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**
NAME OF FACILITY OR AGENCY

Located at **7 SOUTH NEW STREET, NAZARETH, PA 18064**
(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 **93**
(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 **February 15, 2024** until **May 15, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **210641**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email [redacted]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: FEBRUARY 15, 2024

[redacted] Owner
Alexandria Manor of Allentown Inc.
7 South New Street
Nazareth, Pennsylvania 18064

RE: Alexandria Manor
7 South New Street
Nazareth, Pennsylvania
18064 License # 210641

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on September 26, 2023 and January 4, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (210640) dated August 15,2023 to August 15, 2024 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated August 15, 2023 to August 15, 2024 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to <62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4);(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from February 15, 2024 to May 15, 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 or § 2800 (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 or 2800 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
82c	II	67	$5	$335	5 calendar days from mailing date of this letter
85a	II	67	$5	$335	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.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

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

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *ALEXANDRIA MANOR* **License #:** *21064* **License Expiration:** *08/15/2024*

Address: *7 SOUTH NEW STREET, NAZARETH, PA 18064*

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

Administrator

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

Legal Entity

Name: *ALEXANDRIA MANOR OF ALLENTOWN INC*

Address: *7 SOUTH NEW STREET, NAZARETH, PA, 18064*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *05/17/1994* **Issued By:** *DLI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *77* **Waking Staff:** *58*

Inspection Information

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

Reason: *Complaint, Incident, Interim* **Exit Conference Date:** *01/04/2024*

Inspection Dates and Department Representative

01/04/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *93* **Residents Served:** *67*

Secured Dementia Care Unit

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

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *66*

Diagnosed with Mental Illness: *4* **Diagnosed with Intellectual Disability:** *3*

Have Mobility Need: *10* **Have Physical Disability:** *2*

Inspections / Reviews

01/04/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/01/2024*

02/12/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/31/2024*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

65f - Training Topics

1. 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.
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.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff member B hired [redacted] did not receive training in instructions on meeting the needs of the residents as identified in the preadmission screening, documentation of medical evaluation and the resident assessment and support plan and care for residents with mental illness and intellectual disabilities in 2023.

Direct care staff member C hired [redacted] did not receive training in medication self-administration, instructions on meeting the needs of the residents as identified in the preadmission screening, documentation of medical evaluation and the resident assessment and support plan, infection control and care for residents with mental illness and intellectual disabilities in 2023.

Plan of Correction ***Directed [redacted] - 02/01/2024)***

Unable to resolve immediate violation at time of inspection. Moving forward, [redacted] Administrator will be responsible to maintain and monitor compliance in training topics for annual training of direct care staff persons. [redacted] Administrator has developed an annual training schedule for 2024 with multiple dates and times to ensure staff participation and certification in all mandatory training topics in order to sustain compliance with DHS regulations. This annual training schedule will also be developed and scheduled in December of every year for the following year. [redacted] Administrator and [redacted] Assistant Administrator have also developed and will incorporate with all new hires an extensive orientation process to include all annual training topics upon hire to ensure all staff maintain adequate annual training. Attached scheduled 2024 annual training for all DCS staff and new hire orientation checklist. [redacted] Administrator

Proposed Overall Completion Date: 01/31/2024

All direct care employee training records for training year 2023 will be audited to ensure all the required training topics under this regulation have been completed. Staff members that have not received training will be retrained. The 2024 staff training plan will include training on all of the required topics to include:
(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.

65f - Training Topics (continued)

(7) Care for residents with mental illness or mental retardation, or both, if the population is served in the home.

Documentation will be kept for the Departments review upon request.

Directed Completion Date: *03/13/2024*

65g - Annual Training Content

2. 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:

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.

Description of Violation

Direct care staff member B hired [redacted] *and C hired* [redacted] *did not receive training in emergency preparedness, The Older Adults Protective Services Act, and falls and accident prevention in 2023.*

Ancillary staff member D hired [redacted] *did not receive training in resident rights, emergency preparedness, The Older Adults Protective Services Act, and falls and accident prevention in 2023.*

Plan of Correction ***Directed ([redacted] - 02/01/2024)***

Unable to resolve immediate violation at time of inspection. Moving forward, [redacted] *Administrator will be responsible to maintain and monitor compliance in training topics for annual training of direct care staff persons.* [redacted] *Administrator has developed an annual training schedule for 2024 with multiple dates and times to ensure staff participation and certification in all mandatory training topics in order to sustain compliance with DHS regulations. This annual training schedule will also be developed and scheduled in December of every year for the following year.* [redacted] *Administrator and* [redacted] *Assistant Administrator have also developed and will incorporate with all new hires an extensive orientation process to include all annual training topics upon hire to ensure all staff maintain adequate annual training. Attached scheduled 2024 annual training for all DCS staff and new hire orientation checklist.* [redacted] *Administrator*

Proposed Overall Completion Date: 01/31/2024

All employee training records for training year 2023 will be audited to ensure all the required training topics under this regulation have been completed. Staff members that have not received training will be retrained. The 2024 staff training plan will include training on all of the required topics to include:

(1) Fire safety completed by a fire safety expert or by a 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.

65g - Annual Training Content (continued)

(6) New population groups that are being served at the home that were not previously served, if applicable.

Documentation will be kept for the Departments review upon request.

Directed Completion Date: *03/13/2024*

82c - Locking Poisonous Materials

3. Requirements

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

Description of Violation

A cleaning cart was located outside of Room #318 at approximately 10:22am unlocked and unattended. The cart had a bottle of Odo Ban and a gallon jug of Clorox cleaner with bleach labeled if swallowed contact poison control or a doctor. All the residents in the home are unable to safely handle and identify poisonous materials.

Repeat Violation: 4/5/23

Plan of Correction ***Directed ([redacted] - 02/01/2024)***

Staff person responsible for cleaning cart on day of immediate violation received a written warning and re-education in Regulation 82c on [redacted] by [redacted] Administrator and [redacted] Assistant Administrator, who are both responsible for fixing the immediate problem. [redacted] Administrator, [redacted] Assistant Administrator, with the assistance of the Supervisors of shift will be responsible to monitor ongoing compliance to ensure cleaning carts with cleaning solutions are not left unlocked, nor unattended on a daily basis. Attached written warning and re-education. [redacted] Administrator.

Proposed Overall Completion Date: 01/31/2024

All staff members will be retrained on this regulation. The administrator or designee will complete weekly audits for unlocked poisons throughout the home thereafter. Documentation of the audits will be kept for the Departments review upon request.

Directed Completion Date: *02/22/2024*

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

Resident #1's glucometer was mistakenly used to test the blood sugar of resident #2 on 11/30/23 by staff person A.

Repeat Violation: 4/5/23

Plan of Correction ***Directed ([redacted] - 02/12/2024)***

Contamination was reported to PCP and designated person for both Resident #1 and #2 on day of violation. A

85a - Sanitary Conditions (continued)

new meter was immediately purchased by Alexandria Manor for Resident #1. Staff person A received re-education in Medication Errors and Sanitation on 12/1/2023 by Assistant Administrator, [redacted] who is responsible to fix the immediate problem also as the Medication Trainer. All diabetic cases and machines are clearly labeled with the Resident names to avoid further violation. As Med Tech Supervisors, [redacted] are responsible to monitor ongoing compliance with all glucometers, results, and sliding scale on a bi-weekly and as needed basis. Attached re-education training for staff person A and bi-weekly audits. [redacted] Administrator

Proposed Overall Completion Date: 01/31/2024

All medication trained staff members will be retrained in medication errors and sanitation. Bi-weekly audits of all glucometers will be completed.

Directed Completion Date: *02/22/2024*

85d - Trash Receptacles

5. Requirements

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

Description of Violation

A garbage can under the counter did not have a lid on it in the kitchen.

Plan of Correction ***Directed ([redacted] - 02/12/2024)***

[redacted] *Cooks (Department Heads) are responsible to fix the immediate violation and to monitor ongoing compliance while Administrator, [redacted] will oversee. On 1/4/2024, a garbage can lid was retrieved and placed on the can. As of today, 1/31/2024, (picture attached) the garbage can remain with lid in correct placement under the cabinet. [redacted] Administrator has scheduled an Implementation class for all kitchen staff and will maintain annual training in such topics. Attached picture of garbage can maintaining compliance and scheduled kitchen staff training. [redacted] Administrator.*

Proposed Overall Completion Date: 02/26/2024

All trash cans in kitchens and bathrooms throughout the home will be audited to make sure lids are attached. Missing lids will be put in place immediately. The home will complete weekly audits thereafter. Documentation of the audit will be kept for the Departments review upon request.

Proposed Overall Completion Date: 02/22/2024

Directed Completion Date: *02/22/2024*

92 - Windows

6. Requirements

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

Description of Violation

The right window in Room # 14 was open and there was no screen in place. The left window in Room # 17 was open

92 - Windows (continued)

and there was no screen in place.

Plan of Correction ***Directed (- 02/01/2024)***

The screen in both room 14 and room 17 have been securely placed. (Picture attached). Maintenance personnel, [redacted] is responsible to fix immediate violation and monitor ongoing compliance during weekly maintenance audits (attached).

Proposed Overall Completion Date: 01/31/2024

All doors and windows throughout the home will be audited to ensure all windows and doors are in good repair and securely screened when doors or windows are open. All windows and doors will be fixed immediately. The home will complete weekly audits thereafter. Documentation of the audits will be kept for the Departments review upon request.

Directed Completion Date: *02/22/2024*

103e - Left Overs

7. 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.

Description of Violation

A tray of applesauce and salad were noted in the refrigerators in the 1st, 2nd and 3rd floor kitchenettes without labels or dates. In addition, the refrigerator located in the 2nd floor kitchenette had mandarin oranges without a label or date. The freezer had a bag of pizza bites that did not have a label or date.

Plan of Correction ***Directed (- 02/01/2024)***

[redacted] and [redacted] Cooks (Department Heads) are responsible to fix the immediate violation. The tray of applesauce and salad were covered and dated, the mandarin oranges were removed, and the bag of frozen pizza bites were discarded by [redacted] on day of inspection, as instructed by [redacted] Administrator. [redacted] and [redacted] (Department heads) are responsible to monitor ongoing compliance. [redacted] Administrator has scheduled an Implementation class for all kitchen staff and will maintain annual training in such topics in order to maintain ongoing compliance with DHS regulations. Attached scheduled Implementation training. [redacted] Administrator

Proposed Overall Completion Date: 02/26/2024

All dietary staff will be retrained in this regulation. All of the home's food storage areas will be audited to ensure all food is labeled and dated. Unlabeled/dated food will be labeled and dated immediately. The home will complete weekly audits thereafter. Documentation of the audits will be kept for the Departments review upon request.

Directed Completion Date: *02/22/2024*

103g - Storing Food

8. Requirements

103g - Storing Food *(continued)*

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

There were 4 trays of jello in the refrigerator in the kitchen that were not covered. The jello was prepared at approximately 7:30am. The jello was still without a covering at 10:45am. In addition, a slice of shoe fly pie was noted in the refrigerator of the 2nd floor kitchenette without a cover.

Plan of Correction ***Directed (- 02/01/2024)***

and Cooks, are responsible to fix the immediate violation. The Jello was covered and dated, and the slice of pie was removed at time of inspection. Overseen by Administrator and Assistant Administrator, and Cooks are responsible for monitoring ongoing compliance. Administrator has scheduled an Implementation class for all kitchen staff and will maintain annual training in such topics in order to maintain compliance with DHS regulations. Attached scheduled implementation training for all kitchen staff. Administrator

Proposed Overall Completion Date: 02/26/2024

All dietary staff will be retrained in this regulation. All of the home's food storage areas will be audited to ensure all food is stored in closed or sealed containers Unsealed food will be closed or sealed immediately. The home will complete weekly audits thereafter. Documentation of the audits will be kept for the Departments review upon request.

Directed Completion Date: *02/22/2024*

183e - Storing Medications

9. 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 Novolog insulin pen belonging to resident #3 was not labeled with the date the pen was opened.
The Lantus insulin pen belonging to resident # 4 was not labeled with the date the pen was opened.
Both insulin pens are to be discarded 28 days after being opened for use as per the manufacturer's instructions.

Plan of Correction ***Directed (- 02/01/2024)***

All Med Techs are responsible to fix the immediate violation and to monitor ongoing compliance. All Med techs, and have received new responsibility lists (attached), in which they are all individually responsible for one of the four medication carts with responsible for all diabetic supplies. and Med Tech Supervisors are responsible to oversee all others effective 1/3/2024 and to maintain weekly medication audits. Attached-responsibility lists. Administrator.

Proposed Overall Completion Date: 01/31/2024

183e - Storing Medications (continued)

An audit of all prescription medications, OTC medications and CAM will be audited to ensure it is stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions. Any medications found not stored in accordance with the manufacturer's instructions will be immediately fixed. The home will complete weekly audits thereafter. Documentation of the audits will be kept for the Departments review upon request.

Directed Completion Date: *02/22/2024*

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

Facility Information

Name: *ALEXANDRIA MANOR* **License #:** *21064* **License Expiration:** *08/15/2024*

Address: *7 SOUTH NEW STREET, NAZARETH, PA 18064*

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

Administrator

Name: [redacted] **Phone:** [redacted]*0* **Email:** [redacted]

Legal Entity

Name: *ALEXANDRIA MANOR OF ALLENTOWN INC*

Address: *7 SOUTH NEW STREET, NAZARETH, PA, 18064*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *05/17/1994* **Issued By:** *DLI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *91* **Waking Staff:** *68*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date:** *10/02/2023*

Inspection Dates and Department Representative

09/26/2023 - On-Site: [redacted]

10/02/2023 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *93* **Residents Served:** *76*

Secured Dementia Care Unit

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

Hospice

Current Residents: *18*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *76*

Diagnosed with Mental Illness: *4* **Diagnosed with Intellectual Disability:** *3*

Have Mobility Need: *15* **Have Physical Disability:** *0*

Inspections / Reviews

09/26/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/03/2023*

11/17/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/17/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/27/2023*

12/05/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/17/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/16/2023*

01/25/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *12/17/2023*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted] staff person A observed agency staff person B slap resident #1 on the head twice. Staff person A did not report the abuse until [redacted].

Plan of Correction ***Accept ([redacted] - 12/05/2023)***

Administrator, [redacted] and Assistant Administrator, [redacted] are responsible to fix the immediate violation. On [redacted], Assistant Administrator, [redacted] initiated Staff person A receiving a written warning pertaining to Regulation 2600.15a and Staff person A receiving immediate re-education in Regulation 2600.15a and the Older Adult Protective Services Act, relating to reporting suspected abuse on [redacted]. Assistant Administrator, [redacted] will be responsible for initial training at time of hire during new employee orientation and Administrator, [redacted] is responsible for ongoing education annually and will perform an employee chart audit immediately after orientation and will initiate ongoing compliance with every three-month staff meeting beginning 12/11/2023. [redacted] Administrator.

Licensee's Proposed Overall Completion Date: *12/11/2023*

Implemented ([redacted] - 01/25/2024)

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

A treatment log book was found on the counter of the 3rd floor kitchenette. The book contained sensitive resident information regarding bowel movements and treatments completed.

Repeat Violation 7/12/2022

Plan of Correction ***Accept ([redacted] - 12/05/2023)***

All treatment logbooks were removed from all kitchenettes at time of inspection (9/26/2023) and will be kept in locked medication rooms by Administrator, [redacted] Administrator, [redacted] is responsible to fix immediate violation. Starting 9/26/2023, Med Tech Supervisors, [redacted] and [redacted] will be responsible for ongoing compliance during weekly medication/med room audits. on 12/4/2023, Administrator, [redacted] will initiate new processes of locking all kitchenette door with a keyless entry system with the implementation of locked treatment carts to ensure ongoing compliance. After the initial implementation on 12/4/2023, Med Tech Supervisors, [redacted] and [redacted] will be responsible for ongoing compliance weekly during Ancillary Room Audits. [redacted] Administrator.

17 - Record Confidentiality *(continued)*

Licensee's Proposed Overall Completion Date: *12/04/2023*

Implemented (- 01/25/2024)

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

The contract dated for resident #2 did not contain a signature page.

Plan of Correction ***Accept (- 12/05/2023)***

Resident # 2 signature page was completed at time of inspection (9/26/2023) by Assistant Administrator and is responsible to fix the immediate violation. Assistant Administrator was re-educated in Regulation 25a-h by Administrator, on 9/28/2023. Moving forward, Assistant Administrator will be scheduling documentation meetings with all new admissions upon admission to Alexandria Manor and will be responsible for ongoing compliance effectively immediately as of 9/26/2023. Assistant Administrator and Administrator will be performing initial resident chart audits upon admission and every three months thereafter starting 12/11/2023 to maintain compliance with DHS regulations. Administrator.

Licensee's Proposed Overall Completion Date: *12/11/2023*

Implemented (- 01/25/2024)

42b - Abuse

4. 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 staff person A observed agency staff person B slap resident #1 in the head twice. Staff person B was frustrated that resident #1 would not follow directions during care. Resident and staff interviews conducted after the incident indicate that staff person B is frequently rough and verbally aggressive with other residents as well.

Plan of Correction ***Accept (- 12/05/2023)***

On Staff person B was suspended from duty pending a facility investigation in relation to Regulation 2600.42b by Assistant Administrator, After said investigation, staff person B was terminated due to the substantiated claim on . Administrator, has scheduled a mandatory Resident Rights/Abuse Inservice for all staff to be held 11/30/2023 and will maintain orientation and annual training in such topics to maintain ongoing compliance with DHS regulations. Effective immediately, as of 9/26/2023, all management staff, direct care staff, and ancillary staff are responsible to maintain ongoing compliance and Administrator, and Assistant Administrator, are responsible to oversee such responsibility during every three-month staff meeting beginning 12/11/2023 Administrator

Licensee's Proposed Overall Completion Date: *12/11/2023*

Implemented (- 01/25/2024)

42b - Abuse *(continued)*

57c - 2 Hours/Day

5. 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

On 9/15/23 there were 74 total residents, 15 with mobility needs. The facility is required to have 104 hours of direct care hours available. The facility had 90.25 direct care staffing hours available.

9/17/23 there were 74 total residents, 15 with mobility needs. The facility is required to have 104 hours of direct care hours available. The facility had 90.25 direct care staffing hours available.

Repeat violation: 12/1/22

Plan of Correction ***Accept (- 12/05/2023)***

Unable to correct at time of inspection. Administrator, [redacted] is responsible to fix immediate violation. At present time, Alexandria Manor holds 74 in house residents, 62 mobile, 12 immobile, including 2 hoyers. Alexandria Manor is required to have 88 hours of direct care hours available. 66 day and 22 overnight. Effective immediately (9/26/2023), the Administrator, [redacted] and Assistant to Administrator, [redacted] will ensure daily staffing hours are met to maintain compliance with DHS regulations. Administrator, [redacted] and Assistant Administrator, [redacted] are currently using a staffing sourcing agency to ensure staffing hours are met and perform daily scheduling audits and both responsible to maintain ongoing compliance. [redacted] Administrator.

Licensee's Proposed Overall Completion Date: *11/29/2023*

Implemented (- 01/25/2024)

65f - Training Topics

6. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
3. Care for residents with dementia and cognitive impairments.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct Care Staff Person D, hired [redacted], did not complete mandatory training topics for training year 2022: Medication Self-Administration, Care for Residents with Dementia & Cognitive Impair, Care for Residents with MH/ID.

Direct Care Staff Person E, hired [redacted] did not complete the mandatory training topics for training year 2022: Medication Self-Administration.

Direct Care Staff Person F , hired [redacted], did not complete the mandatory training topics for training year 2022: Medication self-administration.

65f - Training Topics (continued)

Direct Care Staff Person G, hired [redacted], did not complete the mandatory training topics for training year 2022: Medication self-administration.

Plan of Correction ***Accept ([redacted] - 12/05/2023)***

Unable to complete at time of Inspection. Administrator, [redacted] is responsible to fix the immediate violation. However, please note attached Medication Self-Administration Training conducted on September 16, 2022, with Staff person E, F, & G in attendance. Staff person D was re-educated in Medication Self-Administration; Care for Residents with Dementia & Cognitive Impair; and Care for Residents with MH/ID on 10/11/2023 with Administrator, [redacted] documentation attached. Moving forward, [redacted] Administrator will be responsible for scheduling and conducting all direct care staff training on an inspection-to-inspection year. All mandatory DCS training is in the process of being scheduled. All will be scheduled by 12/15/2023. [redacted] Administrator.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Not Implemented ([redacted] - 01/25/2024)

65g - Annual Training Content

7. 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.

Description of Violation

Direct Care Staff Person D, hired [redacted] did not complete mandatory training topics for training year 2022: Fire Safety, Emergency Preparedness, Resident Rights, Older Adult Protective Services Act (OAPSA)

Direct Care Staff Person E, hired [redacted] did not complete the mandatory training topics for training year 2022: Fire Safety, Emergency Preparedness, Resident Rights, Older Adult Protective Services Act (OAPSA)

Direct Care Staff Person F, hired [redacted], did not complete the mandatory training topics for training year 2022: Fire Safety, Emergency Preparedness, Resident Rights.

Direct Care Staff Person G, hired [redacted], did not complete the mandatory training topics for training year 2022: 65g Fire Safety, Emergency Preparedness, Resident Rights Older Adult Protective Services Act (OAPSA), Falls and Accident Prevention.

Plan of Correction ***Accept ([redacted] - 12/05/2023)***

Unable to correct at time of inspection. Administrator, [redacted] is responsible for fixing the immediate

65g - Annual Training Content (continued)

violation. Staff persons D, E, and F have received Fire Safety training on 5/24/2023. Moving forward, Administrator, [redacted] will be responsible for all annual training and maintaining compliance with DHS regulations. Administrator, [redacted] has scheduled with Ombudsman office for Resident Rights and Older Adult Protective Services Class on 11/30/2023 and will maintain annual training schedule. [redacted] Administrator.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented ([redacted] - 01/25/2024)

82c - Locking Poisonous Materials

8. Requirements

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

Description of Violation

The first floor kitchenette contained the following poisonous cleaners: Boulder dish soap, Virex TB Disinfectant. They were located under the sink in a room that was unlocked. Not all residents on this floor can safely handle poisonous materials. Both Labels state to seek medical attention if ingested.

The second floor kitchenette contained Clorox Cleanup, Dawn, and Odarban cleaners. They were located under the sink in a room that was unlocked. Not all residents on this floor can safely handle poisonous materials. The labels of the Clorox Cleanup and Odarban state to seek medical attention if ingested. The Dawn Dish Soap label states to seek medical attention or poison control center if it is ingested and the person feels unwell.

Repeat Violation 4/5/2023.

Plan of Correction ***Accept ([redacted] - 12/05/2023)***

All poisonous materials were removed at time of inspection on 9/26/2023 by Med Tech Supervisor, [redacted] Administrator, [redacted] will have maintenance department, [redacted] put a lock on one cabinet in each kitchenette for the use of these materials and to ensure these materials cannot be accessed by any residents who cannot safely handle poisonous materials by 12/4/2023. Med Tech Supervisors, [redacted] and [redacted] will be responsible to perform daily audits of all kitchenettes to ensure no poisonous materials remain in these areas until the locked cabinet can be maintained and daily thereafter to ensure ongoing compliance.
[redacted] Administrator.

Licensee's Proposed Overall Completion Date: *12/04/2023*

Not Implemented ([redacted] - 01/25/2024)

83a - Indoor Temperature

9. Requirements

2600.
83.a. The indoor temperature, in areas used by the residents, must be at least 70°F when residents are present in the home.

Description of Violation

The temperature of the common area located near resident rooms 34 and 35 was between 62 and 68 degrees Fahrenheit during the inspection. Also, the temperature in the hallway adjacent to this area was 68 degrees Fahrenheit.

83a - Indoor Temperature *(continued)*

Plan of Correction ***Accept (- 12/05/2023)***

Indoor temperature increased to 70-72 degrees Fahrenheit at time of inspection on 9/26/2023 by Maintenance personnel, [redacted] Administrator, [redacted] responsible to fix immediate violation. Efectively immediately, 9/26/2023, Maintenance personnel, [redacted] and [redacted] will be responsible to ensure the indoor temperature remains at regulated temperature daily and during weekly maintenance checks to ensure and maintain compliance with DHS regulations. Administrator, [redacted] will be responsible to monitor ongoing compliance. [redacted] Administrator.

Licensee's Proposed Overall Completion Date: *11/29/2023*

Implemented (- 01/25/2024)

85a - Sanitary Conditions

10. Requirements

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

Description of Violation

Upon exiting the elevator on the 2nd floor a strong odor of urine was detected throughout the area, which includes a resident dining area.

Plan of Correction ***Accept (- 12/05/2023)***

Administrator, [redacted] is responsible to fix immediate violation. On 9/26/2023, at time of inspection, the presence of odor was distinguished by housekeeping staff, [redacted]. Effective immediately, 9/26/2023, Med Tech Shift Supervisors, [redacted] and [redacted] with the assistance of housekeeping personnel [redacted] and [redacted] will be responsible for ongoing compliance and Administrator, [redacted] and Assistant Administrator, [redacted] will be responsible for monitoring ongoing compliance. [redacted] Administrator

Licensee's Proposed Overall Completion Date: *11/29/2023*

Not Implemented (- 01/25/2024)

91 - Telephone Numbers

11. Requirements

2600.
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 near telephones located in the 1st floor and 3rd floor kitchenettes.

Plan of Correction ***Accept (- 12/05/2023)***

Administrator, [redacted] is responsible to fix the immediate violation. The emergency telephone numbers were posted in the 1st and 3rd floor kitchenettes at time of inspection on 9/26/2023 by Assistant Administrator, [redacted] Beginning 12/4/2023, the Administrator has implemented ancillary room audits to be performed weekly and as needed by all direct care staff per shift to ensure and maintain compliance with DHS regulations. Med tech Supervisors, [redacted] and [redacted] will monitor ongoing compliance and report necessities to

91 - Telephone Numbers (continued)

Administrator, [redacted] and/or Assistant Administrator, [redacted] [redacted] Administrator.

Licensee's Proposed Overall Completion Date: *12/04/2023*

Implemented ([redacted] - 01/25/2024)

92 - Windows

12. Requirements

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

Description of Violation

Upon arrival to the home at 9am on 9/26/23 the main entrance doorway located in the rear of the building was propped open several inches with a bundled sheet placed on the floor.

Plan of Correction ***Accept ([redacted] - 12/05/2023)***

Administrator, [redacted] is responsible to fix the immediate violation. The ongoing and outgoing Med Tech Shift Supervisors, [redacted] and [redacted] will be responsible to monitor all door and windows are in good repair and secure to ensure and maintain DHS regulations at the start and end of every shift. This will also be part of the weekly maintenance checks. [redacted] Administrator.

Licensee's Proposed Overall Completion Date: *11/29/2023*

Not Implemented ([redacted] - 01/25/2024)

100a - Exterior - Free of Hazards

13. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The Exit off the second floor dining room opened to a small porch with steps to the lawn area. At the bottom of the steps there was a drain pipe across the entire length of the steps posing a fall or tripping hazard at the bottom of a staircase.

Plan of Correction ***Accept ([redacted] - 12/05/2023)***

Maintenance personnel, [redacted] and [redacted] are responsible to fix immediate violation and to monitor ongoing compliance. The drainpipe was moved at time of inspection on 9/26/2023. Documentation attached on previous submission. Moving forward, 11/15/2023, Administrator, [redacted] has added the exterior of the building to the weekly maintenance checks performed by all maintenance to ensure and maintain compliance with DHS regulations.

Licensee's Proposed Overall Completion Date: *11/29/2023*

Implemented ([redacted] - 01/25/2024)

103d - Storing Food Off Floor

14. Requirements

2600.
103.d. Food shall be stored off the floor.

103d - Storing Food Off Floor *(continued)*

Description of Violation

A large bag of onions were stored directly on the floor of the pantry located adjacent to the kitchen.

Plan of Correction ***Accept (- 12/05/2023)***

Kitchen staff and are responsible to fix the immediate violation and monitor ongoing compliance. Food items were removed and restored off the floor at time of inspection on 9/26/2023 by Cook, All kitchen staff were re-educated in Regulation 103d on 10/19/2023 by Administrator, Moving Forward, Administrator, will implement annual training for all kitchen staff pertaining to Regulations 104a-e; 103a-j; 161-164 to ensure and maintain compliance with DHS regulations. This annual training will be scheduled by December 15, 2023, and will be maintained in annual training for all kitchen staff moving forward, Administrator.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented (- 01/25/2024)

103e - Left Overs

15. 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.

Description of Violation

A tray of chicken salad sandwiches were found in the cooler; the foil that covered the tray of leftover sandwiches did not include a label with the date they were placed in the cooler.

Plan of Correction ***Accept (- 12/05/2023)***

Kitchen personnel, and are responsible to fix immediate violation and monitor ongoing compliance. Left overs labeled at time of inspection on 9/26/2023. All kitchen staff re-educated in Regulation 103e on 10/19/2023 by Administrator, Moving Forward, Administrator, will implement annual training for all kitchen staff pertaining to Regulations 104a-e; 103a-j; 161-164 to ensure and maintain compliance with DHS regulations. This training will be scheduled by 12/15/2023. Administrator.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Not Implemented (- 01/25/2024)

103f - Refrigerator/Freezer Temps

16. 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

The freezer marked "Freezer #1" had a thermometer in it that indicated the temperature was 30 degrees Fahrenheit.

Plan of Correction ***Accept (- 12/05/2023)***

Kitchen personnel, and are responsible to fix immediate violation and monitor ongoing compliance with freezer/refrigerator temperature audits performed daily. A new thermometer was purchased for Freezer # 1 and installed by Maintenance personnel, at time of inspection on 9/26/2023. Moving forward, Administrator, will implement annual training for all kitchen staff

103f - Refrigerator/Freezer Temps (continued)

pertaining to Regulations 104a-e; 103a-j; 161-164 to ensure and maintain compliance with DHS regulations. This training will be schedule by 12/15/2023. [redacted] Administrator.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Implemented ([redacted] - 01/25/2024)

103g - Storing Food

17. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

Two opened and uncovered plastic containers of blueberry yogurt were found in the resident refrigerator in the 1st floor kitchenette area.

Plan of Correction ***Accept ([redacted] - 12/05/2023)***

Direct Care Staff assigned to each floor assisting in the serving of meals will be responsible to fix immediate violation and monitor ongoing compliance as part of their daily responsibilities while on duty. the two opened containers were removed at time of inspection on 9/26/2023 by Med Tech Supervisor, [redacted] Moving forward, Administrator, [redacted] will implement annual training for all kitchen staff pertaining to Regulations 104a-e; 103a-j; 161-164 to ensure and maintain compliance with DHS regulations. This training will be scheduled by 12/15/2023. [redacted] Administrator.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Not Implemented ([redacted] - 01/25/2024)

132e - Fire Drill Sleeping Hours

18. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

Fire drill log indicates the sleeping hours fire drills occurred 3/30/2022 and eight months later on 11/40/2022.

Plan of Correction ***Accept ([redacted] - 12/05/2023)***

Assistant Administrator, [redacted] is responsible to fix immediate violation and monitor ongoing compliance. Unable to correct at time of inspection. Moving forward, Assistant Administrator, [redacted] is responsible for carrying out ongoing fire drills. Administrator, [redacted] and [redacted] will meet every three months to schedule fire drill and Administrator, [redacted] will ensure set schedule is carried out Next meeting is scheduled for 12/7/2023. An overnight fire drill is scheduled to be performed on 11/28/2023 at approx. 11pm [redacted] Administrator.

Licensee's Proposed Overall Completion Date: *12/07/2023*

Implemented ([redacted] - 01/25/2024)

141a 1-10 Medical Evaluation Information

19. 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 Documentation of Medical Evaluation form dated 8/23/23 for resident #3 did not include the resident's height or weight.

Repeat Violation: 9/19/22, 7/12/22

Plan of Correction ***Accept (- 12/05/2023)***

Unable to correct at time of inspection. Moving forward, as of 9/26/2023, Med Tech [redacted] is responsible for annual DME's and Assistant Administrator, [redacted] is responsible for initial DME's. Once received all DME's will be monitored for all accurate and complete information by those receiving them, then again by Administrator, [redacted] before chart audit. We will then add this information to our every three month and annual chart audit. Every three-month chart audit is scheduled to begin 12/11/2023. [redacted] Administrator.

Licensee's Proposed Overall Completion Date: *12/11/2023*

Implemented (- 01/25/2024)

162c - Menus Posted

20. 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

The home did not have the following week's menus posted in the #2 new dining room or in the 1st floor dining room.

Plan of Correction ***Accept (- 12/05/2023)***

Kitchen personnel, [redacted] and [redacted] and Activity Director [redacted] are responsible to fix immediate violation and monitor ongoing compliance. As of 11/15/2023, Cooks, [redacted] and Activity Director, [redacted] will be responsible for weekly posting of the menus to ensure and maintain compliance with DHS regulations. [redacted] Administrator.

Proposed Overall Completion Date: 11/29/2023

162c - Menus Posted (continued)

Administrator will monitor for ongoing compliance. [redacted]

Licensee's Proposed Overall Completion Date: *11/29/2023*

Implemented ([redacted] - 01/25/2024)

183b - Meds and Syringes Locked

21. Requirements

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

Description of Violation

A green plastic tub containing resident treatment medications was found in the unlocked cupboard of the 3rd floor kitchenette. The plastic tub contained prescription labeled treatments for the following residents:
Resident #4—Muscle Rub; Resident #5—Arthritis cream; Resident #6 Triamcinolone 1% cream; Resident #7—Dicolfenac 1% gel.

Plan of Correction ***Accept ([redacted] - 12/05/2023)***

All resident treatments were removed and placed in the locked medication room at time of inspection on 9/26/2023 by Administrator, [redacted] *and Med Tech Supervisor,* [redacted] *who is responsible to fix immediate violation and monitor ongoing compliance. Starting 9/26/2023, Med Tech Supervisors,* [redacted] *and* [redacted] *will be responsible for ongoing compliance during weekly medication/med room audits. on 12/4/2023, Administrator,* [redacted] *will initiate new processes of locking all kitchenette door with a keyless entry system with the implementation of locked treatment carts to ensure ongoing compliance. After the initial implementation on 12/4/2023, Med Tech Supervisors,* [redacted] *and* [redacted] *will be responsible for ongoing compliance weekly during Ancillary Room Audits.* [redacted] *Administrator*

Licensee's Proposed Overall Completion Date: *12/04/2023*

Implemented ([redacted] - 01/25/2024)

183e - Storing Medications

22. 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

Resident #9 had an opened Humalog pen and an open Lantus Pen. There was no date on the pen indicating when it was opened. Manufacturer's instructions state they expire 28 days after opening.

Plan of Correction ***Accept ([redacted] - 12/05/2023)***

Med Tech Supervisors, [redacted] *and* [redacted] *are responsible to fix immediate violation and monitor ongoing compliance. They will also perform weekly and as needed medication audits to ensure and maintain compliance with DHS regulations, effective immediately 9/26/2023.* [redacted] *Administrator.*

Licensee's Proposed Overall Completion Date: *11/29/2023*

Not Implemented ([redacted] - 01/25/2024)

184a - Resident's Meds Labeled

23. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #9 had an opened Humalog pen and an open Lantus Pen. There was no prescription label on the pen. There was no resident name on the pen, date of opening, or the opener's initials.

Repeat Violation: 9/28/22, 7/12/22

Plan of Correction ***Accept (- 12/05/2023)***

Med Tech Supervisors, and are responsible to fix immediate violation and monitor ongoing compliance. They will also perform weekly and as needed medication audits to ensure and maintain compliance with DHS regulations, effective immediately 9/26/2023. Administrator.

Licensee's Proposed Overall Completion Date: *11/29/2023*

Implemented (- 01/25/2024)

185a - Implement Storage Procedures

24. Requirements

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

Description of Violation

Resident #10 glucometer reading on 9/22/2023 at 522pm showed 240. The reading recorded on the Medication Administration Record (MAR) was 216.

Repeat Violation 12/1/22, 7/12/22

Plan of Correction ***Accept (- 12/05/2023)***

Med Tech Supervisors, and are responsible for fixing immediate violation and monitoring ongoing compliance. Staff person responsible for improper documentation of Resident #10 glucometer reading was given a written warning and re-education of regulation 185a by Administrator, Effective immediately, 9/26/2023, Med Tech Supervisors, and are responsible for bi-weekly and as needed glucometer audits to maintain compliance with DHS regulations. Documentation attached of written warning and re-education. Administrator.

Licensee's Proposed Overall Completion Date: *11/29/2023*

Implemented (- 01/25/2024)

224a - Preadmission Screen Form

25. Requirements

224a - Preadmission Screen Form *(continued)*

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

The prescreen form for resident #1, admitted [redacted], was not dated to indicate when it was completed.

Plan of Correction ***Accept ([redacted] - 12/05/2023)***

Administrator, [redacted] is responsible to fix immediate violation and both Administrator, [redacted] and Assistant, [redacted] are responsible to monitor ongoing compliance. Unable to complete at time of inspection. Moving forward, [redacted], Marketing Director is responsible for Preadmission Screen Forms. [redacted] has been re-educated in Regulation 2600.224a by Administrator, [redacted] on 9/28/2023. [redacted] Assistant Administrator and/or [redacted] Administrator will conduct an initial, every three months, and annual chart audit upon admission to ensure all documentation is properly signed and dated to ensure ongoing compliance with DHS regulations. First chart audit scheduled for 12/11/2023. [redacted] Administrator.

Licensee's Proposed Overall Completion Date: *12/11/2023*

Implemented ([redacted] - 01/25/2024)

225a - Assessment 15 Days

26. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #8 was admitted to the home on [redacted]. The home did not complete a Resident Assessment and Support Plan (RASP) for resident #8.

Plan of Correction ***Accept ([redacted] - 12/05/2023)***

Resident # 8 was sent to emergency room on [redacted] and was transferred to [redacted] Therefore, at time of inspection, 9/26/2023, was unable to complete. [redacted] Assistant Administrator was re-educated in Regulation 225a-c by Administrator, [redacted] on 9/28/2023. Moving forward, [redacted] Assistant Administrator, is responsible for the completion of all Rasp forms. [redacted] Administrator will complete RASP audits with [redacted] to ensure completion by appropriate dates and to ensure ongoing compliance with DHS regulations. This will be maintained monthly, effective immediately, 9/26/2023. [redacted] Administrator.

Licensee's Proposed Overall Completion Date: *11/29/2023*

Implemented ([redacted] - 01/25/2024)