pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SYDLYNN INC**
LEGAL ENTITY

To operate **PARADISE MANOR**
NAME OF FACILITY OR AGENCY

Located at **206 EAST LINCOLN AVENUE, HATFIELD, PA 19440**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

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 **37**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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

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

and shall remain in effect from **December 26, 2023** until **June 26, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **144461**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 26, 2023

Owner/Administrator
Sydlynn Inc

RE: Paradise Manor
206 East Lincoln Avenue
Hatfield, Pennsylvania 19440
License #: 144461

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection May 22, 2023, June 13, 2023, August 2, 3, 7, 9, 10, 11, 12, 14, and 15, 2023, and October 19, 2023 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 144460 dated April 1, 2023 to April 1, 2024 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated April 1, 2023 to April 1, 2024 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(1) ;(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from December 26, 2023 to June 26, 2024.

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

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
183e	2	21	$5	$105	5 calendar days from mailing date of this letter
185a	2	21	$5	$105	5 calendar days from mailing date of this letter

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

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

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

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

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: *PARADISE MANOR* **License #**: *14446* **License Expiration**: *04/01/2024*

Address: *206 EAST LINCOLN AVENUE, HATFIELD, PA 19440*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *SYDLYNN INC*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date**: *12/31/1981* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *22* **Waking Staff**: *17*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *05/22/2023*

Inspection Dates and Department Representative

05/22/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *37* **Residents Served**: *21*

Secured Dementia Care Unit

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

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *19*
Diagnosed with Mental Illness: *9* **Diagnosed with Intellectual Disability**: *2*
Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

05/22/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/16/2023*

Inspections / Reviews *(continued)*

06/22/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/11/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/27/2023*

07/06/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/11/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/04/2023*

11/15/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *07/11/2023*

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

During a resident interview on 05/22/2023, it was discovered that resident #1 tried to hit staff A, which required a call to the police, who responded to the call and came out to the home. It happened about a month ago but the home did not report this incident to the department.

Plan of Correction ***Accept - 06/22/2023)***

Immediate: (5/22/23) Administrator informed Resident Care Coordinator of need to report this incident since the police were called even though no one was actually hit or injured but the police were called by staff.
Training: (6/1/23) Resident Care coordinator and Assistant Resident Care Coordinator were trained by Adminstrator on Incident Reporting.
How trained: Inservice by Administrator
Responsible Staff: Resident Care Coordinator, Asst RCC and Administrator

Licensee's Proposed Overall Completion Date: *06/16/2023*

Implemented - 11/15/2023)

18 - Compliance With Laws

2. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Care Facility Carbon Monoxide Alarm Standards Act requires a carbon monoxide detector at least 15 feet away from fossil burning devices. On 05/22/2023, there was no carbon monoxide detector near the kitchen gas stove.

Plan of Correction ***Accept (- 07/06/2023)***

Corrected on site.
Immediate: (5/22/23) Maintenance put a new Carbon Monoxide Detector in the Kitchen where the previous one had been.
Training: (6/1/23) Maintenance staff trained to check for missing detectors.
On-going: (6/1/23) Maintenance staff will look for carbon monoxide detectors on weekly rounds.
How trained: Inservice by Administrator
Responsible Staff: Maintenance

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented (- 11/15/2023)

65f - Training Topics

3. Requirements

65f - Training Topics *(continued)*

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
6. Safe management techniques.

Description of Violation

Direct care staff person A did not receive training in Medication self-administration training and Safe management techniques during training year 2022.

Plan of Correction ***Accept (- 07/06/2023)***

Immediate: (5/22/23) RCC was told by administrator to make sure all employees get the required monthly training even if they don't attend the group training.
Training: (6/1/23) RCC and Asst RCC were trained by the Administrator to make sure all employees receive all required training for the year. RCC and Asst RCC will review staff records monthly.
Review: (6/27/23) All staff training records were reviewed by RCC and Asst RCC.
How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented (- 11/15/2023)

95 - Furniture and Equipment

4. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

Resident room #5 has a bed equipped with an enabler, which is 10 inches wide and 8 inches high and not covered.

Plan of Correction ***Accept (- 07/06/2023)***

Immediate: (5/22/23) Enabler was removed from bed by Administrator. All rooms/enablers were reviewed to ensure regulation is met.
Training: (6/1/23) RCC and Asst RCC were trained not to use enablers 10 inches wide and 8 inches high without a cover.
On-going: (6/1/23) Maintenance staff will check on weekly rounds to ensure that any enabler being used has a cover.
How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented (- 11/15/2023)

96a - First Aid Kit

5. Requirements

2600.

96a - First Aid Kit *(continued)*

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

Description of Violation

The first aid kit in the med room does not include a breathing shield.

Plan of Correction ***Accept [redacted] - 07/06/2023)***

Corrected on site as breathing shield was right next to the first aid kit.All first aid kits were checked to ensure all required items were in the box.
Immediate: (5/22/23) Breathing shield was placed in first aid kit. All other required items were in the first aid kit.
Training: (6/1/23) Care staff were trained to put all required first aid kit items back into the box after use.
How trained: Inservice by Administrator
On-going: (6/1/23) Lead Med Tech will check monthly to ensure first aid kits have all required items.
Responsible Staff: All care staff/Lead Med Tech

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented ([redacted] - 11/15/2023)

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

6. Requirements

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

Description of Violation

There is no grab bar, hand rail or assist bar in the shower in resident room #103.

Plan of Correction ***Accept [redacted] - 07/06/2023)***

Immediate: (5/23/23) Hand bar was added to resident shower and all showers were checked to ensure presence and safety of rails/bars by maintenance.
Training: (6/1/23) Maintenance was trained by Administrator to make sure all showers have grab bars.
How trained: Inservice by Administrator
On-going: (6/1/23) Maintenance staff will check on weekly rounds to ensure that all hand rail/bars are checked for presence and safety.
Responsible Staff: Maintenance

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 11/15/2023)

105g - Lint Removal and Duct Cleaning

7. 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 05/22/2023, there was an approximate 1/4 inch accumulation of lint in the lint trap of one of the two dryers in

105g - Lint Removal and Duct Cleaning (continued)

the laundry room. There were no clothes in the dryer at the time.

Plan of Correction ***Accept (- 07/06/2023)***

Immediate: (5/22/23) Lint was removed by housekeeper.

Training: (6/1/23) Housekeeping was trained by Administrator to make sure lint is removed from dryer after each load.

How trained: Inservice by Administrator

Responsible Staff: Housekeeping

On-going: (6/29/23) Administrator will check the dryers weekly to ensure staff is removing lint as trained. Administrator placed sign in laundry room to remind staff on the removal of lint from the dryers.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented - 11/15/2023)

141a 1-10 Medical Evaluation Information

8. 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 #2's medical evaluation dated /2023 did not include:

(1) General Physical Examination

(4) Special Health or Dietary Needs

(6) Immunization History

(8) Body Positioning/Movement

(9) Health Status/Cognitive Functioning

Resident #3's medical evaluation dated /2023 did not include blood pressure and temperature and the one dated /2022 did not include (4) Special Health or Dietary Needs.

Plan of Correction ***Accept (- 07/06/2023)***

Immediate: (5/22/23) Resident Care Coordinator and Asst RCC were told by Administrator to make sure all required boxes are filled in by doctors on the DME.

Training: (6/1/23) Resident Care Coordinator and Asst Resident Care Coordinator were trained to make sure all required boxes are filled out completely by the physician completing the DME and to give back to them if not filled out completely.

141a 1-10 Medical Evaluation Information (continued)

How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC and Administrator
On going: (7/5/23) Administrator and RCC will do quarterly audits of all resident files to ensure the medical evaluations are filled out completely and on time.
Note: Even with constant phone calls and faxing of DME's months prior to due date, the Veterans Administration and other resident physicians are not responsive, tying the hands of our community.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 11/15/2023)

141b1 - Annual Medical Evaluation

9. Requirements

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

Description of Violation

Resident #3's most recent medical evaluation was completed on [redacted]/2023. The resident's previous medical evaluation was completed on [redacted]/2022.

Plan of Correction ***Accept ([redacted] - 07/06/2023)***

Immediate: (5/22/23) RCC and Asst RCC were trained to make sure medical evaluation is filled out completely by physician or registered nurse with ALL required information filled out at least annually.
Training: (6/1/23) RCC and Asst RCC were trained to make sure medical evaluation is filled out completely by physician or registered nurse with ALL required information filled out at least annually.
On going: (7/5/23) Administrator and RCC will do quarterly audits of all resident files to ensure the medical evaluations are filled out completely and on time.
How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 11/15/2023)

182b - Prescription Medication

10. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

Description of Violation

On 05/22/2023, staff person B administered medications to residents including resident #1, 2, 4, and 5. Staff person B was recertified on 04/09/2022 as a medication administration technician but has not completed the recertification process due in April 2023.

Plan of Correction ***Accept ([redacted] 07/06/2023)***

Immediate: (5/23/23) Staff person B was recertified by certified Med Trainer
Training: (5/23/23) Staff person B was recertified by certified Med Trainer

182b - Prescription Medication (continued)

Responsible Staff: Certified Med Trainer and Med Tech
Review: (6/27/23) All staff training records were reviewed by RCC and Asst RCC.
On-Going: (7/5/23) RCC will keep a list of Med Techs with the renewal dates and review quarterly. Renewals and trainings will be scheduled accordingly.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented (- 11/15/2023)

187a - Medication Record

11. 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 #1 is prescribed Pantoprazole 40 mg and Vitamin B-12 1000 MCG once daily and Loratadine 10 mg and Fluticasone spray 50 MCG once daily as needed. However, the resident's May medication administration record (MAR) does not indicate the diagnosis or purpose.

Resident #3 is prescribed Docusate Sod 100 mg. However, the resident's May MAR does not indicate the diagnosis or purpose.

Resident #5 is prescribed Hydroco/Apap 5-325 mg every 8 hours as needed. However, the resident's May MAR does not indicate the diagnosis or purpose.

Plan of Correction ***Accept (- 07/06/2023)***

Immediate: (5/22/23) RCC verbally spoke with all med techs regarding proper documentation of MAR
Training: (6/1/23) RCC trained Med Techs on proper documentation of MAR
How trained: Inservice by RCC
Responsible Staff: Med Techs
On-Going: (7/5/23) RCC will audit the MAR bi-weekly to ensure proper documentation in an effort to prevent recurrence.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Not Implemented (- 11/15/2023)

187b - Date/Time of Medication Admin.

12. Requirements

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

Description of Violation

Resident #3 is prescribed Tramadol 50 mg 1/2 tab twice daily as needed. The resident's May MAR does not include the initials of the staff person who administered it:

187b - Date/Time of Medication Admin. (continued)

on 05/04/2023 at 08:00 AM and 08:00 PM
on 05/05/2023 at 08:00 AM
on 05/05/2023 at 08:00 PM
on 05/06/2023 at 08:00 AM
on 05/07/2023 at 08:00 AM
on 05/08/2023 at 08:00 AM and 08:00 PM
on 05/09/2023 at 08:00 AM and 08:00 PM
on 05/10/2023 at 08:00 AM
on 05/20/2023 at 08:00 PM
on 05/21/2023 at 08:00 PM

Plan of Correction ***Accept [redacted] 07/06/2023)***

Immediate: (5/22/23) RCC verbally spoke with all med techs regarding proper documentation of MAR including initials
Training: (6/1/23) RCC trained Med Techs on proper documentation of MAR including initials
How trained: Inservice by RCC
Responsible Staff: Med Techs
On-Going: (7/5/23) RCC will audit the MAR bi-weekly to ensure proper documentation in an effort to prevent recurrence.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 11/15/2023)

187c - Refusal of Medication

13. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #3 is prescribed Tramadol 50 mg every 8 hours and Docusate Sod 100 mg twice a day. The resident refused to take these scheduled medications multiple times in May. However, these refusals were not reported to the prescriber within 24 hours.

Plan of Correction ***Accept [redacted] - 07/06/2023)***

Immediate: (5/22/23) Resident Care Coordinator verbally instructed Med Techs to report within 24 hours to prescriber if resident is refusing medications.
Training: (6/1/23) Med techs were trained to report within 24 hours to prescriber if resident is refusing medications
How trained: Inservice by Resident Care Coordinator
Responsible Staff: Med Techs
On-Going: (7/5/23) RCC will audit the resident charts monthly to ensure proper documentation and to ensure staff is calling prescribing physicians to prevent recurrence.

Licensee's Proposed Overall Completion Date: *06/30/2023*

187c - Refusal of Medication *(continued)*

Implemented (- 11/15/2023)

187d - Follow Prescriber's Orders

14. Requirements

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

Description of Violation

Resident #3 is prescribed Tramadol 50 mg every 8 hours. However, this medication is scheduled and administered to the resident at 08:00 AM, 02:00 PM, and 08:00 PM.

Plan of Correction ***Accept - 07/06/2023)***

Immediate: (5/22/23) RCC verbally spoke with all med techs regarding following directions of the prescriber and paying close attention to times.

Training: (6/1/23) Med techs were trained to follow directions of the prescriber and pay close attention to times.

How trained: Inservice by Resident Care Coordinator

Responsible Staff: Med Techs

On-Going: (7/5/23) RCC will audit the resident charts monthly to ensure proper documentation and to ensure staff is following the directions of the prescribing physicians to prevent recurrence.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Not Implemented 11/15/2023)

190a - Completion Medication Course

15. 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 person B, who has not completed the med administration recertification process due in April 2023, administered meds in May 2023.

Plan of Correction ***Accept (- 07/06/2023)***

Immediate: (5/23/23) Staff person B was recertified by certified Med Trainer

Training: (5/23/23) Staff person B was recertified by certified Med Trainer

Responsible Staff: Certified Med Trainer and Med Tech

Review: (6/27/23) All staff training records were reviewed by RCC and Asst RCC.

On-Going: (7/5/23) RCC will keep a list of Med Techs with the renewal dates and review quarterly. Renewals and trainings will be scheduled accordingly.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented (- 11/15/2023)

190b - Insulin Injections

16. 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

Staff person B, who has not completed the diabetes patient education program within the past 12 months, administered insulin to resident #3. The staff's most recent diabetes education was dated 01/12/2022.

Plan of Correction ***Accept - 07/06/2023)***

Staff member B had diabetic training in December 2022. Certificate was in the training binder and was not asked for by the inspector.
Immediate: (5/23/23) RCC placed the training certificate in the employee file.
Training: (5/23/23) RCC and Asst RCC were trained by the administrator at in-service to place all required documentation in the employees file, as well as the training binder.
Responsible Staff: RCC
Review: (6/27/23) All staff training records were reviewed by RCC and Asst RCC.
On-Going: (7/5/23) RCC will keep a list of Med Techs with the renewal dates and review quarterly. Renewals and training will be scheduled accordingly.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented - 11/15/2023)

221c - Post Activity Calendar

17. Requirements

2600.
221.c. A current weekly activity calendar shall be posted in a conspicuous and public place in the home.

Description of Violation

The home does not have a current weekly activity calendar posted in a public and conspicuous place in the home. The activity calendar that is posted is for the month of April.

Plan of Correction ***Accept (- 07/06/2023)***

Corrected on Site(5/22/23)
Training: (6/1/23) Med Techs were trained by RCC to update the calendar monthly
Responsible Staff: RCC
On-Going: (7/5/23) RCC will audit the monthly activities calendar to ensure it has been changed and updated for the current month.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented - 11/15/2023)

226a - Mobility Assessment

18. Requirements

226a - Mobility Assessment *(continued)*

2600.
226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

Resident #3's assessment, dated [redacted] 2023, does not include an assessment of the resident's mobility needs.

Plan of Correction ***Accept [redacted] - 07/06/2023)***

Immediate: (5/22/23) Administrator spoke with RCC and Asst RCC about making sure all boxes are checked on assessment.
Training: (5/2/22) Resident Care Coordinator and Asst Resident Care Coordinator were trained by Administrator to make sure assessments are completed in full including double checking to make sure all boxes are checked.
How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC
On-Going: (7/5/23) RCC and Administrator will audit all resident charts quarterly to ensure assessments are complete and correct to prevent recurrence.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Implemented [redacted] - 11/15/2023)

227d - Support Plan Medical/Dental

19. Requirements

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

Description of Violation

Resident #3's bed is equipped with an enabler, which is not addressed in the resident's assessment/support plan dated [redacted]/2023. The resident's supervision need is not answered.

Resident #5 pushed resident #3 on 04/30/2023 while waiting for [redacted] turn in front of the med room. However, the summary and determination section of the resident's support plan dated [redacted]/2023 indicates no aggression or agitation noted.

Plan of Correction ***Accept [redacted] - 07/06/2023)***

Immediate: (5/22/23) RCC and Asst RCC were reminded by Administrator to make sure the support plan Medical/Dental is filled out completely with ALL required information filled out at least annually or upon change of condition.
Training: (6/1/23) RCC and Asst RCC were trained by Administrator to make sure the support plan Medical/Dental is filled out completely with ALL required information filled out at least annually or upon change of condition.
How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC
6/1/23 The RCC and assistant RCC will begin to review all RASPs to ensure they are updated with all current information. They will continue to review until they are all reviewed for accuracy.
6/28/23 Resident #5 RASP was updated.

227d - Support Plan Medical/Dental (continued)

On-Going: (7/5/23) RCC and Administrator will audit all resident charts quarterly to ensure assessments are complete and correct to prevent recurrence.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Not Implemented [redacted] - 11/15/2023)

251b - Record Entries Legible

20. 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

On resident #3's May MAR, the insulin units given on 05/18/2023 at 12:00 PM was written over and illegible.

There was a strike out observed on resident # 3"s May Control Drug Receipt Record on the 5/5/23 date.

Plan of Correction ***Accept ([redacted] 07/06/2023)***

Immediate: (5/22/23) RCC verbally spoke with all med techs regarding proper documentation of MAR including illegible and written over entries
Training: (6/1/23) RCC trained Med Techs on proper documentation of MAR including illegible and written over entries
How trained: Inservice by RCC
Responsible Staff: Med Techs
On-Going: (7/5/23) RCC will audit the MAR bi-weekly to ensure proper documentation in an effort to prevent recurrence.

Licensee's Proposed Overall Completion Date: *06/30/2023*

Not Implemented [redacted] 11/15/2023)

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

Facility Information

Name: *PARADISE MANOR* **License #**: *14446* **License Expiration**: *04/01/2024*

Address: *206 EAST LINCOLN AVENUE, HATFIELD, PA 19440*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *SYDLYNN INC*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date**: *12/31/1981* **Issued By**: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *22* **Waking Staff**: *17*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *06/13/2023*

Inspection Dates and Department Representative

06/13/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *37* **Residents Served**: *21*

Secured Dementia Care Unit

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

Hospice

Current Residents: *NM*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *19*
Diagnosed with Mental Illness: *9* **Diagnosed with Intellectual Disability**: *2*
Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

06/13/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/17/2023*

Inspections / Reviews *(continued)*

07/28/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/14/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/02/2023*

08/11/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/14/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/15/2023*

11/15/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/14/2023*

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

42s - Privacy

1. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 6-13-23 at 9:13am, various surveillance cameras were observed. The home does not have a sign that communicates the home is under video surveillance.

Plan of Correction ***Accept (- 08/11/2023)***

Immediate: (6/13/23) Signs were ordered showing there are security cameras in use.

Training: (6/29/23) Maintenance staff trained to check for missing camera surveillance signs.

On-going: (6/27/23) Maintenance staff will look for missing camera surveillance on weekly rounds.

How trained: Inservice by Administrator

Responsible Staff: Maintenance

Update: (7/7/23)Signs were installed upon arrival.

Licensee's Proposed Overall Completion Date: *07/28/2023*

Implemented - 11/15/2023)

65a - FS Orientation 1st Day

2. 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:

- *Evacuation procedures*
- *Staff duties and responsibilities during fire drills, emergency evacuation, transportation, emergency location*
- *Designated meeting place outside the building or within the fire-safe in the event of a fire*
- *Smoking safety procedures, the home's smoking policy and location of smoking area*
- *The location and use of fire extinguishers*
- *Smoke detectors and fire alarms*
- *Telephone use and notification of emergency services*

65a - FS Orientation 1st Day *(continued)*

Plan of Correction ***Accept ███ 07/28/2023)***

Employee was re-hire and RCC thought we could use old file.
Immediate: (6/13/23) RCC completed new employee file with all required orientations.
Training: (6/27/23) RCC and Asst RCC were trained to make sure 1st day orientation is completed for all new employees. RCC and Asst RCC will review staff records monthly.
Review: (6/27/23) All staff training records were reviewed by RCC and Asst RCC.
How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC

Licensee's Proposed Overall Completion Date: *07/14/2023*

Implemented ███ - 11/15/2023)

65b - Rights/Abuse 40 Hours

3. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

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

Description of Violation

Staff person C, completed ███ 40th scheduled work hour on ███-23. However, this staff person did not complete training in the following topics:

- *Resident rights*
- *Emergency medical plan*
- *Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act*
- *Reporting of reportable incidents and conditions*

Plan of Correction ***Accept ███ - 07/28/2023)***

Employee was re-hire and RCC thought we could use old file.
Immediate: (6/13/23) RCC completed new employee file with all required orientations.
Training: (6/27/23) RCC and Asst RCC were trained to make sure 1st day orientation and all other rights/abuse trainings in first 40 hours of scheduled working hours is completed for all new employees. RCC and Asst RCC will review staff records monthly.
Review: (6/27/23) All staff training records were reviewed by RCC and Asst RCC.
How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC

65b - Rights/Abuse 40 Hours *(continued)*

Licensee's Proposed Overall Completion Date: *07/14/2023*

Implemented (11/15/2023)

65c - Ancillary Staff Orientation

4. Requirements

2600.
65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Ancillary staff person C, whose first day of work was 23, did not have a general orientation to specific job functions.

Plan of Correction ***Accept (- 07/28/2023)***

Employee was re-hire and RCC thought we could use old file.
Immediate: (6/13/23) RCC completed new employee file with all required orientations.
Training: (6/27/23) RCC and Asst RCC were trained to make sure 1st day orientation and all other rights/abuse trainings in first 40 hours of scheduled working hours, and general orientation to specific job functions is completed for all new employees. RCC and Asst RCC will review staff records monthly.
Review: (6/27/23) All staff training records were reviewed by RCC and Asst RCC.
How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC

Licensee's Proposed Overall Completion Date: *07/14/2023*

Implemented - 11/15/2023)

187d - Follow Prescriber's Orders

5. Requirements

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

Description of Violation

Resident #1 is prescribed AIMVOG Injection 140 MG/ML once monthly. However, this medication was not administered to resident #1 in the month of May because the medication was not available in the home.

Plan of Correction ***Accept (- 07/28/2023)***

Immediate: (6/13/23) RCC verbally spoke with all med techs regarding following directions of the prescriber and paying close attention to all medications prescribed to be in the home.
Training: (6/27/23) Med techs were trained to follow directions of the prescriber and pay close attention that all prescribed medications are in the home.
How trained: Inservice by Resident Care Coordinator
Responsible Staff: Med Techs
On-Going: (7/5/23) RCC will audit the resident charts monthly to ensure proper documentation and to ensure staff is following the directions of the prescribing physicians to prevent recurrence.

Licensee's Proposed Overall Completion Date: *07/14/2023*

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

Not Implemented ([redacted] - 11/15/2023)

188c - Medication Error Documentation

6. Requirements

2600.
188.c. Documentation of medication errors and the prescriber's response shall be kept in the resident's record.

Description of Violation

Resident #1 is prescribed AIMOVIG Injection 140 MG/ML once monthly. However, resident #1 did not receive the injection for the month of May. There is no documentation of the error in the resident's record.

Plan of Correction ***Accept ([redacted] - 07/28/2023)***

Immediate: (6/13/23) Med Techs were verbally told to properly document errors in resident records.
Training: (6/27/23) Med techs were trained to properly document errors in resident records.
Responsible Staff: Med Techs
Review: (6/27/23) All staff training records were reviewed by RCC and Asst RCC.
On-Going: (7/5/23) RCC will audit the resident charts monthly to ensure proper documentation and to ensure staff is following the directions of documenting medication errors.

Licensee's Proposed Overall Completion Date: *07/14/2023*

Implemented ([redacted] - 11/15/2023)

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

Facility Information

Name: *PARADISE MANOR* **License #**: *14446* **License Expiration**: *04/01/2024*

Address: *206 EAST LINCOLN AVENUE, HATFIELD, PA 19440*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *SYDLYNN INC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *24* **Waking Staff**: *18*

Inspection Information

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

Reason: *Complaint, Incident, Interim* **Exit Conference Date**: *08/15/2023*

Inspection Dates and Department Representative

08/02/2023 - On-Site:
08/02/2023 - Off-Site:
08/03/2023 - Off-Site:
08/03/2023 - On-Site:
08/07/2023 - Off-Site:
08/09/2023 - On-Site:
08/10/2023 - On-Site:
08/10/2023 - Off-Site:
08/11/2023 - Off-Site:
08/12/2023 - On-Site:
08/14/2023 - Off-Site:
08/15/2023 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *37* **Residents Served**: *22*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *1*
Are 60 Years of Age or Older: *20*
Diagnosed with Mental Illness: *9*
Diagnosed with Intellectual Disability: *4*
Have Mobility Need: *2*
Have Physical Disability: *1*

Inspections / Reviews

08/02/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/27/2023*

09/07/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/18/2023*
Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/12/2023*

09/28/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/18/2023*
Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/26/2023*

11/15/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *10/18/2023*
Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

5a1 - DHS Access

1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

1. Agents of the Department.

Description of Violation

On 8/3/23, at 1:20 pm, an agent of the Department, requested access to resident records and staff records. Staff person A was unable to come to the home to provide access to the records in the locked office.

Plan of Correction ***Accept [redacted] - 09/07/2023)***

Immediate: (8/24/23) Key to the office was added to the med cart lockbox.

Training: (6/29/23) Maintenance staff trained to check med cart lockbox for keys.

On-going: (6/27/23) Maintenance staff will confirm keys are in lockbox on weekly rounds.

How trained: Inservice by Administrator

Responsible Staff: Maintenance

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

Implemented ([redacted] - 11/15/2023)

15a - Resident Abuse Report

2. Requirements

2600.

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

Description of Violation

On 7/13/23, at approximately 11:33 am, staff person B and resident 1 got into an argument over a fan in the home's common area. Staff person B struck resident 1 in the back with an elbow. This incident was observed by staff person C. This incident was reported to staff person A and staff person D on 7/13/23. However, this allegation of abuse was not reported to Area Agency on Aging in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707).

Plan of Correction ***Accept [redacted] - 09/27/2023)***

Immediate: (8/17/23) Administrator informed Resident Care Coordinator of need to report any incident of abuse to Area Agency on Aging.

Training: (8/28/23) Resident Care coordinator and Assistant Resident Care Coordinator were trained by Administrator on Abuse Incident Reporting. This included a review of the Regulatory Compliance Guide, Policies and Procedures, interviews with residents/staff to evaluate resident rights.

(9/14/23) Administrator called and left a message with Montgomery County Senior Service requesting training for all staff on mandatory abuse reporting and prevention. Still waiting for the return call.

How trained: Inservice by Administrator

Responsible Staff: Resident Care Coordinator, Asst RCC and Administrator

15a - Resident Abuse Report *(continued)*

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented (- 11/15/2023)

17 - Record Confidentiality

3. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 8/2/23 at 9:54 am, the file drawers that contain resident's medication administration records were unlocked, unattended, and accessible in the front of the home. On top of the drawers was a pharmacy refill sheet with resident's names and medication listed.

Plan of Correction ***Accept 09/27/2023)***

Immediate: (8/17/23) Med Techs were immediately told not to leave file drawers unlocked, unattended or accessible and not to leave any resident personal information, or medical information on top of the drawers.
Training: (8/28/23) Med Techs were trained by Resident Care Coordinator on record confidentiality.
Update: Administrator and RCC will do random spot checks by checking locks on file drawers and looking to make sure resident information is put away. This will be done on various shifts to make sure the staff is maintaining record confidentiality. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week.
How trained: Inservice by Resident Care Coordinator
Responsible Staff: All staff responsible, checks to be conducted by Administrator and RCC.
How trained: Inservice by Resident Care Coordinator
Responsible Staff: Med Techs

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented (- 11/15/2023)

20b8 - Quarterly Account

4. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

Residents 2, 3, 4, 5, and 6 do not receive a quarterly account of financial transactions. Staff member D indicated that they were unaware that this was a regulation requirement.

Plan of Correction ***Accept - 09/27/2023)***

Immediate: (8/17/23) Administrator reviewed the regulation in the Regulatory Compliance Guide.
Training: (8/28/23) Administrator trained on this regulation by reviewing the Regulatory Compliance Guide.
Update: (8/28/23) Administrator created a form for quarterly account review and had each resident sign they

20b8 - Quarterly Account (continued)

received and sent to each residents designated person if they have one. Administrator added quarterly reminder to google calendar for the completion of the form. Next quarter due is 3rd quarter of 2023 and will be completed first week of October 2023 and will continue to be completed quarterly by the Administrator.
How trained: Read Regulatory Compliance Guide.
Responsible Staff: Administrator

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented (- 11/15/2023)

20b9 - Record Keeping

5. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
9. A copy of the itemized account shall be kept in the resident's record.

Description of Violation

There is no copy of the quarterly account of financial transactions in the record for residents 2, 3, 4, 5, and 6. Staff member D indicated that they were unaware that this was a regulation requirement.

Plan of Correction ***Accept (- 09/27/2023)***

Immediate: (8/17/23) Administrator reviewed the regulation in the Regulatory Compliance Guide.
Training: (8/28/23) Administrator trained on this regulation by reviewing the Regulatory Compliance Guide.
Update: (8/28/23) Administrator created a form for quarterly account review and had each resident sign they received and sent to each residents designated person if they have one.
Update: (8/28/23) Administrator created a form for quarterly account review and had each resident sign they received and sent to each residents designated person if they have one. Administrator added quarterly reminder to google calendar for the completion of the form. Next quarter due is 3rd quarter of 2023 and will be completed first week of October 2023 and will continue to be completed quarterly by the Administrator.
How trained: Read Regulatory Compliance Guide.
Responsible Staff: Administrator

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented - 11/15/2023)

29a SOPb7 - Hospice Care: Sufficient Staff for Safe Evacuation

6. Requirements

2600.
29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:
7. The home is to maintain sufficient staffing at all times to provide for the safe evacuation of all residents, including the resident who is actively dying while receiving hospice care and services, in accordance with the fire drill practice requirements specified in paragraph (5) and § 2600.132(a)—(j). A resident who meets the conditions of paragraphs (1)—(3) is a resident with mobility needs in accordance with § 2600.4 (relating to definitions).

29a SOPb7 - Hospice Care: Sufficient Staff for Safe Evacuation *(continued)*

Description of Violation

Resident 7 is actively dying, and the home is not sufficiently staffed. There is only 1 direct care person working the 1st and 2nd shift 7 days per week. Sunday through Thursday, there is only 1 direct care person working overnight. Friday and Saturday, there are no direct care staff working overnight.

Plan of Correction ***Accept (09/27/2023)***

Immediate: (8/17/23) Administrator reviewed staffing and requirements with Resident Care Coordinator.
Training: (8/28/23) Administrator trained RCC and Asst RCC on staffing requirements.
How trained: Inservice by Administrator
Responsible Staff: Resident Care Coordinator and Assistant Resident Care Coordinator
Update: (8/28/23) We have hired a universal worker housekeeping/direct care who started full-time on /23. Another direct care staff member who was on a leave of absence returned to working the overnight shift on /23. Another universal worker maintenance/direct care returned from a 30 day medical leave on /23. In addition, we have two full-time med techs and a part-time universal housekeeper/direct care staff in the process of being hired.
/23 Additional staff have been hired and trained. There is direct care staff working on all shifts, seven days a week. RCC creates the bi-weekly schedule, and the Administrator will audit the schedule bi-weekly to confirm compliance. Administrator has added this audit to google calendar and will continue on-going. Next bi-weekly schedule audit is on 9/25/23.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented - 11/15/2023)

29a SOPb10 - Hospice Care: Resident Assessment and Support Plan

7. Requirements

2600.

29.a.b. A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met:

10. The resident’s assessment and support plan are to be kept current and specify the requirements of this section as it relates to the specific resident.

Description of Violation

Resident 7's assessment and support plan do not address the resident's exclusion from evacuation during fire drills due to status in an active dying process.

Plan of Correction ***Accept (- 09/27/2023)***

Immediate: (8/17/23) RCC and Asst RCC were reminded by Administrator to make sure the support plan Medical/Dental is filled out completely with all required information filled out at least annually or upon change of condition. This includes resident’s exclusion from evacuation during fire drills due to actively dying.
Training: (8/28/23) RCC and Asst RCC were trained by Administrator to make sure the support plan Medical/Dental is filled out completely with ALL required information filled out at least annually or upon change of condition.
How trained: Inservice by Administrator
Responsible Staff: Resident Care Coordinator and Assistant Resident Care Coordinator
Update: (9/5/23) The RCC and assistant RCC will review all RASPs again to ensure they are updated with all current information. They will continue to review until they are all reviewed for accuracy. A checklist has been created and

29a SOPb10 - Hospice Care: Resident Assessment and Support Plan (continued)

will be used monthly and on-going.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented ▇▇ - 11/15/2023)

42b - Abuse

8. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 7/13/23, staff person B struck resident 1 in the back with an elbow.

On 7/19/23, resident 2 attacked resident 3 by knocking the resident down with a rollator walker, twice. Resident 2 has a history of aggressive behavior that was not being addressed by the home.

On 7/19/23, resident 2 was abandoned in the hospital. The resident was sent to the emergency room by the home for a change in mental status and the ER determined that they did not require medical or psychological treatment at that time. The ER notified the home reported that resident 1 could not return to the home and the staff of the home refused to take resident back. The resident lived in the emergency room from ▇▇/23 to ▇▇/23.

Resident 7 moved into the home on ▇▇/23. The resident moved in with diagnoses of coronary artery disease, diabetes type 2, and hypertension. In June of 2023, the resident had 2 toes amputated and was prescribed medication to be taken for 14 days to fight infection. On 8/10/23, The following medications were observed still in the home on 8/10/23 because they had not been administered to the resident:

- *Doxcycl Hyc Cap 100 MG, 1 cap by mouth 2 times per day for 14 days. 28 pills were dispensed on 6/20/23. 11 pills were remaining.*
- *Cefdinir 300 MG, 1 cap by mouth every 12 hours for 14 days. 28 pills were dispensed on 6/20/23. 11 pills were remaining.*
- *Metronidazole 500 MG, 1 tab by mouth every 8 hours for 14 days. 42 pills were dispensed on 6/20/23. The bottle was almost full.*

Resident 7 is prescribed Morphine 100/5ML, take 0.25 ML(5MG) by mouth daily prior to wound care. According to the controlled substance log, the last time the resident was given Morphine prior to wound care was 7/28/23. Wound care was ordered daily on 6/17/23 for resident's gangrenous right toes and bottom of foot. Wound care treatment was documented daily from 6/17/23 to 8/10/23.

Resident 7 was prescribed Lyumjev Kwikpen on a sliding scale and was ordered to have blood sugar checks 3 times per day. The resident was not receiving blood sugar checks and not receiving insulin.

Resident 7 has a special diet and needs ground food. Staff persons A and C reported that they offer the resident chopped food and ▇▇ does not eat it. Resident 7 is not offered any food that the resident can consume nor offered any nutritional supplement, such as Ensure.

42b - Abuse (continued)

Resident 7 went to the hospital on /23 and was determined to be severely dehydrated. The resident was admitted to the intensive care unit on /23 with several diagnoses including sepsis, gangrene of foot, and Diabetes Mellitus, type 2.

There is no staff certified to administer medications working overnight and there are residents in the home prescribed medications to be taken on an as needed basis. Additionally, there are no direct care staff working overnight on Fridays and Saturdays.

Plan of Correction ***Directed - 09/28/2023)***

Staff person B was terminated on /23 for poor behavior/decision making but staff person B did not appear to strike resident upon review of the cameras.
Resident 2's aggressive behavior was addressed by the administrator with staff and discussed with the resident numerous times. RCC was late in documenting the care plan but the resident's aggression was definitely discussed with all staff and the resident.
Immediate: (8/17/23) RCC and Asst RCC were reminded by Administrator to make sure the support plan Medical/Dental is filled out completely with all required information filled out at least annually or upon change of condition.
Training: (8/28/23) RCC and Asst RCC were trained by Administrator to make sure the support plan Medical/Dental is filled out completely with ALL required information filled out at least annually or upon change of condition.
How trained: Inservice by Administrator
Responsible Staff: Resident Care Coordinator and Assistant Resident Care Coordinator
Update: (9/5/23) The RCC and assistant RCC will review all RASPs again to ensure they are updated with all current information. They will continue to review until they are all reviewed for accuracy.
Resident 2 was to the hospital after attacking resident 3 and knocking down twice. Due to the serious nature of the attack and the fact that the other residents feared we told the hospital we were not comfortable taking the resident back. We acted in the manner necessary to keep our remaining twenty residents safe.
Immediate: (8/17/23) The administrator informed the RCC, and Asst RCC to allow all residents to come back to the community regardless of situation while community works to find another solution within the guidelines.
Training: (8/28/23) The administrator trained the RCC, and Asst RCC to allow all residents to come back to the community regardless of situation while community works to find another solution within the guidelines.
How trained: Inservice by Administrator
Responsible Staff: Resident Care Coordinator and Assistant Resident Care Coordinator
Update: (8/28/23) We have hired a universal worker housekeeping/direct care who started full-time on /23. Another direct care staff member who was on a leave of absence returned to working the overnight shift on /23. Another universal worker maintenance/direct care returned from a 30 day medical leave on /23. In addition, we have two full-time med techs and a part-time universal housekeeper/direct care staff in the process of being hired.
Resident 7 was actively dying on hospice and would refuse to take medications, refuse blood sugar checks, and would not eat or drink. Med techs did not document properly as they believed hospice documentation was sufficient. All staff working overnight have direct care training as of 8/12/23.
Training: (9/6/23) The administrator will train all staff on proper documentation even when residents are on hospice. Staff will be trained on the difference between ground and chopped food and to ask the physician for a doctors order for ensure if resident is refusing to eat or drink. All staff will be trained on the RCG guide regulation 42b.
How trained: Inservice by Administrator
9/14/23 Additional staff have been hired and trained. There are certified staff to administer medications working

42b - Abuse (continued)

on all shifts, seven days a week. RCC creates the bi-weekly schedule, and the Administrator will audit the schedule bi-weekly to confirm compliance. Administrator has added this audit to google calendar and will continue on-going. Next bi-weekly schedule audit is on 9/25/23.
9/14/23 Administrator has contacted the local ombudsman office and Montgomery County Senior Services about coming out to do a training in mandatory abuse reporting and prevention. Still awaiting a return call.
8/15/23 Certified Diabetic trainer did a training of qualified staff and is scheduled to do another for new staff on 9/26/23.
(9/5/23) The RCC and assistant RCC will review all Staff Training Records again to ensure they are updated with all current information. They will continue to review until they are all reviewed for accuracy. A checklist has been created and will be used monthly and on-going.
Responsible Staff: All Staff

Directed Plan of Correction:
In addition to the above plan of correction, the administrator or designee shall engage a qualified medication trainer to complete remediation training for all current medication technician staff. Remediation training for all med tech staff shall be completed within 15 calendar days of the receipt of this plan of correction.
Beginning within 15 calendar days of the receipt of this plan of correction, the administrator or designee shall complete weekly audits of medication carts/MAR's to review for proper administration and documentation of all medications/physician orders. Weekly med cart audits shall continue for 1 month and then shall be conducted twice monthly for 3 months.
Documentation of trainings, trainer credentials and audits shall be kept and made available for Department review upon request.

Directed Completion Date: *10/15/2023*

Not Implemented (- 11/15/2023)

42i - Health Services

9. Requirements

2600.
42.i. A resident shall receive assistance in accessing health services.

Description of Violation

On 8/10/23, resident 8 needed to go to a doctor's appointment but did not have transportation. Another resident made transportation arrangements for resident 8, as the home did not have enough staff to make the arrangements.

Plan of Correction ***Directed - 09/28/2023)***

This is just not true. We help all our residents with transportation if needed. Resident 8 is very friendly with another resident who went ahead and ordered an uber without speaking to our staff. The community found out about it after the fact. The other resident on resident 8 and is constantly trying to do things for We are asking this violation to be removed as the community cannot be held responsible for these residents securing

42i - Health Services (continued)

transportation without our knowledge.
Immediate: (8/17/23) Administrator reviewed staffing and requirements with Resident Care Coordinator.
Training: (8/28/23) Administrator trained RCC and Asst RCC on staffing requirements.
How trained: Inservice by Administrator
Responsible Staff: Resident Care Coordinator and Assistant Resident Care Coordinator

Directed Plan of Correction:
In addition to the above plan of correction, the administrator or designee shall provide education to staff on assisting residents with accessing health services including scheduling of medical appointments and arranging transportation. Additionally, a resident council meeting shall be scheduled and the administrator or designee shall remind residents to notify staff of appointments and need for transportation arrangements. Education to staff and to residents shall be provided within 15 calendar days of the receipt of this plan of correction. Documentation of trainings and resident council meeting minutes shall be kept and made available for Department review upon request.

Directed Completion Date: *09/15/2023*

Not Implemented (- 11/15/2023)

42p - Restraints

10. Requirements

2600.
42.p. A resident shall be free from restraints.

Description of Violation

Resident 9 has a diagnosis of dementia and requires supervision in the home. Resident 9 is restricted to the home's common area when the resident is awake. According to staff person A, each time the resident attempts to leave the common area, the resident is redirected to remain in the common area.

Plan of Correction ***Accept (09/07/2023)***

Resident 9 has a diagnosis of dementia and the community is working on finding a higher level of care. The only reason the resident has been re-directed is for own safety.
Immediate: (8/17/23) Administrator spoke with staff about not re-directing resident unless appears to be putting r in danger.
Training: (8/28/23) Administrator trained direct care staff on this regulation.
How trained: Inservice by Administrator
Responsible Staff: Direct care staff

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

Implemented (- 11/15/2023)

42u - Right to Remain in Home

11. Requirements

2600.
42.u. A resident has the right to remain in the home, as long as it is operating with a license, except as specified in § 2600.228 (relating to notification of termination).

42u - Right to Remain in Home *(continued)*

Description of Violation

On /23, the home discharged resident 2 against resident's will.

Plan of Correction ***Accept - 09/07/2023)***

Resident 2 was to the hospital after attacking resident 3 and knocking down twice. Due to the serious nature of the attack and the fact that the other residents feared we told the hospital we were not comfortable taking the resident back. We acted in the manner necessary to keep our remaining twenty residents safe.
Immediate: (8/17/23) The administrator informed the RCC, and Asst RCC to allow all residents to come back to the community regardless of situation while community works to find another solution within the guidelines.
Training: (8/28/23) The administrator trained the RCC, and Asst RCC to allow all residents to come back to the community regardless of situation while community works to find another solution within the guidelines.
How trained: Inservice by Administrator
Responsible Staff: Resident Care Coordinator and Assistant Resident Care Coordinator

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

Not Implemented (- 11/15/2023)

Withdrawn(- 11/15/2023)

57c - 2 Hours/Day

13. Requirements

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

There are 22 residents in the home, including 2 residents with mobility needs, requiring a total minimum of 24 hours of direct care service. On Sundays through Thursdays, only 16 hours of direct care staffing are provided. On Fridays and Saturdays only 12 hours of direct care staffing are provided.

Plan of Correction ***Accept (09/28/2023)***

Immediate: (8/17/23) Administrator reviewed staffing and requirements with Resident Care Coordinator.
Training: (8/28/23) Administrator trained RCC and Asst RCC on staffing requirements.
How trained: Inservice by Administrator
Responsible Staff: Resident Care Coordinator and Assistant Resident Care Coordinator
Update: (8/28/23) We have hired a universal worker housekeeping/direct care who started full-time on /23. Another direct care staff member who was on a leave of absence returned to working the overnight shift on /23. Another universal worker maintenance/direct care returned from a 30 day medical leave on /23. In addition, we have two full-time med techs and a part-time universal housekeeper/direct care staff in the process of being hired. 9/14/23 Additional staff have been hired and trained. There are certified staff to administer medications and direct care staff working on all shifts, seven days a week. RCC creates the bi-weekly schedule, and the Administrator will audit the schedule bi-weekly to confirm compliance. Administrator has added this audit to google calendar and will continue on-going. Next bi-weekly schedule audit is on 9/25/23.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented - 11/15/2023)

57d - Waking Hours

14. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On a daily basis, a total of 24 hours of direct care are required. However, only 12 of the required hours, or 50% percent, are provided during waking hours.

Plan of Correction ***Accept - 09/28/2023)***

Immediate: (8/17/23) Administrator reviewed staffing and requirements with Resident Care Coordinator.
Training: (8/28/23) Administrator trained RCC and Asst RCC on staffing requirements.

57d - Waking Hours (continued)

How trained: Inservice by Administrator
Responsible Staff: Resident Care Coordinator and Assistant Resident Care Coordinator
Update: (8/28/23) We have hired a universal worker housekeeping/direct care who started full-time on [redacted]/23. Another direct care staff member who was on a leave of absence returned to working the overnight shift on [redacted]/23. Another universal worker maintenance/direct care returned from a 30 day medical leave on [redacted]/23. In addition, we have two full-time med techs and a part-time universal housekeeper/direct care staff in the process of being hired.
9/14/23 Additional staff have been hired and trained. There are certified staff to administer medications and direct care staff working on all shifts, seven days a week. RCC creates the bi-weekly schedule, and the Administrator will audit the schedule bi-weekly to confirm compliance. Administrator has added this audit to google calendar and will continue on-going. Next bi-weekly schedule audit is on 9/25/23.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented ([redacted] - 11/15/2023)

60c - Housekeeping/Maintenance

15. Requirements

2600.
60.c. Additional staff hours, or contractual hours, shall be provided as necessary to meet the laundry, food service, housekeeping and maintenance needs of the home.

Description of Violation

The home does not have dietary aides. Minor volunteers were being utilized instead of dietary staff from 6/21/23 to 8/11/23. As of 8/11/23, the volunteers are no longer in the home.

Plan of Correction ***Accept [redacted] - 09/28/2023)***

Prior to the volunteers in the home, the cook would serve the residents directly as we are a very small community.
Immediate: (8/11/23) Now that the volunteers are no longer in the home, the cook went back to serving all the residents.
Training: (8/28/23) Chef was trained to continue serving the residents at meal times.
How trained: Inservice by Administrator
Responsible Staff: Chef
How trained: Inservice by Administrator
9/14/23 Additional staff have been hired and trained. There are certified staff to administer medications and direct care staff working on all shifts, seven days a week. There are sufficient staff hours to meet the laundry, food service, housekeeping, and maintenance needs of the home. RCC creates the bi-weekly schedule, and the Administrator will audit the schedule bi-weekly to confirm compliance. Administrator has added this audit to google calendar and will continue on-going. Next bi-weekly schedule audit is on 9/25/23.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented ([redacted] 11/15/2023)

62 - Contact List

16. Requirements

2600.

62 - Contact List *(continued)*

62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

There is not a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Plan of Correction ***Accept - 09/28/2023)***

Immediate: (8/17/23) Administrator reviewed contact list requirements with Resident Care Coordinator and Assistant Resident Care Coordinator
Training: (8/28/23) Administrator trained RCC and Asst RCC on contact list
How trained: Inservice by Administrator
Update: (8/28/23) New contact list created
9/14/23 Administrator will audit the schedule bi-weekly to confirm and compare to the staff contact list. Administrator has added this audit to google calendar and will continue on-going. Next bi-weekly schedule audit is on 9/25/23.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented - 11/15/2023)

65a - FS Orientation 1st Day

17. 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 F, volunteer, whose first day of work was /23, and Staff person G, volunteer, whose first day of work was /23, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Plan of Correction ***Accept (- 09/07/2023)***

Immediate: (8/17/23) Administrator spoke with RCC and Asst RCC regarding not having completed the first day

65a - FS Orientation 1st Day (continued)

orientation of the volunteers. There was confusion regarding the need for the training since it was the first time the home has used volunteers.
Training: (8/28/23) RCC and Asst RCC were trained to make sure 1st day orientation is completed for all new employees including volunteers. RCC and Asst RCC will review staff records monthly.
Review: (8/28/23) All staff training records were reviewed by RCC and Asst RCC.
Update: (8/11/23) Volunteers no longer working for the home.
How trained: Inservice by Administrator

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

Implemented [redacted] - 11/15/2023)

65b - Rights/Abuse 40 Hours

18. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

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

Description of Violation

Staff person F completed [redacted]r 40th scheduled work hour on or about [redacted]/23. Staff person G completed [redacted] 40th scheduled work hour on or about [redacted]/23. Both staff persons were [redacted] volunteers. Neither staff person completed training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Plan of Correction ***Accept [redacted] 09/07/2023)***

Immediate: (8/17/23) Administrator spoke with RCC and Asst RCC regarding not having completed the training of the volunteers. There was confusion regarding the need for the training since it was the first time the home has used volunteers.
Training: (8/28/23) RCC and Asst RCC were trained to make sure training is completed for all new employees including volunteers. RCC and Asst RCC will review staff records monthly.
Review: (8/28/23) All staff training records were reviewed by RCC and Asst RCC.
Update: (8/11/23) Volunteers no longer working for the home.
How trained: Inservice by Administrator

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

Implemented ([redacted] - 11/15/2023)

65c - Ancillary Staff Orientation

19. Requirements

2600.
65.c. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Ancillary staff person F, G, who are [redacted] volunteers, and staff person H, whose first day of work was [redacted]/23, [redacted]23, and [redacted]23, respectively, did not have a general orientation to [redacted] specific job functions.

Plan of Correction ***Accept [redacted] 09/07/2023)***

Immediate: (8/17/23) Administrator spoke with RCC and Asst RCC regarding not having completed the general orientation of the volunteers. There was confusion regarding the need for the training since it was the first time the home has used volunteers.
Training: (8/28/23) RCC and Asst RCC were trained to make sure orientation is completed for all new employees including volunteers. RCC and Asst RCC will review staff records monthly.
Review: (8/28/23) All staff training records were reviewed by RCC and Asst RCC.
Update: (8/11/23) Volunteers no longer working for the home.
How trained: Inservice by Administrator

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

Implemented [redacted] - 11/15/2023)

65d - Initial Direct Care Training

20. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.
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 H, hired on [redacted]/23, began providing unsupervised ADL services on or about [redacted]23. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test and did not complete training that included a demonstration of job duties, followed by supervised practice.

Plan of Correction ***Accept [redacted] - 09/07/2023)***

Immediate: (8/17/23) Administrator spoke with RCC and Asst RCC regarding not having completed the initial direct care training of the volunteers. There was confusion regarding the need for the training since it was the first time the home has used volunteers.
Training: (8/28/23) RCC and Asst RCC were trained to make sure training is completed for all new employees including volunteers. RCC and Asst RCC will review staff records monthly.
Review: (8/28/23) All staff training records were reviewed by RCC and Asst RCC.
Update: (8/11/23) Volunteers no longer working for the home.
How trained: Inservice by Administrator

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

Implemented ([redacted] - 11/15/2023)

82b - Poisonous Material Storage

21. Requirements

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

Description of Violation

On 8/9/23, 4 bottles of cleaning liquid, were stored on a shelf in the kitchen next to plastic tubs of sugar and flour.

Plan of Correction ***Accept (- 09/28/2023)***

Immediate: (8/17/23) Administrator spoke with the chef in charge of the kitchen about the discovery of the cleaning liquid on the same shelf as sugar and flour and the need to keep them separate.
Training: (8/28/23) Chef was trained on poisonous material storage.
How trained: Inservice by Administrator
Responsible Staff: Kitchen Staff/Chef
How trained: Inservice by Administrator
Update: Administrator and RCC will do random spot checks in the kitchen to audit food storage areas and poisonous food storage areas. This will be done on various shifts to make sure the staff is following safety standards. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented - 11/15/2023)

85a - Sanitary Conditions

22. Requirements

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

Description of Violation

On 8/9/23, a volunteer was observed pouring a cup of punch from one resident's cup back into a serving pitcher used to serve other residents.

On 8/9/23, the air conditioner unit in kitchen was very dirty with what appeared to be grime and dust on intake vents.

Plan of Correction ***Accept - 09/28/2023)***

Immediate: (8/11/23) The volunteers are no longer working in the home.
(8/23/23) The air conditioner was replaced with a new one.
Training: (8/28/23) Chef and Maintenance were trained on sanitary conditions.
How trained: Inservice by Administrator
Responsible Staff: Chef and Maintenance
How trained: Inservice by Administrator
Update: Administrator and RCC will do random spot checks to look for sanitary conditions in the home. This will be done on various shifts to make sure the staff is following sanitary condition compliance. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented (- 11/15/2023)

91 - Telephone Numbers

23. Requirements

2600.

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

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in the first floor wing by the common shower room.

Plan of Correction ***Accept [redacted] - 09/28/2023)***

We are very confused on this as the only phone we have in the first-floor wing by the common area shower has all the emergency numbers taped to the shelf above the phone. This has been there for years and I can send a photo. We are asking that this violation be removed.
Update: Administrator, RCC, and maintenance will do random spot checks to look for emergency numbers by the telephones in the home. This started on 8/17/23 and will continue on-going. These checks will be done at least once per month.
Immediate: (8/17/23) Administrator looked for phone numbers and they are still posted by the telephone.
Training: (8/28/23) Maintenance staff trained to check to make sure phone numbers are posted on weekly rounds.
On-going: (8/28/23) Maintenance staff will confirm phone numbers are posted on weekly rounds.
How trained: Inservice by Administrator
Responsible Staff: Maintenance

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented [redacted] - 11/15/2023)

101i - Access to Bedroom

24. Requirements

2600.

101.i. A resident shall have access to his bedroom at all times.

Description of Violation

Resident 9, who had a diagnosis of dementia. They are denied access to [redacted] bedroom by all staff. The resident is confined to the common area while [redacted] is awake. They are only allowed access to their bedroom during naps and to sleep at night.

Plan of Correction ***Accept ([redacted] - 09/28/2023)***

Resident 9 has a diagnosis of dementia and the community is working on finding a higher level of care.
Administrator has contacted local Ombudsman office and Montgomery County Senior Services for assistance with finding the resident a higher level of care. Still awaiting return calls and/or emails from both.
Immediate: (8/17/23) Administrator spoke with staff about allowing resident to go to [redacted] room at anytime.
Training: (8/28/23) Administrator trained direct care staff on this regulation.
How trained: Inservice by Administrator
Responsible Staff: Direct care staff
Update: Administrator and RCC will observe staff randomly on all shifts to make sure all residents have access to their rooms. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week.

101i - Access to Bedroom *(continued)*

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented (█ - 11/15/2023)

103c - Food Protected

25. Requirements

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

Description of Violation

On 8/9/23, there was an uncovered bowl of boiled chicken stored in the kitchen on the prep table.

Plan of Correction ***Accept (█ - 09/28/2023)***

Immediate: (8/17/23) Administrator spoke with the chef in charge of the kitchen about the discovery of the uncovered bowl of boiled chicken stored in the kitchen on the prep table.
Training: (8/28/23) Chef was trained on protecting food from contamination while being stored, prepared, transported an served.
How trained: Inservice by Administrator
Responsible Staff: Kitchen Staff/Chef
How trained: Inservice by Administrator
Update: Administrator and RCC will do random spot checks/routine monitoring in the kitchen and dining room to audit that food is protected from contamination while being stored, prepared, transported and served. This will be done on various shifts to make sure the staff is following the guidelines. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented (█ - 11/15/2023)

103d - Storing Food Off Floor

26. Requirements

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

Description of Violation

On 8/9/23, a box of coffee was stored on the floor in the kitchen.

Plan of Correction ***Accept █ - 09/28/2023)***

Immediate: (8/17/23) Administrator spoke with the chef in charge of the kitchen about the discovery of the box of coffee on the floor of the kitchen.
Training: (8/28/23) Chef was trained on Storing food off floor.
How trained: Inservice by Administrator
Responsible Staff: Kitchen Staff/Chef
How trained: Inservice by Administrator
Update: Administrator and RCC will do random spot checks/routine monitoring in the kitchen and dining room to audit that food shall be stored off the floor. This will be done on various shifts to make sure the staff is following the guidelines. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week.

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

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented 11/15/2023)

103e - Left Overs

27. 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 8/9/23, a cup of punch was poured back in to a serving pitcher used to serve other residents.

Plan of Correction ***Accept - 09/28/2023)***

Immediate: (8/17/23) Administrator spoke with the chef in charge of the kitchen about the volunteer pouring a cup of punch back into a serving pitcher. knew nothing about it. Volunteer no longer in the home as of /23.
Training: (8/28/23) Chef was trained on leftover requirements.
How trained: Inservice by Administrator
Responsible Staff: Kitchen Staff/Chef
How trained: Inservice by Administrator
Update: Administrator and RCC will do random spot checks/routine monitoring in the kitchen and dining room to audit that food served and returned from an individual's plate and returned is not served again or used in any way. Will also check that leftover food is labeled and dated. This will be done on various shifts to make sure the staff is following the guidelines. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented - 11/15/2023)

103g - Storing Food

28. Requirements

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

Description of Violation

On 8/9/23, the box of powdered sugar on the kitchen shelf was opened and unsealed.

Plan of Correction ***Accept - 09/28/2023)***

Immediate: (8/17/23) Administrator spoke with the chef in charge of the kitchen about opened and unsealed box of powdered sugar.
Training: (8/28/23) Chef was trained on storing food in sealed or closed containers.
How trained: Inservice by Administrator
Responsible Staff: Kitchen Staff/Chef
How trained: Inservice by Administrator
Update: Administrator and RCC will do random spot checks/routine monitoring in the kitchen and dining room to audit that food is stored in closed or sealed containers. This will be done on various shifts to make sure the staff is following the guidelines. This started on 8/17/23 and will continue on-going. These checks will be done at least

103g - Storing Food (continued)

once per week.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented (MS - 11/15/2023)

103i - Outdated Food

29. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was a dented can of pineapples in the kitchen on a shelf used to store dry goods used for resident meals.

Plan of Correction ***Accept (MS - 09/28/2023)***

Immediate: (8/17/23) Administrator spoke with the chef in charge of the kitchen about the dented can of pineapples found on the shelf of the kitchen.
Training: (8/28/23) Chef was trained on not using dented cans or outdated food.
How trained: Inservice by Administrator
Responsible Staff: Kitchen Staff/Chef
How trained: Inservice by Administrator
Update: Administrator and RCC will do random spot checks/routine monitoring in the kitchen and dining room to audit that outdated or spoiled food or dented cans are not used. This will be done on various shifts to make sure the staff is following the guidelines. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented [redacted] - 11/15/2023)

127a - Portable Space Heaters

30. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

On 8/2/23 and 8/10/23, a portable space heater was observed in the fireplace in the home's common area.

Plan of Correction ***Accept ([redacted] 09/07/2023)***

This decorative space heater in the fireplace has been in the fireplace since the administrator started with Paradise Manor. It was not plugged in, and no one even knew it was an actual space heater.
Immediate: (8/17/23) Administrator told the maintenance [redacted] to remove it. [redacted] did same day.
Training: (8/28/23) Maintenance was trained to look for space heaters and remove them if found on [redacted] weekly rounds.
How trained: Inservice by Administrator
Responsible Staff: Maintenance
How trained: Inservice by Administrator

127a - Portable Space Heaters *(continued)*

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

Implemented - 11/15/2023)

141a - Medical Evaluation

31. 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

The medical evaluation for resident 8 was not completed within 60 days prior to admission or within 30 days after admission of the resident.

Plan of Correction ***Accept - 09/07/2023)***

Resident 8 has own primary care physician and was made aware that the home needed the DME within 30 days of admission. physician did the evaluation within the thirty day time-frame but did not complete the form until day 31 making it one day late. The community did everything we could but our hands are tied when resident physicians are unresponsive.
Immediate: (8/17/23) Resident Care Coordinator and Asst RCC reviewed the time-frame requirements with the Administrator
Training: (8/28/23) RCC and Asst RCC were trained by Administrator the time-frames for DME's
How trained: Inservice by Administrator
On going: (9/6/23) RCC and Asst RCC will do quarterly audits of all resident files to ensure the medical evaluations are filled out completely and on time.
Responsible Staff: RCC and Asst RCC

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

Implemented (- 11/15/2023)

141a 1-10 Medical Evaluation Information

32. 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.

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

Description of Violation

Resident 5's medical evaluation, dated /23, did not include immunization history.

Resident 9's medical evaluation, dated /22, did not include immunization history and ability to self-administer medications.

Resident 10's medical evaluation, dated /23, did not include height, special health dietary needs, immunization history, body positioning, medications, health status and cognitive functioning, and mobility needs assessment.

Repeat Violation Date: 4/29/22

Plan of Correction ***Accept - 09/07/2023)***

Immediate: (8/17/23) Resident Care Coordinator and Asst RCC were told by Administrator to make sure all required boxes are filled in by doctors on the DME.
Training: (8/28/23) Resident Care Coordinator and Asst Resident Care Coordinator were trained to make sure all required boxes are filled out completely by the physician completing the DME and to give back to them if not filled out completely.
How trained: Inservice by Administrator
On going: (9/6/23) RCC and Asst RCC will do quarterly audits of all resident files to ensure the medical evaluations are filled out completely and on time.
Note: Even with constant phone calls and faxing of DME's months prior to due date, the Veterans Administration and other resident physicians are not responsive, tying the hands of our community.

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

Implemented 11/15/2023)

141b1 - Annual Medical Evaluation

33. Requirements

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

Description of Violation

Resident 9's most recent medical evaluation was completed on /22.

Plan of Correction ***Accept (- 09/28/2023)***

Resident 9 did have annual evaluation in file dated /23.
Immediate: (8/17/23) Resident Care Coordinator and Asst RCC were told by Administrator to make sure all residents have an annual medical evaluation in their file.
Training: (8/28/23) Resident Care Coordinator and Asst Resident Care Coordinator were trained to make sure all residents have an annual medical evaluation in their file.
How trained: Inservice by Administrator
On going: (9/6/23) RCC and Asst RCC will do quarterly audits of all resident files to ensure the medical evaluations are filled out completely, annually, and on time.
Note: Even with constant phone calls and faxing of DME's months prior to due date, the Veterans Administration and other resident physicians are not responsive, tying the hands of our community.
Responsible Staff: RCC and Asst RCC

141b1 - Annual Medical Evaluation (continued)

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented (- 11/15/2023)

161d - Dietary Needs

34. 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

On 1/2/23, resident 7 was prescribed a low concentrated sweets, no salt added, ground diet with thin consistency liquids. However, on 8/9/23 at lunch the resident was served cut up pizza. Resident 7 did not consume the pizza.

Plan of Correction ***Accept (- 09/28/2023)***

Immediate: (8/17/23) Administrator spoke with the RCC and the chef in charge of the kitchen about special dietary needs and following prescribers' orders.
Training: (8/28/23) Administrator trained the RCC and the chef in charge of the kitchen about special dietary needs and following prescribers orders.
How trained: Inservice by Administrator
Responsible Staff: RCC and Chef
How trained: Inservice by Administrator
Update: Administrator and RCC will do random spot checks/routine monitoring in the kitchen and dining room to audit that a resident's special dietary needs as prescribed by a physician are being met by the home and kept in the resident's record. This will be done on various shifts to make sure the staff is following the special dietary needs. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Not Implemented (- 11/15/2023)

161e - Dietary Alternatives

35. Requirements

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

Description of Violation

On 8/9/23, the home did not provide a dietary alternative to the pizza served at the lunch meal for resident 7. The resident requires a low concentrated sweets, no salt added, ground diet with thin consistency liquids.

Plan of Correction ***Accept (- 09/28/2023)***

Immediate: (8/17/23) Administrator spoke with the RCC and the chef in charge of the kitchen about special dietary needs and offering a dietary alternative.
Training: (8/28/23) Administrator trained the RCC and the chef in charge of the kitchen about special dietary

161e - Dietary Alternatives (continued)

needs and offering a dietary alternative.
How trained: Inservice by Administrator
Responsible Staff: RCC and Chef
How trained: Inservice by Administrator
Update: Administrator and RCC will do random spot checks/routine monitoring in the kitchen and dining room to audit that a dietary alternatives shall be available for a resident who has special health needs or religious beliefs regarding dietary restrictions This will be done on various shifts to make sure the staff is following the special dietary needs. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Not Implemented (11/15/2023)

162b - Missed Meals

36. Requirements

2600.
162.b. When a resident misses a meal, food adequate to meet daily nutritional requirements shall be available and offered to the resident.

Description of Violation

On 8/9/23, resident 7 missed all meals for the day because they were unable to consume the meals that were offered. The resident was not offered any food adequate to meet daily nutritional requirements. Resident was admitted to the hospital on /23 for severe dehydration and failure to thrive.

Plan of Correction ***Accept - 09/28/2023)***

Resident 7 was actively dying at the time.
Immediate: (8/17/23) Administrator spoke with the RCC and the chef in charge of the kitchen about offering adequate food to meet daily requirements.
Training: (8/28/23) Administrator trained the RCC and the chef in charge of the kitchen about offering adequate food to meet daily requirements. This includes requesting a doctor's order for ensure from the physician.
How trained: Inservice by Administrator
Responsible Staff: RCC and Chef
How trained: Inservice by Administrator
Update: Administrator and RCC will do random spot checks/routine monitoring in the kitchen and dining room to audit that when a resident misses a meal, food adequate to meet daily nutritional requirements shall be available and offered to the resident. This will be done on various shifts to make sure the staff is following the guidelines. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Not Implemented (11/15/2023)

162c - Menus Posted

37. Requirements

2600.

162c - Menus Posted *(continued)*

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

Description of Violation

On 8/2/23, the home's menu for the month of July was posted.

Plan of Correction ***Accept (- 09/28/2023)***

Immediate: (8/17/23) Administrator spoke with the chef in charge of the kitchen about posting the menus on time.

Training: (8/28/23) Administrator trained the chef in charge of the kitchen about posting the menus on time.

How trained: Inservice by Administrator

Responsible Staff: Chef

How trained: Inservice by Administrator

Administrator will check to make sure all menus are current. Administrator added a monthly reminder to google calendar to check to make sure current set of menus is posted. First audit completed 9/5/23.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented (11/15/2023)

162e - Menu Changes

38. 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 8/9/23, grilled cheese, stewed tomatoes, fruit, and beverage were listed on the menu for the lunch meal. Pizza was served instead. No notice was provided to the residents in advance of the meal.

Plan of Correction ***Accept (MS - 09/28/2023)***

Immediate: (8/17/23) Administrator spoke with the chef in charge of the kitchen about posting any menu changes in advance in a public place in the home.

Training: (8/28/23) Administrator trained the chef in charge of the kitchen about posting any menu changes in advance in a public place in the home.

How trained: Inservice by Administrator

Responsible Staff: Chef

How trained: Inservice by Administrator

Update: Administrator and RCC will do random spot checks/routine monitoring in the kitchen and dining room to audit that any changes to the menu will be posted in a public place and accessible to the resident in advance of the meal. This will be done on various shifts to make sure the staff is following the guidelines. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented - 11/15/2023)

164c - Resident Refusal Eat/Drink

39. Requirements

2600.
164.c. If a resident refuses to eat or drink continuously during a 24-hour period, the resident's primary care physician and the resident's designated person shall be immediately notified.

Description of Violation

For the entire day of 8/9/23 and at breakfast and lunch on 8/10/23, staff of the home reported resident refused to eat and drink. The home did not notify the resident's physician until 8/10/23 at approximately 1:30 pm after being instructed to do so by an agent of the Department.

Plan of Correction ***Accept [redacted] - 09/28/2023)***

Immediate: (8/17/23) Administrator spoke with the direct care staff about notifying the physician and designated person if a resident refuses to eat/drink continuously during a 24-hour period.
Training: (8/28/23) Administrator trained the direct care staff about notifying the physician and designated person if a resident refuses to eat/drink continuously during a 24-hour period.
How trained: Inservice by Administrator
Responsible Staff: Direct Care Staff
How trained: Inservice by Administrator
Update: Administrator and RCC will do random spot checks/routine monitoring of the dining room to audit that if residents are refusing food or drink during a 24 hour period, staff will inform the physician and designated person immediately. This will be done on various shifts to make sure the staff is following the guidelines. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented ([redacted] - 11/15/2023)

183b - Meds and Syringes Locked

40. Requirements

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

Description of Violation

On 8/2/23 at 9:05 am, the medication cart was unlocked, unattended, and accessible in the common area near the front door of the home.

Plan of Correction ***Accept [redacted] - 09/28/2023)***

Immediate: (8/17/23) Med Techs were immediately told by administrator not to leave med cart unlocked, unattended or accessible.
Training: (8/28/23) Med Techs were trained by administrator not to leave med cart unlocked, unattended or accessible.
How trained: Inservice by Administrator
Responsible Staff: Med Techs
Update: Administrator and RCC will do random spot checks by checking locks on med cart. This will be done on various shifts to make sure the staff is securing medications and syringes. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented ([redacted] - 11/15/2023)

183b - Meds and Syringes Locked *(continued)*

183d - Prescription Current

41. 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

The following medications were prescribed for resident 7 on 6/20/23: Doxcycl Hyc Cap 100 MG, Cefdinir 300 MG, and Metronidazole 500 MG. On 8/10/23, these medications were in the home's medication cart; however, the medications were to be discontinued after 14 days.

On 8/10/23, Venlafaxine ER 225 MG prescribed for individual resident 11, was in the home's medication cart; however, the medication was discontinued on 7/28/23.

Plan of Correction ***Accept [redacted] 09/28/2023)***

Immediate: (8/17/23) Med Techs were immediately told by administrator not to leave discontinued medications in the home. All discontinued medications were removed from the home.
Training: (8/28/23) Med Techs were trained by administrator not to leave discontinued medications in the home.
How trained: Inservice by Administrator
Responsible Staff: Med Techs
Update: RCC will do random spot checks of carts to make sure the discontinued meds are removed from the cart. This will be done on various shifts to make sure the staff is complying with the regulation. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week. In addition, our pharmacy came out to do a med cart audit on 8/30/23.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented ([redacted] - 11/15/2023)

183e - Storing Medications

42. 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 8/10/23 Lyumjev Kwikpen belonging to resident 7, was in the home's medication cart with an open date of 4/27/23. According to the manufacturer's instructions the medication should be discarded after 28 days.

Repeat Violation Date: 4/29/22

Plan of Correction ***Accept [redacted] - 09/28/2023)***

Immediate: (8/17/23) Med Techs were immediately told by administrator to discard medications in accordance with manufacturer's instructions. Kwikpen was discarded.
Training: (8/28/23) Med Techs were trained by administrator to discard medications in accordance with manufacturer's instructions.

183e - Storing Medications (continued)

How trained: Inservice by Administrator
Responsible Staff: Med Techs
Update: RCC will do random spot checks of carts to make sure expired meds are discarded. This will be done on various shifts to make sure the staff is complying with the regulation. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week. In addition, our pharmacy came out to do a med cart audit on 8/30/23.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Not Implemented █ - 11/15/2023)

185a - Implement Storage Procedures

43. 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 8/3/23 at 1:34pm, the glucometer for resident 3 was not calibrated for the correct time. The meter had a date and time of 8/3/23, 7:39am.

Resident 3's glucometer had a reading of 89 for the morning of 8/3/23. This was not recorded on the resident's blood sugar log.

On 8/3/23, the controlled substance log for resident 3's Oxycod/Apap did not accurately reflect the number of pills remaining. There were 52 pills and the log read 51.

On 8/3/23, the glucometer for resident 12 was not operable because the batteries died.

Resident 13's blood sugar log shows a before lunch reading on 8/4/23 of 297 and a before breakfast reading on 8/7/23 of 279. Neither of these number are on the resident's glucometer.

On 8/10/23 11:28am, the glucometer for resident 6 was not calibrated for the correct time. The meter had a date and time of 8/10/23, 10:34am.

Repeat Violation Date: 4/29/22

Plan of Correction ***Directed █ - 09/28/2023)***

Immediate: (8/17/23) Med Techs were immediately told by administrator to make sure glucometers are calibrated for correct time and that they are recording the blood sugar logs immediately and accurately. Also informed to call pharmacy for any medications not received by the home.
Training: (8/28/23) Med Techs were trained by administrator to make sure glucometers are calibrated for correct time and that they are recording the blood sugar logs immediately and accurately in accordance with regulation. Also trained to call pharmacy for any medications not received by the home.
(8/31/23) Pharmacy recalibrated glucometers.
How trained: Inservice by Administrator
Responsible Staff: Med Techs

185a - Implement Storage Procedures (continued)

Update: RCC will do random spot checks of carts, MAR's, and blood sugar logs to make sure glucometers are calibrated, and resident information is being logged correctly, and that all required medications are in the home. This will be done on various shifts to make sure the staff is complying with the regulation. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week. In addition, our pharmacy came out to do a med cart audit on 8/30/23 and again on 8/31/23. Pharmacy recalibrated the glucometers on 8/31/23.

Directed Plan of Correction:

In addition to the above plan of correction, the administrator or designee shall engage a qualified medication trainer to complete remediation training for all current medication technician staff. Remediation training for all med tech staff shall be completed within 15 calendar days of the receipt of this plan of correction.

Documentation of trainings, trainer credentials and audits shall be kept and made available for Department review upon request.

Directed Completion Date: *10/15/2023*

Not Implemented (11/15/2023)

44. 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 9 is prescribed Vitamin B-12 as needed. On 8/10/23 this medication was not available in the home.

Resident 11 is prescribed Senna 8.6 MG as needed. On 8/10/23 this medication was not available in the home.

Resident 13 is prescribed Acetaminophen 325 MG as needed. On 8/10/23 this medication was not available in the home.

Plan of Correction ***Directed - 09/28/2023)***

Immediate: (8/17/23) Med Techs were immediately told by administrator to make sure glucometers are calibrated for correct time and that they are recording the blood sugar logs immediately and accurately. Also informed to call pharmacy for any medications not received by the home.
Training: (8/28/23) Med Techs were trained by administrator to make sure glucometers are calibrated for correct time and that they are recording the blood sugar logs immediately and accurately in accordance with regulation. Also trained to call pharmacy for any medications not received by the home.
(8/31/23) Pharmacy recalibrated glucometers.
How trained: Inservice by Administrator
Responsible Staff: Med Techs
Update: RCC will do random spot checks of carts, MAR's, and blood sugar logs to make sure glucometers are calibrated, and resident information is being logged correctly, and that all required medications are in the home. This will be done on various shifts to make sure the staff is complying with the regulation. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week. In addition, our pharmacy came out to do a med cart audit on 8/30/23 and again on 8/31/23. Pharmacy recalibrated the glucometers on 8/31/23.

185a - Implement Storage Procedures (continued)

Directed Plan of Correction:
In addition to the above plan of correction, the administrator or designee shall engage a qualified medication trainer to complete remediation training for all current medication technician staff. Remediation training for all med tech staff shall be completed within 15 calendar days of the receipt of this plan of correction.

Documentation of trainings, trainer credentials and audits shall be kept and made available for Department review upon request.

Directed Completion Date: *10/15/2023*

Not Implemented (█ - 11/15/2023)

187a - Medication Record

45. 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 6's medication administration record does not list the diagnosis or purpose for the following medications: Lisinopril Tab 20 MG, Metformin Tab 500 MG, Omeprazole Cap 20 MG, Pantoprazole Tab 40 MG, Celebrex, Asperflex Pad 4%, Fluticasone Spr 50 MCG, and Calc Antacid Chw 500 MG.

Resident 7 is prescribed Morphine 100/5ML, take 0.25 ML(5MG) by mouth daily prior to wound care. This medication is not on the resident's medication administration record.

Resident 7's medication administration record does not list the diagnosis or purpose for Lorazepam 0.5 MG/0.2 ML and Lyumjev Kwikpen.

Resident 13 is prescribed Novolog Insulin. This medication is crossed out on the resident's medication administration record.

Plan of Correction ***Directed (█ - 09/28/2023)***

Immediate: (8/17/23) Med Techs were immediately told by administrator to make sure medication record contains for each resident for whom medications are administered: (1) Resident's name. (2) Drug allergies. (3) Name of medication. (4) Strength. (5) Dosage form. (6) Dose. (7) Route of administration. (8) Frequency of administration. (9) Administration times. (10) Duration of therapy, if applicable. (11) Special precautions, if applicable. (12) Diagnosis or purpose for the medication, including pro re nata (PRN). (13) Date and time of medication administration. (14) Name and initials of the staff person administering the medication.
Training: (8/28/23)) Med Techs were trained by administrator to make sure medication record contains for each resident for whom medications are administered: (1) Resident's name. (2) Drug allergies. (3) Name of medication. (4) Strength. (5) Dosage form. (6) Dose. (7) Route of administration. (8) Frequency of administration. (9) Administration times. (10) Duration of therapy, if applicable. (11) Special precautions, if applicable. (12) Diagnosis or purpose for the medication, including pro re nata (PRN). (13) Date and time of medication administration. (14) Name and initials

187a - Medication Record (continued)

of the staff person administering the medication.
How trained: Inservice by Administrator
Responsible Staff: Med Techs
Update: RCC will do random spot checks of the MAR's to make sure medication record contains for each resident for whom medications are administered: (1) Resident's name. (2) Drug allergies. (3) Name of medication. (4) Strength. (5) Dosage form. (6) Dose. (7) Route of administration. (8) Frequency of administration. (9) Administration times. (10) Duration of therapy, if applicable. (11) Special precautions, if applicable. (12) Diagnosis or purpose for the medication, including pro re nata (PRN). (13) Date and time of medication administration. (14) Name and initials of the staff person administering the medication. In addition, our pharmacy came out to do a med cart audit on 8/30/23 and again on 8/31/23.

Directed Plan of Correction:
In addition to the above plan of correction, the administrator or designee shall engage a qualified medication trainer to complete remediation training for all current medication technician staff. Remediation training for all med tech staff shall be completed within 15 calendar days of the receipt of this plan of correction.
Beginning within 15 calendar days of the receipt of this plan of correction, the administrator or designee shall complete weekly audits of medication carts/MAR's to review for proper administration and documentation of all medications/physician orders. Weekly med cart audits shall continue for 1 month and then shall be conducted twice monthly for 3 months.
Documentation of trainings, trainer credentials and audits shall be kept and made available for Department review upon request.

Directed Completion Date: *10/15/2023*

Not Implemented [redacted] - 11/15/2023)

187d - Follow Prescriber's Orders

46. Requirements

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

Description of Violation

Resident 3 is prescribed 4 blood sugar checks per day. However, resident 3 only received 2 blood sugar checks daily through 8/1/23 to 8/3/23.

Resident 3 is prescribed Novolog Inj Flexpen, inject 10 units Sub-Q three times daily before meals (hold for BS<150). On 8/1/23, 8/2/23, and 8/3/23, the residents blood sugar was 123, 109, and 89, respectively, requiring insulin to be held at each check. The resident was administered 10 units of insulin on all three occasions.

Resident 6 is prescribed Asperflex Pad 4% 1 and ½ patch apply topically to both knees, on in the morning and off at bedtime. The medication administration record has "PRN" handwritten on it but there is no corresponding physician's order for a change this to as needed. This medication is not being administered daily as prescribed.

Resident 7 is prescribed Morphine 100/5ML, take 0.25 ML(5MG) by mouth daily prior to wound care. According to the controlled substance log, the last time the resident was administered Morphine prior to wound care was 7/28/23.

187d - Follow Prescriber's Orders (continued)

Wound care was documented daily from 6/17/23 to 8/10/23.

Resident 7 was prescribed is Doxcycl Hyc Cap 100 MG, 1 cap by mouth 2 times per day for 14 days, Cefdinir 300 MG, 1 cap by mouth every 12 hours for 14 days, and Metronidazole 500 MG, 1 tab by mouth every 8 hours for 14 days. The number of pills dispensed were only to cover the amount of time the resident needed to take the medication. They were dispensed on 6/20/23, and on 8/10/23, there were 10 Doxcycl Hyc capsules and 11 Cefdinir capsules remaining in the home.

Resident 12 has medications in packs labeled with the date and time. The packs are numbered 1, 2, 3, and 4. Packs 1 and 2 are for 8:00 am. Packs 3 and 4 are for 8:00 pm. On 8/3/23 at 1:11pm, pack 3 was missing. Staff person C denied administering pack 3 early. The pills in pack 3 are Tamsulosin, Divalproex Sodium ER, and Metformin.

Resident 13 is prescribed Humalog, inject 2 units three times daily before meals and Novolog sliding scale. The resident's Humalog medication is not in the home. Staff person C stated they are not administering the Novolog mediation according to the prescribed sliding scale and instead the Novolog insulin is being administered using the directions for the Humalog. Staff of the home were not aware that the resident's Humalog was not present in the home.

Plan of Correction ***Directed (- 09/28/2023)***

Immediate: (8/17/23) Administrator verbally spoke with all med techs regarding following directions of the prescriber and paying close attention to all medications prescribed to be in the home.
Training: (8/28/23) Med techs were trained to follow directions of the prescriber and pay close attention that all prescribed medications are in the home.
How trained: Inservice by Administrator
Responsible Staff: Med Techs
On-Going: (9/5/23) RCC will audit the resident charts monthly to ensure proper documentation and to ensure staff is following the directions of the prescribing physicians to prevent recurrence.
Update: RCC will do random spot checks of carts, MAR's, and blood sugar logs to make sure glucometers are calibrated, and resident information is being logged correctly, and that all required medications are in the home. This will be done on various shifts to make sure the staff is complying with the regulations. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week. In addition, our pharmacy came out to do a med cart audit on 8/30/23 and again on 8/31/23. RCC has contacted the Certified Med Trainer who will be doing remediation training for the staff who was working at time of inspections. Training will be sometime between 9/18/23 and 9/22/23, but at the time of submission we do not have the exact date locked down.

Directed Plan of Correction:
The administrator or designee shall engage a qualified medication trainer to complete remediation training for all current medication technician staff. Remediation training for all med tech staff shall be completed within 15 calendar days of the receipt of this plan of correction.

Documentation of trainings, trainer credentials and audits shall be kept and made available for Department review upon request.

Directed Completion Date: *10/15/2023*

Not Implemented - 11/15/2023)

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

47. Requirements

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

Description of Violation

Resident 3 is prescribed Amlodipine Tab 5 MG, 1 tablet by mouth daily . However, this medication was not administered to resident 3 on 8/1/23, 8/2/23, and 8/3/23 because the medication was not available in the home.

Plan of Correction ***Directed [redacted] - 09/28/2023)***

Immediate: (8/17/23) Administrator verbally spoke with all med techs regarding following directions of the prescriber and paying close attention to all medications prescribed to be in the home.
Training: (8/28/23) Med techs were trained to follow directions of the prescriber and pay close attention that all prescribed medications are in the home.
How trained: Inservice by Administrator
Responsible Staff: Med Techs
On-Going: (9/5/23) RCC will audit the resident charts monthly to ensure proper documentation and to ensure staff is following the directions of the prescribing physicians to prevent recurrence.
Update: RCC will do random spot checks of carts, MAR's, and blood sugar logs to make sure glucometers are calibrated, and resident information is being logged correctly, and that all required medications are in the home. This will be done on various shifts to make sure the staff is complying with the regulations. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week. In addition, our pharmacy came out to do a med cart audit on 8/30/23 and again on 8/31/23. RCC has contacted the Certified Med Trainer who will be doing remediation training for the staff who was working at time of inspections. Training will be sometime between 9/18/23 and 9/22/23, but at the time of submission we do not have the exact date locked down.

Directed Plan of Correction:

The administrator or designee shall engage a qualified medication trainer to complete remediation training for all current medication technician staff. Remediation training for all med tech staff shall be completed within 15 calendar days of the receipt of this plan of correction.

Documentation of trainings, trainer credentials and audits shall be kept and made available for Department review upon request.

Directed Completion Date: *09/15/2023*

Not Implemented [redacted] - 11/15/2023)

188b - Medication Error Reporting

48. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

188b - Medication Error Reporting *(continued)*

Description of Violation

Resident 3 is prescribed Novolog Inj Flexpen, inject 10 units Sub-Q three times daily before meals (hold for BS<150). On 8/1/23, 8/2/23, and 8/3/23, the residents blood sugar was 123, 109, and 89, respectively. The resident was administered insulin on all three occasions. These medication errors were not reported to the resident, the resident's designated person and the prescriber.

Resident 7 was prescribed Doxcycl Hyc Cap 100 MG, 1 cap by mouth 2 times per day for 14 days, Cefdinir 300 MG, 1 cap by mouth every 12 hours for 14 days, and Metronidazole 500 MG, 1 tab by mouth every 8 hours for 14 days. The number of pills dispensed were only to cover the amount of time the resident needed to take the medication. They were dispensed on 6/20/23, and on 8/10/23, there were pills remaining for each of the medications in the home meaning the resident did not take the medications as prescribed. This medication error was not reported to the resident, the resident's designated person and the prescriber.

Resident 13 is prescribed Humalog, inject 2 units three times daily before meals and Novolog sliding scale. The resident's Humalog medication is not in the home. Staff person C stated they are not administering the Novolog mediation according to the prescribed sliding scale and instead the Novolog insulin is being administered using the directions for the Humalog. This medication error was not reported to the resident, the resident's designated person and the prescriber.

Plan of Correction ***Directed ██ - 09/28/2023)***

Immediate: (8/17/23) Administrator verbally spoke with all med techs regarding the immediate reporting of med errors to the resident, resident's designated person, and to the prescriber.
Training: (8/28/23)) Administrator trained all med techs regarding the immediate reporting of med errors to the resident, resident's designated person, and to the prescriber.
How trained: Inservice by Administrator
Responsible Staff: Med Techs
Update: RCC will do random spot checks of carts, MAR's, and blood sugar logs to look for medication errors and reporting. This will be done on various shifts to make sure the staff is complying with the regulations. This started on 8/17/23 and will continue on-going. These checks will be done at least once per week. In addition, our pharmacy came out to do a med cart audit on 8/30/23 and again on 8/31/23. RCC has contacted the Certified Med Trainer who will be doing remediation training for the staff who was working at time of inspections. Training will be sometime between 9/18/23 and 9/22/23, but at the time of submission we do not have the exact date locked down.

Directed Plan of Correction:
The administrator or designee shall engage a qualified medication trainer to complete remediation training for all current medication technician staff. Remediation training for all med tech staff shall be completed within 15 calendar days of the receipt of this plan of correction.

Documentation of trainings, trainer credentials and audits shall be kept and made available for Department review upon request.

Directed Completion Date: *09/15/2023*

Not Implemented (██ - 11/15/2023)

188b - Medication Error Reporting *(continued)*

201 - Positive Interventions

49. Requirements

2600.
201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident 2, has had episodes of aggression since moving into the home on /23. According to staff person D, the administrator, the resident becomes physically and verbally aggressive towards staff when having to wait to be administered medication. The home has not implemented positive interventions to modify or eliminate the resident's behavior. On 7/19/23, staff person D sent resident 2 to the hospital after they attacked resident 3. Resident 2 was subsequently told the resident could not come back to home because of the aggressive behavior.

Plan of Correction ***Accept (09/28/2023)***

Resident 2's aggressive behavior was addressed by the administrator with staff and discussed with the resident numerous times. RCC was late in documenting the care plan but the resident's aggression was definitely discussed with all staff and the resident. Positive interventions were used on multiple occasions but resident 2 refused to listen, refused to be patient, and was just not a good fit for the community.
Immediate: (8/17/23) RCC and Asst RCC were reminded by Administrator to make sure the support plan Medical/Dental is filled out completely with all required information filled out at least annually or upon change of condition, including the use of positive interventions.
Training: (8/28/23) RCC and Asst RCC were trained by Administrator to make sure the support plan Medical/Dental is filled out completely with all required information filled out at least annually or upon change of condition, including the use of positive interventions. In addition, all staff were trained on positive Interventions/Safe Management Techniques.
How trained: Inservice by Administrator
Responsible Staff: Resident Care Coordinator and Assistant Resident Care Coordinator
Update: (9/5/23) The RCC and assistant RCC will review all RASPs again to ensure they are updated with all current information. They will continue to review until they are all reviewed for accuracy.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented - 11/15/2023)

202 - Prohibitions

50. Requirements

2600.
202. The following procedures are prohibited:

Description of Violation

Resident 9, who has a diagnosis of dementia, is restricted to the home's common area when awake. According to staff

202 - Prohibitions (continued)

person A, each time the resident attempts to leave the common area, the resident is redirected back to the common area.

Plan of Correction ***Accept - 09/07/2023)***

Resident 9 has a diagnosis of dementia and the community is working on finding a higher level of care. The only reason the resident has been re-directed is for own safety.
Immediate: (8/17/23) Administrator spoke with staff about not re-directing resident unless she appears to be putting in danger.
Training: (8/28/23) Administrator trained direct care staff on this regulation.
How trained: Inservice by Administrator
Responsible Staff: Direct care staff

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

Implemented - 11/15/2023)

225a - Assessment 15 Days

51. Requirements

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

Description of Violation

Resident 7's assessment, dated /23, does not include an assessment for transferring in/out of chair/bed.

Repeat Violation Date: 4/29/22

Plan of Correction ***Accept - 09/28/2023)***

Assistant Resident Care Coordinator completed the assessment on time and filled out the assessment correctly for this resident as was walking with a walker and able to transfer at time of admission. What did not do correctly was to update at change of condition.
Immediate: (8/17/23) RCC and Asst RCC were reminded by Administrator to make sure the support plan Medical/Dental is filled out completely with ALL required information filled out at least annually or upon change of condition.
Training: (8/28/23) RCC and Asst RCC were trained by Administrator to make sure the support plan Medical/Dental is filled out completely with ALL required information filled out at least annually or upon change of condition.
How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC
Update: (9/5/23) The RCC and assistant RCC will review all RASPs again to ensure they are updated with all current information. They will continue to review until they are all reviewed for accuracy. A checklist has been created and will be used monthly and on-going.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented (- 11/15/2023)

225c - Additional Assessment

52. Requirements

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

Description of Violation

Resident 5's assessment, dated ██/23, does not include any assessments in the Behavioral or Cognitive Need section.

Resident 6's assessment, dated ██/23, does not include an assessment for supervision and does not list the resident's medical diagnoses.

Resident 12's assessment, dated ██/23, does not include the resident's medical and psychological diagnoses.

Plan of Correction ***Accept ██ - 09/28/2023)***

Immediate: (8/17/23) RCC and Asst RCC were reminded by Administrator to make sure the support plan Medical/Dental is filled out completely with ALL required information filled out at least annually or upon change of condition.
Training: (8/28/23) RCC and Asst RCC were trained by Administrator to make sure the support plan Medical/Dental is filled out completely with ALL required information filled out at least annually or upon change of condition.
How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC
Update: (9/5/23) The RCC and assistant RCC will review all RASPs again to ensure they are updated with all current information. They will continue to review until they are all reviewed for accuracy. A checklist has been created and will be used monthly and on-going.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented ██ - 11/15/2023)

53. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident 2's most recent assessment was completed on ██/23. This assessment does not address any needs for agitation and aggression. The resident began to show agitation and aggressive behaviors shortly after moving in and a new assessment was not completed.

Plan of Correction ***Accept ██ - 09/28/2023)***

Immediate: (8/17/23) RCC and Asst RCC were reminded by Administrator to make sure the support plan Medical/Dental is filled out completely with ALL required information filled out at least annually or upon change of condition.
Training: (8/28/23) RCC and Asst RCC were trained by Administrator to make sure the support plan Medical/Dental is filled out completely with ALL required information filled out at least annually or upon change of condition.
How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC

225c - Additional Assessment (continued)

Update: (9/5/23) The RCC and assistant RCC will review all RASPs again to ensure they are updated with all current information. They will continue to review until they are all reviewed for accuracy. A checklist has been created and will be used monthly and on-going.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented (- 11/15/2023)

226a - Mobility Assessment

54. Requirements

2600.
226.a. The resident shall be assessed for mobility needs as part of the resident’s assessment.

Description of Violation

Resident 6's assessment, dated /23, does not include an assessment of the resident's mobility needs.

Plan of Correction ***Accept (- 09/07/2023)***

Immediate: (8/17/23) Administrator spoke with RCC and Asst RCC about making sure all boxes are checked on assessment.
Training: (8/28/23) Resident Care Coordinator and Asst Resident Care Coordinator were trained by Administrator to make sure assessments are completed in full including double checking to make sure all boxes are checked.
How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC
On-Going: (9/5/23) RCC and Asst RCC will audit all resident charts quarterly to ensure assessments are complete and correct to prevent recurrence.

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

Implemented (- 11/15/2023)

227e - Self Administer Medication

55. Requirements

2600.
227.e. The resident’s support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident 6's assessment, dated /23, does not address the resident's ability to self-administer medications.

Plan of Correction ***Accept (- 09/07/2023)***

RCC and Asst RCC missed checking off the box. This resident receives medication administration.
Immediate: (8/17/23) Administrator spoke with RCC and Asst RCC about making sure all boxes are checked on assessment.
Training: (8/28/23) Resident Care Coordinator and Asst Resident Care Coordinator were trained by Administrator to make sure assessments are completed in full including double checking to make sure all boxes are checked.
How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC
On-Going: (9/5/23) RCC and Asst RCC will audit all resident charts quarterly to ensure assessments are complete

227e - Self Administer Medication (continued)

and correct to prevent recurrence.

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

Implemented (- 11/15/2023)

227g -Support Plan Signatures

56. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident 7 participated in the development of support plan on /23. However, the resident did not sign the support plan.

Resident 14's support plan dated /23 was not signed by the assessor.

Plan of Correction ***Accept - 09/07/2023)***

RCC reviewed with resident and had resident sign but did not sign the box .
Immediate: (8/17/23) Administrator spoke with RCC and Asst RCC about making sure all boxes are checked on assessment and all required signatures are completed.
Training: (8/28/23) Resident Care Coordinator and Asst Resident Care Coordinator were trained by Administrator to make sure assessments are completed in full including double checking to make sure all boxes are checked and all required signatures are completed.
How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC
On-Going: (9/5/23) RCC and Asst RCC will audit all resident charts quarterly to ensure assessments are complete and correct to prevent recurrence.

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

Implemented - 11/15/2023)

227i - Support Plan Accessible

57. Requirements

2600.
227.i. The support plan shall be accessible by direct care staff persons at all times.

Description of Violation

On 8/2/23, 8/3/23, 8/9/23, and 8/10/23, resident support plans were locked in staff person D's office and were inaccessible to direct care staff.

Plan of Correction ***Accept - 09/07/2023)***

Support plans were accidentally locked in the administrator office and admin staff was away. Binder containing all the support plans were moved back to inside the med room on 8/17/23. A key to the administrators office was also placed in a lockbox on the med cart on 8/24/23.

227i - Support Plan Accessible (continued)

Immediate: (8/17/23) Administrator spoke with RCC and Asst RCC about making sure all support plans are always accessible.
Training: (8/28/23 Administrator trained RCC and Asst RCC about making sure all support plans are always accessible.
How trained: Inservice by Administrator
Responsible Staff: RCC and Asst RCC
On-Going: (9/5/23) RCC and Asst RCC will audit all resident charts quarterly to ensure assessments are complete and correct to prevent recurrence.

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

Implemented [redacted] - 11/15/2023)

228b - Discharge or Transfer

58. Requirements

2600.
228.b. If the home initiates a discharge or transfer of a resident, or if the legal entity chooses to close the home, the home shall provide a 30-day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. This shall be stipulated in the resident-home contract. A 30-day advance written notice is not required if a delay in discharge or transfer would jeopardize the health, safety or well-being of the resident or others in the home, as certified by a physician or the Department. This may occur when the resident needs psychiatric or long-term care or is abused in the home, or the Department initiates closure of the home.

Description of Violation

On [redacted]/23, the home discharged resident 2. However, the home did not give the resident a 30-day notice.

Plan of Correction ***Accept ([redacted] - 09/07/2023)***

Resident 2 was [redacted] [redacted] to the hospital after attacking resident 3 and knocking [redacted] down twice. Due to the serious nature of the attack and the fact that the other residents feared [redacted] we told the hospital we were not comfortable taking the resident back. We acted in the manner necessary to keep our remaining twenty residents safe.
Immediate: (8/17/23) The administrator informed the RCC, and Asst RCC to allow all residents to come back to the community regardless of situation while community works to find another solution within the guidelines, including giving a 30-day notice.
Training: (8/28/23) The administrator trained the RCC, and Asst RCC to allow all residents to come back to the community regardless of situation while community works to find another solution within the guidelines including giving a 30-day notice.
How trained: Inservice by Administrator
Responsible Staff: Resident Care Coordinator and Assistant Resident Care Coordinator

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

Implemented ([redacted] - 11/15/2023)

251b - Record Entries Legible

59. Requirements

2600.

251b - Record Entries Legible *(continued)*

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 12 is illegible. The document was received via fax at the home and the document can not be read due to poor print quality.

Plan of Correction ***Accept ([redacted] - 09/07/2023)***

Immediate: (8/17/23) Administrator spoke with RCC about making sure entries in the resident record are permanent and legible. Upon receipt of the poor-quality document, [redacted] should have immediately requested it again from the physician.
Training: (8/28/23) Administrator trained RCC about making sure entries in the resident record are permanent and legible. Upon receipt of the poor-quality document, she should have immediately requested again from the physician.
How trained: Inservice by Administrator
Responsible Staff: Resident Care Coordinator

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

Not Implemented [redacted] - 11/15/2023)

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

Facility Information

Name: *PARADISE MANOR* **License #:** *14446* **License Expiration:** *04/01/2024*

Address: *206 EAST LINCOLN AVENUE, HATFIELD, PA 19440*

County: *MONTGOMERY* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *SYDLYNN INC*

Address:

Phone: **Email:**

Certificate(s) of Occupancy

Type: *Other* **Date:** *12/31/1981* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *21* **Waking Staff:** *16*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *10/19/2023*

Inspection Dates and Department Representative

10/19/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *37* **Residents Served:** *21*

Secured Dementia Care Unit

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

Hospice

Current Residents: *NM*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older:** *19*

Diagnosed with Mental Illness: *9* **Diagnosed with Intellectual Disability:** *2*

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

Inspections / Reviews

10/19/2023 - Partial

Lead Inspector: **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/11/2023*

Inspections / Reviews *(continued)*

11/15/2023 - POC Submission

Submitted By: [redacted]
Date Submitted: *11/16/2023*
Reviewer: [redacted] *er*
Follow-Up Type: *Document Submission* **Follow-Up Date**: *12/04/2023*

11/16/2023 - Document Submission

Submitted By: [redacted]
Date Submitted: *11/16/2023*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

131f - Fire Extinguisher Inspection

1. 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 extinguisher at the main entrance has not been inspected by a fire safety expert since September 2022.

Plan of Correction ***Accept [redacted] - 11/15/2023)***

The community uses Emergency Response for all fire related services, monitoring, inspections, etc. The annual inspection was scheduled for 9/19/23 but was canceled by Emergency Response and rescheduled for 11/16/23 at 9AM. This caused the extinguishers to expire.
Immediate: (10/19/23) Confirmed by looking at emails with Emergency Response the date of the next inspection which is 11/16/23.
Training: (11/6/23) Maintenance staff (New employee hired [redacted]/23) trained to check extinguishers and to call Emergency Response for immediate service if expired.
On-going: (12/1/23) Maintenance staff will check dates of Extinguishers monthly on rounds.
How trained: Inservice by Administrator
Responsible Staff: Maintenance

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

Not Implemented [redacted] - 11/16/2023)

183e - Storing Medications

2. 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 10/19/23, a NovoLog FlexPen belonging to Resident 1 was in the home's medication cart with an open date of 9/18/23. According to the manufacturer's instructions, the medication should be discarded after 28 days.

On 10/19/23, a Levemir FlexPen belonging to Resident 1 was in the home's medication cart. According to the manufacturer's instructions, the medication should be discarded after 42 days after opening, but there was no open date specified.

Repeat violation date: 4/29/22.

Plan of Correction ***Accept ([redacted] - 11/15/2023)***

Immediate: (10/19/23) Med Techs were immediately told by administrator to discard medications in accordance with manufacturer's instructions.
Training: (11/1/23) Med Techs were trained by administrator to discard medications in accordance with manufacturer's instructions.
How trained: Inservice by Administrator
Responsible Staff: Med Techs

183e - Storing Medications (continued)

On-going: RCC will do weekly checks of carts to make sure expired meds are discarded. This will be done on various shifts to make sure the staff is complying with the regulation. This was last done on 11/9/23.

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

Not Implemented ██ - 11/16/2023)

185a - Implement Storage Procedures

3. 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 1 is prescribed Clonazepam tab 1mg, take 1 tablet by mouth three times daily. On 10/19/23, the actual pill count was 41. However, the narcotics declining inventory log documented it as 42, and the home could not explain the discrepancy.

On 10/8/23 at 7:38am, Resident 1's blood glucose reading was 86. However, it was documented as 82 on the Medication Administration Record.

On 10/10/23 at 6:26pm, Resident 1's blood glucose reading was 237. However, it was documented as 186 on the Medication Administration Record.

On 10/15/23 at 5:41pm, Resident 1's blood glucometer had multiple readings on 10/15/23. At 5:41 the reading was 301, at 5:44pm reading was 261, at 6:41pm, the reading was 312, . However, it was documented as 192 on the Medication Administration Record at the 8pm time.

On 10/19/23 at 10:46am, Resident 2's glucometer was not calibrated to the correct date. The glucometer was set to 9/20/23 at 10:46am.

Plan of Correction ***Accept ██ - 11/15/2023)***

Immediate: (10/19/23) Med Techs were immediately told by administrator to make sure glucometers are calibrated for correct time and that they are recording the blood sugar logs immediately and accurately. Staff were reminded to do narc counts with next shift and report any inaccuracies to management.
Training: (11/1/23) Med Techs were immediately told by administrator to make sure glucometers are calibrated for correct time and that they are recording the blood sugar logs immediately and accurately. Staff were reminded to do narc counts with next shift and report any inaccuracies to management.
(11/7/23) Pharmacy recalibrated glucometers.
How trained: Inservice by Administrator
Responsible Staff: Med Techs
On-going: RCC will do weekly checks of carts to make glucometers are calibrated for correct time and that staff are recording the blood sugar logs immediately and accurately. ██ will also check that narc count is accurate. This will be done on various shifts to make sure the staff is complying with the regulation. This was last done on 11/9/23.

185a - Implement Storage Procedures *(continued)*

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

Not Implemented ███ - 11/16/2023)

187d - Follow Prescriber's Orders

4. Requirements

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

Description of Violation

On 10/17/23 at 8:00pm, Resident 1's glucometer did not register a reading. However, a blood glucose level of 114 was documented on the Medication Administration Record.

Plan of Correction ***Accept ███ - 11/15/2023)***

Immediate: (10/19/23) Med Techs were immediately told by administrator to make sure glucometers are calibrated for correct time and that they are recording the blood sugar logs immediately and accurately
Training: (11/1/23) Med Techs were immediately told by administrator to make sure glucometers are calibrated for correct time and that they are recording the blood sugar logs immediately and accurately.
(11/7/23) Pharmacy recalibrated glucometers.
How trained: Inservice by Administrator
Responsible Staff: Med Techs
On-going: RCC will do weekly checks of carts to make glucometers are calibrated for correct time and that staff are recording the blood sugar logs immediately and accurately. This will be done on various shifts to make sure the staff is complying with the regulation. This was last done on 11/9/23.

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

Not Implemented ███ - 11/16/2023)

190c - Record of Training

5. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for Staff person A does not include the initial training on medication administration program.

Plan of Correction ***Accept ███ - 11/15/2023)***

Immediate: (10/19/23) Administrator directed the RCC to make sure all med trainings are current and in the employee files.
Training: (11/1/23) Administrator trained the RCC to make sure all med trainings are current and in the employee files.
How trained: Inservice by Administrator
Responsible Staff: Resident Care Coordinator
On-going: (11/6/23) Resident Care Coordinator will audit employee files monthly to make sure all required

190c - Record of Training (continued)

information is present.

Update: (11/8/23) Employee A completed the training on the medication administration program. A record of the training was placed in the employees file.

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

Not Implemented (█ - 11/16/2023)

227d - Support Plan Medical/Dental

6. Requirements

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

Description of Violation

The medical evaluation for Resident 3, dated █/23, indicates the resident has a need for mechanical soft diet. The resident's support plan dated █/23 does not document how this need will be met and there is no attached addendum.

Plan of Correction ***Accept █ 11/15/2023)***

Immediate: (10/19/23) Administrator directed the RCC to make sure to pay attention to the DME and to carry over the information to the support plan.

Training: (11/1/23) Administrator trained the RCC to make sure to pay attention to the DME and to carry over the information to the support plan.

How trained: Inservice by Administrator

Responsible Staff: Resident Care Coordinator

On-going: (11/9/23) Resident Care Coordinator will audit resident files monthly to make sure all required information is present. This was last done on 11/9/23.

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

Not Implemented (█ 11/16/2023)

251b - Record Entries Legible

7. 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 narcotics declining inventory log for Resident 1 was not legible. The entry for remaining balance of Clonazepam was written over on several dates without notation.

251b - Record Entries Legible *(continued)*

Plan of Correction ***Accept (- 11/15/2023)***

Immediate: (10/19/23) Administrator spoke with med techs about making sure entries in the resident record are permanent and legible.
Training: (11/1/23) Administrator trained Med Techs about making sure entries in the resident record are permanent and legible.
How trained: Inservice by Administrator
Responsible Staff: Med Techs
On-going: (11/9/23) Resident Care Coordinator will audit resident files monthly to make sure all required information is present and make sure all entries are legible. This was last done on 11/9/23.

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

Not Implemented - 11/16/2023)