



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to COUNTRY MANOR PCH LP
LEGAL ENTITY

To operate COUNTRY MANOR
NAME OF FACILITY OR AGENCY

Located at 111 ALTMeyer DRIVE, KITTANNING, PA 16201
(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 50
(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 June 11, 2024 until December 11, 2024,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **446291**

Janette Biderup
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.



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JUNE 11, 2024

[REDACTED]
Country Manor PCH LP
[REDACTED]

RE: Country Manor
License/COC #: 446291

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, Office of Long-Term Living licensing inspections on October 19, 2023, October 20, 2023, December 21, 2023, February 1, 2024, and March 12, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summaries (LISs) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from June 11, 2024 to December 11, 2024.

All violations specified on each LIS must be corrected by the dates specified on the reports 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	Class of Violation	Census at Inspection X	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
Section:					
51	II	29	\$5	\$145	5 calendar days from mailing date of this letter
54(a)	II	29	\$5	\$145	5 calendar days from mailing date of this letter
85(a)	II	29	\$5	\$145	5 calendar days from mailing date of this letter
103(f)	II	29	\$5	\$145	5 calendar day from mailing date of this letter
184(a)	II	29	\$5	\$145	5 calendar days from mailing date of this letter
187(a)	II	29	\$5	\$145	5 calendar days from mailing date of this letter
187(d)	II	29	\$5	\$145	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 each 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]
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:

[REDACTED]

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

Facility Information

Name: *COUNTRY MANOR* License #: *44629* License Expiration: *03/21/2024*
Address: *111 ALTMAYER DRIVE, KITTANNING, PA 16201*
County: *ARMSTRONG* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *COUNTRY MANOR PCH LP*
Address: *111 ALTMAYER DRIVE, KITTANNING, PA, 16201*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *06/20/1996* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *28* Waking Staff: *21*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint* Exit Conference Date: *10/20/2023*

Inspection Dates and Department Representative

10/19/2023 - On-Site: [REDACTED]
10/20/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* Residents Served: *27*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *14* Are 60 Years of Age or Older: *24*
Diagnosed with Mental Illness: *5* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *1* Have Physical Disability: *0*

Inspections / Reviews

10/19/2023 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *11/12/2023*

12/07/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/05/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 12/11/2023

01/12/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/05/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 02/01/2024

05/03/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/05/2024

Reviewer: [REDACTED]

Follow-Up Type: Exception

3c - Post Current License

1. Requirements

2600.

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

Description of Violation

On 10/19/23, the home did not have a copy of the following items posted in a conspicuous and public place in the home:

* The Department's Chapter 2600 regulations

* A current license issued by the Department

* The home's licensing inspection summaries dated 11/30/22, 2/16/23, 3/1/23, 3/8/23, 3/23/23, 3/30/23, 4/27/23, 6/7/23, 7/11/23, and 8/31/23

Plan of Correction

Accept [redacted] 01/12/2024)

On day of inspection, 10/20/2023 administrator posted current licenses and past summaries, along with chapter 2600 regulations. Regional Consultant did a training with Administrator on 11-8-2023 on 2600.3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home. For administration. Documentation kept. Beginning 11/8/2023 Administrator will keep a checklist to be sure proper documentation is posted, to be checked monthly by Administrator or Designee.

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

Implemented [redacted] - 05/02/2024)

17 - Record Confidentiality

2. Requirements

2600.

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

Description of Violation

On 10/19/23, old resident files, including resident #1's contract and resident #2's financial information and medical evaluation were unlocked, unattended, and accessible in the closet labeled "employees only", across from the laundry room in the back hallway.

Plan of Correction

Accept [redacted] - 11/22/2023)

The door to file was locked immediately with inspectors present by administrator on 10/19/2023. The storage closet holds past resident info. Resident no. #1 was no longer a Resident in the facility. The only person to have a key to this is the administrator now. Administrator will check daily with documentation to be in compliance with 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. This regulation will be reviewed with all Staff in a training by Administrator

17 - Record Confidentiality (continued)

on 11-22-2023

Licensee's Proposed Overall Completion Date: 11/22/2023

NOT IMPLEMENTED 5/3/24

51 - Criminal Background Check

3. Requirements

2600.

- 51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

On 10/19/23, staff person A, hired [REDACTED]/22, did not have a Pennsylvania criminal background check completed in accordance with the Older Adult Protective Service Act.

Repeat Violation: 11/30/22 et al.

Plan of Correction

Accept [REDACTED] - 11/22/2023)

On 10/19/2023, day of inspection, Administrator did background check on staff person A. Regional director did training with administrator on 11/08/2023. To include regulation 2600.51.Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults). All other staff files were reviewed by administrator on 11/08/2023 to be in compliance with this regulation. An employee file checklist is now available on tabula pro that will be used by Administrator for all new staff to monitor and verify required documentation.

Licensee's Proposed Overall Completion Date: 11/15/2023

NOT IMPLEMENTED 5/3/24

53a - Qualifications

4. Requirements

2600.

- 53.a. The administrator shall have one of the following qualifications:
 - 1. A license as a registered nurse from the Department of State.
 - 2. An associate's degree or 60 credit hours from an accredited college or university.
 - 3. A license as a licensed practical nurse from the Department of State and 1 year of work experience in a related field.
 - 4. A license as a nursing home administrator from the Department of State.
 - 5. For a home serving 8 or fewer residents, a general education development diploma or high school diploma and 2 years direct care or administrative experience in the human services field.

Description of Violation

On 10/19/23, the home was serving 26 residents. Staff person B, the home's administrator is not a registered nurse, does not have 60 credited hours from an accredited college or university, licensed practical nurse with 1 year work experience, or licensed nursing home administrator. Staff person B completed 53 credited hours.

Plan of Correction

Directed [REDACTED] - 01/12/2024)

Staff person B was told at [REDACTED] 100 hour course that [REDACTED] had the required documentation for Administrator. [REDACTED] is missing 7 credits. A waiver was applied for on 11-13-2023. The required documentation is being sent by Regional

53a - Qualifications (continued)

Consultant. The waiver asks for Staff person B to continue being the Administrator while finishing the required courses to earn the 7 credits needed. Current Administrator (Staff person B) signed up for classes to run for 5 weeks beginning January. 30, 2024 to achieve [redacted] credits needed. Owner is actively interviewing at this time. Current Administrator has been working in healthcare for many years and will only benefit the Residents by [redacted] presence. The waiver is being reviewed by [redacted] for approval and [redacted] granted a 2 week extension to find a temporary Administrator to work with staff person b.

Proposed Overall Completion Date: 01/11/2024

DIRECTED PLAN:

By 2/1/24 - The legal entity shall employ an administrator who meets the qualifications of 2600.53a-h and has completed all of the required initial training of 2600.64a. Documentation of administrator qualifications and initial training shall be kept. Or, if a waiver is granted by the Department for staff person B, the home shall follow all of the requirements of the waiver. [redacted] 1/12/24

Directed Completion Date: 02/01/2024

NOT IMPLEMENTED 5/3/24 [redacted]

54a - Direct Care Staff

5. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

- 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

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

Repeat Violation: 11/30/22 et al.

Plan of Correction

Accept [redacted] - 11/29/2023)

On 10/20/2023 the diploma for staff person 3 was given to Administrator and presented to Inspectors. On 10-23-2023 Administrator reviewed all other staff records to be in compliance 2600.54.a. Direct care staff persons shall have the following qualifications: 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry. Regional consultant reviewed this regulation with administrator on 11/08/2023. Checklist from Tabula pro will be used by Administrator or Designee for all new hires for verification of all required documentation. This is being disputed as Administrator presented diploma for Staff person 3 on second day of inspection.

Licensee's Proposed Overall Completion Date: 11/15/2023

NOT IMPLEMENTED 5/3/24 [redacted]

63a - First Aid/CPR Training

6. Requirements

2600.

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

Description of Violation

On 10/19/23. from 2:00 pm-10:00 pm, 26 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid, obstructed airway techniques or CPR.

63a - First Aid/CPR Training (continued)

Plan of Correction

Accept [REDACTED] - 11/29/2023)

Staff member G had CPR and first aid training 10/25/2023. Administrator reviewed all staff files on 11/08/2023. Beginning 11/12/2023. Administrator will highlight each CPR and first aide trained staff on schedule to be sure each shift is covered to be in compliance with 2600.63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times. All staff in facility will be trained on CPR and First Aide on 11/16/2023

Licensee's Proposed Overall Completion Date: 11/22/2023

NOT IMPLEMENTED 5/3/24 [REDACTED]

65f - Training Topics

7. Requirements

2600.

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

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

Description of Violation

Direct care staff person D did not receive training in any of the required training during training year 2022.

Repeat Violation: 3/1/23, 4/27/23

Plan of Correction

Accept [REDACTED] - 01/12/2024)

All current staff files were reviewed by Administrator on 10-23-2023. All current year trainings are up to date. Staff person D was on leave of absence and was not working at the facility for most of the year. Regional Consultant did a training with Administrator on 11-8-2023, and they decided that when anyone leaves employment, then returns, they would have paperwork started over as if it was first time new Employee. Training included -2600.65 f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home. Tabula pro has an area to keep track of and print training hours. All topics required by DHS are in this area. Administrator or Designee will monitor monthly with documentation for compliance of regulation.

65f - Training Topics (continued)*Documentation kept***Licensee's Proposed Overall Completion Date: 12/11/2023****Implemented [REDACTED] - 05/02/2024)****65g - Annual Training Content****8. Requirements**

2600.

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

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

Description of Violation*Staff person D did not receive any of the required training during training year 1/1/22 to 12/31/22.**Staff person E did not receive training in fire safety during training year 1/1/22 to 12/31/22.**Repeat Violation: 4/27/23***Plan of Correction****Accept [REDACTED] 01/12/2024)**

All current staff files were reviewed on 10-23-2023 by Administrator. All current year trainings are up to date. Staff person D was on leave of absence and was not working at the facility for most of the year. Staff person E is up to date. Regional Consultant did a training with Administrator on 11-8-2023, and they decided that when anyone leaves employment, then returns, they would have paperwork started over as if it was first time new Employee. Training included -2600.65 f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
 2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
 3. Care for residents with dementia and cognitive impairments.
 4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
 5. Personal care service needs of the resident.
 6. Safe management techniques.
 7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.
- Tabula pro has a section with all training subjects and hours for each Employee. Administrator or Designee will audit monthly to be sure all requirements of regulation are met. Documentation kept*

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

65g - Annual Training Content (continued)

Implemented [redacted] 05/02/2024)

82c - Locking Poisonous Materials

9. Requirements

2600.

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

Description of Violation

On 10/19/23, a 33-ounce container of window cleaner, with a manufacture's label indicating "if swallowed, drink glassful of water and consult a physician", was unlocked, unattended, and accessible to residents in the unlocked staff bathroom in the dining room area. Not all the residents of the home, including resident #3, have been assessed capable of recognizing and using poisons safely.

Plan of Correction

Accept [redacted] 11/29/2023)

On 10/19/2023 the window cleaner was removed by Aide from unlocked, unattended area and locked in the storage area with all other poisonous materials, Training for all staff will be done 11/22/2023 by administrator to be in compliance with 2600.82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials. Weekly walkthrough to check for poisonous materials will be done by Administrator or Designee will be done by administrator beginning 11/20/2023. Documentation Checklist will be kept as verification.

Licensee's Proposed Overall Completion Date: 11/22/2023

Implemented [redacted] - 05/02/2024)

85a - Sanitary Conditions

10. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 10/19/23, the following examples of unsanitary conditions were observed:

- * There was debris on the carpet throughout the entire building, including shreds of what appeared to be shredded pieces of toilet paper or Kleenex on the carpet outside of bedroom #7
- * A strong odor of urine upon entering the home, including in bedrooms #7, and #17
- * Dried food particles on the interior/exterior of the microwave in the kitchen
- * Approximately 50 cigarette butts were in the large flower pot outside of the east hallway exit door.
- * Food particles and a 1" by 1/2" spot of a pink substance frozen to the base of the freezer in the black freezer in the kitchen

On 10/20/23, there was feces on the toilet seat in the shared bathroom for bedroom #11 and #12

On 10/20/23, multiple resident glucometers, including resident #4's, #5's, and #6's were being shared on the following dates and times:

85a - Sanitary Conditions (continued)

- * Resident #4's glucometer was used for resident #5 on 10/20/23, at 5:38 am.
- * Resident #5's glucometer was used for resident #8 on 10/18/23, at 7:00 am. and on 10/19/23, at 4:20 pm.
- * Resident #6's glucometer was used for resident #4 on 10/19/23, at 1:16 am. and 8:30 am.
- * Resident #7's glucometer was used for resident #6 on 10/13/23, at 9:00 pm. and 10/20/23, at 1:21 pm.

Repeat Violation: 7/11/23

Plan of Correction

Accept [redacted] - 01/12/2024)

On 10/19/2023 the debris on the carpet was swept up immediately by DCS. On 10/19/2023 the floors and bedrooms were scrubbed by DCS and housekeeping. On 10/19/2023 dried food particles in the microwave were cleaned by kitchen aid immediately. On 10/20/2023 the large flower with cigarette' butts was removed from the east hallway exit door by DCS. On 10/19/2023 the black freezer was cleaned by kitchen aide. On 10/20/2023 the feces on the toilet seat in room #11 and #12 was cleaned immediately by DCS and housekeeping.

On 10-23-23 All new glucometers were obtained by administrator through pharmacy at owners expense.

Glucometers were marked by med tech with picture and name for easier clarification of resident. Walkthroughs done daily beginning 11-20-2023 to address sanitation issues by administrator or designee. Weekly checks of glucometers will be done by administrator or designee for one month then monthly after that with documentation. A training is scheduled on 11-22-2023 by Administrator to re-train all Staff to include regulation 2600. 85.a. Sanitary conditions shall be maintained. They were also reminded at that time that Glucometers and diabetic supplies must only be used for the Resident for which they were ordered.

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

NOT IMPLEMENTED 5/3/24 [redacted]

85b - Infestation

11. Requirements

2600.

85.b. There may be no evidence of infestation of insects or rodents in the home.

Description of Violation

On 10/19/23, a bed bug was observed on the bed and evidence of bed bugs nesting near the drop ceiling above the bed was observed in bedroom [redacted].

Plan of Correction

Accept [redacted] 12/07/2023)

On 10-23-2023, Orkin came and inspected building and there was no evidence of infestation in room [redacted] or any other part of the building. receipt was retained and sent on 10-23-2023 to state inspector to be in compliance 2600.85.b. There may be no evidence of infestation of insects or rodents in the home. Weekly monitoring by administrator or designee will be done to check for infestation starting on 11-20-2023. A training is scheduled by Administrator for all Staff for 11-22-2023 to include this regulation and responsibility of Staff to report any infestation.

This violation is being disputed due to an inspection by the experts in pest control. Orkin Pest Control is a leading expert in pest control. They inspected the room in question along with other rooms on 10-23-2023 and found zero evidence of bedbugs. They did pull the ceiling tile that Inspector pulled and found a dead bug (not a bed bug) that was a normal find for attics. The Orkin Specialist said there would not be just one bedbug without others and said

85b - Infestation (continued)

it must have been a different stray bug that was spotted in Room [REDACTED]

Licensee's Proposed Overall Completion Date: 11/22/2023

Implemented ([REDACTED] 05/02/2024)

85d - Trash Receptacles

12. Requirements

2600.

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

Description of Violation

On 10/19/23, there was a half full, uncovered, unattended trash can in the shower room next to bedroom #9 in the west hallway.

On 10/20/23, there was a full, uncovered, unattended trash can in the shared bathroom of bedrooms #13 and #14.

Plan of Correction

Accept ([REDACTED] - 11/29/2023)

On 10/20/2023 all trash cans were emptied and replaced with trash cans with lids, Beginning 11-20-2023 Weekly Walkthroughs will be done by administrator or designee and documentation will be kept to be in compliance with 85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents. A training by Administrator is scheduled for all Staff on 11-22-2023. Documentation was kept

Licensee's Proposed Overall Completion Date: 11/22/2023

NOT IMPLEMENTED 5/3/24 [REDACTED]

88a - Surfaces

13. 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

On 10/19/23, the double emergency fire exit doors in the back hallway do not close fully. The right door does not latch and the left door remains open approximately 6".

On 10/19/23, the exterior emergency exit door at the end of the back hallway near bedroom #25 is missing the top latch of the self-closer, causing the door to not close on its own.

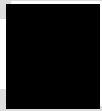
Plan of Correction

Accept ([REDACTED] - 11/29/2023)

On 10/21/2023 the fire exit door was fixed by maintenance and now latches and closes properly. Also on 10/21/2023 the exterior emergency exit door near bedroom #25. latch was replaced by Maintenance and now closes properly. A training by Administrator for all Staff is scheduled for 11-22-23 to include review of this regulation. Documentation kept. Beginning 11-20-2023, Weekly walk throughs will be done by administrator or designee to be in compliance with 2600.88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

88a - Surfaces (continued)

Licensee's Proposed Overall Completion Date: 11/22/2023 NOT IMPLEMENTED 5/3/24



89b - Hot Water Temperature

14. Requirements

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 10/19/23, the hot water temperature at the sink in the shower room next to bedroom #9 in the west hallway measured 123.6 degrees Fahrenheit.

Plan of Correction

Accepted [Redacted] - 11/29/2023)

On 10/19/2023 the water temperature at the sink in the shower room next to room # 9 was turned down by Staff member to 120.0. All other hot water tanks were checked by Staff member. A training by Administrator is scheduled for 11-22-2023 to include regulation. 2600.89 b. Hot water temperature in areas accessible to the resident may not exceed 120°F. Weekly checks of temperatures with documentation by Administrator or Designee will begin 11-20-2023

Licensee's Proposed Overall Completion Date: 11/22/2023

Implemented [Redacted] - 05/02/2024)

102l - Shelves/Hooks

16. Requirements

2600.

102.l. Shelves or hooks for the resident's towel and clothing shall be provided.

Description of Violation

On 10/20/23, multiple shared bathrooms, including the shared bathroom for bedrooms #13 and #1 and #16 and #17 did not have the towel racks labeled for each resident.

On 10/20/23, the shared bathroom for bedrooms #11 and #12 had 3 residents sharing the bathroom. However, there was only one unlabeled towel rack and one towel rack missing the bar to hang the towel on.

Plan of Correction

Accepted [Redacted] - 11/30/2023)

On 10/21/2023 the towel racks in shared bathroom for room #13, #1, and #16 and #17 were labeled with the residents names by DCS. On 10/21 /2023 towel racks were purchased by Administrator for rooms #11 and #12, The towels racks were installed and labeled by Maintenance person on 11/08/2023 to be in compliance with 2600.102.l. Shelves or hooks for the resident's towel and clothing shall be provided. A training for all Staff by Administrator is scheduled for 11-22-2023. Weekly walkthroughs by Administrator will begin 11-20-2023 with documentation kept to verify this regulation is being followed.

Licensee's Proposed Overall Completion Date: 11/22/2023

IMPLEMENTED 5/3/24



103e - Left Overs

17. Requirements

2600.

103e - Left Overs (continued)

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 10/19/23, there were 6 containers of cereal in a clear sealed container unlabeled, undated in the kitchen.

Plan of Correction

Accept [redacted] - 11/30/2023)

On 10/19/2023 the six containers were immediately labeled and dated by Cook. Training scheduled 11-22-23 for all staff by administrator to be in compliance with 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. Weekly checks beginning 11-20-2023 for all food and labeling will be documented by administrator or designee.

Licensee's Proposed Overall Completion Date: 11/22/2023

NOT IMPLEMENTED 5/3/24

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 10/19/23, the thermometer was broken in the freezer in the kitchen. Repeated violation 11/20/22 et al.

Plan of Correction

Accept [redacted] - 11/30/2023)

On 10/19/2023 there was new thermometer placed in freezer by Administrator and checked 2 hours later be sure the temperature was in compliance with 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. A training for all staff by Administrator is scheduled for 11-22-23. Refrigerator and freezer temps are being monitored daily by Administrator or designee. Documentation kept,

Licensee's Proposed Overall Completion Date: 11/22/2023

NOT IMPLEMENTED 5/3/24 [redacted]

103i - Outdated Food

19. Requirements

2600.

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

Description of Violation

On 10/19/23, there was a 10-ounce dented can of pears in the home's pantry.

Plan of Correction

Accept [redacted] - 11/30/2023)

On 10/19/2023 the 10-ounce can of dented pears was removed from facility and not used to be in compliance with 2600.103.i. Outdated or spoiled food or dented cans may not be used. Food orders come in weekly and staff will be trained by administrator on 11-22-23 to include this regulation. if any dented come in the order, staff is to mark on the order and item sent back to company. Administrator or Designee will do weekly walk throughs to verify compliance. Documentation kept.

Licensee's Proposed Overall Completion Date: 11/22/2023

NOT IMPLEMENTED 5/3/24 [redacted]

105c - Supply Linens/Towels

20. Requirements

2600.

105.c. The supply of bed linens and towels shall be sufficient to ensure a complete change of bed linen and towels at least once per week.

Description of Violation

Multiple interviews indicate during the period of 10/7/23 - 10/14/23, the home did not have enough clean towels and wash cloths to provide to the residents to allow the residents to shower due to broken washers.

Plan of Correction

Accepted (redacted) 11/30/2023)

In between the dates of 10-7- 2023 and 10-14-2023 the laundry was taken to laundry mat by Staff to ensure that we were in compliance 2600.

105.c. The supply of bed linens and towels shall be sufficient to ensure a complete change of bed linen and towels at least once per week. if a washer or dryer in need of repair in the future daily checks of linen supply. A training is scheduled for 11-22-23 by Administrator for all staff to include this regulation. Weekly walkthroughs by Administrator or Designee will begin 11-20-23 with documentation kept

Licensee's Proposed Overall Completion Date: 11/22/2023

Implemented (redacted) 05/02/2024)

107c - Food/Water 3 Day Supply

21. Requirements

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 10/19/23, the home served 26 residents, requiring 78 gallons of emergency drinking water. However, the home had only 40.17 gallons. The home does not have a contract with a local bottled water supplier.

Plan of Correction

Accepted (redacted) - 12/07/2023)

On 10/21/2023 40 more gallons of water were ordered by Administrator and in the facility to be in compliance with 2600.107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents. A training by Administrator for all staff will be held on 11-22-23 to include this regulation and not using the designated resident water. A monthly count beginning 11-20-23 will be done and documentation kept by the Administrator or Designee

Licensee's Proposed Overall Completion Date: 11/22/2023

Implemented (redacted) - 05/02/2024)

121a - Unobstructed Egress

22. 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 10/19/23, the emergency exit door in the east hallway was obstructed by a 4" by 6" brick allowing the exit door to not open beyond 24".

121a - Unobstructed Egress (continued)

Plan of Correction

Accept (█ - 12/07/2023)

On 10/20/2023 the emergency exit door in the east hallway was made accessible and the brick was removed by Administrator and the exit door is fully functional to be in compliance with 2600.121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed. A training by Administrator is scheduled for 11-22-23 to include this regulation. Weekly walk throughs beginning 11-20-2023 will be done by administrator or designee to ensure Egresses are not obstructed. Documentation will be kept

Licensee's Proposed Overall Completion Date: 11/22/2023

NOT IMPLEMENTED 5/3/24



132h - Designated Meeting Place

23. Requirements

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 1/4/23, at 6:00 am., 31 residents were present in the home, only 25 residents evacuated to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction

Accept (█ /07/2023)

The fire drill on 1-4-23 was the first fire drill conducted by the new Administrator at that time. It was early morning and the Administrator at that time did not enforce the rules of the home to have ALL Residents participate in the Mandatory fire drills. Regional Consultant spoke with Administrator at that time and █ was aware another drill for the month needed done. █ left her position with the Facility shortly after and the drill never got done. A training is scheduled by Administrator on 11-22-23 to review regulation 2600. 132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill. Documentation will be kept. Beginning with the November fire drill, Administrator will highlight all aspects of the fire drill record to be sure all areas are in compliance.

Licensee's Proposed Overall Completion Date: 11/22/2023

Implemented (█ - 05/02/2024)

184a - Resident's Meds Labeled

24. Requirements

2600.

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

- 2. The name of the medication.

Description of Violation

Resident #9 is prescribed, Promethazine, 25mg, Suppository. However, the pharmacy label indicates Compro, 25mg.

Resident #10 is prescribed, Insulin Glargine Solostar. However, the pharmacy label indicates Lantus Solostar.

Repeat Violation: 3/23/23, 6/7/23

184a - Resident's Meds Labeled (continued)

Plan of Correction

Accept [REDACTED] - 01/12/2024)

On 10-23-2023 Administrator checked medications for Residents # 9 and #10. They were given the correct medications, they were the generic forms. New labels were sent by pharmacy on 10-23-2023 and replaced by Med tech. Administrator brought it to the attention of the pharmacy to be sure whether the medication was generic or regular it needed to match the MAR and bottle. Administrator has a training scheduled for all staff on 11-22-23 to include this regulation 2600.184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

2. The name of the medication.

Administrator or Designee will do monthly MAR audits beginning 11-20-2023 to check for compliance with this regulation. Documentation will be kept.

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

NOT IMPLEMENTED 5/3/24 [REDACTED]

185a - Implement Storage Procedures

25. 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 10/20/23, the home did not implement their policy on the accountability of narcotic medications. The home's policy indicates the home will count narcotic medications at the beginning and end of each shift. However, on 10/20/23, resident #9's following narcotic medications were not counted and the narcotic count sheets was blank:

* Morphine Sulf, 100mg/5ml, give 0.5/10mg sublingually every 2 hours as needed for pain or shortness of breath

* Morphine Sulf, 100mg/5ml, take 1ml sublingually every 2 hours as needed for pain or shortness of breath

Resident #9 is prescribed, ABR Gel, 1/12.5/20mg Syringe, apply 1 syringe to wrist or behind ear every 6 hours as needed for nausea/hospice supplies. However, on 10/20/23, the medication was not available.

On 10/20/23, multiple glucometers, including residents #5, #6, #7, and #10 were not calibrated to current date and time:

Repeat Violation: 6/7/23, 3/23/23

Plan of Correction

Accept [REDACTED] - 12/07/2023)

On 10/21/2023 the narcotics were counted by med tech and sheet was documented on for resident #9. On 10/21/2023 ABR gel was ordered for Resident # 9 by Monarch Hospice Nurse after home received medication narcotic count sheet was made and the medication was counted and signed for by med techs. On 10/21/2023 new glucometers were bought at the homes expense after home received glucometers they were calibrated to current date and time to be in compliance. Training scheduled for all med techs by administrator on 11/22-2023 to be in compliance with 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. Administrator or Designee will

185a - Implement Storage Procedures (continued)

do weekly audits beginning 11-20-2023 for 1 month then monthly thereafter to be sure glucometers are calibrated. Documentation kept. Hospice has their own narc count sheet for their Residents. Administrator will include in the 11-22-23 training the need to use the facility narc count sheet for all residents instead of the one sent by Hospice. This will make less confusion and more accuracy.

Licensee's Proposed Overall Completion Date: 11/22/2023

NOT IMPLEMENTED 5/3/24

187a - Medication Record**26. Requirements**

2600.

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

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.

Description of Violation

Resident #9 is prescribed Haloperidol, 2mg/ml, take 0.25 ml under the tongue every 4 hours as needed for nausea/vomiting. On 10/20/23, this medication was not included on the resident's October 2023 medication administration record (MAR).

Repeat violation: 11/30/22 et al, 3/23/23

Plan of Correction

Accept [REDACTED] - 01/12/2024)

On 10/23/2023 the medication for Resident 9 was sent from the Hospice AGENCY to the pharmacy to package and was added to the MAR. Bi-Weekly mar audits beginning 11-20-2023 will be done by administrator or designee documentatin will be kept. Training will be done by Administrator with all med techs on 11-22-23 to be in compliance with regulation 2600.187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

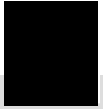
1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.

187a - Medication Record (continued)

- 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.

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

NOT IMPLEMENTED 5/3/24



187b - Date/Time of Medication Admin.

27. 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 #4 is prescribed the following medications. The resident's October 2023 MAR indicates these medications were administered on 10/18/23, 9:00 pm., however on 10/20/23, these medications were still in the medication cart and not administered:

- * Atorvastatin
- * Docusate
- * Melatonin
- * Topiramate, 100mg and 50mg
- * Verapamil

Repeat violation: 11/30/22, 3/23/23

Plan of Correction

Directed [Redacted] - 01/12/2024)

On 10-22-2023 Administrator checked each time slot in the Med cart for each Resident to be sure all meds to date were given. A training by Administrator for all staff is scheduled for 11-22-23 to include 187b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered. The training will include training med techs to check all drawers and time slots before their shift ends to check for any missed meds. Administrator or Designee will audit med cart bi-weekly beginning 11-20-23 for any medications that could have been missed to be sure only medications administered are initialed as given.

Proposed Overall Completion Date: 01/10/2024

DIRECTED PLAN:

By 1/20/24 and at least weekly thereafter: a staff person who is qualified to administer medications shall audit resident MARS to ensure that medication is initialed in the MAR at the time it is administered. Documentation of the audits shall be kept. [Redacted] 1/12/24

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

Directed Completion Date: 02/01/2024

Implemented [redacted] - 05/02/2024)

187d - Follow Prescriber's Orders

28. Requirements

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

Description of Violation

Resident #4 is prescribed the following medications that were not administered on 10/18/23, at 9:00 pm.:

- * Atorvastatin
- * Docusate
- * Melatonin
- * Topiramate, 100mg and 50mg
- * Verapamil

Repeat Violation: 3/23/23, 11/30/22 et al. , 8/31/23

Plan of Correction

Accept [redacted] - 01/12/2024)

On 10/21/2023 all other medications were audited by med tech and administrator, to be sure all other medications were given. All med techs will be trained by administrator on 11-22-23 to be in compliance with 2600.187.d. The home shall follow the directions of the prescriber. They will also be instructed to recheck each resident slot at the end of their shift to ensure all prescribed medications were given. Bi-weekly mar audits will be done by Administrator or Designee and documentation will be kept. Beginning 12-21-2023 Administrator or Designee will do private interviews with 5 Residents per week to be sure they are receiving all their medications. DOCUMENTATION KEPT AT FACILITY.

Licensee's Proposed Overall Completion Date: 01/10/2024 NOT IMPLEMENTED 5/3/24 [redacted]

225a - Assessment 15 Days

29. 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 #3's assessment, dated [redacted]/23, does not include all the resident's diagnoses, including Dysphagia and Hypertensive Heart Disease and does not address the resident's ability to self-administer medications. This area was blank.

Repeat Violation: 3/8/23, 4/27/23

225a - Assessment 15 Days (continued)

Plan of Correction

Accept [redacted] - 01/12/2024)

10/21/2023 resident #3 residents assessment was updated by Administrator to include correct diagnosis and ability to self-administer medication was updated correctly. All other resident files were reviewed by Administrator between 10-21-23 and 11-3-2023. Regional consultant did training with administrator on 11-8-23 to be in compliance with 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. Beginning 12-21-2023 Administrator or Designee will do monthly audits of resident files to check for compliance with this regulation. DOCUMENTATION KEPT AT THE FACILITY.

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

Implemented [redacted] - 05/02/2024)

225c - Additional Assessment

30. Requirements

2600.

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

- 1. Annually.

Description of Violation

Resident #9's assessment, dated [redacted]/23, does not include the resident's need for bed and chair alarms for safety in transferring from bed and chair. The resident's assessment indicates that the resident requires only prompting and cueing.

Repeat Violation: 11/30/22, 4/27/23, 7/11/23

Plan of Correction

Accept [redacted] - 01/12/2024)

On 10-19-2023 Administrator updated Resident # 9's Assessment to include the need for bed and chair alarms for safety in transferring from bed and chair. A training will be held on 11-22-23 for all staff by Administrator to include this regulation 2600.225c The resident shall have additional assessments as follows:

- 1. Annually.

Training will include informing Staff that any changes for any Resident should be reported to Administrator for documentation where it is needed. There is a list available for Resident updates and change in status that will be posted in break room and med room for staff to document. Beginning 12-21-2023 Administrator or Designee will do monthly audits of all Resident files to be sure this regulation is followed. DOCUMENTATION KEPT AT THE FACILITY

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

Implemented [redacted] - 05/02/2024)

252 - Record Content

31. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

- 19. An inventory of the resident's property entrusted to the administrator for safekeeping.

Description of Violation

Resident 10's record does not include an inventory of the resident's property.

252 - Record Content (continued)

Plan of Correction

[REDACTED] - 12/07/2023)

On 10/21/2023 an inventory list was completed for resident #10. Regional Consultant did training with administrator on 11-8-2023 to be sure the content for admission papers was understood as per regulation 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. Documentation will be kept. A new checklist is now available in Tabula pro to be used for Resident File. It will be implemented beginning 11-20-23.

Licensee's Proposed Overall Completion Date: 11/20/2023**Implemented [REDACTED] - 05/02/2024)**

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

Facility Information

Name: *COUNTRY MANOR* License #: *44629* License Expiration: *03/21/2024*
Address: *111 ALTMAYER DRIVE, KITTANNING, PA 16201*
County: *ARMSTRONG* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *COUNTRY MANOR PCH LP*
Address: *111 ALTMAYER DRIVE, KITTANNING, PA, 16201*
Phone: [REDACTED] [REDACTED] [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *06/20/1996* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *29* Waking Staff: *22*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint* Exit Conference Date: *12/21/2023*

Inspection Dates and Department Representative

12/21/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* Residents Served: *27*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *10* Are 60 Years of Age or Older: *24*
Diagnosed with Mental Illness: *7* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *2* Have Physical Disability: *0*

Inspections / Reviews

12/21/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/21/2024*

Inspections / Reviews (*continued*)

02/06/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/08/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 02/08/2024

03/01/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/08/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 03/08/2024

05/03/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/08/2024

Reviewer: [REDACTED]

Follow-Up Type: Exception

85a - Sanitary Conditions

1. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 12/21/23, at approximately 9:00 am., there was a strong odor of urine in the entrance/dining room area and throughout the West hallway, including bedrooms #1, #2, and #6 and a lingering odor of sewage in bedrooms #7 and #8.

On 12/16/23, at approximately 2:00 am, the toilet in the shared bathroom for bedrooms #7 and #8 was clogged and overflowed, causing dirty toilet water and toilet tissue to flow onto the floor of the bathroom and the carpet in bedrooms #7 and #8. Resident #1, in bedroom #8, diagnosed with COPD, complained to the staff of the odor in [redacted] room, requesting the bedroom and bathroom to be cleaned. On 12/16/23, the toilet was unplugged, the bathroom was cleaned, and the carpet in the bedrooms were vacuumed. Resident #1 continued to complain about the odor of sewage in [redacted] bedroom, so on 12/19/23 resident #1 was moved to another bedroom. The residents in bedroom #7 remained in bedroom #7 until 12/21/23, until a representative of the Department indicated the smell of sewage in the bedroom and requested the residents to be moved. Resident #2 in bedroom #7, indicated the odor was, "overcoming my breath, taking my breath away." Multiple staff indicated in interview that bedrooms #7 and #8 did and still does have an odor of sewage.

On 12/18/23, the home had a plumbing company to clear drain the lines with cable due to multiple toilets slow flushing, caused likely to too much toilet paper used.

Plan of Correction

Accept [redacted] - 03/01/2024)

On 12/21/23 the entrance, dining area, and the west hall including bedrooms # #2 and #6 and and bedrooms #7 and # 8 were thoroughly cleaned and scrubbed by housekeeping. On 12/16/23, the toilet was unplugged, the bathroom was cleaned, and the carpet in the bedrooms were vacuumed by Housekeeper. On 12/19/23 resident #1 was moved to another bedroom. Residents in room #7 were moved as requested to a different room free of sewage odor. On 12/18/23, the home had a plumbing company to clear drain the lines with cable due to multiple toilets slow flushing, caused likely to too much toilet paper used. Weekly walkthrough's to check for sanitary conditions by Administrator or designee will be done starting 1-29-2023 , documentation will be kept. A training for all staff by the administrator is scheduled for January 30, 2024 to include this regulation

Licensee's Proposed Overall Completion Date: 02/09/2024

NOT IMPLEMENTED 5/3/24 [redacted]

88a - Surfaces

2. Requirements

2600.

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

Description of Violation

There is an approximate 5 1/2" by 2" rip in the carpet of the threshold of bedroom #3. The carpet is fraying from the rip, causing a possible trip/fall hazard. Resident #2 now resides in bedroom #3 and uses a walker for safe ambulation.

88a - Surfaces (continued)**Plan of Correction**

Accept [REDACTED] - 03/01/2024)

On 12/23 /2023 the carpet on threshold of bedroom # 3 was repaired by maintenance to be in compliance with regulation 2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards. Administrator or designee will do a weekly walkthrough of the building to ensure the requirements of this regulation are met. Documentation will be kept. A training by Administrator for all staff to cover this regulation is scheduled for 1-30-2023

Licensee's Proposed Overall Completion Date: 02/09/2024

NOT IMPLEMENTED 5/3/24 [REDACTED]

187a - Medication Record**3. Requirements**

2600.

187.a. A medication record shall be kept to include the following 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.

Description of Violation

The following medications are in the medication cart but not indicated on resident #3's December medication administration record (MAR):

* Oxycodone HCL, 10mg, 1 tab every 12 hours for pain

* Oxycodone HCL, 10mg, 1 tab every twice a day for pain

Repeat Violation: 10/19/23, et all

Plan of Correction

Accept [REDACTED] - 03/01/2024)

On 12/22/23 for resident # 3 the doctor was notified and home was given new orders to update MAR for resident #3 to be in compliance with regulation 2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered: Beginning 1-29-2024 Administrator or designee will do bi-weekly medication audits to ensure

187a - Medication Record (continued)

medication records are complete with all requires information. A med tech training by Administrator was given on 12/23/2023 to ensure all information as requires is in the mar. Documentation will be kept

Licensee's Proposed Overall Completion Date: 02/09/2024

NOT IMPLEMENTED 5/3/24



187d - Follow Prescriber's Orders

4. Requirements

2600.

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

Description of Violation

Resident #1 is prescribed, Advair, 250/50, inhale twice a day. However, on 12/11/23, at 8:30 pm., the medication was not available.

Resident #3 is prescribed, Oxycodone HCL ER, 10mg, 1 tablet every 8 hours for pain at 6:00 am., 2:00 pm., and 10:00 pm. However, on 12/18/23, resident #3 received this medication at 6:00 am., 2:00 pm., and 8:24 pm.

Resident #3 is prescribed, B-12, 1,000MCG, 1 tablet once a day on Monday and Wednesday. However, staff interview indicates on 12/20/23 (Wednesday), the medication not available.

Repeat Violation: 10/19/23, et all

Plan of Correction

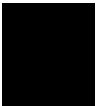
Accept 03/01/2024)

Resident # 1 no longer resides in the facility as of /2024 however on 12/12/2023 the Health Direct pharmacy was notified and medication was in the facility by 2pm that afternoon. Resident #1 then resumed medication as instructed Medication audits will be done bi-weekly by administrator or designee. Documentation is being kept. On 12/23/23 resident # 3 was informed of the error and med techs were given training on following direction of prescriber. VA pharmacy was contacted concerning Resident # 3 B-12 1000 mcg not being in building to administer. VA pharmacy was filled resident #3s medication and it was received in the facility by 12/23/2023 in time for resident #3 to receive next dose as prescribed . All med tech were giving training by Administrator on 12/23/2024 to be in compliance with regulation 2600.

187.d. The home shall follow the directions of the prescriber. Training was completer by Administrator. Documentation will be kept.

Licensee's Proposed Overall Completion Date: 02/09/2024

NOT IMPLEMENTED 5/3/24



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

Facility Information

Name: *COUNTRY MANOR* License #: *44629* License Expiration: *03/21/2024*
Address: *111 ALTMAYER DRIVE, KITTANNING, PA 16201*
County: *ARMSTRONG* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *COUNTRY MANOR PCH LP*
Address: *111 ALTMAYER DRIVE, KITTANNING, PA, 16201*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *06/20/1996* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *28* Waking Staff: *21*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Incident* Exit Conference Date: *02/01/2024*

Inspection Dates and Department Representative

02/01/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *50* Residents Served: *27*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *22* Are 60 Years of Age or Older: *23*
Diagnosed with Mental Illness: *15* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *1* Have Physical Disability: *0*

Inspections / Reviews

02/01/2024 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *02/25/2024*

Inspections / Reviews (*continued*)

03/01/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/08/2024

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 03/08/2024

05/03/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/08/2024

Reviewer: [REDACTED]

Follow-Up Type: *Exception*

23a - Activities of Daily Living Assistance

1. Requirements

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plan, dated [redacted]/23, for resident #1 indicates the resident requires assistance with supervision with showering and staff and resident interviews indicate the resident requires assistance with washing of back and hair. Staff documentation and resident interview indicates resident #1 has not been given or assisted with a shower since 1/17/23.

Plan of Correction

Accept [redacted] 03/01/2024)

Resident#1 has gotten a shower as scheduled with assistance from staff on every scheduled day twice weekly since 2/1/2024. All residents will sign a shower refusal form if the shower is refused on scheduled day. Staff has access to care plans and assessment to be in compliance with regulation 2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan. Training was provided by administrator for All Staff on 2/20/2024 for regulation 2600 23.a. requirements. Staff was also given updated shower schedule and provided forms for documentation and also shown how to document ADL's in Tabula pro. Documentation will be kept

Licensee's Proposed Overall Completion Date: 02/20/2024

Evidence of Completion

Implemented [redacted] 05/03/2024)

See attached.

85a - Sanitary Conditions

2. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 2/1/24, there was a strong foul odor in bedroom #2 due to resident #2's catheter bag not being emptied and cleaned and a very strong odor of urine in bedroom #12.

Repeat Violation: 12/21/23, 7/11/23

Plan of Correction

Accept [redacted] - 03/01/2024)

On 2/1/24 the bedrooms #2 and # 12 were thoroughly cleaned and scrubbed to be in compliance with 2600.85.a. Sanitary conditions shall be maintained. Resident #2's catheter bag was immediately emptied and cleaned by DCS. All Staff were given a training by administrator on 2/20 /24 on catheter care and are required to sign a form stating when catheter emptied which is as needed and end of shift. Training was given by Administrator on sanitary conditions the same day and time, A daily walkthrough by administration or designee was also started on 2/20/24. Documentation kept at Facility

Licensee's Proposed Overall Completion Date: 02/20/2024

Evidence of Completion

Not Implemented [redacted] - 05/03/2024)

See attached.

85d - Trash Receptacles

3. Requirements

2600.

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

Description of Violation

On 2/1/24, at approximately 10:00 am., there was a half full, uncovered, unattended trash can in the shared bathroom of bedroom #1 and #2.

Plan of Correction

Accept [redacted] - 03/01/2024)

On 2/1/24 the trash can in shared bathroom of bedroom #1 a bedroom #2 was emptied and new trash can with lid was ordered. To be in compliance with regulation 2600.85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents. A training was given on 2/20/24 to all DCS by administrator for 2600.85.d. A weekly walkthrough will be done by administrator which started on 2/20/24 and documentation will be kept.

Licensee's Proposed Overall Completion Date: 02/20/2024

Evidence of Completion

Not Implemented ([redacted] - 05/03/2024)

See attached.

88a - Surfaces

4. 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

On 2/1/24, at approximately 10:00 am., the toilet seat was not attached to the toilet in the shared bathroom of bedroom #1 and #2. The toilet seat was sitting on the floor next to the toilet. Resident interview indicated that the residents still use the toilet without the seat.

Plan of Correction

Accept [redacted] - 03/01/2024)

On 2/1/24 the toilet seat was installed by maintenance to the toilet in shared bathroom of bedroom #1 and #2. Training by administrator was given on 2/20/24 to all staff to be in compliance with regulation 2600.88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards. A weekly walkthrough beginning 2-20-2024 will be done by administrator or designee and documentation will be kept

Licensee's Proposed Overall Completion Date: 02/20/2024

Evidence of Completion

Not Implemented ([redacted] /03/2024)

See attached.

Facility Information

Name: COUNTRY MANOR License #: 44629 License Expiration: 03/21/2025
 Address: 111 ALTMAYER DRIVE, KITTANNING, PA 16201
 County: ARMSTRONG Region: WESTERN

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: COUNTRY MANOR PCH LP
 Address: 111 ALTMAYER DRIVE, KITTANNING, PA, 16201
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 06/20/1996 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 30 Waking Staff: 23

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Interim Exit Conference Date: 03/20/2024

Inspection Dates and Department Representative

03/12/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 50 Residents Served: 29
 Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:
 Hospice
 Current Residents: 1
 Number of Residents Who:
 Receive Supplemental Security Income: 28 Are 60 Years of Age or Older: 23
 Diagnosed with Mental Illness: 8 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 1 Have Physical Disability: 0

Inspections / Reviews

03/12/2024 - Partial
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/09/2024

04/25/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 04/09/2024
 Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 05/15/2024

17 - Record Confidentiality

1. 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 3/12/24, at approximately 9:50 am., resident #1's patient discharge instruction report, including a medication list, was sitting on the freezer chest and multiple residents', including resident #2's hourly staff check forms were in a binder in a file folder sitting on a desk unlocked, unattended, and accessible in the staff breakroom located next to the dining room.

Plan of Correction

Accept [REDACTED] - 04/24/2024)

On 3/12/23 Resident # 1 discharge papers including medication list list were removed from the freezer. The folder containing resident checks were removed from desk and both were locked in the file cabinet in the office to be in compliance of regulation 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. Training was given by administrator concerning above on 4/6/2024. Weekly checks by administrator or designee will be completed to ensure proper record confidentiality. Documentation will be kept

Licensee's Proposed Overall Completion Date: 04/09/2024 NOT IMPLEMENTED 5/9/24 [REDACTED]

51 - Criminal Background Check

2. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A, hired [REDACTED]/23, staff person B, hired [REDACTED]/23, staff person C, hired [REDACTED]/24, and staff person D, [REDACTED]/24, did not have a Pennsylvania criminal background check completed in accordance with the Older Adult Protective Service Act.

Repeat Violation: 3/8/23 et al, 11/30/22

Plan of Correction

Directed [REDACTED] - 04/25/2024)

Pennsylvania background checks were done for staff person A and staff person B on 3/8/2024 to be in compliance with regulation 2600.

51 - Criminal Background Check (continued)

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults). Training was given on 4/8/2024 by Regional consultant to administration for above violation. Monthly checks of employee files will be done to ensure compliance of regulation. Documentation will be kept

Proposed Overall Completion Date: 04/09/2024

DIRECTED PLAN:

By 5/5/24: The administrator or designee shall complete a PA State Police criminal background check for staff person C in accordance with the Older Adult Protective Services Act and place the results of the check in the staff person's record.

By 5/5/24: The administrator or designee shall check all current staff records to ensure each current staff person has a PA State Police criminal background check completed and present in the staff record. Documentation of the check shall be kept.

Directed Completion Date: 05/05/2024

Update: 04/25/2024

NOT IMPLEMENTED 5/9/24



54a - Direct Care Staff

3. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

- 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff persons A, B, and D do not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Repeat Violation: 11/30/22

Plan of Correction

Directed  04/25/2024)

Diplomas for staff person A & B was obtained on 3/12/2024. Staff person was in housekeeping and did not do resident care. Training was given by Regional consultant to Administrator and designee to ensure regulation 2600.

54.a. Direct care staff persons shall have the following qualifications:

- 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry. Documentation will be kept

Proposed Overall Completion Date: 04/09/2024

54a - Direct Care Staff (continued)

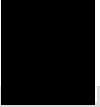
DIRECTED PLAN:

By 5/5/24: The administrator or designee shall obtain a high school diploma, GED diploma or active registry status on the PA nurse aide registry for staff person D or ensure that staff person D does not perform direct care services on residents.

By 5/5/24 and monthly thereafter: The administrator or designee shall check staff records to ensure each staff who performs personal care services with residents has documentation of a high school diploma, GED diploma or active registry status on the PA nurse aide registry in their record. Documentation of these checks shall be kept.

Directed Completion Date: 05/05/2024

NOT IMPLEMENTED 5/9/24



63a - First Aid/CPR Training

4. Requirements

2600.

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

Description of Violation

From 3/3/24 at 6:00 pm. to 3/4/24 at 6:00 am., 29 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid.

From 3/8/24 at 2:00 pm. to 3/9/24 6:00 am., 29 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid.

From 3/10/24 at 6:00 am. to 3/11/24 at 6:00 am., 29 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid.

Plan of Correction

Directed 04/25/2024)

Additional first aide training was scheduled for all staff on 4/9/2024. Training was given on 4/9/2024 by administrator to all staff persons to be in compliance with 2600.

54.a. Direct care staff persons shall have the following qualifications:

2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry. Documentation will be kept.

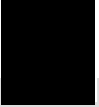
Proposed Overall Completion Date: 04/09/2024

DIRECTED PLAN:

By 5/5/24 and weekly thereafter: The administrator or designee shall check the schedule and staff person records to ensure

Directed Completion Date: 05/05/2024

NOT IMPLEMENTED 5/9/24



85a - Sanitary Conditions

5. Requirements

2600.

85a - Sanitary Conditions (continued)

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 3/12/24, the following examples of unsanitary conditions were observed:

- * Smearred feces on the toilet seat in the shared bathroom for bedrooms #7 and #8.
- * Smearred feces on the raised toilet seat, wall between the toilet and sink, and what appeared to be feces and urine on the floor throughout the bathroom for bedrooms #11 and #12.
- * Multiple areas of dried urine on the toilet and what appeared to be urine on the floor of the shared bathroom for bedrooms 16 and 17.
- * A very large amount of cigarette butts on the ground throughout the outside smoke area.

Repeat Violation: 7/11/23

Plan of Correction

Accept [redacted] - 04/25/2024)

On 3/12/24 shared bathroom of bedroom #7 and# 8 was cleaned by housekeeper on floor that day. Shared bathroom of room #11 and #12 was also cleaned by housekeeper on staff that day. Floor in shared bathroom of room #11 and #12 wad mopped and cleaned. Cigarette butts were cleaned by staff and thrown away in the dumpster outside. Shared bathroom of #16 and #17 floor was mopped and cleaned by housekeeper. Training was provided by administrator to all staff on 4/7/2024 to be in compliance with 2600. Daily walkthroughs will be done by administrator or designee to insure compliance of above. Documentation will be kept

85.a. Sanitary conditions shall be maintained

Licensee's Proposed Overall Completion Date: 04/09/2024

NOT IMPLEMENTED 5/9/24 [redacted]

6. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

Resident #3's glucometer was being used to measure the blood glucose levels of residents #4 and #5 on multiple dates and times, including the following:

- * Resident #4: 3/13/24 at 3:31
3/11/24 at 4:27
3/10/24 at 4:34
3/9/24 at 4:49
- * Resident #5: 3/12/24 at 3:29
3/11/24 at 6:48
3/10/24 at 8:12
3/9/24 at 7:39

Resident #3 ceased to breathe on Date of Death.

Multiple resident glucometers were being used to measure the blood glucose levels of other residents on the following dates and times:

- * Resident #4's glucometer was used for resident #5 on 10/20/23, at 5:38 am.
- * Resident #5's glucometer was used for resident #8 on 10/18/23, at 7:00 am. and on 10/19/23, at 4:20 pm.
- * Resident #6's glucometer was used for resident #4 on 10/19/23, at 1:16 am. and 8:30 am.
- * Resident #7's glucometer was used for resident #6 on 10/13/23, at 9:00 pm. and 10/20/23, at 1:21 pm.

85a - Sanitary Conditions (continued)

Plan of Correction

Directed [REDACTED] - 04/25/2024)

New glucometers were gotten for residents #4, #5, #8 #6 and #7 on 3/15/2024. Training was given to Med Techs by administrator on 4/8/2024 to be in compliance with regulation 2600.

85.a. Sanitary conditions shall be maintained. Weekly checks of glucometers will be done by administrator or designee to ensure regulations of above. Documentation will be kept.

Proposed Overall Completion Date: 04/09/2024

DIRECTED PLAN:

By 5/5/24: The administrator or designee shall replace the glucometer for resident #3 at no cost to the resident. Documentation of the replacement shall be kept.

By 5/5/24; The administrator or designee shall notify the primary care physicians of residents #3, #4, #5, #6, and #7 and follow any additional directions from these physicians. Documentation of these notifications shall be kept.

By 5/5/25 and at least weekly thereafter: The administrator or designee shall check resident glucometer readings and the documentation of resident blood glucose levels to ensure accurate recording of blood glucose levels and that each glucometer is only being used on the resident for whom it was prescribed. Documentation of the checks shall be kept.

By 5/15/24: All staff persons who are qualified to administer medication and insulin to residents shall be retrained by a Department-approved outside source on infection control and only using glucometers and diabetic supplies on the resident for whom they were prescribed. Documentation of the training shall be kept.

Directed Completion Date: 05/15/2024

NOT IMPLEMENTED 5/9/24 [REDACTED]

85d - Trash Receptacles

7. Requirements

2600.

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

Description of Violation

On 3/12/24, the following partially full trash cans were uncovered and unattended in the following areas:

- * Shared bathroom for bedrooms #1 and #2
- * Shared bathroom for bedrooms #11 and #12
- * Shared bathroom for bedrooms #13 and #14
- * Shared bathrooms for #16 and #17
- * Large kitchen trash can

85d - Trash Receptacles (continued)

Plan of Correction

Accept ([redacted] 04/25/2024)

On 3/9/2024 new trash can with lids were purchased for the home. Training was given by administrator to all staff on 4/8/2024 to be in compliance with 2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents. Weekly walkthrough will be done by administrator or designee to ensure compliance of above. Documentation will be kept.

Licensee's Proposed Overall Completion Date: 04/09/2024

NOT IMPLEMENTED 5/9/24 [redacted]

102I - Shelves/Hooks

[redacted]

103e - Left Overs

9. 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 3/12/24, there was an unlabeled, undated chunk of cheese and a bag of hard-boiled eggs in the black refrigerator in the kitchen.

Plan of Correction

Accept [redacted] - 04/25/2024)

On 3/12/2024 the unlabeled cheese and bag of hard boiled was removed by kitchen staff and thrown away. Training was given to staff by administrator in 4/8/2024 to be in compliance with regulation 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. Daily checks will be done by administrator or designee to

103e - Left Overs (continued)

ensure compliance of above. Documentation will be kept.

Licensee's Proposed Overall Completion Date: 04/09/2024 NOT IMPLEMENTED 5/9/24

103f - Refrigerator/Freezer Temps

10. 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 3/12/24, at 10:51 am., the temperature in the black refrigerator was 42 degrees Fahrenheit and on 3/14/23, at 3:46 pm., it was 42 degrees Fahrenheit.

On 3/12/24, there was no thermometer in the white refrigerator in the kitchen.

Repeat Violation: 11/30/22

Plan of Correction

Directed [redacted] - 04/25/2024)

On 3/14/2024 Black fridge temp was adjusted to right temperature. On 3/13/2024 a new thermometer was placed in white refrigerator and was checked to be the right temperature. Training was given to all staff to be in compliance with 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. Daily checks will be done by administrator or designee to ensure compliance of above. Documentation will be kept.

Proposed Overall Completion Date: 04/09/2024

DIRECTED PLAN:

By 5/5/24: All staff persons shall be retrained that food requiring refrigeration shall be stored at or below 40°F, frozen food shall be kept at or below 0°F, and that thermometers are required in refrigerators and freezers. Documentation of the training shall be kept.

Directed Completion Date: 05/05/2024

NOT IMPLEMENTED 5/9/24

103i - Outdated Food

11. Requirements

2600.

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

Description of Violation

On 3/12/24, there was an unlabeled, undated plastic bag of biscuits in the black freezer in the kitchen.

On 3/12/24, there were 2 unlabeled, undated bags of pizza rolls in the white freezer in the kitchen.

On 3/12/24, there was a dented can of chocolate pudding sitting on the shelf in the pantry.

103i - Outdated Food (continued)

Plan of Correction

Directed [REDACTED] - 04/25/2024)

On 3/12/2024 all unlabeled food in both freezer was removed from both freezers and disposed of properly. On 3/12/2024 the dented can of chocolate pudding was disposed of properly. Training was given on 4/8/2024 to be in compliance with regulation 2600.

103.i. Outdated or spoiled food or dented cans may not be used. Daily checks will be done by administrator or designee to ensure compliance with above regulation documentation will be kept.

Proposed Overall Completion Date: 04/09/2024

DIRECTED PLAN;

By 5/5/24: The administrator or designee shall retrain staff that outdated or spoiled food or dented cans may not be used. Documentation of the training shall be kept.

Directed Completion Date: 05/05/2024

NOT IMPLEMENTED 5/9/24



121a - Unobstructed Egress

12. 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 3/12/24, at 9:10 am., a rocking chair partially blocked egress from the home's emergency exit by bedroom #1.

Plan of Correction

Directed [REDACTED] 04/25/2024)

On 3/12/2024 rocking chair was moved by administrator to unblock egress. Training was given to all staff by administrator to be in compliance with regulation 2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed. Weekly walkthroughs by administrator or designee will be done to ensure compliance of above regulation.

Proposed Overall Completion Date: 04/09/2024

DIRECTED PLAN:

By 5/5/24 and daily thereafter: The administrator or designee shall conduct daily walkthroughs of the building to ensure all stairways, hallways, doorways, passageways and egress routes from rooms and from the building are unlocked and unobstructed. Documentation of the walkthroughs shall be kept.

Directed Completion Date: 05/05/2024

NOT IMPLEMENTED 5/9/24



132b - Safety Inspection/Fire Drill

13. 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.

132b - Safety Inspection/Fire Drill (continued)

Description of Violation

The last fire drill and inspection observed by a fire safety expert was conducted on 11/17/22.

Repeat Violation: 11/30/22

Plan of Correction

Directed [redacted] - 04/25/2024)

On 3/12/2024 The fire safety expert was called and he will be in the facility for inspection and drill on 4/12/2024.

Training was given by regional consultant to administrator to be in compliance with regulation 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. Documentation shall be kept in the facility.

Proposed Overall Completion Date: 04/09/2024

DIRECTED PLAN:

By 5/5/24: The administrator shall develop and implement a tracking system to ensure a fire safety inspection and fire drill are conducted by a fire safety expert annually.

Directed Completion Date: 05/05/2024

NOT IMPLEMENTED 5/9/24 [redacted]

132d - Evacuation

14. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills:

* 11/18/23 at 8:00 am.- 5 minutes, 8 seconds

* 12/28/23 at 4:10 - 5 minutes, 20 seconds

* 1/14/24 at 11:02 pm. - 5 minutes, 20 seconds

* 2/15/24 at 11:10 pm. - 5 minutes, 2 seconds

Plan of Correction

Accept [redacted] - 04/25/2024)

A fire safety expert is due in the building on 4/12/2024 to evaluate for safe evacuation times for drills. Training was given by regional consultant to administrator and staff to ensure compliance of regulation 2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home. Monthly checks will be done by administrator or designee to ensure compliance with above regulation.

Documentation will be kept.

Licensee's Proposed Overall Completion Date: 04/09/2024

NOT IMPLEMENTED 5/9/24 [redacted]

183d - Prescription Current

15. Requirements

183d - Prescription Current (continued)

2600.

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

Description of Violation

On 3/12/24, Kloxxado Nasal Spray, 8mg., 1 spray nasally into 1 nostril; repeat with second device into other nostril after 2-3 minutes if no response, for Opioid dependence, is prescribed for individual #1; however, the medication was discontinued on 1/3/24 and expired on 10/2023.

On 3/12/24, the medication, Doxycycline Hyclate 100 mg., take by mouth 1 tablet twice daily for 21 days for resident #5 was in the medication cart. The medication was filed on 1/15/24.

On 3/12/24, the medication, Risperidone 2mg, take by mouth 1 tablet at bedtime for 10 days until patient gets next injection for resident #5, was in the medication cart. The medication was filed 1/10/24 with 10 pills left in cart.

On 3/12/24, the medication, Muscle Rub Cream, apply topically to posterior neck/shoulder area 2x daily for 2 weeks for resident #6, was in the medication cart. The medication was filed on 6/25/22.

On 3/12/24, the medication, Compro 25mg suppository, one every 6 hours as needed for resident #7, was in the medication cart. The medication was filed on 10/23/21 and expired.

Repeat Violation: 11/30/22

Plan of Correction

Directed [redacted] - 04/25/2024)

On 3/15/2024 Mar Audits were done by administrator and designee to ensure compliance with 2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home. Weekly Mar audits will be done by administrator or designee to ensure compliance with above regulation documentation will be kept.

Proposed Overall Completion Date: 04/09/2024

DIRECTED PLAN:

By 5/5/24 and twice weekly thereafter: The administrator or designee shall audit the medication storage area to ensure only current prescription, OTC, sample and CAM for individuals living in the home are kept in the home. Any expired or discontinued medications shall be returned to the pharmacy or destroyed in accordance with 2600.183f. Documentation of audits shall be kept.

Directed Completion Date: 05/05/2024

NOT IMPLEMENTED 5/9/24 [redacted]

184a - Resident's Meds Labeled

16. Requirements

2600.

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

184a - Resident's Meds Labeled (continued)

Description of Violation

Resident #7 is prescribed Morphine Sulf, 100mg/5ml, 1ml/20ml, every 2 hours as needed for severe pain or shortness of breath. The pharmacy label indicates every 2 hours as needed for moderate to severe pain or SOB.

Resident #7 is prescribed Morphine Sulf, 100mg/5ml, 0.5ml/10mg, every 2 hours as needed for moderate pain or shortness of breath. The pharmacy label indicates every 2 hours as needed for moderate to severe pain or SOB.

Repeat Violation: 6/7/23, 3/23/23

Plan of Correction

Directed [REDACTED] - 04/25/2024)

Resident #2 physician was called for correct orders. The orders were received and put into the MAR by pharmacy as written. Training was provided by administrator to staff to be in compliance with regulation 2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following: Weekly MAR audits will be done by administrator or designee to ensure compliance of above. Documentation will be kept.

Proposed Overall Completion Date: 04/09/2024

DIRECTED PLAN:

By 5/5/24: The administrator or designee shall obtain from the pharmacy medication labels which match the current physician's order for resident #2's Morphine Sulf.

By 5/5/24 and at least twice weekly thereafter: The administrator or designee shall check the home's medication storage areas to ensure the pharmacy labels include all required information under 2600.184a, including instructions for administration.

Directed Completion Date: 05/05/2024

NOT IMPLEMENTED 5/9/24

185a - Implement Storage Procedures

17. 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, Acetaminophen 325mg, take 2 tablets by mouth every 6 hours as needed. On 3/11/24, the

185a - Implement Storage Procedures (continued)

resident requested the medication, but the medication was not available. On 3/12/24, the medication still was not available. The resident receives all medications for Veterans Affairs.

On 3/12/24, resident #4's glucometer was not calibrated to the correct time.

On 3/12/24, resident #8 and #9's glucometer was not calibrated to the correct date and time.

Resident #7 is prescribed, Acetaminophen 650mg Suppository, unwrap and insert one suppository rectally every 4 hours as needed for temperature > 100 degrees Fahrenheit or mild pain. On 3/12/24, the medication was not available.

Plan of Correction

Directed [REDACTED] - 04/25/2024)

On 3/12/2024 resident#4, #8, and #9s glucometer calibrated to correct date and time by med tech. Resident #7's Acetaminophen 650 mg was reordered through hospice and was sent by pharmacy the same evening. Training was given to all med techs by administrator to in compliance with regulation 2600.

185.a. Weekly MAR will be done by administrator or designee to ensure compliance of above Documentation will be kept.

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

Proposed Overall Completion Date: 04/09/2024

DIRECTED PLAN:

By 5/5/24: The administrator or designee shall ensure resident #1's Acetaminophen 325mg is present in the home for administration per the physician's order.

By 5/5/24 and at least weekly thereafter: The administrator or designee shall check medication storage areas to ensure all currently prescribed medication is available for administration and all resident glucometers are set to the correct date and time. Documentation of these checks shall be kept.

Directed Completion Date: 05/05/2024

NOT IMPLEMENTED 5/9/24 [REDACTED]

187a - Medication Record

18. 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, Amlodipine Besylate, 5mg, take 1 tablet by mouth daily for blood pressure and Potassium Chloride 20meq/15ml, take 15ml. by mouth daily for low Potassium in blood dilute each 15ml. (1 TBSP) w/ 3 fluid ounces or more of water or juice. However, on 3/14/24, these medications and multiple other medications were not included on resident 1's March 2024, medication administration record (MAR).

187a - Medication Record (continued)

Resident #1 is prescribed, Oxycodone Sustained Release SA, 10mg 1 tablet by mouth every 12 hours. However, on 3/14/24, resident #1's March MAR, indicated, Oxycodone HCL ER 10mg., 1 tablet by mouth every 8 hours.

Resident #1 id precribed, Oxycodone Sustained Release SA, 10mg 1 tablet by mouth every 12 hours. However, on 3/14/24, resident #1's March 2024 MAR, indicates, Oxycontin ER, 10mg, take by mouth 1 tablet every 12 hours.

Resident #4 is prescribed, Nystatin 100,000 un/gm powder, apply liberally to affected area twice daily as needed. However, this medication was not included on resident 4's March 2024, MAR.

Resident #7 is prescribed, Haloperidol Lac, 2mg./ml., take 0.25ml. under the tongue every 4 hours as needed for nausea/vomiting/aggression or restlessness. However, this medication was not included on resident 7's March 2024, MAR.

Repeat Violation: 3/23/23

Plan of Correction

Directed [REDACTED] - 04/25/2024)

On 3/15/2024 Resident #4 #7 and #1s MAR was audited by administrator and designee. Training was provided by administrator to med techs To ensure compliance of regulation 2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered. Weekly mar audits will be done by administrator or designee to ensure compliance of above regulation

Proposed Overall Completion Date: 04/09/2024

DIRECTED PLAN:

By 5/5/24: The administrator or designee shall correct the MARs for resident #1, #4 and #7 so that they include the current prescription order for the mediations cited.

By 5/5/24 and at least twice weekly thereafter: The administrator or designee shall check the residents' MARs and physician's orders to ensure the MARs include all required information under 2600.187a for currently prescribed medication. Documentation of the checks shall be kept.

Directed Completion Date: 05/05/2024

NOT IMPLEMENTED 5/9/24 [REDACTED]

187d - Follow Prescriber's Orders

19. Requirements

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

Description of Violation

The medication, NAC 600mg capsule, take by mouth 1 capsule twice daily for resident #1, was discontinued on

187d - Follow Prescriber's Orders (continued)

1/3/24. However, the medication, NAC was administered on the followings dates and times:

* 3/1/24-3/9/24 - 8:30 am.

* 3/4/24 - 9:00 pm.

On 3/14/24, there was no order for the medication, Oxycodone HCL (IR) 5mg., take 1 tab by mouth twice daily as needed for breakthrough pain, for resident #1. However, the medication, Oxycodone HCL (IR) 5mg. was administered on the following dates and times:

* 3/9/24 at 8:56 pm.

* 3/10/24 at 9:18 pm.

Resident #1 is prescribed, Oxycodone Sustained Release SA, 10mg. 1 tablet by mouth every 12 hours. However, resident #1 was administered the medication, Oxycodone HCL ER 10mg, take 1 tablet by mouth every 8 hours, on the following dates and times:

* 3/9/24-3/11/24 at 6:00 am.

* 3/7/24-3/11/24 at 2:00 pm.

* 3/9/24 at 10:00 pm.

Resident #7 is prescribed, Atenolol, 25mg., take by mouth 1 tablet twice daily, hold for heart rate <60 or systolic BP <110. Staff did not enter the resident's heart rate and systolic BP on multiple days, including the following dates and times:

* 3/1/24 - 8:00 am. and 8:00 pm.

* 3/2/24 - 8:00 pm.

* 3/4/24 - 8:00 am. and 8:00 pm.

* 3/5/24 - 8:00 am. and 8:00 pm.

* 3/6/24 - 8:00 am. and 8:00 pm.

Repeat Violation: 8/31/23, 6/7/23, 3/23/23, 11/30/22

Plan of Correction**Directed** [REDACTED] **- 04/25/2024)**

On 3/15/2024 Mar Audits were completed for all residents above by administrator and designee. Training was provided to MedTech on 4/8/2024 to ensure compliance of regulation 2600.

187.d. The home shall follow the directions of the prescriber. Weekly MAR audit will be completed by administrator or designee to ensure compliance of above regulation. Documentation will be kept

Proposed Overall Completion Date: 04/09/2024

187d - Follow Prescriber's Orders (continued)

DIRECTED PLAN:

By 5/5/24: The administrator or designee shall ensure that all currently prescribed medications for residents #1 and #7 are available in the home for administration.

By 5/5/24: The administrator or designee shall observe at least 3 medication passes by different staff persons per week to ensure that the direction of the prescriber are being followed. Documentation of these observations shall be kept.

Directed Completion Date: 05/05/2024

NOT IMPLEMENTED 5/9/24

