pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **KAYMARIE BRIDDELL**
LEGAL ENTITY

To operate **VINE STREET MANOR**
NAME OF FACILITY OR AGENCY

Located at **230 NORTH 65TH STREET, PHILADELPHIA, PA 19139**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **84**
(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 **May 14, 2024** until **November 14, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **142343**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MAY 14, 2024

[redacted]
KayMarie Briddell
[redacted]

RE: Vine Street Manor
230 North 65th Street
Philadelphia, Pennsylvania 19139
License #: 142343

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection November 2, 2023 and February 7, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a THIRD PROVISIONAL license to operate the above facility. A THIRD PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your THIRD PROVISIONAL license is enclosed and is valid from May 14, 2024 to November 14, 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.

If you disagree with the decision to issue a THIRD 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.

[redacted]

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

[redacted]
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

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *VINE STREET MANOR* **License #**: *14234* **License Expiration**: *10/18/2023*

Address: *230 NORTH 65TH STREET, PHILADELPHIA, PA 19139*

County: *PHILADELPHIA* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *KAYMARIE BRIDDELL*

Address: [redacted]

[redacted] of Occupancy

Type: *Other* **Date**: *09/07/2018* **Issued By**: *City of Phila L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *64* **Waking Staff**: *48*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional* **Exit Conference Date**: *11/02/2023*

Inspection Dates and Department Representative

11/02/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* **Residents Served**: *60*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *57* **Are 60 Years of Age or Older**: *38*

Diagnosed with Mental Illness: *60* **Diagnosed with Intellectual Disability**: *3*

Have Mobility Need: *4* **Have Physical Disability**: *2*

Inspections / Reviews

11/02/2023 - Full

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

12/14/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/17/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/26/2023*

01/16/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/17/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/09/2024*

04/24/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/17/2024*

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 11/2/23, an agent of the Department, requested access to the bank statements for the checking account that all residents' funds are being transferred into. Staff persons A and B refused to provide access to this information.

Plan of Correction ***Accept ([redacted] - 01/16/2024)***

The corporate entity has ownership and control over the account that the inspector is requesting access to. However, due to privacy and security concerns, there is currently no way for individuals to access this account. To ensure compliance, the corporate entity has established a distribution account for future resident transactions and staff has access to this account.
On January 4th, 2024 the home's administrator, designee, benefits director and a DCS member received re-training in finance and proper book-keeping. Please see attached.
o.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Implemented [redacted] - 04/24/2024)

20b1 - Financial Records

2. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
1. The home shall keep a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance.

Description of Violation

The home manages the finances for resident 1. However, the home's written financial records do not include all withdrawals from the resident's account and the balance on the written form does not match the resident's bank account balance. The home's written financial transaction record has a balance of $0. The resident's bank statement has an account balance of $3.70.

The home manages the finances for resident 2. However, the home's written financial records do not have accurate math computations and do not list all withdrawals. Based on the entries on the written form, the resident's account balance should be $170. The resident's bank statement has an account balance of $5.91.

The home manages the finances for resident 3. The resident's bank account balance is $1020.80. The home's written financial transaction records have a balance of $1190. There is no explanation for the discrepancy in the resident's funds. There is no documentation of any withdrawals on the financial transaction records.

Repeat Violation: 3/22/22 et al.

Plan of Correction ***Accept ([redacted] - 01/16/2024)***

The discrepancy in values arose from the transition to different distribution forms and residents' resistance to receiving their funds. Additionally, it was necessary to keep funds in escrow accounts to ensure they remained

20b1 - Financial Records (continued)

open. To ensure accuracy, the facility will conduct monthly audits of the resident funds log alongside escrow audits. The monthly audits will be conducted by the Administrator and Designee for 4 months unless an extension is found to be necessary.
On January 4th, 2024 the home's administrator, designee, benefits director and a DCS member received re-training in finance and proper book-keeping. Please see attached. The home's administrator, designee and a 3rd party benefits consultant will review the transactional records to ensure accuracy.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Not Implemented [redacted] - 04/24/2024)

20b4 - Use of Funds

3. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
4. Resident funds and property shall only be used for the resident's benefit.

Description of Violation

Resident 1's rent is $1468.30. On 10/2/23, $1560 was withdrawn from the resident's checking account and transferred to the home's business checking account. The home's written financial transaction records show that the resident did not receive a personal needs allowance payment in October [redacted] This leaves a total of $91.70 missing, and staff person A, the administrator, does not have proof this money was used for the resident's benefit.

Resident 3's rent is $650 monthly. The home removed $852 from the resident's checking account in October [redacted] and $1000 from the resident's account in August [redacted]. All money was transferred to the home's business checking account. There is no documentation showing the money withdrawn from the resident's account was used to benefit the resident. The resident's checking account balance is $1020.80. The home's written financial transaction records have a balance of $1190. Staff person A, the administrator, does not have an explanation for the discrepancy in the resident's funds.

Resident 4's rent is $709 monthly. On [redacted]/2/23, $935 was withdrawn from the resident's checking account and transferred to the home's business checking account. This leaves a total of $226 missing, and staff person A, the administrator, does not have proof this money was used for the resident's benefit.

Plan of Correction ***Accept [redacted] - 01/16/2024)***

All residents received their $85 personal needs allowance. On occasion, like for resident 1 in particular, funds were distributed to the residents prior to the escrow accounts receiving the direct deposit. In order to provide the residents with convenient access to cash, these funds are often distributed prior to the weekend and then the transactions are performed in the bank accounts at a later date. The facility was under the impression that as long as the residents were receiving their funds, that compliance was achieved. After this inspection it is clear that bookkeeping practice must be cleaned up to reflect the transactions accurately. The Administrator is undertaking a complete audit of escrow, distribution and rent amounts. Once complete, the administrator and designee will conduct monthly audits for 4 months unless an extension is found to be necessary.
The audit for the rental amounts of residents mentioned in the violation was completed on January 9, 2024. The audit of all rental amounts for all residents will be completed by January 26th, 2024. On January 4th, 2024 the home's administrator, designee, benefits director and a DCS member received re-training in finance and proper

20b4 - Use of Funds (continued)

book-keeping. Please see attached. The home's administrator, designee and a 3rd party benefits consultant will review the transactional records to ensure accuracy.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Not Implemented [redacted] - 04/24/2024)

20b5 - No Commingling

4. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
5. Commingling of resident funds and home funds is prohibited.

Description of Violation

Funds for residents 1, 2, 3, 4, 5, and 6 are commingled in an account with the home's business funds.

Plan of Correction ***Accept [redacted] - 01/16/2024)***

The facility received instructions to establish escrow accounts and believed that it met compliance requirements with this action. However, the facility now recognizes the necessity and has established an additional account for PNA distribution. To address this, the facility has taken the necessary measures to create the PNA distribution account, conduct an audit of the escrow and grant access to relevant staff members for account information.
On January 4th, 2024 the home's administrator, designee, benefits director and a DCS member received re-training in finance and proper book-keeping. Please see attached. The home's administrator, designee and a 3rd party benefits consultant will review the transactional records to ensure accuracy.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Not Implemented [redacted] - 04/24/2024)

20b6 - Interest Bearing Account

5. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
6. If a home is holding more than $200 for a resident for more than 2 consecutive months, the administrator shall notify the resident and offer assistance in establishing an interest-bearing account in the resident's name at a local Federally-insured financial institution. This does not include security deposits.

Description of Violation

The home held money for resident 3, from 12/1/22, during which time the balance of those funds did not fall below $200. The home has not offered to put the funds in an interest-bearing account.

Plan of Correction ***Accept [redacted] - 12/14/2023)***

The escrow accounts were believed to be interest bearing. Once this issue was raised corporate opened an interest bearing savings account for resident 3. These accounts will be included in the monthly audit conducted by the Administrator/designee. The audit will take place for 4 months unless an extension is found to be necessary.

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

Not Implemented [redacted] - 04/24/2024)

20b8 - Quarterly Account

6. 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 3 and 6 have not received a quarterly account of financial transactions since [redacted]/30/23.

Repeat Violation: 3/22/22 et al.

Plan of Correction ***Accept [redacted] - 01/16/2024)***

This oversight has been brought to the attention of the administrator who, in response, has reviewed the BHL and created a reminder on the company calendar to include this compliance issue in the regular monthly audit. The benefits director has corrected the missing quarterly reports and distributed them to residents 3 and 6.
The quarterly accounts were reviewed with the residents on December 5th, 2023. Additional copies were given to the residents on December 20th, 2023. Please see attached.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Not Implemented [redacted] - 04/24/2024)

20b9 - Record Keeping

7. 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 resident 3's record for the period of 4/1/23 to 6/30/23.

There is no copy of the quarterly account of financial transactions in resident 6's record for the period of 4/1/23 to 6/30/23.

Plan of Correction ***Accept [redacted] - 01/16/2024)***

This oversight has been brought to the attention of the administrator who, in response, has reviewed the BHL and created a reminder on the company calendar to include this compliance issue in the regular monthly audit. The benefits director has corrected the missing quarterly reports and distributed them to residents 3 and 6.
The quarterly accounts were reviewed with the residents on December 5th, 2023. Additional copies were given to the residents on December 20th, 2023. Please see attached.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Not Implemented ([redacted] - 04/24/2024)

27a - SSI Benefits

8. Requirements

2600.

27a - SSI Benefits *(continued)*

27.a. If a home agrees to admit a resident eligible for SSI benefits, the home's charges for actual rent and other services may not exceed the SSI resident's actual current monthly income reduced by the current personal needs allowance.

Description of Violation

Resident 2's monthly rent charge is $1137.30. However, the resident's monthly income is $936.10.

Plan of Correction ***Accept [redacted] - 01/16/2024)***

The reason the reason the rent was listed as $1137.30 was because upon admission, resident 2 was receiving a supplement. However, the supplement was unexpectedly discontinued for unknown reasons. The recipient promptly filed an appeal, resulting in the reinstatement of the supplement. However, the Social Security Administration has not yet disbursed the appropriate funds. Please refer to the attached supplement approval documentation for further details. All agreements are being audited and corrected so that rent charges are in compliance. These will be included in the monthly audit going forward. The administrator will conduct the monthly audits for 4 months unless an extension is found to be necessary.

The audit for the rental amounts of residents mentioned in the violation was completed on January 9, 2024. The audit of all rental amounts for all residents will be completed by January 26th, 2024. On January 4th, 2024 the home's administrator, designee, benefits director and a DCS member received re-training in finance and proper book-keeping. Please see attached. The home's administrator, designee and a 3rd party benefits consultant will review the transactional records to ensure accuracy.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Not Implemented [redacted] - 04/24/2024)

42b - Abuse

9. 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

Resident 1's rent is $1468.30. On 10/2/23, $1560 was withdrawn from the resident's checking account and transferred to the home's business checking account. The home's written financial transaction records show that the resident did not receive a personal needs allowance payment in October 2023. This leaves a total of $91.70 missing, and staff person A, the administrator, does not have proof this money was used for the resident's benefit.

Resident 3's rent is $650 monthly. The home removed $852 from the resident's checking account in October 2023 and $1000 from the resident's account in August 2023. All money was transferred to the home's business checking account. There is no documentation showing the money withdrawn from the resident's account was used to benefit the resident. The resident's checking account balance is $1020.80. The home's written financial transaction records have a balance of $1190. Staff person A, the administrator, does not have an explanation for the discrepancy of $170 in the resident's funds.

Resident 4's rent is $709 monthly. On 10/2/23, $935 was withdrawn from the resident's checking account and transferred to the home's business checking account. This leaves a total of $226 missing, and staff person A, the administrator, does not have proof this money was used for the resident's benefit.

42b - Abuse *(continued)*

Plan of Correction ***Accept [redacted] - 01/16/2024)***

While the facility can admit that certain transactions were confusing due to clerical errors we maintain that no abuse occurred and all residents received their personal needs allowance in accordance with regulations and agreements. As stated previously, sometimes residents received their personal needs allowance before the deposits hit their accounts. Corporate imagined they were being benevolent in this act, however a reverse in action will be taken and all resident funds will be transferred only when SSA deposits funds and the PNA funds are transferred to the PNA account and then withdrawn and distributed to the resident. The administrator will manage logistics and audit monthly for 4 months unless an extension is found to be necessary.
The audit for the rental amounts of residents mentioned in the violation was completed on January 9, 2024. The audit of all rental amounts for all residents will be completed by January 26th, 2024. On January 4th, 2024 the home's administrator, designee, benefits director and a DCS member received re-training in finance and proper book-keeping. Please see attached. The home's administrator, designee and a 3rd party benefits consultant will review the transactional records to ensure accuracy.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Not Implemented [redacted] - 04/24/2024)

42v - Resident-Home Contract

10. Requirements

2600.
42.v. A resident has the right to receive services contracted for in the resident-home contract.

Description of Violation

On 1/1/23, the home failed to provide 30 days' notice prior to increasing rent for resident 1, as contracted for in the resident-home contract.

On 1/1/23, the home failed to provide 30 days' notice prior to increasing rent for resident 5, as contracted for in the resident-home contract.

Plan of Correction ***Accept [redacted] - 01/16/2024)***

All resident contracts are being audited and corrected by the Benefits Director. The administrator will conduct monthly audits for 4 months unless an extension is found to be necessary.
The audit for the rental amounts of residents mentioned in the violation was completed on January 9, 2024. The audit of all rental amounts for all residents will be completed by January 26th, 2024. Monthly audits will continue in February, March, April and May.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Not Implemented [redacted] - 04/24/2024)

53g - Financial Management

11. Requirements

2600.

53g - Financial Management *(continued)*

53.g. The administrator shall have the ability to maintain or supervise the maintenance of financial and other records.

Description of Violation

The home manages finances for 20 residents. Neither staff person A, the administrator, nor staff person B, the designee, have access to the home's business checking account where resident funds are being transferred into on a monthly basis. According to resident interviews, the personal needs allowance is not distributed by either staff person. The written financial transaction records are kept by staff person A and staff person B and they have the following discrepancies which neither staff person can explain:

- *The math calculations on resident 2's written financial transaction record is incorrect. Based on the entries on the form, the balance should be $170. Resident 2 has a checking account balance of $5.91.*
- *Resident 3 has a checking account balance of $1020.80. The written financial transaction records have a balance of $1190.*
- *The math calculations on resident 5's written financial transaction record is incorrect. Based on the entries on the form, the balance should be $85. Resident 5 has a checking account balance of $3.31.*
- *The math calculations on resident 6's written financial transaction record is incorrect. Based on the entries on the form, the balance should be $45. Resident 6 has a checking account balance of $6.02.*

Plan of Correction ***Accept [redacted] 01/16/2024)***

Please note the facility is only the representative payee for 10 residents, not 20 residents. The corporate entity has ownership and control over the account that the inspector is requesting access to. However, due to privacy and security concerns, there is currently no way for staff to access this account. To ensure compliance, the corporate entity has established a distribution account for future resident transactions and granted staff access to this account. The balances were purposely left to keep the accounts open at the corporation's expense. The miscalculations are being audited and corrected by the administrator who will audit monthly for 4 months. PNA will be handled exclusively by on site staff going forward.

The audit for the rental amounts of residents mentioned in the violation was completed on January 9, 2024. The audit of all rental amounts for all residents will be completed by January 26th, 2024. On January 4th, 2024 the home's administrator, designee, benefits director and a DCS member received re-training in finance and proper book-keeping. Please see attached. The home's administrator, designee and a 3rd party benefits consultant will review the transactional records to ensure accuracy.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Not Implemented ([redacted] - 04/24/2024)

65a - FS Orientation 1st Day

12. 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.

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

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 [redacted]3, 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 until 10/26/23.

Plan of Correction ***Accept [redacted] - 01/16/2024)***

The home has appointed a senior staff member as the training supervisor who will report to the administrator and designee. The training supervisor will be responsible for all new staff training needs. This includes new staff orientation, first day training, training to be completed within 40 hours of being hired and annual staff training needs. The training supervisor will use the home's staff training plan to assist them. Please see attached.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Implemented [redacted] - 04/24/2024)

65g - Annual Training Content

13. Requirements

2600.

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

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

Description of Violation

Staff person D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention during training year January 2022 to December 2022.

Staff person E did not receive training in the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) during training year January 2022 to December 2022.

Plan of Correction ***Accept [redacted] - 01/16/2024)***

Staff person E did receive training in the Older Adult Protective Services Act on 5/09/2022 and documentation of this was in [redacted] file and given to the inspector. Staff person D has received fire safety training as of 12/4/2023.

65g - Annual Training Content (continued)

Staff persons were provided training opportunities however oversight on completion was absent.
The home has appointed a senior staff member as the training supervisor who will report to the administrator and designee. The training supervisor will be responsible for all new staff training needs. This includes new staff orientation, first day training, training to be completed within 40 hours of being hired and annual staff training needs. The training supervisor will use the home's staff training plan to assist them. The training supervisor will be responsible for conducting monthly audits for 4 months unless and extension is found necessary. Monthly audits will start in January 2024. See attached.

Licensee's Proposed Overall Completion Date: *01/10/2024*

Implemented [redacted] - 04/24/2024)

66b - Training Plan Content

14. Requirements

2600.
66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:
1. The name, position and duties of each direct care staff person.
2. The required training courses for each staff person.
3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home's staff training plan does not include training for the required annual topics: safe management techniques, fire safety, emergency preparedness, resident rights, the Older Adult Protective Services Act , falls/accidents prevention.

Repeat Violation: 12/15/22

Plan of Correction ***Accept [redacted] - 01/16/2024)***

The administrator will work with a third party payroll management firm "Paychex" to audit and create a complete HR system including an appropriate staff training plan and oversight on a monthly basis to remain compliant. This process will be complete on 01/01/2024.
As of 1/09/2024, the home has appointed a new training supervisor who will be responsible for all staff members training needs. This includes new staff orientation, first day training, training to be completed within 40 hours of being hired and annual staff training needs. The training supervisor will use the home's staff training plan to assist them. The training supervisor will be responsible for conducting monthly audits for 4 months unless and extension is found necessary. Monthly audits will start on or before January 31, 2024. See attached.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Implemented [redacted] - 04/24/2024)

88a - Surfaces

15. Requirements

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

Description of Violation

At 10:00 am, both bathrooms on the first floor, the bathroom on the second floor, and bathroom #2 on the third floor had wet floors and no caution sign indicating the floors were wet.

88a - Surfaces (continued)

Outside bathroom #2 on the third floor, near the fire exit ceiling tiles were broken/falling down.

There was a feces-soiled toilet and a dirty sink in bathroom #2 on the third floor.

Plan of Correction ***Accept [redacted] - 01/16/2024)***

We respectfully ask that it be noted that we are proud of the general cleanliness of our bathrooms. Our housekeeping staff faces an incredibly tough challenge maintaining restroom facilities for an 84 bed facility caring for the mentally disabled. In fact visitors, including the state's inspectors, have remarked how well they are maintained. Alas, even the whitest sheet has a speck of dirt so, all maintenance and housekeeping staff will complete OSHA training by 12/18/23 in order to fully understand the importance of proper cleaning techniques. Staff members have been verbally instructed to conduct building rounds every 2 hours to ensure all bathrooms are cleaned and in good condition. Cleaning rounds will be completed by maintenance staff members during the day, and DCS members at night. This process will be in place for 4 months unless an extension is found to be necessary. Cleaning logs have been added for maintenance staff members to document findings of the daily rounds. All logs will be reviewed by a senior staff member who reports to the administrator and designee on a daily basis.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Not Implemented [redacted] /24/2024)

95 - Furniture and Equipment

16. Requirements

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

Description of Violation

The door handle in room C6 was broken and missing a handle on one side. The wood veneer on the door is also peeling off/splintered around the handle.

Plan of Correction ***Accept ([redacted] - 12/14/2023)***

The door knob has been replaced by a maintenance person on 11/25/2023. In addition, newly hired housekeeper will head up a maintenance initiative to include minor repairs and monitor the facility. Starting on 11/25/23 DCS has been verbally informed that they are required to report maintenance issues on a newly implemented group communication system as well as a PA system so issues can be addressed promptly.

Licensee's Proposed Overall Completion Date: *12/01/2023*

Not Implemented [redacted] 04/24/2024)

96a - First Aid Kit

17. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

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

Plan of Correction ***Accept [redacted] - 01/16/2024)***

The necessary correction has been successfully implemented by a third party that stocks the first aid kit. The

96a - First Aid Kit (continued)

third-party company that the facility uses is validated by OSHA . This third party has been made aware of the regulation breach and will undertake necessary corrections. The administrator will monitor the first aid kit on a monthly basis for 3 months unless and extension is necessary.
The first aid kit was brought into compliance on December 1, 2023. Monthly audits will start in January 2024. The home has also created a log to monitor the use of first aid kit items and ensure it remains in compliance. A senior staff member will monitor the log on a monthly basis and report to the administrator and designee. Please see attached.

Licensee's Proposed Overall Completion Date: *01/10/2024*

Implemented [redacted] - 04/24/2024)

103f - Refrigerator/Freezer Temps

18. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 11/2/23 at 3:05 pm the temperature in the refrigerator was 48 degrees Fahrenheit.

Repeat Violation: 3/22/22 et al, 11/2/22 et al

Plan of Correction ***Accept [redacted] - 01/16/2024)***

The built in thermometer in the unit registers a higher temperature as soon as the door is opened. It requires some time to return to an accurate reading. A separate thermometer was purchased and placed in the unit. The built in thermometer was covered however the inspector removed the covering and used the reading from the malfunctioning thermometer. The separate, working thermometer was moved into a more prominent location to avoid confusion for inspectors on 11/20/2023.
The home has added temperature logs to document the thermometers. On January 9th, 2024 the home appointed a senior staff member who will be responsible for checking the temperature logs on a monthly basis. Reviews of the temperature logs will begin on January 9, 2024 and will continue for 2 months unless an extension is found to be necessary. The refrigeration repair company has been called and will repair or replace the temperature gauge on or before January 26th.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Implemented [redacted] - 04/24/2024)

124 - Notice to Fire Department

19. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

124 - Notice to Fire Department *(continued)*

Plan of Correction ***Accept [redacted] - 01/16/2024)***

The local fire department was contacted in order to conduct the monitored fire drill performed on 9/13/23. In that email, the address and nature of the facility was communicated. It was assumed by the facility and our local Philadelphia fire department that the ongoing relationship between the local fire department and the facility ensured the local fire department was well aware of all of the necessary information. The administrator has contacted the local fire department and informed them of our address, exact number of bedrooms and assistance needed to evacuate in an emergency.

The fire department received written documentation on December 5th, 2023. Please see attached. The home's administrator will be responsible for ensuring that the fire department receives the necessary written documentation on an annual basis. The administrator will reach out to the fire department once a year starting 12/5/2023. The home contacted a private firm on December 21, 2023. Tri-State will be at the facility on January 18, 2024 to conduct the fire safety inspection and a supervised fire drill.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Implemented [redacted] - 04/24/2024)

131f - Fire Extinguisher Inspection

20. 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 on the third floor has not been inspected by a fire safety expert.

Plan of Correction ***Accept [redacted] - 01/16/2024)***

The facility has contacted a fire safety company and they have started servicing all extinguishers in the building. All fire extinguishers at Vine Street will be serviced on or before 12/6/2023. The administrator will monitor all extinguishers on a monthly basis for three months to ensure compliance is maintained.

The fire safety company was contacted on 11/20/2023 and service of the extinguishers began on 11/27/2023. Emergency Response will complete service of all extinguishers on February 8, 2024. Monthly monitoring will begin February 2024.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Implemented [redacted] 04/24/2024)

132a - Monthly Fire Drill

21. Requirements

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

Description of Violation

An unannounced fire drill was not held during the month of October 2023.

Plan of Correction ***Accept [redacted] - 12/14/2023)***

This violation is an oversight which can not be explained or excused. The administrator and designee will work together using a company calendar reminder system and the groupme company communication to ensure

132a - Monthly Fire Drill (continued)

compliance is strictly maintained.

Licensee's Proposed Overall Completion Date: *12/01/2023*

Implemented [redacted] - 04/24/2024)

132b - Safety Inspection/Fire Drill

22. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection observed by a fire safety expert was conducted on 3/15/22.

Plan of Correction ***Accept [redacted] - 01/16/2024)***

An annual fire drill was conducted by the Philadelphia fire department on 9/13/2023. [A member of] Local Fire Unit 4 refused to sign the standard documentation stating that it was not their policy to do so. The facility will contract with a private firm in the future to ensure compliance.
The home contacted a private firm on December 21, 2023. Tri-State will be at the facility on January 18, 2024 to conduct the fire safety inspection and a supervised fire drill. The home's administrator will work with the company on an annual basis to ensure compliance. This process has already started as of 12/21/2023. Please see attached.

Proposed Overall Completion Date: 01/09/2024

Licensee's Proposed Overall Completion Date: *01/09/2024*

Implemented [redacted] - 04/24/2024)

132e - Fire Drill Sleeping Hours

24. Requirements

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

Description of Violation

The last fire drill conducted during sleeping hours was on 12/16/22 at 11:15 pm.

Plan of Correction ***Accept [redacted] - 01/16/2024)***

This violation is an oversight which can not be explained or excused. The administrator and designee will work together using a company calendar reminder system and the groupme company communication to ensure compliance is strictly maintained.
Review of drills will take place every other month for the next 4 months unless an extension is found to be necessary. Reviews will be conducted by a senior staff member who will report to the administrator and designee.

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

Implemented [redacted] - 04/24/2024)

144d - Smoking Outside

25. Requirements

2600.

144d - Smoking Outside *(continued)*

144.d. Smoking outside of the smoking room is prohibited.

Description of Violation

On 11/2/23 at 10:00 am, resident 1 was smoking in the back of the home, between the two buildings in an area with a sign that read "no smoking".

Plan of Correction ***Accept [redacted] 01/16/2024)***

After consulting PA state smoking regulations and fire safety experts we have determined that the area designated as non-smoking is actually an area that is far enough from an egress to allow smoking. We have removed the sign and will continue to monitor our residents for compliance with our smoking policies and continually review PA State fire regulations to ensure safety and compliance.
The home gave residents 30 day notices of the change in smoking policy on 12/01/2023. Residents were told the change in policy would go into effect on January 1st, 2024. See attached.
Tri-State Training & Safety Consulting will be consulted during their January 18th fire inspection and fire drill for further instruction on the matter.

Licensee's Proposed Overall Completion Date: *01/10/2024*

Implemented [redacted] - 04/24/2024)

225c - Additional Assessment

26. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 1's assessment, dated [redacted]20/23, does not include an accurate assessment of the resident's ability to manage finances. The resident is unable to manage finances, however the assessment does not indicate that need.

Resident 5's assessment, dated [redacted]/8/23, does not include an accurate assessment of the resident's ability to manage finances. The resident is unable to manage finances, however the assessment does not indicate that need.

Repeat Violation: 12/15/22.

Plan of Correction ***Accept ([redacted] - 01/16/2024)***

The facility's understanding of "manage" is different from the inspector's. The residents in question are able to manage their personal needs allowance. However, they do need some assistance with applying for benefits, etc. Residents #1 and #5 have been re-evaluated and their RASPs have been updated by the administrator to better reflect their needs.
Both RASPs were updated on 12/1/2023 by the administrator. A review of all resident RASP's will be completed by January 26th, 2024. The home's administrator and designee will continue to audit the resident's RASPs for 2 months unless an extension is deemed necessary.

Licensee's Proposed Overall Completion Date: *01/09/2024*

Implemented [redacted] - 04/24/2024)

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

Facility Information

Name: *VINE STREET MANOR* **License #:** *14234* **License Expiration:** *10/18/2023*

Address: *230 NORTH 65TH STREET, PHILADELPHIA, PA 19139*

County: *PHILADELPHIA* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *KAYMARIE BRIDDELL*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date:** *09/07/2018* **Issued By:** *City of Phila L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *64* **Waking Staff:** *48*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *02/07/2024*

Inspection Dates and Department Representative

02/07/2024 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *84* **Residents Served:** *60*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *57* **Are 60 Years of Age or Older:** *38*

Diagnosed with Mental Illness: *60* **Diagnosed with Intellectual Disability:** *3*

Have Mobility Need: *4* **Have Physical Disability:** *2*

Inspections / Reviews

02/07/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/02/2024*

03/11/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/24/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/13/2024*

03/14/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/24/2024*

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

04/25/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/24/2024*

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

18 - Compliance With Laws

1. 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

Fire safety expert states that the emergency exit lights are not in compliance with NFPA code 101.7.9 Life safety code as they were not working when the fire safety expert was on-site 1/18/2024 and have not been inspected annually.

Plan of Correction ***Accept [redacted] - 03/11/2024)***

An outside fire company has been contacted and will come out to the facility on March 8th to start all mentioned repairs. The home was under the impression that the company would complete an inspection and repairs when they came out on January 18th, 2024, however, only an inspection was done on that date. Please see attached.

Licensee's Proposed Overall Completion Date: *03/06/2024*

Not Implemented [redacted] - 04/25/2024)

20b1 - Financial Records

2. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
1. The home shall keep a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance.

Description of Violation

The home manages the finances for resident #1. However, the home's financial records do not include the rent rebate received by the resident on 12/08/23.

The home manages the finances for resident #2. However, the home's financial records do not include the rent rebate received by the resident on 12/01/23.

Plan of Correction ***Accept [redacted] - 03/14/2024)***

The facility uses a separate ledger from the personal needs allowance to record rent rebates. On 3/8/24, staff was verbally instructed to submit all financial ledgers during inspections for accuracy.
The home's acting administrator and finance supervisor will conduct an audit of all resident's rent rebate ledgers on or before 3/22/24. The mentioned staff members will conduct monthly audits to ensure compliance with the rules and regulations. This process will continue for three months unless an extension is found to be needed.

Licensee's Proposed Overall Completion Date: *03/13/2024*

Not Implemented [redacted] - 04/25/2024)

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

3. Requirements

2600.

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

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

Description of Violation

Resident #1 was discharged on [redacted]/24. The home did not provide the required refund.

Plan of Correction ***Accept ([redacted]/11/2024)***

Resident #1 did not provide a 30 day notice. Resident #1 immediately left the building. Resident #1 was mailed [redacted] refund check on 2/20/2024. The home understands the need to provide refunds in a timely manner regardless of circumstances. Administrator reviewed regulations and will be responsible for continued compliance.

Licensee's Proposed Overall Completion Date: *03/06/2024*

Not Implemented [redacted] - 04/25/2024)

56 - Admin 20 Hours/Week

4. Requirements

2600.
56. Administrator Staffing - The administrator shall be present in the home an average of 20 hours or more per week, in each calendar month.

Description of Violation

During calendar month January 2024, and through February 7, 2024, staff person A, the administrator of the home, was in the home an average of 0 hours per week.

Plan of Correction ***Accept[redacted] - 03/11/2024)***

Staff person A sent the state notification of replacement administrator on January 8th, 2024. Please see attached waiver.

Licensee's Proposed Overall Completion Date: *03/07/2024*

Implemented [redacted] - 04/25/2024)

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

On 02/07/24 at 9am, the main lobby at the entrance of the building had a strong odor of urine, and the same odor of urine was identified again at 2:30pm.

Plan of Correction ***Accept[redacted] - 03/14/2024)***

While staff didn't detect the same issue as the inspectors, sanitary conditions remain a top priority. Starting March 8th, two direct care staff members will be directed to walk the building twice a day during their shifts specifically for monitoring maintenance and surface issues and will report these issues to administration. This process will continue for 1 month unless an extension is found to be needed. The acting administrator and staff supervisor will be training the rest of the maintenance staff and direct care staff on appropriate cleaning practices to maintain safe and compliant conditions. This training is scheduled for 3/15/24.

Licensee's Proposed Overall Completion Date: *03/12/2024*

85a - Sanitary Conditions *(continued)*

Not Implemented [redacted] - 04/25/2024)

88a - Surfaces

6. Requirements

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

Description of Violation

The middle bathroom on the 3rd floor has ceiling tiles that are not properly attached.

Bathroom on 2nd floor next to bathroom marked as "3" has a tile missing above the toilet.

Plan of Correction ***Accept [redacted] - 03/14/2024)***

All mentioned issues were fixed on 2/19/24 by an outside maintenance person. Starting March 8th, two direct care staff members will be directed to walk the building twice a day during their shifts specifically for monitoring maintenance and surface issues and will report these issues to administration. This process will continue for 1 month unless an extension is found to be needed.
The home's licensed contractor, will train the acting administrator , staff supervisor, maintenance staff and direct care staff on appropriate maintenance practices. This training is scheduled for 3/13/24.

Licensee's Proposed Overall Completion Date: *03/12/2024*

Not Implemented [redacted] - 04/25/2024)

92 - Windows

7. Requirements

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

Description of Violation

The first-floor storm window in the lobby is cracked with a large hole and a piece of plexiglass underneath.

Plan of Correction ***Accept [redacted] - 03/14/2024)***

The first-floor storm window was repaired on 2/19/24 by an outside maintenance person. Starting March 8th, two direct care staff members will be directed to walk the building twice a day during their shifts specifically for monitoring maintenance and surface issues and will report these issues to administration. This process will continue for 1 month unless an extension is found to be needed.
The home's licensed contractor, will train the acting administrator , staff supervisor, maintenance staff and direct care staff on appropriate maintenance practices. This training is scheduled for 3/13/24.

Licensee's Proposed Overall Completion Date: *03/12/2024*

Not Implemented [redacted] - 04/25/2024)

95 - Furniture and Equipment

8. Requirements

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

Description of Violation

The shower has no sprayer or shower head attached to the shower hose, which is dangling inside the stand-up shower in the 2nd bathroom on the 3rd floor. It is the bathroom nearest to the stairs.

Plan of Correction ***Accept[redacted] - 03/14/2024)***

The mentioned shower head was repaired on 2/19/24. Starting March 8th, two direct care staff members will be directed to walk the building twice a day during their shifts specifically for monitoring maintenance and surface issues and will report these issues to administration. This process will continue for 1 month unless an extension is found to be needed.
The home's licensed contractor, will train the acting administrator , staff supervisor, maintenance staff and direct care staff on appropriate maintenance practices. This training is scheduled for 3/13/24.

Licensee's Proposed Overall Completion Date: *03/12/2024*

Not Implemented[redacted] - 04/25/2024)

101o - Walls, Floors, Ceilings

9. Requirements

2600.
101.o. The bedrooms must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

Resident#3's bedroom floor is peeling and lifting away in multiple areas, some are ducted tape down, however the condition of the floor tiles is a significant trip hazard.

Repeat Violation 01/18/23.

Plan of Correction ***Accept[redacted] - 03/14/2024)***

Resident #3's floor was repaired on 2/19/24 by an outside maintenance person. Starting March 8th, two direct care staff members will be directed to walk the building twice a day during their shifts specifically for monitoring maintenance and surface issues and will report these issues to administration. This process will continue for 1 month unless an extension is found to be needed.
The home's licensed contractor, will train the acting administrator , staff supervisor, maintenance staff and direct care staff on appropriate maintenance practices. This training is scheduled for 3/13/24.

Licensee's Proposed Overall Completion Date: *03/12/2024*

Not Implemented[redacted] - 04/25/2024)

102k - No Common Towel

10. Requirements

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

Description of Violation

There were no paper towels, mechanical hand dryer or other sanitary means of hand drying in the 2nd bathroom on the 3rd floor.

Plan of Correction ***Accept (- 03/14/2024)***

Paper towels were placed in the bathroom on 2/7/2024. Also, the electric hand dryer was repaired on 2/19/24 and is currently in working condition. Starting March 8th, two direct care staff members will be directed to walk the building twice a day during their shifts specifically for monitoring maintenance and surface issues and will report these issues to administration. This process will continue for 1 month unless an extension is found to be needed.
The acting administrator and staff supervisor will be training the rest of the maintenance staff and direct care staff on appropriate practices to maintain safe and compliant conditions. This training is scheduled for 3/13/24.

Licensee's Proposed Overall Completion Date: *03/12/2024*

Not Implemented 04/25/2024)

121a - Unobstructed Egress

11. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 01/17/24 at 11:40am, a bucket and dustpan were found jammed on the staircase blocking the egress from the home's fire's escape.

Plan of Correction ***Accept - 03/14/2024)***

The buckets and dustpan have been removed from the staircase. To prevent this from occurring again, starting March 8th, two direct care staff members will be directed to walk the building twice a day during their shifts specifically for monitoring maintenance and surface issues and will report these issues to administration. This process will continue for 1 month unless an extension is found to be needed.
The acting administrator and staff supervisor will be training the rest of the maintenance staff and direct care staff on appropriate practices to maintain safe and compliant conditions. This training is scheduled for 3/13/24.

Licensee's Proposed Overall Completion Date: *03/12/2024*

Not Implemented (- 04/25/2024)

162c - Menus Posted

12. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 2/7/24 The home's menu for the week of February 13th through February 19th, 2024, was not posted in advance.

Plan of Correction ***Accept - 03/14/2024)***

The home's cook will complete training on the rules and regulations on menu posting. The cook will be responsible

162c - Menus Posted (continued)

for posting menus on a weekly basis.
The staff supervisor with the aid of virtual training materials, will train kitchen staff on safe food handling and menu posting to remain in compliance with state regulations. Training will take place on 3/15/24.

Licensee's Proposed Overall Completion Date: *03/12/2024*

Not Implemented [redacted] - 04/25/2024)

163b - Sanitary Practices

13. Requirements

2600.
163.b. Staff persons, volunteers and residents shall follow sanitary practices while working in the kitchen areas.

Description of Violation

On 02/07/24 at 9 a.m., staff person B was observed giving toast out of a plastic bin to residents in the common area while working in the kitchen. It was observed that residents reached into the plastic bin and grabbed their toast with bare hands and no tongs or other sanitary method.

Plan of Correction ***Accept ([redacted] - 03/14/2024)***

The home is aware that a container was brought out to the lobby area with food in it. However, staff person B did have gloves on and was handing out food items to residents in a sanitary fashion. No residents were reaching inside of the container themselves at any time. Regardless, sanitary practices remain a top priority. Therefore, staff has been instructed to only serve residents using individual plates in the future. The cook will be responsible for monitoring in order to maintain compliance.
The staff supervisor with the aid of virtual training materials, will train kitchen staff on safe food handling and menu posting to remain in compliance with state regulations. Training will take place on 3/15/24.

Licensee's Proposed Overall Completion Date: *03/12/2024*

Not Implemented [redacted] - 04/25/2024)