pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ALEXANDRIA MANOR OF ALLENTOWN INC**
LEGAL ENTITY

To operate **ALEXANDRIA MANOR II**
NAME OF FACILITY OR AGENCY

Located at **313 S. WALNUT ST., BATH, PA 18014**
(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 **78**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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 **December 19, 2023** until **December 19, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **205260**

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 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Mailing Date: December 19, 2023

[redacted]
President
Alexandria Manor of Allentown, Inc.
[redacted]

RE: Alexandria Manor II
313 South Walnut Street
Bath, Pennsylvania 18014
License #: 205260

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on September 6, 2023 and September 7, 2023 which we conducted on-site inspections, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

Facility Information

Name: *ALEXANDRIA MANOR II* **License #**: *20526* **License Expiration**: *11/05/2023*

Address: *313 S. WALNUT ST., BATH, PA 18014*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *ALEXANDRIA MANOR OF ALLENTOWN INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/27/1998* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *44* **Waking Staff**: *33*

Inspection Information

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

Reason: *Provisional* **Exit Conference Date**: *09/07/2023*

Inspection Dates and Department Representative

09/06/2023 - On-Site: [redacted]

09/07/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *78* **Residents Served**: *39*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *39*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *5* **Have Physical Disability**: *0*

Inspections / Reviews

09/06/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/30/2023*

Inspections / Reviews *(continued)*

10/02/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/12/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/06/2023*

10/03/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *12/12/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/09/2023*

10/17/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/12/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/20/2023*

12/07/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/12/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/11/2023*

12/12/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *12/12/2023*

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

3c - Post Current License

1. Requirements

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

Description of Violation

Upon arrival at the home the home's current license was posted on the bulletin board underneath the Ombudsman poster along with all of the home's previous License Inspection Summary (LIS) reports. Also, the home did not post the LIS report dated 6/5/23.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

All inspections are now posted including the June 5, 2023 LIS report. This was corrected on the date of this finding, 9/6/2023.

Staff have been educated on Regulation 3C posting of current license and LIS reports and the need for this information to remain on the bulletin board.

Weekly audits will be performed by the admin/designee to assure compliance. Weekly times 6 weeks, then monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

All inspections are now posted including the June 5, 2023 LIS report. This was corrected on the date of this finding, 9/6/2023.

Staff have been educated on Regulation 3C posting of current license and LIS reports and the need for this information to remain on the bulletin board.

Weekly audits will be performed by the admin/designee to assure compliance. Weekly times 6 weeks, then monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Not Implemented [redacted] - 10/17/2023)***

See attached.

Evidence of Completion ***Not Implemented [redacted] - 12/07/2023)***

See attached.

3c - Post Current License *(continued)*

Evidence of Completion ***Implemented [redacted] - 12/12/2023)***

See attached.

28f - Resident's Funds and 30-day Refund

2. Requirements

2600.
28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident #1 passed away on [redacted] The home did not issue a refund check to their responsible party until [redacted].

Plan of Correction ***Do Not Accept ([redacted] - 10/02/2023)***

Financial staff was educated on Regulation 28f resident funds and the 30day refund.

Financial staff will identify date payment is required to meet this regulation upon the discharge of any resident to assure funds are made within the 30 days of discharge.

An audit will be performed by admin monthly to assure compliance with this regulation.

Audits will be reviewed by admin [redacted] monthly, times 6 months to assure compliance.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were financial staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

Financial staff was educated on Regulation 28f resident funds and the 30day refund.

Financial staff will identify date payment is required to meet this regulation upon the discharge of any resident to assure funds are made within the 30 days of discharge.

An audit will be performed by admin monthly to assure compliance with this regulation.

Audits will be reviewed by admin [redacted] monthly, times 6 months to assure compliance.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

28f - Resident's Funds and 30-day Refund *(continued)*

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented [redacted] - 10/17/2023)***

See attached.

51 - Criminal Background Check

3. 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

The home did not have documentation of a criminal background check for staff person A who was hired on [redacted]/23.
REPEAT VIOLATION: 8-16-22, 3-29-23

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

Criminal history check of this staff person has been completed and is on file.

Staff who complete the onboarding process will be re-educated on regulation 51 criminal background check requirement. New process for criminal background checks is currently pending and being put into place.

Moving forward no staff will start employment without this being completed and on file.

Monthly audits will be performed by admin/designee, monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

Criminal history check of this staff person has been completed and is on file.

Staff who complete the onboarding process will be re-educated on regulation 51 criminal background check requirement. New process for criminal background checks is currently pending and being put into place.

Moving forward no staff will start employment without this being completed and on file.

Monthly audits will be performed by admin/designee, monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

51 - Criminal Background Check *(continued)*

Evidence of Completion ***Implemented [redacted] 10/17/2023)***

See attached.

54a - Direct Care Staff

4. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Staff person B, who was hired on [redacted]/23 as a personal care aide, does not have a high school diploma, GED, or active registry in a nursing field.
REPEAT VIOLATION: 8-16-22

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

Staff member quit when documentation was requested to meet regulation.

Staff who complete the onboarding process will be educated on 54aDirect Care Staff GED, diploma or registry requirement.

No staff will start employment without meeting the requirement of this regulation.

Monthly audits will be performed by admin/designee, monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

Staff member quit when documentation was requested to meet regulation.

Staff who complete the onboarding process will be educated on 54aDirect Care Staff GED, diploma or registry requirement.

No staff will start employment without meeting the requirement of this regulation.

Monthly audits will be performed by admin/designee, monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

54a - Direct Care Staff (continued)

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented ([redacted] - 10/17/2023)***

See attached.

64c - Annual Training

5. Requirements

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

The home's administrator, staff person[redacted], did not have documentation of completing 24 hours of administrator training for the training year 2022.

Plan of Correction ***Accept[redacted] - 10/02/2023)***

Staff person[redacted] is in the process up completing their annual training requirements.

Admin will establish a system to assure ongoing monitoring of staff/admin education completion and compliance.

Audits will be performed by admin/designee to assure all staff have completed required annual training.

As the administrator I am responsible for proper ongoing compliance.

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

Evidence of Completion ***Implemented[redacted] - 10/17/2023)***

See attached.

65d - Initial Direct Care Training

6. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Staff person B, who was hired as a personal care aide on [redacted]/23, did not take the department's direct care competency test until [redacted]/23.

Plan of Correction ***Accept[redacted] - 10/02/2023)***

Admin reviewed the regulation related to direct care training and has completed a review of all staff files to assure testing was completed and done timely.

All new hires will have this competency testing prior to any unsupervised ADL services are performed.

Audit was performed by admin to assure this regulation requirement is met. Admin/designee will perform monthly

65d - Initial Direct Care Training (continued)

audit times 6 months to ensure compliance with regulation.

As the administrator I am responsible for proper ongoing compliance.

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

Evidence of Completion ***Implemented [redacted] - 10/17/2023)***

See attached.

65f - Training Topics

7. Requirements

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

The home did not have documentation that staff persons D, E, and F completed the trainings required under this regulation in 2022.

Plan of Correction ***Accept [redacted] - 10/02/2023)***

Employees D,E and F have now completed their annual training requirements.

All staff files reviewed by admin to assure all staff have now completed their annual training requirements.

Staff education will be provided to all staff related to the requirement of annual training.

Admin will establish a system to assure ongoing monitoring of staff education completion and compliance.

Audits will be performed by admin/designee to assure all staff have completed required annual training.

As the administrator I am responsible for proper ongoing compliance.

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

Evidence of Completion ***Not Implemented ([redacted] - 10/17/2023)***

See attached.

65f - Training Topics *(continued)*

Evidence of Completion ***Not Implemented (- 12/07/2023)***

Fire Training scheduled for November 3rd at 2pm with Fire Expert

Update: *12/07/2023*

Please send training.

Evidence of Completion ***Implemented - 12/12/2023)***

See attached.

65g - Annual Training Content

8. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

The home did not have documentation that staff persons D, E, and F completed the trainings required under this regulation in 2022.

Plan of Correction ***Accept - 10/02/2023)***

Employees D,E and F have now completed their annual training requirements.

All staff files reviewed by admin to assure all staff have now completed their annual training requirements.

Staff education will be provided to all staff related to the requirement of annual training.

Admin will establish a system to assure ongoing monitoring of staff education completion and compliance.

Audits will be performed by admin/designee to assure all staff have completed required annual training.

As the administrator I am responsible for proper ongoing compliance.

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

Evidence of Completion ***Implemented - 10/17/2023)***

See attached.

82c - Locking Poisonous Materials

9. Requirements

2600.

82c - Locking Poisonous Materials *(continued)*

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

A 1.5 oz bottle of Medline deodorant and a 16.9 oz. bottle of Assured Brand mouth rinse antiseptic were noted in Resident #2's bathroom. Both bottles have the instructions to get medical help or contact Poison Control if swallowed. Review of resident #2's Documentation of Medical Evaluation (DME) form dated [redacted]/23 does not indicate that they can safely use or avoid poisonous materials.

Plan of Correction ***Do Not Accept [redacted] 10/02/2023)***

Deodorant and mouth wash was removed from resident's bathroom on 9/6/2023.

All staff have been re-educated on the importance of regulation 82c locking poisonous material.

PCA's will audit rooms daily while on shift.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

Deodorant and mouth wash was removed from resident's bathroom on 9/6/2023.

All staff have been re-educated on the importance of regulation 82c locking poisonous material.

PCA's will audit rooms daily while on shift.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented [redacted] - 10/17/2023)***

See attached.

85a - Sanitary Conditions

10. Requirements

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

Description of Violation

The 2nd floor memory care area had a strong odor of urine throughout the common areas.
A strong smell of urine was noted in the first-floor hall near the exit to the resident smoking area.
Mold was noted on the shower floor in the common bathroom located on the first floor.
The refrigerator/freezer in the 2nd floor kitchenette has spilled food and liquids on the shelves.

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

All areas cleaned thoroughly on 9/7/2023.

All staff educated on 85a Sanitary Conditions. Staff educated on need to report any areas in need of attention. Staff educated on disposing of items such as incontinent briefs immediately in order to assist with environmental odor.

Senior cook was placed in charge of all kitchen duties, including cleaning of main kitchen refrigerator/freezer and kitchenette refrigerator/freezer. Along with dry storage areas. Weekly audits will be done times 6 months.

Daily audits will be completed by medtech on duty regarding odors and cleanliness times 6 months.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept ([redacted] - 10/03/2023)***

All areas cleaned thoroughly on 9/7/2023.

All staff educated on 85a Sanitary Conditions. Staff educated on need to report any areas in need of attention. Staff educated on disposing of items such as incontinent briefs immediately in order to assist with environmental odor.

Senior cook was placed in charge of all kitchen duties, including cleaning of main kitchen refrigerator/freezer and kitchenette refrigerator/freezer. Along with dry storage areas. Weekly audits will be done times 6 months.

Daily audits will be completed by medtech on duty regarding odors and cleanliness times 6 months.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented ([redacted] - 10/17/2023)***

See attached.

85d - Trash Receptacles

11. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

85d - Trash Receptacles *(continued)*

Description of Violation

The trash can in the kitchen area of the 2nd floor contained food garbage and did not have a lid that covered the can to prevent intrusion of pests.
A trash can in the bathroom of room # 15 was not covered and was filled with soiled adult briefs

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

This trash can was removed day of inspection 9/6/2023

An immediate audit of all trash cans was completed to assure proper lid coverage on 9/6/2023

Staff were educated on the 85-d trash receptacle regulation and the need to report broken items in need of replacement.

Audits will be completed weekly times 4 weeks by senior cook, then monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

This trash can was removed day of inspection 9/6/2023

An immediate audit of all trash cans was completed to assure proper lid coverage on 9/6/2023

Staff were educated on the 85-d trash receptacle regulation and the need to report broken items in need of replacement.

Audits will be completed weekly times 4 weeks by senior cook, then monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Not Implemented ([redacted] - 10/17/2023)***

See attached.

Evidence of Completion ***Not Implemented [redacted] 12/07/2023)***

Trash cans were audited same day. Staff were told to remove garbage bag after use. All must have lids.

Evidence of Completion ***Implemented [redacted] - 12/12/2023)***

See attached.

88a - Surfaces

12. Requirements

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

Description of Violation

A hole was observed in the flooring of room # 19 measuring approximately 12" long and 2" wide which posed a tripping hazard.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

The hole observed has been repaired.

Admin and maintenance staff have completed a facility wide inspection to assure no other surfaces in need of repair.

Staff education will be completed to help all staff be aware of 88a Surface regulation and to report any findings so they may be addressed.

Audits will be performed by admin and maintenance staff weekly times 6 weeks, then monthly for 6 months.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

The hole observed has been repaired.

Admin and maintenance staff have completed a facility wide inspection to assure no other surfaces in need of repair.

Staff education will be completed to help all staff be aware of 88a Surface regulation and to report any findings so they may be addressed.

Audits will be performed by admin and maintenance staff weekly times 6 weeks, then monthly for 6 months.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented [redacted] - 10/17/2023)***

See attached.

91 - Telephone Numbers

13. Requirements

2600.

91 - Telephone Numbers *(continued)*

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

The required emergency phone numbers were not posted on or near the land line phones in Resident #3's room.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

Emergency phone numbers were posted in resident room on 9/6/2023

A facility wide audit was completed on 9/7/2023 to assure all telephones had the required numbers posted.

Staff education will be provided to all staff on this regulation 91 telephone numbers and staff will be instructed to report any missing emergency numbers so they may be re-placed immediately.

Audit will be performed by admin/designee weekly times 6 weeks, then monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

Emergency phone numbers were posted in resident room on 9/6/2023

A facility wide audit was completed on 9/7/2023 to assure all telephones had the required numbers posted.

Staff education will be provided to all staff on this regulation 91 telephone numbers and staff will be instructed to report any missing emergency numbers so they may be re-placed immediately.

Audit will be performed by admin/designee weekly times 6 weeks, then monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented ([redacted] - 10/17/2023)***

See attached.

96a - First Aid Kit

14. Requirements

2600.

96a - First Aid Kit *(continued)*

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

The First Aid kit was missing tweezers, tape, and a thermometer.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

The first aid kit was replenished with the items on 9/7/2023.

Staff will be instructed on the need to replace items in the first aid kits as they are used.

A listing of all items to be in the first aid kit is available with the kit. All staff educated on 96 A First Aid kit regulation.

Audit of the first aid kit will be completed twice daily at change of shift, times 6 weeks.

Audits will additionally be done monthly times 6 monthly, after the 6-week period.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept ([redacted] - 10/03/2023)***

The first aid kit was replenished with the items on 9/7/2023.

Staff will be instructed on the need to replace items in the first aid kits as they are used.

A listing of all items to be in the first aid kit is available with the kit. All staff educated on 96 A First Aid kit regulation.

Audit of the first aid kit will be completed twice daily at change of shift, times 6 weeks.

Audits will additionally be done monthly times 6 monthly, after the 6-week period.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

96a - First Aid Kit *(continued)*

Evidence of Completion ***Not Implemented [redacted] - 10/17/2023)***

See attached.

Evidence of Completion ***Implemented ([redacted] - 12/07/2023)***

See attached.

Firest Aid box was changed, every item added and a band was placed around it.

101j7 - Lighting/Operable Lamp

15. Requirements

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

Description of Violation

Resident #4's room did not have a lamp or other accessible source of lighting at bedside.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

All resident rooms were audited on 9/7/2023 and all resident room have a light at the bedside.

Staff will be educated on this regulation 101j7 and the need to report if lighting is not available so it may be replaced.

Audits will be done by admin/designee weekly times 6 weeks, then monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

All resident rooms were audited on 9/7/2023 and all resident room have a light at the bedside.

Staff were educated on this regulation 101j7 and the need to report if lighting is not available so it may be replaced.

Audits will be done by admin/designee weekly times 6 weeks, then monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented [redacted] - 10/17/2023)***

See attached.

102k - No Common Towel

16. Requirements

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

A used washcloth was hanging in the shower of the 1st floor common bathroom.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

This was corrected immediately at the time of finding during the inspection on 9/6/2023

A facility wide audit was completed to assure no other common bathroom had this item. Disposable hand towels are available in each common area bathroom daily.

All staff will be educated on regulation 102k no common towels allowed.

Audits will be completed daily by housekeeping staff.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

This was corrected immediately at the time of finding during the inspection on 9/6/2023

A facility wide audit was completed to assure no other common bathroom had this item. Disposable hand towels are available in each common area bathroom daily.

All staff will be educated on regulation 102k no common towels allowed.

Audits will be completed daily by housekeeping staff.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented [redacted] - 10/17/2023)***

See attached.

103e - Left Overs

17. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

103e - Left Overs *(continued)*

Description of Violation

Two plastic containers with leftover food were found in the refrigerator in the 2nd floor kitchenette. The containers were not labeled or dated. The following items were not labeled or dated in the refrigerators and freezers in the 2nd floor kitchenettes: several ice cream sandwiches in a zip lock bag; a bag of cheerios; a bag of frosted Mini Wheats; and Frozen Orieda French Fries. Several bags of dried cereal that were not labeled or dated were found in the main kitchen cabinets.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

This was corrected at the time of the finding.

All staff will be educated related to 103e Leftovers with emphasis on the need to label and date any items in the refrigerators.

Audits will be performed daily by kitchen staff to assure no undated/unlabeled food found in refrigerators/freezer.

Admin will review these audits weekly times 6 weeks, then monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

This was corrected at the time of the finding.

All staff will be educated related to 103e Leftovers with emphasis on the need to label and date any items in the refrigerators.

Audits will be performed daily by kitchen staff to assure no undated/unlabeled food found in refrigerators/freezer.

Admin will review these audits weekly times 6 weeks, then monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Not Implemented ([redacted] - 10/17/2023)***

See attached.

Evidence of Completion ***Implemented [redacted] - 12/07/2023)***

All fridge/freezers were audit same day.

105g - Lint Removal and Duct Cleaning

18. Requirements

2600.

105g - Lint Removal and Duct Cleaning *(continued)*

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

Description of Violation

All four dryers located in the basement laundry room had layers of lint in the lint traps from previous uses.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

All dryers were cleaned at the time of this finding on 9/6/2023.

All staff will be educated on regulation 105g and the importance of cleaning the lint trap, drum and vent duct according to manufacturer's instructions.

Lint removal audit sheets have been placed in laundry room for staff to sign when removing items from dryers and checking lint traps.

Maintenance will audit/check dryer vents weekly moving forward.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

All dryers were cleaned at the time of this finding on 9/6/2023.

All staff will be educated on regulation 105g and the importance of cleaning the lint trap, drum and vent duct according to manufacturer's instructions.

Lint removal audit sheets have been placed in laundry room for staff to sign when removing items from dryers and checking lint traps.

Maintenance will audit/check dryer vents weekly moving forward.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented [redacted] - 10/17/2023)***

See attached.

125a - Combustible Storage

19. Requirements

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

Description of Violation

Several cigarette butts were observed on the ground with dried leaves near the storm drain in the back parking lot.

Plan of Correction ***Do Not Accept ([redacted] - 10/02/2023)***

All cigarette remains were cleaned on day of inspection 9/6/2023

All staff and residents who smoke will be educated related to smoking and this regulation and concerns related to combustible materials.

Proper receptacle for smoking are in place and encouraged to be utilized.

Daily audit of the smoking areas will be performed by admin or designee.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept ([redacted] - 10/03/2023)***

All cigarette remains were cleaned on day of inspection 9/6/2023

All staff and residents who smoke will be educated related to smoking and this regulation and concerns related to combustible materials.

Proper receptacle for smoking are in place and encouraged to be utilized.

Daily audit of the smoking areas will be performed by admin or designee.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented ([redacted] - 10/17/2023)***

See attached.

141a 1-10 Medical Evaluation Information

20. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

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

Description of Violation

The Initial DME for resident #5, dated [redacted]/23 does not indicate the need for body positioning or movement if any. The annual DME on record for Resident #3 is missing the following information: the date the resident was evaluated; the date the evaluation was completed; medical diagnosis; special health or dietary needs; immunization history and body positioning.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

Unable to correct current DME, moving forward plan has been put into place.

All staff will be education on regulation 141 a medical evaluation information and requirements of completion.

All records have been audited for these items and found to be compliance.

DME's will be audited day of move in to ensure full compliance.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

Unable to correct current DME, moving forward plan has been put into place.

All staff were education on regulation 141 a medical evaluation information and requirements of completion.

All records have been audited for these items and found to be compliance.

DME's will be audited day of move in to ensure full compliance.

As the administrator I am responsible for proper ongoing compliance.

141a 1-10 Medical Evaluation Information (continued)

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Not Implemented [redacted] - 10/17/2023)***

See attached.

Evidence of Completion ***Not Implemented [redacted] - 12/07/2023)***

All charts audit with completion list available.

Update: *12/07/2023*

Please send resident #3 and #5's DMEs. Please send training and audits.

Evidence of Completion ***Implemented [redacted] - 12/12/2023)***

See attached.

141b1 - Annual Medical Evaluation

21. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

The most recent DME for resident #6 was completed on [redacted]/2019.
The annual DME on record for Resident #3, admitted [redacted]/22, is not dated to indicate when it was completed.
REPEAT VIOLATION: 3-29-23.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

Resident # 6 DME was completed with signature and date.

All residents DME were audited/reviewed to assure compliance with date completed.

All staff we re-educated on regulation 141b1 and the importance of signing and dating the medical evaluation.

Audits will be performed monthly times 6 months to ensure compliance.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

141b1 - Annual Medical Evaluation *(continued)*

Plan of Correction ***Accept (- 10/03/2023)***

Resident # 6 DME was completed with signature and date.

All residents DME were audited/reviewed to assure compliance with date completed.

All staff were re-educated on regulation 141b1 and the importance of signing and dating the medical evaluation.

Audits will be performed monthly times 6 months to ensure compliance.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Not Implemented (10/17/2023)***

See attached.

Evidence of Completion ***Not Implemented (- 12/07/2023)***

All charts audit with completion list available.

Update: *12/07/2023*

Please send residents #3 & #6's annual DMEs with corrections. Please send training documentation.

Evidence of Completion ***Implemented - 12/12/2023)***

See attached.

181c - Self-administration Assessment

22. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

During an interview with resident #3, the resident showed Dept. Rep a bottle of Ibuprofen and bottle of aspirin in their dresser drawer. The resident is not assessed to self-administer medications.

Plan of Correction ***Do Not Accept - 10/02/2023)***

Resident # 3 is unable to self- administrator medication; family has been made aware to not bring medication in for this resident unless it is prescribed by a doctor and given to staff for administration.

All staff were educated on 181C Self administration assessment and the need to report medications at the bedside of resident to medtech or administrator.

181c - Self-administration Assessment (continued)

Audits of resident rooms were completed on 9/7/2023.

Audits of resident rooms will be done weekly by medtech, admin or designee to ensure no medication is in rooms.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

Resident # 3 is unable to self- administrator medication; family has been made aware to not bring medication in for this resident unless it is prescribed by a doctor and given to staff for administration.

All staff were educated on 181C Self administration assessment and the need to report medications at the bedside of resident to medtech or administrator.

Audits of resident rooms were completed on 9/7/2023.

Audits of resident rooms will be done weekly by medtech, admin or designee to ensure no medication is in rooms.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented [redacted] - 10/17/2023)***

See attached.

182b - Prescription Medication

23. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person G's med tech annual practicum training dated 11/12/22 included only one medication administration observation.

182b - Prescription Medication *(continued)*

Plan of Correction ***Accept (- 10/02/2023)***

Staff person G was observed on 9/6/2023, performing a medication pass to ensure compliance.

All training records were audited to assure a complete observation was performed on all staff who pass medications.

Audits will be performed by admin/designee monthly times 12 months.

As the administrator I am responsible for proper ongoing compliance.

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

Evidence of Completion ***Implemented - 10/17/2023)***

See attached.

183e - Storing Medications

24. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

The insulin pen belonging to resident #7 was not dated when the pen was opened for use.
The Advair inhaler belonging to resident #9 was not dated when the inhaler was opened for use.

Plan of Correction ***Do Not Accept - 10/02/2023)***

Resident # 7 and # 9 items were dated and corrected on 9/8/2023

All med carts were audited on 9/8/2023 to ensure compliance with regulation.

All medtechs will be re-educated on 183e storing of medications and the need to date when opening any new item.

Audits of the medication carts will be performed weekly by admin or designee moving forward.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept - 10/03/2023)***

Resident # 7 and # 9 items were dated and corrected on 9/8/2023

All med carts were audited on 9/8/2023 to ensure compliance with regulation.

All medtechs will be re-educated on 183e storing of medications and the need to date when opening any new item.

Audits of the medication carts will be performed weekly by admin or designee moving forward.

183e - Storing Medications (continued)

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented [redacted] - 10/17/2023)***

See attached.

184a - Resident's Meds Labeled

25. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #7 has an order for Lantus insulin, 24 units daily at bedtime. The pharmacy label on the insulin pen indicates the old order which was for 14 units at bedtime.
Resident #8 has an order for Hydrocodone, 1 tablet 3 times daily as needed. The pharmacy label indicates the order is for 1 tablet 3 times daily for 30 days.
Resident #8 had an order for Levofloxacin 500 mg to be taken for 7 days. The pharmacy label states the order is 1 tablet in the morning.
REPEAT VIOLATION: 3-29-23.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

Resident # 7 and # 8 items were corrected on 9/7/2023

Pharmacy was made aware of these issues and was asked by facility admin to include proper instructions on label.

All med carts were audited on 9/8/2023 to ensure compliance with regulation.

All medtechs will be re-educated on 184a resident med labels and the importance of having all instruction listed.

Audits of the medication carts will be performed weekly by admin or designee moving forward.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

Resident # 7 and # 8 items were corrected on 9/7/2023

184a - Resident's Meds Labeled (continued)

Pharmacy was made aware of these issues and was asked by facility admin to include proper instructions on label.

All med carts were audited on 9/8/2023 to ensure compliance with regulation.

All medtechs will be re-educated on 184a resident med labels and the importance of having all instruction listed.

Audits of the medication carts will be performed weekly by admin or designee moving forward.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented [redacted] - 10/17/2023)***

See attached.

185a - Implement Storage Procedures

26. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

The glucometer belonging to resident #9 was not calibrated to the correct month, day, or time of day.
REPEAT VIOLATION: 3-29-23.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

Resident # 9 glucometer was replaced on 9/7/2023.

Medtechs have been re-educated on the importance of glucometer calibration and regulation 185a.

Audits we be performed by admin or designee weekly moving forward.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

Resident # 9 glucometer was replaced on 9/7/2023.

Medtechs have been re-educated on the importance of glucometer calibration and regulation 185a.

Audits we be performed by admin or designee weekly moving forward.

185a - Implement Storage Procedures (continued)

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented [redacted] - 10/17/2023)***

See attached.

187a - Medication Record

27. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #8 has an order for Diclofenac sodium 1% gel. The medication administration record (MAR) doesn't include a diagnosis for the medicated gel.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

Resident # 8 MAR was updated on 9/7/2023

Medtechs will be re-educated on regulation relating to 187a medication record with emphasis on the need to have a diagnosis for the use of medications.

Audits will be performed by admin or designee weekly times 6 weeks, then monthly moving forward.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

Resident # 8 MAR was updated on 9/7/2023

Medtechs were re-educated on regulation relating to 187a medication record with emphasis on the need to have a diagnosis for the use of medications.

Audits will be performed by admin or designee weekly times 6 weeks, then monthly moving forward.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

187a - Medication Record *(continued)*

Evidence of Completion ***Implemented ([redacted] - 10/17/2023)***

See attached.

187b - Date/Time of Medication Admin.

28. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #7 has an order listed on the MAR for Lisinopril 20 mg, 1 tablet at bedtime. The medication was not found in the cart. The medication was labeled as administered from 9/1/23 to 9/5/23.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

Pharmacy was contacted immediately for medication.

Medtechs will be re-educated on regulation relating to 187b date/time medication admin with emphasis on the need to always have medication in facility.

Audits of the medication carts will be performed weekly by admin or designee moving forward to maintain compliance.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept [redacted] - 10/03/2023)***

Pharmacy was contacted immediately for medication.

Medtechs were re-educated on regulation relating to 187b date/time medication admin with emphasis on the need to always have medication in facility.

Audits of the medication carts will be performed weekly by admin or designee moving forward to maintain compliance.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented [redacted] - 10/17/2023)***

See attached.

187d - Follow Prescriber's Orders

29. Requirements

2600.

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

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

Description of Violation

Resident #8 has an order for Metoprolol 25mg, twice daily, to be held if the heart rate is below 55. On 9/6/23 the resident's heart rate was 79 and the MAR indicates the medication was held.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

Staff person was individually educated on this finding on 9/7/2023

All medtechs will be educated on regulation 187d follow prescriber orders with emphasis on training for parameters and holding of medications.

Med Pass Audit will be completed weekly times 6 weeks, monthly times 6 months, then randomly moving forward.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*

When were staff trained?

Plan of Correction ***Accept[redacted] - 10/03/2023)***

Staff person was individually educated on this finding on 9/7/2023

All medtechs were educated on regulation 187d follow prescriber orders with emphasis on training for parameters and holding of medications.

Med Pass Audit will be completed weekly times 6 weeks, monthly times 6 months, then randomly moving forward.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented [redacted] - 10/17/2023)***

See attached.

225c - Additional Assessment

30. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

The most recent annual RASP for resident #10 was completed on [redacted]/22.
The most recent annual RASP for resident #6 was completed on [redacted]/21.
The annual RASP for resident #3 is not dated to indicate when it was completed.

225c - Additional Assessment (continued)

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

A new annual RASP was completed for Resident # 10, Resident 6 and # 3.

Staff education to those who complete the RASP will be completed on regulation 225c and the importance of meeting this regulation with annual assessment date and signature.

All resident charts were audited and reviewed for the date of their next annual assessment and a calendar made to assure compliance with this regulation.

Audits will be performed by admin or designee monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*
When were staff trained?

Plan of Correction ***Accept ([redacted] - 10/03/2023)***

A new annual RASP was completed for Resident # 10, Resident 6 and # 3.

Staff education to those who complete the RASP will be completed on regulation 225c and the importance of meeting this regulation with annual assessment date and signature.

All resident charts were audited and reviewed for the date of their next annual assessment and a calendar made to assure compliance with this regulation.

Audits will be performed by admin or designee monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Not Implemented [redacted] - 10/17/2023)***

See attached.

Evidence of Completion ***Not Implemented [redacted] - 12/07/2023)***

All charts audit with completion list available.

Update: *12/07/2023*
Please send staff training and audts.

225c - Additional Assessment *(continued)*

Evidence of Completion ***Implemented (- 12/12/2023)***

See attached.

227h - Support Plan Refuse Sign

31. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

The annual RASP for resident #3 was not signed by the resident or the person who completed the assessment.

Plan of Correction ***Do Not Accept (- 10/02/2023)***

The annual RASP for Resident # 3 was reviewed with the resident and is now signed by the resident and the person completing the assessment.

Staff who complete these assessments will be re-educated on the RASP requirements including signatures and how to handle if a resident refuses to sign.

Audits will be completed by admin or designee monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*
When were staff trained?

Plan of Correction ***Accept 10/03/2023)***

The annual RASP for Resident # 3 was reviewed with the resident and is now signed by the resident and the person completing the assessment.

Staff who complete these assessments will be re-educated on the RASP requirements including signatures and how to handle if a resident refuses to sign.

Audits will be completed by admin or designee monthly times 6 months.

As the administrator I am responsible for proper ongoing compliance.

Training done 9/26/2023

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented (- 10/17/2023)***

See attached.

254c - Records Storing

32. Requirements

2600.

254c - Records Storing *(continued)*

254.c. Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging.

Description of Violation

On the day of inspection at 10:15am, Dept. Rep. noted the Administrator's office and connecting back office, were unlocked and unattended. Resident records are stored in each room and were accessible to unauthorized persons.

Plan of Correction ***Do Not Accept [redacted] - 10/02/2023)***

This has been corrected and the office is locked when not in attendance.

The admin reviewed the 254c Records Storing requirement and is aware of the need to secure medical records when not in the office.

As the administrator I am responsible for proper ongoing compliance.

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

Update: *10/02/2023*
POC steps
Who is responsible for fixing the problem (their name-title) and what did they do to fix it?
What action that person will take, and when that action will happen - (must have date).
Who (name and title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept ([redacted] - 10/03/2023)***

This has been corrected and the office is locked when not in attendance.

The admin reviewed the 254c Records Storing requirement and is aware of the need to secure medical records when not in the office.

Admin or designee are responsible for making sure all records are locked, records have been moved to different locked location as of 9/12/2023.

As the administrator I am responsible for proper ongoing compliance.

Licensee's Proposed Overall Completion Date: *10/03/2023*

Evidence of Completion ***Implemented [redacted] - 10/17/2023)***

See attached.