document and filed in administrative office.

Licensee's Proposed Overall Completion Date: 09/30/2023

Not Implemented [REDACTED] - 11/08/2023)

## 95 - Furniture and Equipment

**21. Requirements**

2600.

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

**Description of Violation**

According to numerous residents, the home's only washer is frequently inoperable and resident's clothing are unable to be laundered when the washer is inoperable. The home's washer was also inoperable on 8/10/23.

**Plan of Correction**

Directed [REDACTED] - 10/06/2023)

1. Washer was repaired on 8/11/2023 by GE appliance service, service repair ticket is on file.
2. Staff meeting held on 9/6/2023 re-educating staff members on load amounts. System in place on 8/11/2023 if washer does become inoperable, administrator or designee will take clothes to the nearest laundry mat within 24 hours of washer becoming in operable to ensure clothes are cleaned and returned to residents with in the 24 hour period. As of 8/11/2023 the homes laundry room can not hold another washer. Managing members are working on getting a higher grade washing machine to ensure all laundry can be washed inside the home. laundry mat is still in place as of 8/11/2023 should it become inoperable. Target date for a resolution is third week of October due to religious holiday.
3. Administrator, assistant administrator or housekeeping will check washer daily during rounds. Should washer become inoperable, (DIRECTED: The daily rounds shall begin on 10/10/23. [REDACTED] 10/6/23). administrator or designee is responsible to take clothes to the Laundry mat and returned within 24 hours. receipts of transaction will be kept in administrative office.

Directed Completion Date: 10/10/2023

Not Implemented [REDACTED] 11/08/2023)

96a - First Aid Kit

22. Requirements

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

On 8/25/23, the home's first aid kit did not include adhesive tape or adhesive bandages.

Plan of Correction

Accept (████) - 10/06/2023)

1. Tape and bandages were placed in the kit on site 8/10/2023

2. additional supplies were purchased on 8/11/2023. All first aid kits were checked on 8/13/2023 to verify they have all supplies needed. Monthly first aid kit checklist has been created on 8/14/2023 to verify all supplies are present inside kit.

3. Administrator, assistant administrator, DON or med tech will check first aid kits monthly beginning 8/13/2023, sign off they are complete and file paperwork in administrative office.

Licensee's Proposed Overall Completion Date: 09/30/2023

Not Implemented (████) - 11/08/2023)

101j7 - Lighting/Operable Lamp

23. 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 8/25/23 at 1:56 PM, no operable lamp or other source of lighting that could be turned on/off at bedside was present next to resident #7's bed.

Plan of Correction

Accept (████) - 10/06/2023)

1. Lamp was moved back to bedside on site 8/10/2023

2. Resident council meeting held on 9/8/2023, staff meeting held on 9/6/23 re-educating residents and staff that everyone needs a bedside lamp. Monthly resident room checklist implemented on 8/11/2023 to check all resident have an operable bedside lamp. An all resident room review has been completed on 8/13/2023 All resident room checks done and completed on 8/13/2023 by Administrator to ensure residents have everything they need according to regulation 101.j. Administrator, assistant administrator or maintenance director will complete monthly resident room checks beginning 8/11/2023 to ensure all residents equipment are free from hazards and fully operable.

3. Administrator or assistant administrator will complete resident room checks monthly starting 8/13/2023. Documentation will be kept in administrative office

Licensee's Proposed Overall Completion Date: 10/01/2023

Not Implemented (████) - 11/08/2023)

101r - Bedroom - shades/drapes/window covering

24. Requirements

2600.

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

Description of Violation

On 8/25/23 at 1:56 PM, the blinds on the window in bedroom #15 were inoperable and unable to be lowered to cover the window. There were no other drapes, shades, curtains, blinds, or shutters present on the window.

Plan of Correction

Accept ( [redacted] - 10/06/2023)

1. Blinds were fixed on 8/10/2023.

2. additional blinds were ordered on 8/11/2023. Monthly resident room checklist implemented on 8/11/2023 to check all resident have an operable bedside lamp. An all resident room review has been completed on 8/13/2023 All resident room checks done and completed on 8/13/2023 by Administrator to ensure residents have everything they need according to regulation 101.r. Administrator, assistant administrator or maintenance director will complete monthly resident room checks beginning 8/11/2023 to ensure all residents equipment are free from hazards and fully operable.

3. Administrator, assistant administrator or maintenance director will check all resident rooms monthly starting 8/13/2023. Documentation will be kept on file in administrative office

Licensee's Proposed Overall Completion Date: 10/01/2023

Not Implemented [redacted] - 11/08/2023)

103d - Storing Food Off Floor

25. Requirements

2600.

103.d. Food shall be stored off the floor.

Description of Violation

On 8/25/23 at 1:39 PM, a box of red potatoes was stored on the floor in pantry #1.

Plan of Correction

Accept ( [redacted] 10/06/2023)

1. Potatoes were removed from floor on 8/10/2023.

2. Staff meeting was held on 9/8/2023 to re-educate staff on regulation 103.d. daily rounds have been implemented since 8/13/2023 to check all food storage areas throughout the home to verify there is no food stored on the floor. Daily rounds will be completed by Administrator, assistant administrator or kitchen staff member.

3. Administrator, assistant administrator or kitchen staff member will conduct daily rounds and complete the monthly physical site checklist starting 8/13/2023 checking all food is stored off the floor. Documentation will be kept on file in administrative office

Licensee's Proposed Overall Completion Date: 10/01/2023

Not Implemented [redacted] - 11/08/2023)

103f - Refrigerator/Freezer Temps

26. 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 8/10/23 at 11:19 AM, the temperature of the freezer in pantry #1 was 10 degrees Fahrenheit.

On 8/10/23 at 12:02 PM, the temperature of the freezer in pantry #2 was 18 degrees Fahrenheit.

REPEAT VIOLATION: 8/23/2022, et. al.

Plan of Correction

Accept [redacted] - 10/06/2023)

1. All food was removed from freezers and placed in another freezer on 8/10/2023.

2. Allegheny refrigeration was called on 8/31/2023. Date for repair was scheduled for 9/8/2023 but was canceled and rescheduled for 9/20/23. Daily temperature logs are still in place to check all freezer temperatures daily. Staff meeting held on 9/6/23 to re-educate staff members on temperature regulations for refrigerators and freezers. Allegheny refrigeration told us to defrost the freezer and they will return on 9/25/2023 to fix freezer. As of 9/20/2023 one freezer is still inoperable. Staff members have been educated to notify administrator or assistant administrator should temperatures become out of compliance to call for a service visit. One freezer still continues to be the back up freezer should one become inoperable at any time.

3. Administrator, assistant administrator, maintenance director and/or kitchen staff members will record daily temperatures of all refrigerators and freezers starting 9/6/2023. Daily facility walk-thru will be conducted by Administrator, assistant administrator, maintenance director or kitchen staff members starting 9/6/2023 to check temperatures are being recorded three times daily before and after meals to ensure they are within regulation standards. Monthly physical site checklist will be completed and stored in administrative office.

Licensee's Proposed Overall Completion Date: 10/02/2023

Not Implemented [redacted] - 11/08/2023)

103g - Storing Food

27. Requirements

2600.

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

Description of Violation

On 8/10/23 at approximately 11:00 AM, the following food items were open and unsealed in pantry #1:

- 2 bags of pasta
- 3 bags of corn chips
- 2 bags of breadcrumbs

Plan of Correction

Accept [redacted] - 10/06/2023)

1. food was thrown away 8/10/2023.

103g - Storing Food (continued)

2. Staff meeting was held on 9/8/2023 to re-educate staff on regulation 103.g. daily rounds will continue to be implemented on 9/8/2023 to check all food storage areas throughout the home to verify all food is sealed and dated.

3. Administrator or assistant administrator will conduct daily rounds of all pantries starting 9/8/2023. Once daily and weekly before food delivery administrator, assistant administrator or kitchen staff members will check all pantries for sealed and dated food, discard anything that is not sealed or dated. Administrator or assistant administrator will complete the monthly physical site checklist starting 9/8/2023. Documentation will be kept on file in administrative office

Licensee's Proposed Overall Completion Date: 10/02/2023

Not Implemented [redacted] - 11/08/2023)

125a - Combustible Storage

28. Requirements

2600.  
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 8/10/23 at approximately 12:00 PM, 3 baskets of clothes were leaning against the hot water heater in the laundry room.

Plan of Correction

Accept [redacted] - 10/06/2023)

1. clothes were removed from heat source on 8/10/23.

2. a tape barrier was placed on the floor to indicate nothing can be placed in or near heat source area on 9/13/2023 . staff meeting held on 9/8/23 re-educating staff members on 125.a. daily facility walk-thru will continue to be implemented starting 9/8/2023. monthly physical site checklist will be done to check laundry room and placement of clothes and baskets.

3. Administrator, assistant administrator, maintenance director or housekeeper will complete daily walk-thru to check laundry room starting 9/8/2023. monthly physical site checklist will be completed by administrator or assisant administrator starting 9/13/2023. Documentation will be kept on file in administrative office

Licensee's Proposed Overall Completion Date: 10/02/2023

Not Implemented [redacted] - 11/08/2023)

132a - Monthly Fire Drill

29. Requirements

2600.  
132.a. An unannounced fire drill shall be held at least once a month.

132a - Monthly Fire Drill (continued)

Description of Violation

No fire drills were conducted in August 2022, September 2022, October 2022, or November 2022.

Plan of Correction

Accept [redacted] - 10/06/2023)

1. Fire drill log couldn't be found during inspection. two fire drills will be conducted starting 8/10/2023 and will continue through December 2023 to ensure all staff and residents are educated.

2. Meeting was held with assistant administrator on 8/10/2023 re-educating [redacted] on 132.a. A digital fire drill worksheet was created on 8/13/2023 as a back up should paper copy get misplaced. A fire drill binder has been created on 8/13/2023 to keep all fire safety information and important documents filed together. All documents will be electronically scanned and placed in a file on the desktop for easy access. Administrator will check plan monthly dates for fire drills, Administrator will conduct monthly fire drills, Administrator will check all documents are completed and filed away accordingly as of 8/13/2023

3. Administrator or maintenance director will conduct all fire drills monthly. All fire drills will be recorded on paper and scanned electrotonically. Once a month administrator will review documentation to ensure fire drill records are completed and stored away properly starting 8/13/2023

Licensee's Proposed Overall Completion Date: 10/02/2023

Implemented ([redacted] - 11/08/2023)

132b - Safety Inspection/Fire Drill

30. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home's most recent fire safety inspection and supervised fire drill conducted by a fire safety expert was completed on 11/17/21.

Plan of Correction

Directed [redacted] 10/06/2023)

1. A fire inspection and supervised fire drill was completed on 11/15/2022 by Mckeessport fire department. Administrator has been in contact with fire captain and deputy chief to retrieve paperwork. paperwork has been given to administrator on 9/21/2023

2. System in place for the administrator to get all paperwork in hand when inspection and drill are completed. all paperwork will be scanned electronically along with being placed in fire safety binder for easy access during inspections. 2023 fire inspection has already been scheduled for November 15th.

3. Administrator will handle all paperwork during inspection. Administrator will scan all documents electronically for an extra copy. Administrator will place all original documentation in the fire safety binder to guarantee access during inspections, starting 9/21/2023.

DIRECTED: Beginning on 10/10/23: The administrator shall develop and implement a system to ensure a fire safety inspection and fire drill is conducted by a fire safety expert at least annually. Documentation of the inspection/supervised fire drill conducted by the fire safety expert shall be kept. [redacted] 10/6/23

132b - Safety Inspection/Fire Drill (continued)

Directed Completion Date: 10/10/2023

Implemented (█) - 11/08/2023)

132c - Fire Drill Records

31. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the fire drill conducted on 6/23/23 does not indicate the time the fire drill was conducted.

The fire drill record for the fire drill conducted on "7-13" at 5:10 PM does not indicate the year the fire drill was conducted or the evacuation time.

Plan of Correction

Accept (█) - 10/06/2023)

- 1. Fire drill logs were completed to include time and year on each fire drill on 8/11/2023.
- 2. Administrator will conduct all fire drills going forward. all documentation will will be completed and filed both electronically and in fire safety binder
- 3. Once monthly Administrator will conduct all fire drills and record all documentation on department paperwork. administrator will scan document monthly to ensure all paperwork is backed up starting 8/11/2023.

Licensee's Proposed Overall Completion Date: 10/02/2023

Not Implemented (█) - 11/08/2023)

132e - Fire Drill Sleeping Hours

32. Requirements

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The most recent fire drill conducted during sleeping hours was held on 5/18/23 at 2:00 AM; however, the previous fire drill conducted during sleeping hours was held on 5/20/22 at 11:30 PM.

Plan of Correction

Accept (█) - 10/06/2023)

- 1. fire drill was conducted on 9/6/2023 at 12:45 am time was 2 minutes and 13 seconds recorded on fire drill log
- 2. Administrator will conduct all fire drills going forward starting 9/6/2023. all documentation will will be completed and filed both electronically and in fire safety binder

132e - Fire Drill Sleeping Hours (continued)

3. Once monthly Administrator will conduct fire drills and record all documentation on department paperwork starting 9/6/2023. Administrator will conduct an overnight fire drill every 6 months to ensure compliance, a reminder on calendar has been set to complete . Administrator will scan document monthly to ensure all paperwork is backed up

Licensee's Proposed Overall Completion Date: 10/02/2023

Implemented ( [REDACTED] 11/08/2023)

132g - Fire Drills Days/Times

33. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely schedules 1 staff person during the hours of 11:00 PM-7:00 AM; however, the home has not conducted a fire drill with only 1 staff person in the past year.

Plan of Correction

Directed [REDACTED] - 10/06/2023)

1. fire drill was conducted on 9/6/2023 at 12:45 am with only one staff member present time was 2 minutes and 13 seconds recorded on fire drill log

2. Administrator will conduct all fire drills going forward. all documentation will will be completed and filed both electronically and in fire safety binder starting 9/6/2023

3. Once monthly Administrator will conduct fire drills and record all documentation on department paperwork. administrator will scan document monthly to ensure all paperwork is backed up. Monthly fire drill reminders have been created on digital calendar to remind administrator to complete fie drills. (DIRECTED: Beginning on 10/10/23: The administrator shall review all fire drill records monthly to ensure fire drills are held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low. [REDACTED] 10/6/23).

Directed Completion Date: 10/10/2023

Implemented [REDACTED] - 11/08/2023)

141b1 - Annual Medical Evaluation

34. Requirements

2600.

141b1 - Annual Medical Evaluation (continued)

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

Description of Violation

Resident #1's most recent medical evaluation, dated [REDACTED]/23, is not signed by the medical professional who completed the form.

Plan of Correction

Accept ([REDACTED] 10/06/2023)

1. Resident number 1's medical evaluation was signed by MD on 9/15/2023

2. All resident charts were reviewed by DON on 8/13/2023 to make sure all DME's were completed in a timely manner and signed off on by MD. System in place as of 8/11/23 to review all resident forms monthly by DON and administrator to ensure signatures are present on all documents

3. Administrator and DON will check forms monthly starting 8/13/2023 to verify all forms are signed off on by Md, Administrator, DON or designee

Licensee's Proposed Overall Completion Date: 10/02/2023

Not Implemented [REDACTED] - 11/08/2023)

144c2 - Smoking Area Distance

35. 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:

- 2. 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: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

The home's current designated smoking area is located outside the entrance door at the end of hallway #3, which is located on a common walkway.

On 8/10/23 at 11:47 AM, resident #2 was observed smoking outside the exit door near bedroom #1; however, this is not the home's designated smoking area.

REPEAT VIOLATION: 8/23/2022, et. al.

Plan of Correction

Directed [REDACTED] - 10/06/2023)

1. Resident number 2 was educated on where the smoking section is on 8/10/2023.

2. [REDACTED]

(UNACCEPTABLE PORTION OF

PLAN OF CORRECTION. LM 10/6/23)

144c2 - Smoking Area Distance (continued)

DIRECTED: By 10/10/23: The administrator shall relocate the designated smoking section from the end of hallway #3 to an area that is not near common walkways and exits. The home's smoking policy shall be updated by 10/10/23 to include the location of the new designated smoking area. A copy of the updated smoking policy shall be kept. [REDACTED] 10/6/23

DIRECTED: By 10/12/23: All residents shall be notified in writing of the location of the new designated smoking section. Copies of the notification shall be kept in each resident's record. [REDACTED] 10/6/23

DIRECTED: By 10/12/23: All staff persons shall be educated on the location of the new designated smoking section. Documentation of the education shall be kept in accordance with 2600.65i. [REDACTED] 10/6/23

DIRECTED: Beginning on 10/12/23: The administrator/shift supervisor shall inspect the home daily to ensure all persons are smoking in the new designated smoking area and to ensure no person is smoking in an area that is near common walkways and exits, including at the end of hallway #3. [REDACTED] 10/6/23

3. Administrator, assistant administrator and staff members will conduct hour rounds daily (9/8/2023) to ensure residents are smoking in designated smoking area. Residents have been told if they can't follow house rules smoking privileges will be revoked. Documentation of role breaking and hourly checks will be kept in administrative office

Directed Completion Date: 10/12/2023

Not Implemented [REDACTED] - 11/08/2023)

162c - Menus Posted

36. Requirements

2600.

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

Description of Violation

On 8/10/23, the only menu posted in a conspicuous and public place in the home ended on 8/9/23.

Plan of Correction

Directed [REDACTED] - 10/06/2023)

1. 2 week menus have been posted. a 5 week rotating menu has been created and posted on 8/14/2023.

2. 5 weeks of menus have been created and posted on bulletin board. A dry erase board has been purchased and hung in dining room for any menu changes (8/16/2023). staff meeting held on 9/6/2023 discussed menu's and menu changes daily. during daily rounds administrator or assistant admin will check menu to clarify with kitchen staff members they making what is planned or verify they informed residents of menu change. Once a month physical site will be completed ( starting 8/14/2023) and menus will be reviewed to verify they are posted and being followed

162c - Menus Posted (continued)

3. Administrator or assistant administrator will complete daily rounds with kitchen staff members starting 8/14/2023 and monitor menus daily (8/14/2023) to make sure staff are cooking what's on the menu or have the menu change posted on the board in a timely manner. (DIRECTED: The daily rounds shall include ensuring the current weekly menu, as well as a menu for 1 week in advance, are posted in a public and conspicuous place in the home. [REDACTED] 10/6/23).

Directed Completion Date: 10/06/2023

Not Implemented ([REDACTED] - 11/08/2023)

191 - Resident Right to Refuse

37. 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 #5's record does not include documentation indicating resident #5 was educated on their right to question or refuse a medication if resident #5 believe there to be a medication error.

Plan of Correction

Accept ([REDACTED] 10/06/2023)

1. Resident #5 signed resident rights document on 8/10/2023

2. All resident charts were reviewed on 8/11/2023 to ensure all documentation was completed and in resident file. Quarterly review of resident files have been implemented on 8/11/2023 to verify all resident files are completed

3. Administrator and assistant administrator will check all resident files prior to filing away and once quarterly starting 8/11/2023 to ensure all signatures are completed

Licensee's Proposed Overall Completion Date: 10/02/2023

Implemented ([REDACTED] - 11/08/2023)

224a - Preadmission Screen Form

38. 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

A preadmission screening was not completed for resident #8, who was admitted to the home on [REDACTED]/22.

Plan of Correction

Directed ([REDACTED] - 10/06/2023)

1. pre-admission screener was completed on 8/11/2023 for resident 8 by DON.

2. all resident pre-admission screener were reviewed on 8/11/2023 by DON and Administrator to verify each resident had one in their file. system in place to check all resident files during admission and quarterly to verify all paperwork is completed in a timely manner . Implementation to begin on 8/11/2023

224a - Preadmission Screen Form (continued)

3. Administrator and DON will check all resident charts within 15 days of admission and quarterly starting 8/11/2023 to verify all paperwork is completed and filed away within time frame. documentation will be kept in resident file.

DIRECTED: By 10/15/23: The administrator shall develop and implement a new admission checklist to ensure a preadmission screening is completed for each new admission with 30 days prior to admission. Copies of the completed checklists, as well as copies of the completed preadmission screening forms, shall be kept in each resident's record. All staff persons involved in the admission process shall be educated on the new checklist by 10/15/23. [redacted] 10/6/23

Directed Completion Date: 10/15/2023

Not Implemented ([redacted] - 11/08/2023)

225c - Additional Assessment

39. Requirements

2600.

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

1. Annually.

Description of Violation

On 8/10/23 at approximately 9:30 AM, resident #6 overturned the chair resident #1 was sitting in in the home's smoking area. As a result, resident #1 fell and struck [redacted] head on the ground and was sent to the hospital for evaluation. However, as of 8/25/23, resident #6's most recent assessment, dated [redacted]/22, indicates resident #6 requires minimal supervision and has no problem with irritability, agitation or aggression.

REPEAT VIOLATION: 8/23/2022, et. al.

Plan of Correction

Accept ([redacted] - 10/06/2023)

1. Assessment was updated for resident #6 on 8/11/2023.

2. all resident assessment were reviewed by DON and Administrator on 8/13/2023 changes were made, signatures were obtained. System in place on 8/11/2023 for all assessments to be reviewed monthly starting 8/13/2023 for DON and Administrator to review all care plans to ensure all behaviors are recorded, signed off on.

3. DON and administrator will review assessment monthly starting 9/13/2023, record any changes and sign off on resident assessment documentation and place it administrative office and resident chart

Licensee's Proposed Overall Completion Date: 10/02/2023

Not Implemented ([redacted] - 11/08/2023)

227a - Support Plan 30 Days

40. Requirements

227a - Support Plan 30 Days (continued)

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 #5 is currently receiving hospice services, to include assistance with bathing/showering; however, resident #5's most recent support plan, dated 6/6/23, does not indicate the specific services or frequency of services resident #5 is receiving from hospice.

REPEAT VIOLATION: 10/19/2022, et. al.

Plan of Correction

Directed (redacted) - 10/06/2023)

1. support plan was updated for resident #5 on 8/11/2023 by DON.

2. all resident support plans were reviewed by DON and Administrator on 8/13/2023. changes were made. Meeting held with assistant admin, med tech supervisor, DON and Administrator on how to complete a support plan. System in place on 8/11/2023 for DON and Administrator to review all assessments and support plan upon admission, quarterly for any significant change and yearly for renewal.

3. as of 8/13/2023. DON and administrator will review assessment admission, monthly, as needed and annually record any changes and sign off on resident assessment documentation and place in resident file

DIRECTED: By 10/15/23: The administrator shall develop and implement a system to ensure resident support plans are updated as resident care needs change. Documentation of the system shall be kept. All staff persons involved in completing resident support plans shall be educated on the new system by 10/15/23. Documentation of the education shall be kept in accordance with 2600.65i. (redacted) 10/6/23

Directed Completion Date: 10/15/2023

Not Implemented (redacted) - 11/08/2023)

252 - Record Content

41. Requirements

2600.

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

- 10. A record of incident reports for the individual resident.

Description of Violation

On 8/10/23 at approximately 9:30 AM, an incident of physical abuse occurred in the home between residents #1 and #6. The incident was reported to the Department on 8/10/23; however, as of 8/25/23, a copy of the incident report was not present in resident #1 or #6's records.

252 - Record Content (continued)

**Plan of Correction**

Accept [REDACTED] - 10/06/2023)

1. Incident report was placed in resident 1 & 6 chart on 8/10/2023.
  
2. meeting held on 8/25/2023 with Administrator, DON, assistant admin and supervisor to re-educate everyone on regulation 252. system in place on 8/25/2023 to file incident reports in resident files as well as file in administrative office and saved in tabula pro to review reports monthly during QM meetings.
  
3. Administrator and DON will review files monthly starting 8/25/2023. Check resident charts to verify they have a copy filed in chart and sign off on resident chart it was checked and verified. weekly management meetings in place on 8/13/2023 to go discuss incident reports and quarterly QM meetings to ensure documentation is on file.

Licensee's Proposed Overall Completion Date: 10/02/2023

Not Implemented [REDACTED] - 11/08/2023)

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

**Facility Information**

Name: *STERLING HOME* License #: *45269* License Expiration: *11/09/2023*  
Address: *1318 ARCH STREET, MCKEESPORT, PA 15132*  
County: *ALLEGHENY* Region: *WESTERN*

**Administrator**

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

**Legal Entity**

Name: *STERLING HOME LLC*  
Address: [REDACTED]  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *01/30/2023* Issued By: *L&I*  
Type: *C-2 LP* Date: *08/22/2023* Issued By: *L&I*

**Staffing Hours**

Resident Support Staff: Total Daily Staff: *36* Waking Staff: *27*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
Reason: *Incident* Exit Conference Date: *09/21/2023*

**Inspection Dates and Department Representative**

09/21/2023 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *42* Residents Served: *32*

**Secured Dementia Care Unit**

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

**Hospice**

Current Residents: *1*

**Number of Residents Who:**

Receive Supplemental Security Income: *26* Are 60 Years of Age or Older: *25*  
Diagnosed with Mental Illness: *25* Diagnosed with Intellectual Disability: *6*  
Have Mobility Need: *4* Have Physical Disability: *2*

**Inspections / Reviews**

**09/21/2023 - Partial**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *10/13/2023*

10/13/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/07/2023

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 10/19/2023

10/16/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/07/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 11/08/2023

11/08/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/07/2023

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

Resident #1's resident-home contract, dated [redacted]/23, is not signed by the resident or the administrator.

Plan of Correction

Accept ([redacted] - 10/13/2023)

1. Contract was signed by resident #1 and Administrator on 9/21/2023

2. All resident contracts were reviewed by Administrator on 9/22/2023 to verify signatures of all residents contracts. Meeting held with assistant administrator on 9/22/2023 to discuss new resident checklist document implemented on 9/21/2023 of every document that needs to be completed and filed in resident folder on date of admission.

3. Policy in place, implemented on 9/22/2023 for Administrator or assistant administrator to complete new resident checklist document to ensure contract is completed with all signatures required. Documentation will be placed in resident file. All resident files will be reviewed quarterly by Administrator starting 9/22/2023 and signed off on resident chart once completed.

Licensee's Proposed Overall Completion Date: 10/12/2023

Not Implemented ([redacted] - 11/08/2023)

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

From approximately [redacted]/23 through [redacted] 23, staff person A asked resident #1 for money. Resident #1 gave staff person A approximately \$500-\$600, which includes \$20 resident #1 gave to staff person A's [redacted], as well as \$40 resident #1 gave to staff person A's [redacted]. Resident #1 indicated [redacted] gave them the money because [redacted] "felt bad for them". Resident #1 also indicated [redacted] felt embarrassed afterwards, and felt that staff person A took advantage of [redacted].

REPEAT VIOLATION: 10/19/2022, et. al.

Plan of Correction

Directed ([redacted] - 10/16/2023)

1. Staff person A was immediately terminated. Administrator reported abuse to both DHS and AAA on 9/6/2023. Documentation is on file in administrative office. Administrator contact McKeesport police department, officer spoke to resident #1 [redacted] stated "[redacted] didn't want to press charges at this time". Administrator spoke to resident #1 about incident, [redacted] is aware [redacted] is to never give any money to an employee or outside person(s).

2. Resident council meeting was held on 9/6/2023. Administrator spoke to all residents and re-educated them they are not permitted to give anyone rather it's employees, residents or outsiders any money. Residents were educated

42b - Abuse (continued)

that they have the right to their possessions and staff members are never to ask for money. Residents were educated to immediately tell Administrator or member of management if anyone approaches them and asks for money. Administrator contacted local ombudsman to come in and speak to residents and staff members about their rights. Date is set for 10/23/2023 at 10am. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. [REDACTED] 10/16/23). Administrator will complete at least 5 random resident interviews once a month to ensure there is no violation of resident rights. Record of meeting and notes will be place in administrative office for review. (DIRECTED: The monthly resident interviews shall begin on 10/23/23. [REDACTED] 10/16/23). Administrator will review all resident interviews during quality management meetings quarterly. Next meeting is scheduled for November 8, 2023. (DIRECTED: Documentation of the quality management reviews shall be kept, which includes the dates of the reviews, names of staff persons who attended the quality management reviews and meeting minutes from the items discussed during each review. [REDACTED] 10/16/23).

3. Administrator will continue hold resident council meetings monthly. Administrator will hold monthly meetings with at least 5 residents monthly implemented on 9/22/2023. Administrator will have trainings with the ombudsman annually implemented on 9/22/2023. Administrator will continue to conduct quality management meeting to review all trainings and resident complaints. All documentation will be kept in administrative office according to 2600.65i

3.

Proposed Overall Completion Date: 10/13/2023

Directed Completion Date: 11/08/2023

Not Implemented [REDACTED] - 11/08/2023)

252 - Record Content

3. Requirements

2600.

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

10. A record of incident reports for the individual resident.

Description of Violation

On 9/6/23, an incident involving resident #1 was submitted to the Department; however, a copy of the incident report was not present in resident #1's resident record.

Plan of Correction

Directed ([REDACTED] 10/16/2023)

1. incident report was placed in resident #1 chart on 9/22/2023.

2. meeting held with assistant administrator, DON and assistant DON on 9/23/2023 re-educating them on 2600.252. system in place on 9/22/2023 to file all incident reports in resident charts and in incident reporting binder located in administrative office. (DIRECTED: Documentation of the staff education shall be kept in accordance

252 - Record Content (continued)

with 2600.65i. [REDACTED] 10/16/23). System in place on 9/22/2023 to review all incident reports monthly and during quality management meetings quarterly. next meeting is scheduled for November 8, 2023. (DIRECTED: Documentation of the quality management reviews shall be kept, which includes the dates of the reviews, names of staff persons who attended the quality management reviews and meeting minutes from the items discussed during each review. [REDACTED] 10/16/23).

3. Administrator, assistant Admin and DON will review incident reports monthly starting 9/22/2023. Quarterly quality management meetings will be held by Administrator, incident reports will continue to be reviewed as well as resident interviews. All resident charts will be reviewed monthly. All documentation will be kept on file according to regulations in administrative office.

Proposed Overall Completion Date: 10/13/2023

Directed Completion Date: 11/08/2023

Not Implemented ([REDACTED] 11/08/2023)