pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ST JUDES HAVEN INC**
LEGAL ENTITY

To operate **ST. JUDE'S HAVEN PERSONAL CARE HOME**
NAME OF FACILITY OR AGENCY

Located at **1072 MT. AIRY DRIVE, JOHNSTOWN, PA 15904**
(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 **17**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restictions:

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 **May 7, 2024** until **November 7, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **307871**

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.

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: MAY 7, 2024

St. Jude's Haven Inc.
1072 Mt. Airy Drive
Johnstown, Pennsylvania 15904

RE: St. Jude's Haven Personal Care Home
1072 Mt. Airy Drive Johnstown,
Pennsylvania15904
License #: 307871

Dear :

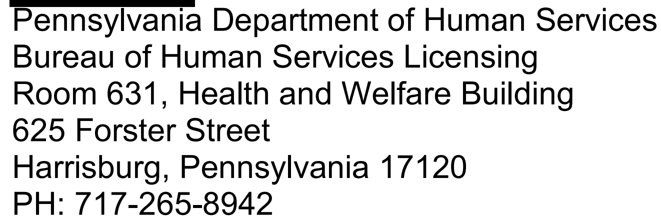
As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on September 27-28, 2023, January 11, 2024 and March 5-6, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) and 55 Pa. Code §20.71(a)(2);(4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department

Bureau of Human Services Licensing
625 Forster Street, Room 631 | Harrisburg, PA 17105 | 717.783.3670 | F 717.783.5662 | www.dpw.pa.gov

of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:



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

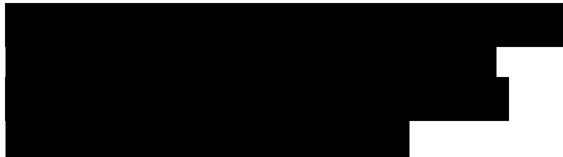
This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:



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

Facility Information

Name: *ST. JUDE'S HAVEN PERSONAL CARE HOME* **License #**: *30787* **License Expiration**: *06/20/2024*

Address: *1072 MT. AIRY DRIVE, JOHNSTOWN, PA 15904*

County: *CAMBRIA* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *ST JUDES HAVEN INC*

Address: *1072 MT. AIRY DRIVE, JOHNSTOWN, PA, 15904*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/23/2000* **Issued By**: *D L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *18* **Waking Staff**: *14*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *09/27/2023*

Inspection Dates and Department Representative

09/27/2023 - On-Site: [redacted]
09/28/2023 - On-Site: [redacted]
10/03/2023 - Off-Site: [redacted]
10/13/2023 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *17* **Residents Served**: *15*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *15*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *3*
Have Physical Disability: *0*

Inspections / Reviews

09/27/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/27/2023*

11/01/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/30/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/08/2023*

11/22/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/30/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/29/2023*

04/23/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *11/30/2023*

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

25a - Written Contract and Review

1. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #5 was admitted to the home on [redacted]/23 and does not have a resident-home contract completed.

Resident #6 was admitted to the home on[redacted]23 and does not have a resident-home contract completed.

Plan of Correction ***Directed [redacted] - 11/20/2023)***

Resident number 5 family member was to ride from [redacted] discharging residence to St. Judes Haven to do paperwork. [redacted] was admitted on [redacted]/23 and [redacted] did not come until Tuesday 9/26/23 with multiple attempts made by me. [redacted] in fact did not want to sign the contract on that day in which I did let [redacted] know if it was not signed then [redacted] would have to take [redacted] out immediately. This was completed by his [redacted] and the administrator.

Resident number 6 is not a resident here, does not reside [redacted]r, and I do not have a file or any information on [redacted]

Any family member will have to do a contract prior to admission unless it is an emergency admit, then we can do it the day of. This will be added into the admission policy.

The administrator has reviewed the regulations per the reg book and also the RCG pertaining to the regulations. This was completed on 11/7/2023. The administrator also monitors resident files monthly for all state required paperwork and will provide the policy update in the handbook. Our checklist does reflect the contract but due to resident #6 not residing in the licensed setting a contract was not completed. Admissions checklist will continue to be followed to ensure all required documents are listed in their file.

Administration will provide the on going monitoring of a new admission and record. New audit will occur within the first 24 hours, the following 48 hours, and then weekly for the first month. The record will then be reviewed monthly along with the others. This has already started as of 11/4/2023

Proposed Overall Completion Date: 11/09/2023

(DIRECTED)

- *The administrator will complete contracts for Residents 5 and 6 by 1/1/24.*
- *The administrator will audit all resident records by 1/1/24 to ensure that completed and signed contracts are in place. Documentation of the audit shall be kept and available for review by the Department.*
- *The administrator will develop and implement a new admission checklist by 1/1/24 to ensure that contracts are completed on the day of admission.*

Directed Completion Date: *01/01/2024*

Implemented [redacted] - 04/23/2024)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated 8/15/23, for Resident #1 was not signed by the resident.

The resident-home contract, dated 8/10/23, for Resident #2 was not signed by the resident.

Plan of Correction ***Directed - 11/20/2023)***

Resident number 1 is unable to sign. mark will be recorded into contract. Administration provided update to contract on 10/27/2023.

Resident number 2 did not want to sign the contract. I should have marked it refused. no longer resides here. contract is unable to be updated.

Residents marks will be recorded or if unable to sign it will be documented. Administration reviewed the regulations per the reg book and also the RCG on 11/7/2023. Administration will provide the on going monitoring of a new admission record. This has started on 11/4/2023. New audit will occur within the first 24 hours, the following 48 hours, and then weekly for the first month. The record will then be reviewed monthly along with the others. This has already started as of 11/4/2023. I will adjust the admissions checklist to list contract signatures of both resident and family member. This was updated 11/9/2023

Proposed Overall Completion Date: 11/09/2023

(DIRECTED)

- *The administrator will audit all resident records by 1/1/24 to ensure that completed and signed contracts are in place. Documentation of the audit shall be kept and available for review by the Department.*
- *The administrator will develop and implement a new admission checklist by 1/1/24 to ensure that contracts are completed on the day of admission.*

Directed Completion Date: *01/01/2024*

Not Implemented - 04/18/2024)

28e - Death of a Resident

3. Requirements

2600.
28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101— 10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident #7 passed away on /23. Resident #7's personal belongings were removed from room on 6/20/23. Despite multiple requests by the of Resident #7 and contact from The Office of the Attorney General, the home has failed to issue the required refund in the amount of $4811.50.

28e - Death of a Resident (continued)

Plan of Correction ***Accept - 11/20/2023)***

The refund was sent out but never received. I was not aware the second check was not received as I never heard back from the family until letter was mailed to me. A cashiers check in the amount of $4811.50 was picked up here by family member.

A change in refund policy is made. Any family due a refund must pick it up in person unless they live out of town where I will mail it with signature required so it is verified that it was received. This will eliminate any mail issues.

Oct 7, 2023 the cashiers check was given to family member by administration. The date of the check was 10/6/2023. Change was made to the refund policy by the administration on 10/27/2023. On 11/7/2023 administration reviewed the refund policy per the regulation book and RCG. Administration will provide the on going monitoring of a new admission record. This has started on 11/4/2023. New audit will occur within the first 24 hours, the following 48 hours, and then weekly for the first month. The record will then be reviewed monthly along with the others. This has already started as of 11/4/2023.

Licensee's Proposed Overall Completion Date: *11/09/2023*

Implemented - 04/23/2024)

41e - Signed Statement

4. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #6's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Directed - 11/20/2023)***

Resident number 6 is not a resident here at St. Judes Haven. I do not have a file on as rents from across the street.

30 day notice was put into writing on 11/7/2023 and provided to the resident. Resident is still living across the street but does not receive any personal care from us. has adjusted and does great for , Admissions education was done by administration on 11/7/2023 per the regulation book and RCG. New admissions checklist was updated on 11/9/2023.

November audit of records will be completed by 11.20.2023.

Proposed Overall Completion Date: 11/09/2023

(Directed)

- *Resident 6 receives personal care services and lives on the premises. The administrator will obtain a signed statement acknowledging receipt of resident rights and complaint procedures by 1/1/24.*

41e - Signed Statement (continued)

- *The administrator will audit all resident records by 1/1/24 to ensure this acknowledgement is present. Documentation of the audit will be kept and be available for review by the Department.*
- *The administrator will develop and implement a new admission checklist that includes the signed statement acknowledging receipt of resident rights and complaint procedures.*

Proposed Overall Completion Date: 01/01/2024

Directed Completion Date: *01/01/2024*

Implemented (- 04/23/2024)

51 - Criminal Background Check

5. 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

Staff Person B, hired /23, has not had a criminal background check completed.

Staff Person C, hired /23, has not had a criminal background check completed.

Repeated Violation - 4/13/23

Plan of Correction ***Directed - 11/22/2023)***

Staff person B and C did have checks ran on 9/28/2023 by the administrator to update the files and be in compliance. An audit of all employee files will be completed by 11/20/2023 by the administrator. New hire checklist will be updated also by the administration and implemented immediately. Hiring regulations have been reviewed by the administration and hiring folders have been made in advance and are readily available for immediate hires. Administration has already implemented the criminal background check before the exit interview but we will put an official date of 11/09/2023. Admin will review record prior to first shift to ensure staff member is in compliance before starting resident care.

Staff members that accept the job will have an onsite immediate criminal background check before exiting the interview. I have done this with 3 recent hires and it has worked perfect and is keeping with compliance. This will ensure it is done before staff starts the first shift. Any requests under review will be checked weekly by admin until they are available to print and will be put into file by admin.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *The administrator will develop and implement a new hire checklist by 1/1/24 to ensure criminal background checks are completed.*

Directed Completion Date: *01/01/2024*

51 - Criminal Background Check *(continued)*

Implemented (█ - 04/23/2024)

54a - Direct Care Staff

6. 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

Direct care Staff Person B, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Direct care Staff Person C, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Directed █ - 11/22/2023)***

Staff person B did have their diploma here but it was in my desk when █ brought it in. Administration found on 9/28/2023 while doing weekly filing. It was put into file by admin on that date. Audit on all staff records will be completed by admin by 11/20/2023. Admin will create new checklist to keep for hiring process.

Staff person C has until friday to provide me with █ diploma.

A list of required items to bring to do paperwork will be provided to new staff member. When they come back in for paperwork all items should be present. In the event they do not, a grace period of 48 hours will be given to comply. Otherwise staff member can not work here until papers a given to me.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *The administrator will develop and implement a new hire checklist by 1/1/24 to ensure every staff has a GED, high school diploma or is active in the nurse registry.*

Directed Completion Date: *01/01/2024*

Not Implemented █ - 04/18/2024)

60a - Staff/Support Plan

7. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 9/17/23 and 9/26/23, Staff Person B and Staff Person C were the only staff working during on the 11:00pm-7:00am shift. Neither staff person is trained as a medication technician, thus leaving the home unable to pass medications if needed.

60a - Staff/Support Plan (continued)

On 9/21/23, 9/22/23, 9/25/23, and 9/27/23, Staff Person B and Staff Person H were the only staff working during on the 11:00pm-7:00am shift. Neither staff person is trained as a medication technician, thus leaving the home unable to pass medications if needed.

On 9/23/23 and 9/24/23, Staff Person C and Staff Person H were the only staff working during on the 11:00pm-7:00am shift. Neither staff person is trained as a medication technician, thus leaving the home to pass medications if needed.

Repeated Violation - 4/13/23

Plan of Correction ***Directed ███ - 11/20/2023)***

It was my mistake in thinking the emergency med training was still available so that it was I had them use.

I am in the process of setting up classes for staff (almost all) to be trained on medications in the event that someone is not available or a position becomes terminated we will have medication compliant staff. Staff is currently working on their med classes in the online portion. Admin intends for all selected staff to have med training completed no later than 12/1/2023

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *The administrator will review the staffing schedule and ensure that a staff person who is trained in medication administration is available on all shifts by 1/1/24.*
- *The administrator will ensure staff to be trained as med techs will receive the appropriate training by 1/1/24.*

Directed Completion Date: *01/01/2024*

Implemented ███ - 04/23/2024)

63a - First Aid/CPR Training

8. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

From 9/21-9/27/23, during the hours of 11:00pm - 7:00am, 16 residents were present in the home. During this time, no staff persons were present in the home who were certified in CPR and first aid.

Repeated Violation - 4/13/23

Plan of Correction ***Directed ███ - 11/21/2023)***

It was my mistake thinking staff person H was in compliance until July of 2024.

63a - First Aid/CPR Training (continued)

A CPR/First Aide class was set up held here on Oct 5, 2023 bringing any uncertified staff to up date with their CPR. A new master list will be started with staff and cpr dates so this can be scheduled ahead. This will be a quarterly review by the admin which will allow time to schedule ahead.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *The administrator will obtain all CPR/First Aid certifications from the training on 10/5/23. The administrator will ensure all these certifications are filed in staff records by 1/1/24.*
- *Starting 12/1/23, the administrator will maintain a CPR/First Aid master list with the expiration dates of the certifications. The administrator will review this quarterly, and schedule CPR/First Aid trainings as needed.*

Directed Completion Date: *01/01/2024*

Not Implemented ███ - 04/18/2024)

65a - FS Orientation 1st Day

9. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Person C, whose first day of work was ███/23, did not receive orientation on the following topics:

1. Evacuation procedures.

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.

4. Smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable.

5. The location and use of fire extinguishers.

6. Smoke detectors and fire alarms.

7. Telephone use and notification of emergency services.

Repeated Violation - 4/13/23

Plan of Correction ***Directed ███ - 11/21/2023)***

Staff person C did have the orientation training paper ███ signed off on and we went over all the procedures in the packet. This was in ███r folder provided. I can add paperwork to this packet to show proof for future inspections.It

65a - FS Orientation 1st Day (continued)

was put into [redacted] file by the admin the following day while doing weekly filing. An audit will be done on new employee file once orientation is completed but before they are put on the schedule. Checklist will be completed by admin and kept in employee file. Admin will review regulations per reg book on orientation on 11/13/2023 and documentation will be kept. Admin will collect all staff required documents and put directly into staff members file. Files will continued to be reviewed monthly when education is added into the file.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *The administrator will ensure Staff Person C's orientation training is filed in the staff's record by 1/1/24.*
- *The administrator will develop and implement a new hire checklist by 1/1/24 to ensure that all initial trainings are completed.*
- *The administrator will complete an audit of all current staff records to all first-day trainings are completed. Audit will be done by 1/1/24. Documentation of the audit shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented [redacted] - 04/23/2024)

65d - Initial Direct Care Training

10. Requirements

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

Description of Violation

Direct care staff person C, hired on [redacted] 23, began providing unsupervised ADL services on 9/24/23. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Repeated Violation - 2/16/23

Plan of Correction ***Directed [redacted] - 11/22/2023)***

Staff member was trying to complete the test but was not prompting [redacted] to finish the test. [redacted] is actively starting over and seeing if this will rectify the issue. [redacted] did previously pass the test with previous employment here. If issue continues, I will contact help if [redacted] issues persist.

Staff member is still having issues. [redacted] will be coming in on 11/13/2023 to use my computer to complete course and print [redacted] certificate to be in compliance. Audit on all staff records will be completed by admin by 11/20/2023. Admin will create new checklist to keep for hiring process no later than 11/13/2023. New hire regs and policy will be reviewed by admin no later than 11/13/2023

65d - Initial Direct Care Training (continued)

This link will be provided upon exit from interview and when new staff member returns to do paperwork the comp test certificate will be expected to be given to me at that point.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *Starting 12/1/23, the administrator will complete quarterly audits of new staff records. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented - 04/23/2024)

65e - 12 Hours Annual Training

11. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person E, hired 21, did not receive any annual training in the 2022 training year.

Direct care staff person F, hired /15, did not receive any annual training in the 2022 training year.

Plan of Correction ***Directed - 11/21/2023)***

Trainings have been kept in a seperate bin. I will keep the current year in employee folders for future inspections so they can be verified.

Staff person E no longer is employed here so folder was not updated. Staff person F had trainings moved to folder on 11/1/2023 by admin and admin will continue to reviewe monthly.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *The administrator will complete an audit of all current staff records to ensure staff received all annual trainings for the 2022 training year. This audit will be completed by 1/1/24.*
- *Starting 1/1/24, the administrator will complete quarterly audits of staff records to ensure staff completed required annual trainings and documentation of these trainings are filed. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented - 04/23/2024)

82c - Locking Poisonous Materials

12. Requirements

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

Description of Violation

On 9/27/23, a cleaning powder with manufacturer's label indicating if swallowed to "contact a poison control center or a doctor immediately", a carpet cleaner with manufacturer's label indicating for prolonged contact "call a physician or poison control center", and a multipurpose stain remover with a manufacturer's label indicating if swallowed to "seek immediate medical attention" were unlocked, unattended, and accessible to residents in a closet near the laundry room. Not all residents of the home, including Resident #1 and Resident #3, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Directed - 11/21/2023)***

Closet has been locked day of inspection and continues with no issues and staff reeducation on 10/30/2023 by admin. Admin is randomly monitoring the closet to check that it is locked. I have had no issues currently. If any issues do reoccur, I will be switching the door knob to an automatic locking one to prevent any further occurrence. A checklist will be made by admin to document audits.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *Starting 12/1/23, the administrator will complete random monthly audits to ensure all poisonous material in the home is locked. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Not Implemented - 04/18/2024)

103c - Food Protected

13. Requirements

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

Description of Violation

On 9/27/23 at approximately 12:55pm, Staff Person A walked down the hall to room #11 to deliver an uncovered plate of food to Resident #4.

Plan of Correction ***Directed - 11/21/2023)***

Staff was reeducated on 10/30/2023 by the admin. We have since corrected this and do have plate coverings to cover food in the event a resident would like to eat in their room. Staff has be educated on the coverings, why it is important, and that this is a regulation. Admin will randomly come out during meals to ensure any required plates are covered.

Proposed Overall Completion Date: 11/10/2023

103c - Food Protected (continued)

(Directed)

- *Starting 12/1/23, the administrator will complete random weekly audits to ensure all plates are covered when being delivered to residents. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented ███ - 04/23/2024)

103e - Left Overs

14. 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

On 9/27/23, there was an unlabeled and undated container of what appeared to be soup as well as an unlabeled and undated container of a thick, white substance in the refrigerator located in the kitchen.

Plan of Correction ***Accept ███ - 11/21/2023)***

Staff was reeducated on 10/30/2023 by admin. All kitchen staff was educated on the importance of labeling and dating food that goes into the fridge. 11-7 shift checks the dates and will discard of any unused open food no longer than 3 days. Formal audits are completed nightly. I will appoint two specific staff members to do those audits. This is effective immediately.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented ███ - 04/23/2024)

131f - Fire Extinguisher Inspection

15. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguishers near the exit at both ends of the hallway and the fire extinguisher near the entrance to the home have not been inspected by a fire safety expert since February of 2022.

Plan of Correction ***Accept ███ - 11/21/2023)***

Blues typically comes for their inspections without us having to call. I am putting a call in today to them and the fire extinguishers will be added to our list of quarterly checks to ensure all are up to date. They will be out to do a full inspection of our system on 11/14/2023. Admin will document the inspection date and will call yearly, at least 2 months prior to due date, to ensure we stay compliant.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented ███ - 04/23/2024)

141a - Medical Evaluation

16. Requirements

2600.
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.

Description of Violation

Resident #1, admitted on [redacted]/23, did not have a medical evaluation completed within 60 days prior to admission or within 30 days after admission.

Resident #2, admitted on [redacted]/23, did not have a medical evaluation completed within 60 days prior to admission or within 30 days after admission.

Resident #6, admitted on [redacted]/23, did not have a medical evaluation completed within 60 days prior to admission or within 30 days after admission.

Repeated Violation - 4/13/23

Plan of Correction ***Directed [redacted] - 11/21/2023)***

Residents moving into the home from another facility will have to have a brand new DME completed prior to moving in to our home. In the event this is not a possibility, I am requiring a dr appt to be scheduled within 30 days. I will require this appointment to be made and communicated to me prior to move in if DME cannot be completed prior to move (if move is urgently needed).

Resident number 1 had an initial DME here with us on 11/3/2023. Resident #2 no longer resides here so one was not able to be completed for [redacted].

Resident #6 was given a 30 day notice on 11/7/2023.

Administration reviewed the regulations per the reg book and also the RCG on 11/7/2023. Audits will be done monthly to ensure DME are completed in timely fashion. I will also make a "monthly" list of when residents are due for med eval. Admin will handle the DME process and will put into resident file.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *The administrator will audit all resident records by 1/1/24 to ensure that all initial medical evaluations are in place. Documentation of the audit shall be kept and available for review by the Department.*
- *The administrator will develop and implement a new admission checklist by 1/1/24 to ensure that all initial medical evaluations are completed by the first 30 days of admission.*

Directed Completion Date: *01/01/2024*

Not Implemented ([redacted] - 04/18/2024)

161a - Meals

17. Requirements

2600.
161.a. Meals shall be offered that meet the recommended dietary allowances established by the United States Department of Agriculture.

Description of Violation

On 9/27/23, the lunch meal served by the home included 4 slices of cheddar bratwurst (equivalent to half a link of bratwurst), approximately 1/3-1/2 cup of green beans and approximately 1/2 cup of fried potatoes. This meal does not meet the recommended dietary allowances established by the United States Department of Agriculture (USDA). This meal did not include fruits, dairy or grains. Also, this meal did not provide the USDA's recommended amount of protein or vegetables. Resident interviews indicate that the meal portions are small, and they receive very little meat.

Plan of Correction ***Directed (█ - 11/21/2023)***

My plate images and pictures have been printed and placed in the kitchen for kitchen staff to utilize correct portions for residents. Staff has also been educated on using dinner plates for lunch with appropriate meals and reeducated on the importance nutrition. All residents will be given same portions instead of individualized portions. Pictures were placed in kitchen on 10/26/2023. Education was provided that day verbally (10/26) but formal education was on 10/30/23 by admin. Admin will complete all menus in advance in accordance with my plate. Admin has already been very hands on as well as staff checking in to ensure meals are compliant. Staff has done very well making this change. Admin will make a formal sheet to document meal audits and if they are compliant.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *Starting 12/1/23, the administrator will complete random weekly meal audits to ensure the appropriate portion sizes are being served. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented █ - 04/23/2024)

161d - Dietary Needs

18. Requirements

2600.
161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

Per physician's notes from 9/21/23, Resident #5 is prescribed a pureed diet. However, on 9/27/23 during the lunch meal, the resident was served oatmeal and cut up pieces of toast.

Per Resident #2's most recent medical evaluation, dated 4/7/23, Resident #2 is on a prescribed mechanical soft diet. However, on 9/28/23 during the breakfast meal, Resident #2 was served bacon. During the noon meal on 9/28/23, Resident #2 was served raw green pepper slices, raw cucumber slices, and raw tomato slices with a shaved steak sandwich served on a hot dog roll. Resident #2 reports often eating lunchmeat sandwiches and is served potato chips.

161d - Dietary Needs (continued)

Resident #6 reports the need for a special low phosphorus diet due to diagnosis of phosphorus retention. Posted in the kitchen of the home, is a very specific diet list for Resident #6. Resident's diet is to include no dairy, no nuts, sausage, peanut butter, bacon, pancakes, and chocolate. On 9/27/23, the resident was observed to be served bratwurst with cheese during the lunch meal. On 9/28/23 during the lunch meal, the resident was served shaved steak meat with cheese.

Plan of Correction ***Directed (- 11/21/2023)***

As per inspection, Resident number 6 does not reside here and is not a resident of St. Judes haven. We did assist with new environment temporarily but now manages absolutely everything for and eats here as a guest. She was given a 30 day notice on 11/7/2023.

New puree machine was purchased on 10/1/2023 by admin. Also, residents are being reevaluated that have moved from other facility. Some have been readjusted as they do tolerate a normal diet.

Once all assessments are complete un updated list will be provided to kitchen staff from admin so they can appropriately follow diets. Until list is updated staff will follow current diet as tolerated. Diets will also be updated on RASP and DME for any changes

Assessments will be completed by either hospice RN if they do not have Speech Therapy. If resident is under home health then speech therapy will be in to do the assessment. Admin intends to have all needed assessments completed by 12/1/2023 which will include an order for the special diet.

I am currently awaiting a call/email from hospice to do an inservice for staff on the different types on diets and the consistency. Admin will do the random audits and document on the list that will be made.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *The administrator and/or outside agency will educate kitchen and dietary staff regarding special diets and identified residents with special diets by 1/1/24.*
- *Starting 1/1/24, the administrator will complete random weekly meal audits to ensure special diets are being followed. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented (- 04/23/2024)

161e - Dietary Alternatives

19. Requirements

2600.
161.e. Dietary alternatives shall be available for a resident who has special health needs or religious beliefs regarding dietary restrictions.

161e - Dietary Alternatives *(continued)*

Description of Violation

On 9/27/23, the home did not provide a dietary alternative to the mechanical soft diet served during the lunch meal for Resident #2. The resident was served a lunch meat sandwich. The resident reports that he/she is only offered grilled cheese or lunch meat sandwiches as an alternative.

Plan of Correction ***Directed C - 11/21/2023)***

We do offer more than sandwiches for an alternative. Resident number 2 would often refuse anything we tried to make right or accommodate once something was served to . Staff has been educated on documentation of refusals, diet, and list of diets to be followed.

Admin will create a list of meal options for special diets once assessments are completed. Being very small, if we are making something we know a resident does not like, staff will let them know what we are having and ask what they would like instead. This is done by the lead on the floor. If we present the resident with a meal and they say they do not want/like it, then staff offers options or will ask what they would like instead. Education will be provided to staff once I receive the date from the trainer. Staff member H will be responsible for the monitoring step so can implement any needed changes.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *The administrator will create a list of alternative meal options for special diets by 12/15/23.*
- *The administrator and/or outside agency will educate kitchen and dietary staff regarding alternative options for special diets by 1/1/24.*
- *Starting 1/1/24, the administrator and/or designee will complete random weekly meal audits to ensure alternative meals to special diets are available and being offered. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented - 04/23/2024)

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

Upon entering the home on 9/27/23, there were no menus posted.

Repeated Violation - 4/13/23

Plan of Correction ***Directed - 11/21/2023)***

Admin did the menus that have been completed and also posted them. Internet was not working and I could not print menus. In addition to the completed menus, one month of hand written menus have been completed and will be kept for emergency in the event we have internet issues.

162c - Menus Posted (continued)

If menus are missing or out of date Staff member H will let admin know and can immediately use the hand written menus. Staff member H will complete the random menu audits. ██ will also work with the wholesale company on any additional menus.

We also have a new wholesale company we are working with who will also provide menus to us based off of our order. We can also add those in addition to the ones we have made for a good variety of meals.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *The administrator will educate staff on this regulation by 1/1/24.*
- *Starting 12/1/23, the administrator will complete random monthly audits to ensure menus are posted in the home. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Not Implemented (██ - 04/18/2024)

162e - Menu Changes

21. Requirements

2600.
162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On 9/28/23, omelets, banana, and toast were listed on the menu for the breakfast meal; however, bacon and eggs were served instead. Honey battered chicken tenders, chicken noodle soup and Jello were listed on the menu for the lunch meal; however, shaved steak sandwiches, tater tots, Jello and raw vegetables with dip were served instead. No notice was provided to the residents in advance of the meal.

Plan of Correction ***Directed ██ - 11/21/2023)***

Staff has been educated on regulation pertaining to following the menu and giving an advance notice to each person. This was completed on 10/30/2023. Admin will randomly do meal audits and document on checklist.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *Starting 12/1/23, the administrator will complete random weekly meal audits to ensure changes to the menu are posted in advance for residents to see. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented ██ - 04/23/2024)

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

On 9/28/23, Resident #6 self-administered medications to include clonazepam, trazodone, mirtazapine, venlafaxine, and rexulti; however, Resident #6 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction ***Accept (- 11/21/2023)***

As per inspection, Resident number 6 does not reside here and is not a resident of St. Judes haven. lives in and rents another property that is separate. We did assist with her new environment temporarily but now manages absolutely everything for and eats here as a guest. was given a 30 day notice on 11/7/2023. We are actively working to get into a new setting.

Audit of medications will be completed by 11/20/23.

Our yearly self administration will be held on 11/21/23 in which these procedures, regulations, and policies will be reviewed.

Proposed Overall Completion Date: 11/21/2023

Licensee's Proposed Overall Completion Date: *01/01/2024*

Implemented - 04/23/2024)

181f - Record of Medication

23. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 9/28/23, the home did not have a record to include a current list of medications for Resident #6.

Plan of Correction ***Directed - 11/21/2023)***

As per inspection, Resident number 6 does not reside here and is not a resident of St. Judes haven. lives in and rents another property that is separate. We did assist with new environment temporarily but now manages absolutely everything for and eats here as a guest. was given a 30 day notice on 11/7/2023. Audit will be completed by admin no later than 11/20/23. Education will be provided through the med training course no later than 12/1/23. Admin will do the random audits of med lists

181f - Record of Medication (continued)

We are actively working to get her into a new setting.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *Starting 12/1/23, the administrator will complete monthly audits of a sample of medication lists. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented ██ - 04/23/2024)

183b - Meds and Syringes Locked

24. Requirements

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

Description of Violation

On 9/27/23 at approximately 9:20am, saline nasal spray and Nasacort ALR were observed unlocked, unattended, and accessible on the night stand in Resident #4's room.

On 9/28/23 at approximately 12:30pm, metronidazole cream was observed unlocked, unattended, and accessible on the chest of drawers in Resident #3's room.

On 9/27/23 and 9/28/23, inspectors entered the living area of Resident #6. All of the resident's medications were unlocked, unattended, and accessible.

Repeated Violation - 4/13/23

Plan of Correction ***Directed ██ - 11/21/2023)***

As per inspection, Resident number 6 does not reside here and is not a resident of St. Judes haven. ██ lives in and rents another property that is separate. ██ administers ██ own medications and is also the only person who lives here at the residence. That residence is not licensed and is not a pch.

We are actively working to get her into a new setting.

Resident number 4 was educated on the importance of compliance and not being allowed to have medications in ██ room. Staff was educated on regulations and also why it is important to keep even the creams locked away. Not just for these two residents, but keeping their eyes open for any medications family brings in and keeps in the rooms.

Residents 3 and 4 had meds removed from the room by the admin. Training was provided to staff on 10/30/23 regarding rules, policy, regs. Resident 6 was given a 30 day notice on 11/7/23. Admin will do random pop ins to

183b - Meds and Syringes Locked (continued)

bedrooms and document what, if anything, was founded.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *Starting 12/1/23, the administrator will complete monthly random resident room checks. Documentation of these checks shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Not Implemented - 04/18/2024)

186a - Authorized Prescriber

25. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

On 9/27/23, Staff Person F administered medications to Resident #6. The home has no orders for these medications.

Plan of Correction ***Directed - 11/22/2023)***

Staff person was assisting outside renter with adjusting to doing r medications. That renter is now able to fully manage medications on own after guidance from staff. Renter is not a resident here. was given a 30 day notice on 11/7/23. Med audit will be completed by admin by 12/1/23. Education will be provided to staff throiugh med training no later than 12/1/23. Admin will handle audits.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *Starting 12/1/23, the administrator will complete monthly audits of a sample of resident medications to ensure all medications have current orders. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented - 04/23/2024)

187a - Medication Record

26. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

187a - Medication Record *(continued)*

Description of Violation

Resident #4's medication administration record (MAR) does not indicate who administered the following medication doses:
- 8:00am dose of Xarelto (20mg) on 9/2/23.
- 8:00am dose of Tradjenta (5mg) on 9/4/23.
- 8:00am dose of Sertraline (100mg) on 9/6/23.
- 8:00pm Lidocaine Patch (4%) on 9/10/23.

On 9/27/23, Staff Person F administered medications to Resident #6. However, the home doesn't have a MAR for Resident #6.

Repeated Violation - 4/13/23

Plan of Correction ***Directed (- 11/22/2023)***

As per inspection, Resident number 6 is not resident here and resides in a separate residence in which manages . We did help adjust but fully manages every aspect of daily routine. was given 30 day notice on 11/7/23. Admin will be placing a call to see if pharmacy can provide paper mars in the event we cannot print them. Admin did update her MAR for resident 4 on 10/30/23. Education will be provided to med techs through training by 12/1/23.

Our internet modem went bad and needed replaced so our internet was down. Staff was able to follow med pass appropriately but the system did not fully upload pass when it was fixed. The computer was freezing as med pass is extremely large. We have had a new computer once again sent to us from the pharmacy. Paper mars could not be printed with internet down but med pass was followed as it should be.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *Starting 12/1/23, the administrator will complete monthly audits of a sample of medication administration records (MAR) to ensure the MARs are filled out completely. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Not Implemented - 04/18/2024)

190a - Completion Medication Course

27. Requirements

2600.

190a - Completion Medication Course *(continued)*

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Person D completed the online Modified Medication Administration course on 5/24/23. However, staff who completed the Modified Medication Training Course during the COVID-19 emergency were required to complete the Standard Medication Administration Training Course no later than 7/31/23. On 9/23/23 and 9/24/23, Staff Person D administered the following medications to Resident #5:
- 8:00pm dose of Morphine Sul Sol.
- 8:00pm dose of bisacodyl.
- 8:00pm dose of quetiapine.

Staff Person E's most recent Medication Administration course completed was the Modified Medication Administration completed on 10/3/21. However, staff who completed the Modified Medication Training Course during the COVID-19 emergency were required to complete the Standard Medication Administration Training Course no later than 7/31/23. On 9/23/23 and 9/24/23, Staff Person E administered the following medications to Resident #5:
- 8:00am, 2:00pm, and 8:00pm doses of Morphine Sul Sol.
- 8:00am dose of pantoprazole.
- 8:00am dose of polyethylene glycol powder.
- 8:00pm dose of bisacodyl.
- 8:00pm dose of quetiapine.

Staff person I has not successfully completed the Department-approved medications administration course. On 9/11/23 at 2:25am, Staff Person I administered acetaminophen to Resident #1.

Repeated Violation - 4/13/23, 2/16/23, et al

Plan of Correction ***Directed [redacted] 11/22/2023)***

I have set up classes now since completing my training for my "lead" med techs to be retrained by admin. Additional staff will also be trained for immediate coverage. Once classes are completed a list with their date of completion, and review due dates will be kept in my binder for quarterly reviews to ensure nothing is missed. Reviews will then be kept up to date along with their recerts.

Staff D and I will not be administering meds, all other staff will be completed by 12/1/23, audit will be completed by admin no later than 11/20/23. review dates will be monthly to ensure no reviews are missed.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *The administrator will educate med techs on the importance of medication administration training to be in compliance by 1/1/24.*
- *Starting 12/1/23, the administrator will complete monthly audits of med tech trainings. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

190a - Completion Medication Course *(continued)*

Not Implemented █ - 04/18/2024)

190b - Insulin Injections

28. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 9/3/23 and 9/20/23 at 8:00pm, Staff Person D, who has not successfully completed a Department-approved medication administration course and has not successfully completed a Department-approved diabetes patient education program within the past 12 months, administered insulin to Resident #8. Staff Person D also performed blood glucose checks on Resident #8 on 9/1/23, 9/4/23, 9/6/23 and 9/13/23.

On 9/21/23 at 8:00pm, Staff Person E, who has not successfully completed a Department-approved medication administration course and has not successfully completed a Department-approved diabetes patient education program within the past 12 months, administered insulin to Resident #8.

Plan of Correction ***Directed █ - 11/22/2023)***

We had an issue finding a trainer. The one we found had a lapse in █ education. I have a class set up for tomorrow (10/27) at 2pm with a certified diabetic trainer. Trainer education is valid through 2027. I will be setting up future trainings with this trainer in advance to stay compliant and scheduled ahead so that no trainings are missed.

Audit will be completed by 11/20/23 by admin. Education was provided to staff during diabetic class and admin also reviewed regs pertaining to insulin. Reviews will be done quarterly for diabetic training by admin

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *Starting 12/1/23, the administrator will complete quarterly audits of diabetic trainings. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented █ - 04/23/2024)

191 - Resident Right to Refuse

29. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

191 - Resident Right to Refuse *(continued)*

Description of Violation

Resident #6, admitted on [redacted]/23, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Directed [redacted] - 11/22/2023)***

As per inspection, Resident number 6 does not reside here and is not a resident of St. Judes haven. [redacted] lives in and rents another property that is separate. [redacted] administers [redacted] own medications and is also the only person who lives here at the residence. That residence is not licensed and is not a pch. [redacted] is treated like a guest because that is what [redacted] is. [redacted] is not a resident and does not even receive the boarding house supplement anymore due to the fact that [redacted] does not live in a licensed setting.

Resident was given 30 day notice on 11/7/23. Audit will be completed by 11/20/23 by admin. Admin will create new compliant checklist and will monitor new records 24 hours, 48 hours, then weekly an onto monthly checks.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *The administrator will develop and implement a new admission checklist by 1/1/24 to ensure a resident's right to refuse medication if the resident believes there is a medication error is reviewed with the resident upon admission.*
- *Starting 12/1/23, the administrator will complete audits of new admission records monthly. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented [redacted] - 04/23/2024)

224a - Preadmission Screen Form

30. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #6 was admitted to the home on [redacted]/23. However, the home did not complete a preadmission screening form for this resident.

Repeated Violation - 4/13/23

Plan of Correction ***Directed [redacted] - 11/22/2023)***

As per inspection, Resident number 6 does not reside here and is not a resident of St. Judes haven. [redacted] lives in and rents another property that is separate. [redacted] administers her own medications and is also the only person who lives

224a - Preadmission Screen Form (continued)

here at the residence. That residence is not licensed and is not a pch. is treated like a guest because that is what is. is not a resident and does not even receive the boarding house supplement anymore due to the fact that does not live in a licensed setting.

Resident was given 30 day notice on 11/7/23. Audit will be completed by 11/20/23 by admin. Admin will create new compliant checklist and will monitor new records 24 hours, 48 hours, then weekly an onto monthly checks.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *The administrator will develop and implement a new admission checklist by 1/1/24 to ensure preadmission screenings are completed within the required timeframe.*
- *Starting 12/1/23, the administrator will complete audits of new admission records monthly. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented - 04/23/2024)

225a - Assessment 15 Days

31. Requirements

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

Description of Violation

An assessment was not completed for Resident #1, who was admitted to the home on /23.

An assessment was not completed for Resident #2, who was admitted to the home on /23.

An assessment was not completed for Resident #6, who was admitted to the home on 23.

Repeated Violation - 4/13/23

Plan of Correction ***Directed - 11/22/2023)***

Upon new admission, I have dated the folder with an assessment date 15 days out so I can track and assessment is not overdue. New resident files will be reviewed weekly for the first month to ensure all files are up to date and no forms are missed especially those that are time sensitive.

Preadmission screens were completed on 9/28/23. Resident 6 was given 30 day notice 11/7/23.

Resident was given 30 day notice on 11/7/23. Audit will be completed by 11/20/23 by admin. Admin will create new compliant checklist and will monitor new records 24 hours, 48 hours, then weekly an onto monthly checks.

Proposed Overall Completion Date: 11/10/2023

225a - Assessment 15 Days (continued)

(Directed)

- *The administrator will develop and implement a new admission checklist by 1/1/24 to ensure initial assessments are completed within the required timeframe.*
- *Starting 12/1/23, the administrator will complete audits of new admission records monthly. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented █ - 04/23/2024)

252 - Record Content

32. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.

Description of Violation

Resident 6's record does not include the following:

- *Name, gender, admission date, birth date and Social Security number.*
- *Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.*
- *A photograph of the resident that is no more than 2 years old.*
- *Language or means of communication spoken or used by the resident.*
- *The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.*
- *The name, address and telephone number of the resident's physician or source of health care.*
- *The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.*

252 - Record Content (continued)

- *A list of prescribed medications, OTC medications and CAM.*
- *Dietary restrictions.*
- *A record of incident reports for the individual resident.*
- *A list of allergies.*
- *The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.*
- *The preadmission screening, initial intake assessment and the most current version of the annual assessment.*
- *A support plan.*
- *Applicable court order, if any.*
- *The resident's medical insurance information.*
- *The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.*
- *An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.*
- *An inventory of the resident's property entrusted to the administrator for safekeeping.*
- *The financial records of residents receiving assistance with financial management.*
- *The reason for termination of services or transfer of the resident, the date of transfer and the destination.*
- *Copies of transfer and discharge summaries from hospitals, if available.*
- *If the resident dies in the home, a copy of the official death certificate.*
- *Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).*
- *A copy of the resident-home contract.*
- *A termination notice, if any.*

Plan of Correction ***Directed (- 11/22/2023)***

As per inspection, Resident number 6 does not reside here and is not a resident of St. Judes haven. lives in and rents another property that is separate. administers own medications and is also the only person who lives here at the residence. That residence is not licensed and is not a pch. is treated like a guest because that is what is. not a resident and does not even receive the boarding house supplement anymore due to the fact that does not live in a licensed setting.

Resident was given 30 day notice on 11/7/23. Audit will be completed by 11/20/23 by admin. Admin will create new compliant checklist and will monitor new records 24 hours, 48 hours, then weekly an onto monthly checks.

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *The administrator will develop and implement a new admission checklist by 1/1/24 to ensure all new resident records include all required information.*
- *Starting 12/1/23, the administrator will complete audits of new admission records monthly. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented (- 04/23/2024)

254a - Records Discharge/Active

33. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 9/27/23 at approximately 9:00am, the Administrator's office was unlocked, leaving resident records unsecure, unattended and accessible.

On 9/27/23 at approximately 12:05pm, the Administrator's office was unlocked, leaving resident records unsecure, unattended and accessible.

On 9/28/23 at approximately 11:00am, the Administrator's office was unlocked, leaving resident records unsecure, unattended and accessible.

Repeated Violation - 4/13/23

Plan of Correction ***Directed (- 11/22/2023)***

New staff has been educated on needing to keep doors locked when i am not in the building. I also keep the door locked at all time that i am not in the office. Even if it is just to step out of the office for a moment. I have been monitoring my door everyday when i come in. I have had no issues with it being unlocked so far. Residents files will have an additional lock added on to ensure HIPPA privacy in the event door is forgotten to be locked. Locks and hinges have been purchased. This should ensure compliance with DHS and HIPPA.

Immediate fix was to keep door locked and compliace at all times. Door has been consistently locked even when staff did not know admin would be popping in. Maintenance got the locks and hinges on 10/30/23. Staff was reeducated on 10/30/23. Also, new hires since that date have also been educated on keeping office door locked. Surprise audits will be documented each time by admin

Proposed Overall Completion Date: 11/10/2023

(Directed)

- *Starting 12/1/23, the administrator will complete random weekly audits to ensure all records are secure. Documentation of these audits shall be kept and available for review by the Department.*

Directed Completion Date: *01/01/2024*

Implemented (- 04/23/2024)

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

Facility Information

Name: *ST. JUDE'S HAVEN PERSONAL CARE HOME* **License #**: *30787* **License Expiration**: *06/20/2024*

Address: *1072 MT. AIRY DRIVE, JOHNSTOWN, PA 15904*

County: *CAMBRIA* **Region**: *CENTRAL*

Administrator

Name: **Email**:

Legal Entity

Name: *ST JUDES HAVEN INC*

Address: *1072 MT. AIRY DRIVE, JOHNSTOWN, PA, 15904*

Phone: **Email**: *S*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/23/2000* **Issued By**: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *18* **Waking Staff**: *14*

Inspection Information

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

Reason: *Interim* **Exit Conference Date**: *01/11/2024*

Inspection Dates and Department Representative

01/11/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *17* **Residents Served**: *14*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *14*

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

Have Mobility Need: *4* **Have Physical Disability**: *0*

Inspections / Reviews

01/11/2024 - Partial

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

Inspections / Reviews *(continued)*

01/30/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *02/14/2024*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date**: *02/19/2024*

04/23/2024 - Document Submission

Submitted By: [redacted]
Date Submitted: *02/14/2024*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

63a - First Aid/CPR Training

1. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 1/2/24 from 3:00 pm to 11:00 pm, there were fourteen (14) residents present in the home. During this time, there were no staff persons present in the home who were trained in first aid and certified in obstructed airway techniques and CPR.

Plan of Correction ***Directed - 01/30/2024)***

Staff member had been actively working on getting CPR certificate from previous facility worked in but they will not give it to I am actively getting a CPR class set up for newer staff members and for anyone else who will need before it expires. Schedules have been made with special attention to CRP regs.

Proposed Overall Completion Date: 01/29/2024

(Directed)

- *The Administrator or designee will complete an audit on all current staff records to ensure staff have current certification in CPR and First Aid by 2/15/2024.*
- *A CPR/FA class will be scheduled for new staff and any staff found to have an expired certification by 2/15/2024. Proof of training and certification will be filed in the home and made available for review by the Department.*
- *Beginning 2/4/2024, the Administrator or designee will review the staff schedule at least one week in advance to ensure there is at least one staff member per shift who is certified in CPR/FA scheduled for each day. If a staff member calls off, the Administrator or designee will ensure certified staff remain in the building.*
- *Starting 2/15/2024, the Administrator will conduct quarterly reviews of staff records to ensure staff remain current in CPR/FA and certification is filed and readily available.*
- *Documentation of audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *02/15/2024*

Not Implemented - 04/18/2024)

82c - Locking Poisonous Materials

2. Requirements

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

Description of Violation

On 1/11/24 at approximately 10:30 am, the medication room was unlocked and unattended. Inside the room, in an open cabinet, there was a bottle of witch hazel and a bottle of Isopropyl Alcohol. On the floor was a bottle of Lestoil cleaner. All of these had a manufacture's label indicating "call a poison control center if ingested". Not all of the residents of the home, including Resident # 1, have been assessed capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials (continued)

Plan of Correction ***Directed █ 01/30/2024)***

Staff member was educated on the importance of double checking that the door is locked. I do random audits as I walk around or need in the med room. All times, the door has remained locked. In the event during an audit, I find the door unlocked I will install automatic locking doors to prevent any further mistakes.

Proposed Overall Completion Date: 01/29/2024

(Directed)

- *The Administrator or designee will complete an audit of all areas of the home to ensure all poisonous materials are kept locked and inaccessible to residents by 2/8/2024.*
- *All staff will be educated on regulation 2600.82(c) by the Administrator or designee no later than 2/8/2024.*
- *Beginning no later than 2/8/2024, the Administrator or designee will complete random audits in the home at least weekly to ensure all poisonous materials remain locked and inaccessible to residents.*
- *Documentation of staff education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *02/08/2024*

Not Implemented █ /18/2024)

162c - Menus Posted

3. 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

Upon entering the home on 1/11/24, there were no menus posted in a conspicuous and public place in the home.

Plan of Correction ***Directed █ 01/30/2024)***

Menu was removed the night prior for changes to be made for the coming week. Menus will remain in tact regardless of changes being made and have been made out for weeks ahead.

Proposed Overall Completion Date: 01/29/2024

(Directed)

- *On 1/11/2024, the menu was posted in the home by the Administrator or designee.*
- *Staff will receive education on regulation 2600.162(c) by 2/15/2024 by the Administrator or designee and will notify the Administrator or designee if a menu is observed to be missing.*
- *Beginning no later than 2/15/2024, the Administrator or designee will complete weekly audits to ensure the current weekly menu and a weekly menu prepared at least 1 week in advance are posted in a conspicuous and public place in the home.*

162c - Menus Posted (continued)

- *Documentation of audits and staff education will be kept by the home and available for review by the Department.*

Directed Completion Date: *02/15/2024*

Not Implemented █ - 04/18/2024)

183b - Meds and Syringes Locked

4. Requirements

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

Description of Violation

On 1/11/24 at approximately 10:30 am, the medication room was unlocked, unattended and accessible. Inside the medication room, the medication cart was unlocked and unattended. The keys to the medication cart were observed sitting in the locks on the cart which also contained narcotics and sitting on top of the medication cart was a clear cup containing multiple pills which was labeled with a resident's name.

Plan of Correction ***Directed █ - 01/30/2024)***

New med staff has been educated on the importance and reasoning of why the keys must be kept on them and the cart locked at all times. Keys have been kept on med techs and staff has been compliant on locking the med cart at all times it is not in use. Random audits have been conducted and will continue to ensure this is not an ongoing occurance.

Proposed Overall Completion Date: 01/29/2024

(Directed)

- *All staff will receive education by the Administrator or designee by 2/8/2024 on regulation 2600.183(b).*
- *Beginning 2/11/2024, the Administrator or designee will complete weekly audits of the home to ensure medications are kept in an area or container that is locked.*
- *Documentation of staff education and audits will be kept by the home and available for review by the Department.*

Directed Completion Date: *02/11/2024*

Not Implemented █ 04/18/2024)

254a - Records Discharge/Active

5. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

254a - Records Discharge/Active *(continued)*

Description of Violation

On 1/11/24 at approximately 12:45 pm, the Administrator's office was unlocked, leaving resident records unsecure, unattended and accessible.

Plan of Correction ***Directed [redacted] 01/30/2024)***

I had unlocked my office and walked down to return the keys to the med tech and I came right back to my office. I will have to have a seperate key made I guess. I have been extremely cautious of this door not being left open and had only walked 50 feet to return the keys and had kept my office locked anytime I had stepped out that day except to take the keys back.

Proposed Overall Completion Date: 01/29/2024

(Directed)

- *The Administrator was educated on the regulation by the Licensing Representative on 1/11/2024.*
- *Staff will receive education on regulation 2600.254(a) by the Administrator or designee and will monitor areas of the home to ensure resident records continue to be maintained in a confidential manner. Education will be conducted no later than 2/15/2024.*
- *Beginning 2/11/2024, the Administrator or designee will complete random audits of the home at least once a week to ensure records are maintained in a confidential manner, which prevents unauthorized access.*

Directed Completion Date: *02/15/2024*

Implemented [redacted] - 04/18/2024)

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

Facility Information

Name: *ST. JUDE'S HAVEN PERSONAL CARE HOME* **License #**: *30787* **License Expiration**: *06/20/2024*

Address: *1072 MT. AIRY DRIVE, JOHNSTOWN, PA 15904*

County: *CAMBRIA* **Region**: *CENTRAL*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *ST JUDES HAVEN INC*

Address: *1072 MT. AIRY DRIVE, JOHNSTOWN, PA, 15904*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/23/2000* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *15* **Waking Staff**: *11*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *03/06/2024*

Inspection Dates and Department Representative

03/05/2024 - On-Site:

03/06/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *17* **Residents Served**: *11*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *11*

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

Have Mobility Need: *4* **Have Physical Disability**: *0*

Inspections / Reviews

03/05/2024 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/22/2024*

03/25/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/02/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/01/2024*

04/24/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/02/2024*

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

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract for Resident 2 was not signed by the administrator.
The resident-home contract for Resident 5 was not signed by the payer.

Plan of Correction ***Directed (█ - 04/22/2024)***

Audit tool put will be put into place for completed resident folder once folder is complete. Signature on all forms will be included in the audit tool. Signatures will include admin, poa, payer, resident, and any additional family/reps. Tool will be created and implemented by April 1, 2024. Admin is responsible for completing the audit tool

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *Resident 2's contract was signed by the Administrator by 4/2/24 and placed in the resident's file.*
- *Resident 5's contract was signed by the payer by 4/2/24 and placed in the resident's file by the Administrator.*
- *The Administrator created an audit tool to ensure that all signatures are present on all forms, the Administrator begin using this tool on 5/15/24.*
- *Any missing signatures identified as part of the audit process will be followed up on by the Administrator within 48 hours of discovery. Documentation of the audit will be kept and made available upon request.*

Directed Completion Date: *05/15/2024*

26a - Quality Management Plan

2. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home's quality management review, completed on 5/28/23, does not include who participated.

Plan of Correction ***Directed (█ - 04/22/2024)***

The Quality Management regulation will be printed and added to the QM folder. Anytime a QM meeting is held, regulation will be reviewed by admin and staff to ensure regulation to followed completely.

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *The Administrator printed the requirements of this regulation and placed it in the QM folder on 4/2/24.*
- *When QM meetings are held, the Administrator will review the requirements of this regulation with all members in attendance to ensure all requirements are being met.*
- *Starting on 5/15/24, following each QM meeting the Administrator will be responsible for reviewing the documentation, if there is any missing information, the Administrator will complete it immediately.*

26a - Quality Management Plan *(continued)*

Directed Completion Date: *05/15/2024*

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

On 3/5/23 from 9:00 AM to 9:40 AM, there was a partially full trash can in the kitchen that was uncovered and unattended.

Plan of Correction ***Directed (04/22/2024)***

Staff is going to be educated by admin on the regulation and also its importance. This will be completed on 3/26/24. Random audits will be completed by admin and documented for future proof.

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *All staff were educated on this regulation and its importance by the Administrator on 3/26/24*
- *Beginning 5/15/24 the Administrator will complete random audits to ensure this regulation is being followed, documentation of these audits will be kept and made available upon request.*

Directed Completion Date: *05/15/2024*

87 - Lighting

6. Requirements

2600.
87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

The exit doors near the chapel and bedroom 17 at one end of the home and near bedrooms 7 and 8 at the other end of the home lack exterior sources of light.

Plan of Correction ***Directed - 04/22/2024)***

Home has already installed solar lights directly above the doors required. They will be inspected monthly by maintenance to be in proper working condition. Exterior lights will be added to maintenance monthly checklist, Documentation of audit will be kept on file. Lights were installed on 3/7/2024

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *Maintenance staff installed solar lights directly above both exit doors identified in the violation on 3/7/24.*
- *Beginning 5/15/24 maintenance staff will be educated by the Administrator on the need to check that all*

87 - Lighting (continued)

exterior lights are present and functioning properly.

- *Maintenance staff will use a monthly checklist moving forward to ensure that the lights are present and functioning properly. Any issues identified as part of the monthly check will be brought to the Administrator's attention and fixed with 48 hours.*

Directed Completion Date: *05/15/2024*

88a - Surfaces

7. Requirements

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

Description of Violation

There is a large brown stain on the suspended ceiling tile in living room of the home. The water-damaged ceiling tile may pose a health risk from mold and may be a safety hazard if it collapses.

Plan of Correction ***Accept [redacted] - 04/22/2024)***

Ceiling tiles will be changed by maintenance no later than 4/10/24 and all ceilings will be inspected throughout the building on this day to ensure any needed changes are made. Roofer is going to be called in to find cause of the leak as it has been an inconsistent issue since a new roof was installed. Ceiling tiles will be added to maintenance monthly checklist and kept on file. Roofer is scheduled 4/25/24. Maintenance completes the maintenance check list and ceilings are added in starting on the 5/1/24 checklist.

Licensee's Proposed Overall Completion Date: *04/02/2024* ***Not Implemented ([redacted]/24/2024)***

103f - Refrigerator/Freezer Temps

8. 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

There was no thermometer in the left-hand freezer in the garage.

Plan of Correction ***Accept ([redacted] - 04/22/2024)***

Thermometer had been found on the chair next to freezer, likely from staff cleaning freezer out. A weekly check will be documented and kept that checks that the thermometer is in the freezer and proper working order. Weekly checks will be documented and kept on file. Admin replaced the thermometer on 3/5/2024. Weekly checks begin

Licensee's Proposed Overall Completion Date: *04/02/2024* ***Not Implemented ([redacted] - 04/24/2024)***

105g - Lint Removal and Duct Cleaning

9. Requirements

2600.
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

On 3/5/24, there was a thick accumulation of lint in the lint traps of the two dryers. There were no clothes in the dryers at the time.

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

Plan of Correction ***Directed (- 04/22/2024)***

Staff is going to be educated of the regulation and also its importance. This will be completed on 3/26/24 by the admin. Random audits of the lint traps will be completed by admin and documented for future proof.

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *The Administrator educated all staff on the importance of this regulation on 3/26/24.*
- *Beginning 5/15/24 the Administrator will complete random audits of the lint traps, documentation will be kept of the audits and available upon request.*

Directed Completion Date: *05/15/2024*

141a 1-10 Medical Evaluation Information

10. Requirements

2600.
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

Resident 3's medical evaluation does not include dietary needs or body positioning.
Resident 4's medical evaluation does not include allergies.

Plan of Correction ***Directed - 04/22/2024)***

DME's will be fully inspected by admin prior to being put into the residents file and documented on the monthly audit list for the resident file. If anything is missed it will be returned to pcp for be fully completed.

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *Resident 3 and 4's medical evaluation will be sent to the doctor's office for the addition of the missing information and will be completed and placed in their files, no later than 4/29/24.*
- *Beginning 4/2/24 any DME's that are completed will be reviewed by the Administrator prior to them being placed in the resident's file. If any missing information is identified in this review, the Administrator will immediately send the DME back to the primary care physician's office for completion.*

141a 1-10 Medical Evaluation Information (continued)

- *Beginning 5/15/24, the Administrator will be completing a monthly audit of resident's DME's to ensure they are completed and accurate. Any issues identified will be corrected within 48 hours of discovery.*

Directed Completion Date: *05/15/2024*

144c1 - Smoking Area Guidelines

11. Requirements

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

Description of Violation

The home's designated smoking area is located off of the property behind the sheds across from the home. At 9:00 AM, licensing representatives observed someone smoking a cigarette and another person using a vape device under the roof at the main entrance of the home.

Plan of Correction ***Directed (- 04/22/2024)***

All staff have been educated but again will be reeducated on 3/26/24 on the regulation by the admin pertaining to smoking and its importance. Visitors will also be reminded of where the designated smoking area is.

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *The Administrator educated all staff on 3/26/24 on this regulation pertaining to using the designated smoking area.*
- *All visitors will also be educated on this regulation and shown where the designated smoking area is upon their arrival to the home.*
- *Beginning 5/15/24 the Administrator will conduct random checks of the home's exterior to ensure that staff, residents, and visitors are using the proper designated smoking area.*

Directed Completion Date: *05/15/2024*

182c - Medication Administration

12. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
6. Place the medication in the resident’s hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).

Description of Violation

On 3/5/24 at 10:40 AM, Staff B dispensed an aspirin to Resident 1 but did not watch the resident ingest the medication. The licensing representative observed the resident leave the medication room and drop the tablet on the floor before drinking from the water fountain in the living room.

Plan of Correction ***Directed - 04/22/2024)***

Staff B was educated by the admin on the importance of fully watching the resident 1 take her medications as

182c - Medication Administration (continued)

hands are shaky at times. ▇ understood and was compliant. All med staff will be reeducated on this reg on 3/26/24. Random audits will be completed watching med passes.

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *Staff B was educated by the Administrator on 3/26/24 on the importance of watching all residents take their medications.*
- *On 3/26/24 all staff members who are trained to administer medications were reeducated by the Administrator on this regulation.*
- *Beginning 5/15/24 the Administrator will conduct random audits and observe medication passes to ensure that staff are following this regulation. Documentation of these checks as well as any remedial action will be kept and available upon request.*

Directed Completion Date: *05/15/2024*

183b - Meds and Syringes Locked

13. Requirements

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

Description of Violation

On 3/5/24 at 2:15 PM, a jar of Aquaphor Ointment was unlocked, unattended, and accessible in Resident 2's bedroom.

Plan of Correction ***Accept ▇ - 04/22/2024)***

Cream was immediately removed upon reporting findings to the admin. Staff was reeducated by the admin and TTT on OTC items and will be again on 3/36/24. An audit of ▇ room was completed by the admin on 3/7/2024 and most recently on 3/29/24 to ensure no other OTC items or other medications were found, which no other meds were founded in ▇ room. Admin will do periodic checks to ensure no OTC items or meds are in any rooms. Periodic checks will be monthly and randomly starting officially 5/1/24. Admin is doing random checks as ▇ works the floor and checks ▇ room as she assists ▇ with morning care.

Licensee's Proposed Overall Completion Date: *04/02/2024* ***Not Implemented ▇ - 04/24/2024)***

183d - Prescription Current

14. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 3/6/24, a bottle of Timolol eye drops prescribed for Resident 3 was present in the medication cart. The drops had a manufacturer expiration date of 2/2024 and there is no current order for these drops.

Plan of Correction ***Directed (▇ - 04/22/2024)***

Admin did not get to complete the monthly med cart audit put in place as 4 residents were declining and passing throughout the month so attention was focused on the residents. Audit tool is put into place and does include checking expiration dates and orders. One med tech is going to be assigned to also do monthly checks on expiration dates. Audits will be documented and kept on file. Drops were disposed of day of the inspection in the drug buster

183d - Prescription Current (continued)

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *The Administrator disposed of the eye drops immediately on the day of the inspection*
- *Beginning 5/15/24 the Administrator will utilize an audit tool to check for expired medications or medications without a current prescription. Any medications found to be expired will be removed from the medication cart immediately and disposed of per the home's policy.*
- *Proof of these audits will be documented and available upon request.*

Directed Completion Date: *05/15/2024*

183e - Storing Medications

15. 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

- On 3/6/24, a plastic cup containing 9 medications labeled with Resident 5's name was present in the medication cart.
- There was a green-blue tablet on the window sill behind the medication cart.
- There was a white tablet on the floor of the medication room.
- There was a white tablet loose inside of the medication cart.

Plan of Correction ***Directed [redacted] - 04/22/2024)***

Staff is going to be educated of the regulation and also its importance. This will be completed on 3/26/24 by the admin who is the TTT. Audits for proper storage will be added to admins med room audit tool and kept on file with the monthly med room audit.

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *All medications were disposed of immediately by the Administrator on the day of the inspection.*
- *All staff were educated by the Administrator on 3/26/24 on the importance of this regulation.*
- *Beginning 5/15/24 the Administrator will be completing audits for the proper storage of medications, this audit will be in addition to the already in place medication room audit tool. Documentation of these audits will be kept on file and available upon request.*

Directed Completion Date: *05/15/2024*

184a - Resident's Meds Labeled

16. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

184a - Resident's Meds Labeled *(continued)*

Description of Violation

On 3/6/24 there was a tube of “We Care” brand Vitamin A & D ointment in the medication cart with a partial Rx label but no name visible.

Plan of Correction ***Directed ██ - 04/22/2024)***

Staff is going to be educated of the regulation and also its importance. This will be completed on 3/26/24 by the admin who is the TTT. Audits for noncompliant labels will be added to admins med room audit tool and kept on file. Audits will be done monthly with the med cart/room audit, and also randomly on days admin works as med tech. Cream was immediately removed and disposed of.

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *The cream was immediately disposed of by the Administrator on the day of the inspection*
- *On 3/26/24 all staff were educated by the Administrator on the importance and the requirements of this regulation.*
- *Beginning 5/15/24 the Administrator will conduct monthly audits for non-compliant/missing medication labels.*
- *Random audits will also be completed beginning on 5/15/24 when the Administrator works as a medication technician. Documentation of both audits will be kept and available upon request.*

Directed Completion Date: *05/15/2024*

184b - Labeling OTC/CAM

17. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident’s name.

Description of Violation

On 3/6/24, there were two 10-count tubes of glucose tablets in the medication cart that are unlabeled and expired.

Plan of Correction ***Directed ██ - 04/22/2024)***

The glucose tabs were house tablets. They were disposed of according to policy. They had no listed expiration date. If a resident is required to have them, we will get a script. Med Staff is going to be educated by admin and TTT of the regulation and also its importance. This will be completed on 3/26/24. Audits for noncompliant labels will be added to admins monthly med room audit tool and kept on file.

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *The glucose tablets were disposed of immediately on the date of the inspection per the home's policy.*
- *If a resident requires glucose tablets in the future the Administrator will be responsible for contacting the resident's physician and obtaining an order for them.*
- *On 3/26/24 the Administrator educated all staff on the importance of this regulation.*
- *Beginning 5/15/24 the Administrator will begin monthly audits to ensure that all medications that are present in the home have current orders with them. Documentation of these audits will be kept and available upon request.*

184b - Labeling OTC/CAM *(continued)*

Directed Completion Date: *05/15/2024*

185a - Implement Storage Procedures

18. 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

On 3/6/24, there was a blister card containing Alprazolam .50 mg tablets belonging to Resident 2 in the medication cart. Staff stated they were unaware this blister card was present and had no method of accounting for the tablets.

Plan of Correction ***Directed [redacted] - 04/22/2024)***

Medication was immediately moved to narcotics drawer and accounted for. Admin did not get to complete the monthly med cart audit put in place as 4 residents were declining and passing throughout the month so attention was focused on the residents. Audit tool is put into place and does include checking expiration dates and orders. One med tech is going to be assigned to also do monthly checks on expiration dates. Audits will be documented monthly by admin and kept on file.

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *The Administrator immediately moved the medication to the locked narcotics drawer on the date of the inspection.*
- *Beginning 5/15/24 the Administrator will utilize an audit tool which will identify all narcotic medications and ensure that they are stored according to the regulations and the home's policy. This audit tool will be completed on a monthly basis. Documentation of the audit tool will be kept and available upon request.*

Directed Completion Date: *05/15/2024*

19. 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 5's glucometer is dated and timed incorrectly. On 3/6/24 at 10:08 AM, the meter stated it was 3/5/24 at 11:13 PM.

There are multiple readings stored on Resident 5's meter which are not recorded on the resident's MAR or differ from those recorded including:
2/20 at 10:06 PM – 86
2/13 at 8:53 PM 117 but the MAR states 116
1/30 at 9:30pm 65
1/28 at 9:30pm 64
1/25 at 9:28pm 94
1/23 at 8:27pm 89

185a - Implement Storage Procedures (continued)

Plan of Correction ***Directed (- 04/22/2024)***

Residents have been switched over to the Libre sensor which is working, recording, and keeping time and BS as it should. Libre are properly programmed on date and time. This seems to work much better. Also paper documentation is kept of BS to ensure they are properly doucmented. Audit tool does include glucometer and will be much easier to check with these glucometers. Med Staff is going to be educated of the regulation and also its importance. This will be completed on 3/26/24. Random audits will be completed by admin and documented for future proof. This is added to the monthly checklist and officially start on 5/1/24.

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *All residents requiring blood sugar monitoring have been switched over to the Libre sensor as of 4/2/24. These sensors are automatically programed with the correct date and time.*
- *Additionally, paper documentation is also kept of the date/time and blood sugar readings.*
- *The Administrator trained all medication certified staff on 3/26/24 regarding the new process as well as the regulatory requirement.*
- *Beginning 5/15/24 and monthly thereafter, the Administrator will complete random audits to verify that the Libre sensors are accurate. Documentation of these audits will be kept and made available upon request.*

Directed Completion Date: *05/15/2024*

187a - Medication Record

20. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident 2 receives Humalog Kwik Pen insulin up to three times daily based on a sliding scale. The home does not record the blood sugar readings or the amount of insulin that is administered.

Resident 4 is prescribed Desitin Cre 13%, apply topically every day. Staff C states that the resident refused this medication on 3/6/24 at 8:00 AM, however, the medication administration record (MAR) is marked as if it was administered.

Resident 5 is prescribed blood sugar checks Monday, Wednesday, and Friday. On 3/6/24, a blood sugar reading of 92 is recorded on the MAR with Staff C's initials, however, Staff D checked the blood sugar and recorded the reading.

Plan of Correction ***Directed (- 04/22/2024)***

The pharmacy had it set up where we were documenting in the notes. We have implemented the paper calendar recordings in addition to the MAR recordings just to ensure all documentation needed is present. Audit was done on meds by admin and had Resident #4 Desitin changed to PRN as he does not need it daily anymore. Staff D will be double checking it is her login so there is no mistake. Med Staff is going to be educated of the regulation and also

187a - Medication Record (continued)

its importance. This will be completed on 3/26/24. Random audits will be completed by admin monthly and documented for future proof

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *Beginning 4/2/24 the Administrator has implemented a paper calendar recording in addition to the MAR recording to ensure that the required documentation is present.*
- *The Adminstrator condcucted an audit by 4/2/24, and discovered that the Destin medication for Resident #4 was changed to a PRN medication by the PCP.*
- *The Administrator conducted a training with all medication certified staff on 3/26/24, to discuss the regulation as well as what is required by the home.*
- *Beginning 5/15/24 the Administrator will conduct random monthly audits of the medications to ensure the MAR is accurate and staff are following the prescribers orders.*

Directed Completion Date: *05/15/2024*

187d - Follow Prescriber's Orders

21. Requirements

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

Description of Violation

Resident 4 did not receive the following prescribed medications:
- Acetaminophen Tab 500 mg on 3/5/24 at 2:00 PM
- Carb/Levo Tab 10 – 100 mg on 3/5/24 at 2:00 PM
- Cran Conc Cap 500 mg – 1 capsule by mouth twice a day on 3/5/24 at 2:00 PM
- Alprazolam Tab 0.25 mg 1 tab at bedtime on 3/5/24 because it wasn't present in the home

Resident 5 is prescribed Oyst Shell/D Tab 500 mg tablets, take one by mouth daily. This medication is supplied by the resident's family, however, it is labeled 600 mg+ D3.

Staff C states that Resident 5 is given an over-the-counter Glucosamine HCI Chondroitin Sulfate Sodium tablet daily which the family provides, however, there is no current order for this medication.

Repeated Violation - 2/16/23

Plan of Correction ***Directed █ - 04/22/2024)***

Resident #5 was added back to MAR, it was pharmacy error. Pcp did change Resident 5 mg to match the MAR. Med Staff is going to be educated by admin of the regulation and also its importance. This will be completed on 3/26/24. Random audits will be completed by admin during med cart audit process monthly and documented for future proof. Resident #4 will be reported as a med error by admin.

Proposed Overall Completion Date: 04/02/2024

(Directed)

187d - Follow Prescriber's Orders (continued)

- *Resident #5's physician was contacted and the orders were changed so that they matched the MAR, this was done by the Administrator on 4/2/24.*
- *The Administrator reviewed Resident #4's medications and ensured that all medications that had current orders were present in the home, this was completed by 4/2/24.*
- *Resident #4's medication errors were reported to the Department by the Administrator on 4/2/24.*
- *All medication certified staff were retrained by the Administrator on 3/26/24 to include double checking the MAR/ensuring that medications have current orders before administering, as well as how/when to re-order medications from the pharmacy.*
- *The Administrator will conduct random monthly audits of the medication cart and the MARS to ensure that all medication errors are reported timely as well as to ensure that medications that are about to be depleted are re-ordered in a timely manor. Documentation of these audits will be kept and made available upon request.*

Directed Completion Date: *05/15/2024*

190a - Completion Medication Course

22. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff B, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:
On 3/1/24 at 8:00 AM and 8:00 PM
On 3/4/24 at 8:00 AM and 8:00 PM
On 3/5/24 at 8:00 AM

Repeated Violation - 2/16/23

Plan of Correction ***Directed [redacted] - 04/22/2024)***

Staff B has been a med tech for over 20 years. [redacted] was having issues with the training course registration in which trainer had reached out for help desk for assistance and was fixed for [redacted]. [redacted] is now in the process of completing the course. All staff that are med trained are up to date as everyone had to re train. Staff B will have training completed by 4/8/2024.

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *The Administrator audited all medication certified staff following the inspection and verified that all staff who are currently administering medications have up to date training certificates.*
- *Staff B was instructed to stop administering medications to residents immediately following the inspection and began the process to re-enroll in the medication training program. Staff B will complete the medication administration training and be certified by 4/8/24.*
- *Beginning 5/15/24, the Administrator will conduct random monthly audits of all medication technicians to*

190a - Completion Medication Course (continued)

ensure that their training is valid and up to date. Documentation of these audits will be kept and made available upon request.

Directed Completion Date: *05/15/2024*

224a - Preadmission Screen Form

23. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department’s preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 2’s preadmission screening form, dated ████/23, does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept ██ - 04/22/2024)***

Audit tool put will be put into place for completed resident folder once folder is complete. Double checking the Preadmission Form will be included in the audit tool. Tool will be created and implemented by April 1, 2024 by the admin. All preadmission screens are completed and in resident folders.

Proposed Overall Completion Date: 04/02/2024

Licensee's Proposed Overall Completion Date: *04/02/2024* ***Not Implemented ██ - 04/24/2024)***

251b - Record Entries Legible

24. Requirements

2600.
251.b. The entries in a resident’s record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

The medical evaluation for Resident 2 is illegible.

Plan of Correction ***Directed ██ - 04/22/2024)***

New PCP will be completing one for this resident. DME's will be fully inspected by admin prior to being put into the residents file. If anything is illegible it will be returned to pcp for be legible copy. PCP will complete a new DME no later than 4/12/24. DME's are on the monthly audit form. Admin will ensure all are legible.

Proposed Overall Completion Date: 04/02/2024

(Directed)

- *The resident's new primary care physician (PCP)will be completing a new DME for this resident by 4/12/24. This new DME will be inspected by the Administrator to ensure that it is legible prior to it being placed in the resident file.*
- *Beginning 5/15/24 the Administrator will be reviewing all new DME's to ensure that they are legible. If any part of the DME is illegible the Administrator will be responsible for contacting the PCP within 24 hours to*

251b - Record Entries Legible (continued)

have it corrected.

- *Beginning 5/15/24 the Administrator will conduct random monthly audits of DME's to ensure that all the information on them is legible. Documentation of these audits will be kept and made available upon request.*

Directed Completion Date: *05/15/2024*