



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to ARK MANOR LLC
LEGAL ENTITY

To operate ARK MANOR
NAME OF FACILITY OR AGENCY

Located at 105 SANDRA DRIVE, DELMONT, PA 15626
(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 70
(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 July 26, 2024 until January 26, 2025,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **446864**

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.



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JULY 26, 2024

[REDACTED]
Ark Manor LLC
105 Sandra Drive
Delmont, Pennsylvania 15626

RE: Ark Manor
License/COC #: 446864

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on January 4, 2024, January 18, 2024, January 25, 2024, and May 9, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

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

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

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

55 Pa. Code Chapter 2600	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
<u>Section:</u>					
82(c)		36	\$5	\$180	5 calendar days from mailing date of this letter
100a		36	\$5	\$180	5 calendar days from mailing date of this letter
183(b)		36	\$5	\$180	5 calendar days from mailing date of this letter
183(e)		36	\$5	\$180	5 calendar days from mailing date of this letter
184(a)		36	\$5	\$180	5 calendar days from mailing date of this letter
185(a)		36	\$5	\$180	5 calendar days from mailing date of this letter
187(d)		36	\$5	\$180	5 calendar days from mailing date of this letter

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

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

Your facility's FOURTH PROVISIONAL license will expire on January 26, 2025. Pursuant to 55 Pa. Code § 20.54, a maximum of four consecutive provisional certificates of compliance may be issued to the legal entity for each specific facility or agency (1 Pa. Code. Part II).

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

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

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

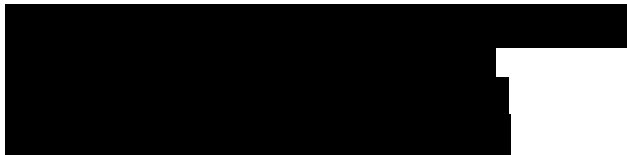
Sincerely,



Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:



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

Facility Information

Name: *ARK MANOR* License #: *44686* License Expiration: *03/26/2024*
Address: *105 SANDRA DRIVE, DELMONT, PA 15626*
County: *WESTMORELAND* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *ARK MANOR LLC*
Address: *105 [REDACTED]*
[REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *06/23/2006* Issued By: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *43* Waking Staff: *32*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Provisional* Exit Conference Date: *01/25/2024*

Inspection Dates and Department Representative

01/04/2024 - On-Site: [REDACTED]
01/18/2024 - On-Site: [REDACTED]
01/25/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *70* Residents Served: *40*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *17* Are 60 Years of Age or Older: *35*
Diagnosed with Mental Illness: *15* Diagnosed with Intellectual Disability: *3*
Have Mobility Need: *3* Have Physical Disability: *0*

Inspections / Reviews

01/04/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/14/2024*

03/21/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: *04/24/2024*
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/28/2024*

04/17/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: *04/24/2024*
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *04/24/2024*

07/01/2024 - Document Submission

Submitted By: [REDACTED] Date Submitted: *04/24/2024*
Reviewer: [REDACTED] Follow-Up Type: *Enforcement*

18 - Compliance With Laws

1. Requirements

2600.

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

Description of Violation

The Certificate of Boiler of Pressure Vessel Operation expired on 9/29/23, for the Cast Iron Hot Water Heating Boiler, #B02709251, PA Serial number 364319B and S/N 2846541, issued by the PA Department of Labor and Industry.

Plan of Correction

Accept [REDACTED] 04/05/2024)

Administrator will contact boiler inspector to schedule inspection within 7 days of the accepted plan of correction. Administrator will keep certificate of boiler pressure operation in inspection book and posted in close proximity to the boiler and will be easily accessible upon request.

Moving forward, administrator will schedule boiler inspection within 3 months prior to due date each year to ensure compliance with 2600.18

The administrator will notify [REDACTED] at BHSL of the scheduled boiler inspection date and ensure documentation of the boiler inspector/ contact information will be kept.

Licensee's Proposed Overall Completion Date: 03/28/2024

Not Implemented [REDACTED] - 07/01/2024)

20b8 - Quarterly Account

2. Requirements

2600.

20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:

8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

Residents #1 and #2 receive financial management from the home. The residents did not receive an itemized account of financial transactions made on the resident's behalf on a quarterly basis in 2023.

Plan of Correction

Accept [REDACTED] - 04/05/2024)

On 01/24/2024 administrator provided resident #1 and [REDACTED] designated person an itemized log of financial transactions and will continue to do so on a quarterly basis. See 01/24/24 entry on log attached.

On 03/11/2024 administrator provided resident #2 and [REDACTED] designated person an itemized log of financial transactions and will continue to do so on a quarterly basis. See attachment.

Administrator will continue to provide this information to all residents and their designated person for all residents who receive financial assistance/ management or facility holds resident's funds. Quarterly documentation will be kept.

Within 30 days of receipt of the plan of correction - The administrator will develop and implement a tracking system to ensure all residents who receive financial management from the home and their designated persons receive an itemized account of financial transactions on a quarterly basis.

Licensee's Proposed Overall Completion Date: 03/28/2024

Implemented [REDACTED] - 07/01/2024)

42s - Privacy

3. Requirements

2600.

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

Description of Violation

On 1/25/24 at 11:55 a.m., agents of The Department observed staff person A, [redacted] technician, administer an insulin injection into resident #3's abdomen while the resident was seated at a dining room table.

On 1/25/224 at 12:00 p.m., agents of the Department observed staff person A measuring resident #4's blood sugar and administering an insulin injection into the resident's arm while the resident was seated at a dining room table.

Plan of Correction

Accept [redacted] 04/05/2024)

Dispute: Staff member A was following doctor's orders for resident #4- Resident #4 order reads: Lispro 100u/ml- Inject 15 units Sub-Q once daily *with lunch*. Please see attached.

All staff will be retrained on 2600.42.s- Privacy- by the Administrator within 7 days of accepted plan of correction. the training will include that all staff persons will be reeducated concerning the right to privacy during medical procedures, including performing blood glucose testing and administering insulin in private area, away from other residents and visitors. Documentation will be kept.

The administrator will monitor insulin administration at lunchtime daily each day she is in the facility for 4 weeks then weekly thereafter to ensure medication administration, including insulin injections and blood glucose testing, is completed in a private area. documentation of these checks will be kept.

Proposed Overall Completion Date: 03/28/2024

Licensee's Proposed Overall Completion Date: 03/28/2024

Not Implemented [redacted] - 07/01/2024)

65f - Training Topics

4. Requirements

2600.

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

- 6. Safe management techniques.

Description of Violation

Direct care staff person B, hired [redacted]/22, and staff person C, hired [redacted]/19, did not receive annual training on safe management techniques during the 2023 training year.

Plan of Correction

Accept [redacted] - 04/05/2024)

Dispute: Staff person B and C completed annual training topic titled 'safe management techniques' in September 2023. Verification of training completion given to inspectors while on site and see attached.

staff B and C will recieve re education within 7 days of receipt of the plan of correction that includes:
- safe management technique training which is positive interventions to modify or eliminate a behavior that

65f - Training Topics (continued)

endangers the resident [REDACTED] or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, de-escalation techniques and alternative techniques or methods to identify and defuse potential emergency situations. Documentation will be kept. Administrator will review annual training plan to ensure all topics are covered in their entirety annually.

Licensee's Proposed Overall Completion Date: 03/28/2024

Implemented [REDACTED] - 07/01/2024)

82c - Locking Poisonous Materials**5. Requirements**

2600.

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

Description of Violation

On 1/4/24, multiple poisons were unlocked and accessible in the garage, to include:

- A 19oz can of disinfectant cleaner with a manufacturer's label indicating "Call a poison control center or doctor for treatment advice."
- An 11oz can of rust penetrating catalyst with a manufacturer's label indicating "If swallowed, do not induce vomiting. Call physician immediately."
- A can of paint and primer with a manufacturer's label indicating "First Aid: If you experience difficulty in breathing, ..., get medical assistance immediately."
- A 10oz tube of Liquid Nails with a manufacturer's label indicating "If swallowed, rinse mouth with water (only if person is conscious). Do not induce vomiting unless directed to do so by medical personnel."

Not all residents of the home, including resident #5, have been assessed capable of recognizing and using poisons safely.

Repeat Violation: 6/1/23 et al

Plan of Correction

Accept [REDACTED] - 04/17/2024)

Dispute: As mentioned, when inspectors were on site- detached garage is a separate structure on separate Real estate entity and is not considered part of the home. Residents do not have access to any part of the garage. Administrator did a walk-through of the actual home on 3/6 No poisonous materials were found. staff will be educated by administrator within 1 week of accepted plan of correction to ensure complainance with 2600.82c. Moving forward administrator or designee will do a weekly walkthrough of the home for 2 months to ensure compliance. documentation of the audit will be kept at the facility. Administrator will ensure garage remains locked and off limits to residents each day in facility, designated person will ensure on the days the administrator is not at the facility. checks began 03/26/2024 and will continue on a daily basis

Proposed Overall Completion Date: 03/28/2024

Licensee's Proposed Overall Completion Date: 03/28/2024

Not Implemented [REDACTED] - 07/01/2024)

85a - Sanitary Conditions**6. Requirements**

85a - Sanitary Conditions (continued)

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

Resident #4s glucometer was used to measure resident #6's blood glucose levels on the following dates and times:

- 1/1/24 at 8:00 a.m.
- 1/2/24 at 8:00 p.m.
- 1/3/24/ at 8:00 a.m. and 8:00 p.m.
- 1/4/24 at 8:00 p.m.
- 1/5/24 at 3:13 p.m. and 8:00 p.m.
- 1/6/24 at 8:00 a.m. and 8:00 p.m.
- 1/7/24 at 8:00 a.m. and 8:00 p.m.
- 1/8/24 at 8:00 a.m.

Resident #6's glucometer was used to measure resident #4's blood glucose levels on the following dates and times:

- 1/1/24 – 8:00 a.m., 8:00 p.m.
- 1/2/24 - 8:00 a.m., 5:00 p.m.
- 1/3/24 - 8:00 a.m., 12:00 p.m., 8:00 p.m.
- 1/4/24 - 8:00 p.m.
- 1/5/24 - 9:00 a.m., 12:00 p.m., 5:00 p.m., 8:00 p.m.
- 1/6/24 - 8:00 a.m., 5:00 p.m., 8:00 p.m.
- 1/7/24 – 12:00 p.m., 5:00 p.m., 8:00 p.m.

Plan of Correction

Accept [redacted] - 04/17/2024)

Dispute: While inspectors were on site- they requested glucose meters for several residents- upon returning the meters it was immediately noted by Ark staff that the incorrect meters were returned by inspectors in the box specified for a different resident. in regards to resident #4, on 01/07/2024- [redacted] was out of the facility. documentation of [redacted] outing is logged on the MAR as well as in the resident's notes. (See attachments.) disputing violation because the documentation in the description of violation has errors and includes inaccurate evidence. Administrator will conduct minimally, 3 audits weekly x 1 month to ensure compliance with 2600.85a is being maintained. audits to begin within 7 days of accepted plan of correction, documentation will be kept at facility.

All med tech staff will be retrained in 2600.85.a, education to include not sharing glucometers. Training will also include proper storage and labeling of glucose meters. (each meter is labeled, each meter case is labeled and all supplies are stored in a labeled pencil box) Administrator will conduct observation of each staff testing and administering insulin at least 2 times to ensure they are following proper procedures. observations to begin within one week of accepted plan of correction and will be completed within 2 weeks. documentation of observations will be kept.

Licensee's Proposed Overall Completion Date: 03/28/2024

Implemented [redacted] - 07/01/2024)

85d - Trash Receptacles

7. Requirements

2600.

85d - Trash Receptacles (continued)

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 1/4/24 at 10:35 a.m., there was a partially filled, uncovered trash can in the shower room on wing 2.

Repeat violation 6/1/23 et al

Plan of Correction

Accept [redacted] - 03/21/2024)

A walk through of the entire facility was completed on 3/12/2024 by administrator to ensure all trash receptacles in the kitchen and bathrooms are covered- including garbage can in wing 2 shower room.

Administrator or designated person will check all trash cans in bathrooms and kitchen to ensure covered weekly x 4 weeks upon accepted plan of correction. Training by done by the administrator for all staff with 7 days of the accepted plan of correctio. Documentation of checks and training will be kept at the facility.

Licensee's Proposed Overall Completion Date: 03/14/2024

Implemented [redacted] - 07/01/2024)

88a - Surfaces

8. 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 1/4/24, approximately 6 feet of the slate floor near the post in the middle of the sunroom was sunken in an area measuring approximately 1¾"; also one of the slate floor tiles was cracked and lifting, posing a trip/fall hazard.

On 1/25/24, approximately 70% of the basement floor was covered in water.

On 1/25/24, the weather stripping was detached approximately 3 feet on the bottom of the left emergency exit door in the TV room to the deck.

On 1/25/24, the weather stripping was detached in multiple areas on the bottom of the emergency exit door from wing 4 to the parking lot.

Plan of Correction

Accept [redacted] - 03/21/2024)

The weather strip on the emergency exit door in the living room to the deck repaired on 03/12/2024.

The weather strip on the emergency exit door in wing 4 leading to parking lot repaired on 03/12/2024.

No water or evidence of water on basement floor on 03/12/2024. Upon accepted plan of correction, administrator or designated person will audit and monitor all areas of the home including the basement to ensure all is in good repair and dry. checks will be conducted minimally, twice per week for 4 weeks documentation will be kept at the facility

The sun room floor will be repaired within 30 days of the accepted plan of correction.

Training will be done by Administrator for all staff within 7 days of accepted plan of correction.

88a - Surfaces (continued)

Proposed Overall Completion Date: 03/14/2024

Licensee's Proposed Overall Completion Date: 03/14/2024

Not Implemented [REDACTED] 07/01/2024)

91 - Telephone Numbers**9. Requirements**

2600.

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

Description of Violation

On 1/4/24, there were no emergency telephone numbers posted on or nearby the phone near the exit door leading to the deck off of the TV room.

On 1/4/24, there were no emergency telephone numbers posted on or nearby the phone in the garage.

Plan of Correction

Accept [REDACTED] - 04/17/2024)

DISPUTE: During inspection on 01/04/2024 the facility landlines were inoperable, including the phone by exit door leading to deck. The facility had a cell phone for the residents to utilize until repairs were completed with the landlines. A phone number list was accessible to all residents with the cell phone. The phone number list also posted in more than 12 other conspicuous areas throughout the home. Prior to landline repairs, administrator posted phone number list by the landline phone near the exit door leading to the deck off the TV room.

As mentioned when inspectors were on site- detached garage is a separate structure under a separate Real estate entity and is not considered part of the home. Residents do not have access to any part of the garage.

Administrator or designated person will conduct a training of all staff within 7 days of the accepted plan of correction on the importance of all phones having emergency numbers posted, a walk-through of the facility each week to ensure continued compliance with 2600.91 will be done. Documentation of the audit and trainings will be kept at the facility. there is not a phone afflicated with the home in the garage.

Licensee's Proposed Overall Completion Date: 03/28/2024

Not Implemented [REDACTED] - 07/01/2024)

92 - Windows**10. Requirements**

2600.

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

92 - Windows (continued)

Description of Violation

On 1/4/24, there was no screen in the laundry room window.

On 1/25/24 at 9:55 a.m., there was no screen in the kitchen open window above the table and the window.

Plan of Correction

Accept [redacted] - 03/21/2024)

On 03/12/2024 administrator checked each window to ensure screens present, in good repair and securely screened when window is open. At this time a screen was placed in the laundry room window by Maintenance man as well as the kitchen window.

Administrator will conduct a training for all staff within 7 days of the accepted plan of correction. Administrator or designated person will conduct monthly checks x 3 months to begin after the accepted plan of correction. documentation will be kept at the facility.

Licensee's Proposed Overall Completion Date: 03/14/2024

Not Implemented [redacted] - 07/01/2024)

95 - Furniture and Equipment

11. Requirements

2600.

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

Description of Violation

On 1/4/24, bathroom sink in bedroom 410 was clogged.

Plan of Correction

Accept [redacted] - 03/21/2024)

Necessary repairs made to bathroom sink in room #410 1/5/24.

Administrator conducted complete walk through of the facility on 01/30/2024.

Administrator or designated person will continue to do weekly walk throughs of the facility to ensure furniture and equipment remain in good repair and free of hazard. Administrator will provide training to all staff within 7 days of accepted plan of correction. Any necessary repairs will be completed promptly by maintenance. upon accepted plan of correction Weekly walk throughs to begin upon accepted plan of correction- documentation will be kept x 4 weeks.

Licensee's Proposed Overall Completion Date: 03/14/2024

Implemented [redacted] - 07/01/2024)

96a - First Aid Kit

12. Requirements

2600.

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

Description of Violation

On 1/25/24, the first aid kit in the medication room did not include antiseptic, scissors, and eye coverings.

96a - First Aid Kit (continued)

Plan of Correction

Accept [REDACTED] - 04/17/2024)

On 03/08/2024 administrator completed inventory on first aid kit. Antiseptic, scissors and eye covering stocked. Administrator will conduct monthly checks beginning March 2024 to ensure compliance with 2600.96.a is being maintained. documentation of checks will be kept x 3 months. education for all staff on requirements for the first aid kit and to inform administrator if anything is used and needs to be replaced will be done within 7 days of the accepted plan of correction by administrator- documentation of reeducation will be kept.

Licensee's Proposed Overall Completion Date: 03/28/2024

Not Implemented [REDACTED] 07/01/2024)

100a - Exterior - Free of Hazards

13. Requirements

2600.

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

Description of Violation

On 1/4/24, numerous deck support joists around the edges of the exterior deck off the living room, were exposed and had openings approximately 11"-14" in depth. And there were several boards which were sunken approximately 2", posing a trip/fall hazard.

Repeat violation 6/1/23 et al

Plan of Correction

Directed [REDACTED] - 04/17/2024)

Dispute: On 10/19/2023 inspectors were on site for a fine verification visit. On this day, the deck mentioned in the description of violation listed above, was assessed by inspector- [REDACTED] The repairs were accepted and considered in good repair. The condition of the deck is unchanged since that inspection and remains in good repair and free of hazard. (This was less than 3 months prior to this inspection and conditions have not changed.)

Administrator and Maintenance will continue to monitor the facility and grounds for needed repairs. Repairs will be made promptly when found. DIRECTED: The monitoring will be completed at least monthly beginning on 4/30/24. - [REDACTED] 4/17/24

DIRECTED: Within 15 days of receipt of the plan of correction - The administrator will have all areas of the deck, including those identified in the violation, repaired to ensure there are no trip/fall hazards. - [REDACTED] 4/17/24

Proposed Overall Completion Date: 04/30/2024

Directed Completion Date: 04/30/2024

Not Implemented [REDACTED] - 07/01/2024)

101r - Bedroom - shades/drapes/window covering

14. Requirements

2600.

101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

On 1/4/24, approximately 12" by 10" of the lower right side of the mini blinds were broken in bedroom 405.

101r - Bedroom - shades/drapes/window covering (continued)

On 1/4/24, 13 slats on the bottom portion of the mini blind were bent downwards and in disrepair in bedroom 410.

Plan of Correction

Accept [REDACTED] - 03/21/2024)

A walk through of the facility in entirety was conducted by administrator on 03/12/2024 to ensure all window coverings are clean, in good repair, provide privacy and cover the entire window when drawn. At this time the mini blinds in room # 405 and #410 were replaced by maintenance man. Administrator will provide training to all staff within 7 days of the accepted plan of correction. Administrator or designated person to conduct weekly checks within 7 days of the accepted plan of correction to ensure compliance with 2600.101r. documentation of checks will be kept x 4 weeks.

Licensee's Proposed Overall Completion Date: 03/14/2024

Not Implemented [REDACTED] - 07/01/2024)

102e - Privacy - Doors/Partitions**15. Requirements**

2600.

102.e. Privacy shall be provided for toilets, showers and bathtubs by partitions or doors.

Description of Violation

On 1/4/24, a slat was broken off on the right side of the mini blind, approximately 10" from the windowsill in the shower room located in the blue wing.

Plan of Correction

Accept [REDACTED] - 03/21/2024)

A walk through of the facility in entirety was conducted by administrator on 03/12/2024 to ensure privacy is being provided for toilets, showers by partitions or doors. At this time the mini blind in blue hall shower room replaced. Administrator will provide training to all staff within 7 days of the accepted plan of correction. Administrator or designated person to conduct weekly checks beginning within 7 days of the accepted plan of correction to ensure compliance with 2600.102.e. documentation of checks will be kept x 4 weeks.

Licensee's Proposed Overall Completion Date: 03/14/2024

Implemented [REDACTED] - 07/01/2024)

103f - Refrigerator/Freezer Temps**16. Requirements**

2600.

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

Description of Violation

On 1/25/24 at 10:07 a.m., the temperature in the walk-in freezer measured 2 degrees Fahrenheit. The freezer was rechecked at 6:17 p.m. and still measured 2 degrees Fahrenheit.

Repeat violation 6/1/23 et al

Plan of Correction

Accept [REDACTED] - 04/17/2024)

Dispute: Upon check when inspectors were on site- kitchen staff was putting inventory into the walk in cooler and freezer, inspectors present and witnessed inventory being put away. because the doors were open, it may have caused the temp to slightly rise. Administrator or kitchen staff logged freezer temps after inspectors were on site x 14 days. Each check confirming regulation is being met and frozen food is being kept at or below 0. temperature log attached. Temperature checks will be conducted by dietary staff or administrator daily for 4 weeks, then weekly

103f - Refrigerator/Freezer Temps (continued)

thereafter to ensure compliance is being maintained. documentation of checks will be kept.

Licensee's Proposed Overall Completion Date: 03/28/2024

Implemented [REDACTED] - 07/01/2024)

107d - Procedure Emergency Management Agency Submission**17. Requirements**

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures were not reviewed in 2023.

Plan of Correction

Accept [REDACTED] - 03/21/2024)

Within 14 days of the accepted plan of correction the home's written emergency procedure will be reviewed. documentation will be kept. Administrator will ensure the written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Licensee's Proposed Overall Completion Date: 03/14/2024

Not Implemented [REDACTED] - 07/01/2024)

123b - Emergency Procedures Posted**18. Requirements**

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On 1/4/24, a copy of the home's emergency procedures was kept in the office of staff person D, the [REDACTED], which is not a conspicuous and public place in the home.

Plan of Correction

Accept [REDACTED] - 03/21/2024)

On 03/12/2024 Copies of the emergency procedures was be posted in a conspicuous and public place in the home. Administrator will check monthly to ensure compliance is being maintained- documentation of checks will be kept x 3 months.

Licensee's Proposed Overall Completion Date: 03/14/2024

Not Implemented [REDACTED] - 07/01/2024)

127a - Portable Space Heaters**19. Requirements**

2600.

127.a. Portable space heaters are prohibited.

Description of Violation

On 1/4/24, there was an unplugged space heater on the floor of the garage.

Plan of Correction

Accept [REDACTED] - 04/17/2024)

Dispute: As mentioned, when inspectors were on site- detached garage is a separate structure and a separate real

127a - Portable Space Heaters (continued)

estate entity is not considered part of the home. Residents do not have access to any part of the garage. An Audit was done on the entire facility to ensure no space heaters were not on site. No space heaters were found. All staff will be re educated to ensure continued compliance with 2600.127.a are being maintained within 7 days of the accepted plan of correction. Administrator will continue with weekly checks to ensure compliance is being maintained. documentation of checks will be kept.

Licensee's Proposed Overall Completion Date: 03/28/2024

Not Implemented [REDACTED] - 07/01/2024)

131f - Fire Extinguisher Inspection**20. Requirements**

2600.

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

Description of Violation

On 1/4/24, there were several fire extinguishers that did not have an inspection tag, including:

- The fire extinguisher to the right of the double French doors leading to the resident smoking area
- The fire extinguisher next to the double doors leading to the parking across from the dining room
- The fire extinguisher at the end of the red hallway near the TV room

On 1/25/24, the Ansul system above the stove did not have an inspection tag at the pull station.

Plan of Correction

Accept [REDACTED] - 04/17/2024)

Dispute: While state inspectors were on site on 01/04/2024, the scheduled annual fire extinguisher inspection was being conducted by ABCO. during the fire extinguisher inspection- the tags are removed as checked- then replaced. Prior to the ABCO employee departing from the facility on 01/04/2024- all fire extinguishers throughout the home were inspected and dated.

Dispute: Ansul system is not used or serviced. No requirement to do so set forth by township or city. the administrator will ensure all fire extinguishers will be inspected and approved annually by a fire safety expert.

Licensee's Proposed Overall Completion Date: 03/28/2024

Implemented [REDACTED] - 07/01/2024)

143a - Emergency Medical Plan**21. Requirements**

2600.

143.a. The home shall have a written emergency medical plan that includes the following:

1. The hospital or source of health care that will be used in an emergency. This shall be the resident's choice, if possible.
2. Emergency transportation to be used.
3. An emergency-staffing plan.

143a - Emergency Medical Plan (continued)

Description of Violation

The home's emergency medical plan is not specific to the home; the plan indicates the hospital that will be used in an emergency is Forbes and transportation, in the case of an emergency will be provided by Turtle Creek Emergency Services. This home is not located near Forbes Hospital nor is it in Turtle Creek. On 1/18/24, staff person D, the administrator, indicated another personal care home provided the plan so this home would have something to give to agents of the Department.

Plan of Correction

Directed [REDACTED] **04/17/2024)**

DISPUTE: Administrator gave the inspectors the wrong policy in error and promptly provided the inspectors with the policy specifically for ark manor within 2 minutes of providing the wrong policy. Inspectors returned the policy given in error and it was disposed of by administrator. See attachment.

The administrator has the written Ark Manor Emergency Medical Plan and it contains all of the correct elements pertaining to this personal care home.

DIRECTED: Within 15 days of receipt of the plan of correction and at least annually thereafter - The Administrator will review the emergency medical plan to ensure it is up-to-date and accurate and will make changes as needed. Documentation of the reviews will be kept.. [REDACTED]/17/24

Directed Completion Date: 04/30/2024

Implemented [REDACTED] **- 07/01/2024)**

144c1 - Smoking Area Guidelines

22. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On 1/4/23, there were in excess of 100 cigarette butts and 4 empty packs of cigarettes scattered on the floor of the garage. There were no fireproof receptacles or ashtrays in this area. There was also a chair with a fabric seat and back cushion, a rollator walker with a vinyl seat, and a wheelchair with a vinyl seat, back and armrests in the garage. This is not the designated smoking area.

Plan of Correction

Directed [REDACTED] **- 04/17/2024)**

Dispute: As mentioned when inspectors were on site- detached garage is a separate structure with a separate Real Estate entity and is not considered part of the home. Residents do not have access to any part of the garage.

Staff will be re educated within 7 days of the accepted plan of correction- to ensure a clear unstanding of smoking areas and rules, during this re education staff will be reminded that the garage is not included in the acceptable smoking areas, they will be reminded that it will remain locked at ALL times and it will not be accessable to residents or staff.

144c1 - Smoking Area Guidelines (continued)

Within 7 calendar days of receipt of the plan of correction - The administrator or a designee will monitor the smoking area and other exterior areas, including the garage, daily and on all shifts, to ensure no one is smoking outside the designated smoking area. [REDACTED] 1/17/24

Directed Completion Date: 04/30/2024

Not Implemented [REDACTED] - 07/01/2024)

183b - Meds and Syringes Locked**23. Requirements**

2600.

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

Description of Violation

On 1/4/23 at 9:10 a.m., there was an unlocked and unattended Albuterol inhaler on top of the medication cart to the left of the double doors that lead to the resident smoking area,

Repeat violation: 6/1/23 et al

Plan of Correction

Accept [REDACTED] - 04/17/2024)

All staff will be retrained on 2600.183.b by administrator within 1 week of the accepted plan of correction.

Documentation of re training will be kept.

Administrator will conduct unannounced checks minimally of 3 times per week x 4 weeks beginning within 1 week of the accepted plan of correction. checks will continue atleast weekly by administrator- ensuring compliance with 2600.183.b. documentation of checks will be kept.

Licensee's Proposed Overall Completion Date: 03/28/2024

Not Implemented [REDACTED] - 07/01/2024)

183d - Prescription Current**24. Requirements**

2600.

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

Description of Violation

On 1/4/23, there were 2 blister packs of MAPAP 325mg for resident #4 on the medication cart. This medication was discontinued on 12/13/23.

Repeat violation: 4/6/23 et al

Plan of Correction

Accept [REDACTED] - 04/17/2024)

Resident #4's MPAP was disposed of by Med tech on 01/04/2024 while inspectors were on site.

DHS med techs will be retrained on 2600.183.d by administrator within 7 days of accepted plan of correction. documentation of retraining will be kept.

Administrator or designated person(s) to conduct a complete med audit on all resident's completed by 04/30/2024 then monthly there after x 6 months to ensure compliance with 2600.183.d. then documentation of med audits will be kept. Audits to begin within 7 days of the accepted plan of correction.

Licensee's Proposed Overall Completion Date: 03/28/2024

183d - Prescription Current (continued)

Not Implemented [redacted] - 07/01/2024)

184a - Resident's Meds Labeled

25. Requirements

2600.

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

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #7 is ordered Albuterol HFA 90mcg, inhale 2 puffs every 6 hours as needed; however, there was no pharmacy label on the inhaler. The resident's first name and last initial was written on it and it was dated 12/14/23.

Repeat violation: 10/13/23, 6/1/23 et al and 4/6/23 et al

Plan of Correction

Accept [redacted] - 04/17/2024)

resident #7's albut was returned to the original pharmacy labeled box while inspectors were on site.

DHS med techs will be retrained on 2600.184.a by administrator within 1 week of accepted plan of correction.

documentation of retraining will be kept.

Administrator or designated person(s) to conduct a complete med audit on all resident's completed by 04/30/2024 then monthly thereafter x 6 months to ensure compliance with 2600.184.a. documentation of med audits will be kept. Audits to begin within 7 days of the accepted plan of correction.

Licensee's Proposed Overall Completion Date: 03/28/2024

Not Implemented [redacted] - 07/01/2024)

185a - Implement Storage Procedures

26. 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 #4 is ordered Lispro 100unit/ml at 8:00 a.m., 12:00 p.m., 5:00 p.m., 8:00 p.m. However, on the following dates and times the blood sugar readings were not accurately recorded on the January 2024 medication administration record (MAR):

- 1/8/24 at 9:09 p.m., the resident's glucometer indicated a blood sugar reading of 539, however, the MAR indicates 453

- 1/12/24 at 12:34 p.m., the resident's glucometer indicated a blood sugar reading of 182, however, nothing was recorded on the MAR

185a - Implement Storage Procedures (continued)

Resident #6 is ordered blood sugar readings twice a day. On the following dates and times, the blood sugar readings were not accurately recorded on the January 2024 MAR:

- 1/9/24 at 8:17 a.m., the resident's glucometer indicated a blood sugar reading of 100, however, it was not recorded on the MAR
- 1/11/24 at 8:20 a.m., the resident's glucometer indicated a blood sugar reading of 118, however, it was not recorded on the MAR
- 1/18/24 at 8:00 a.m., the resident's glucometer indicated a blood sugar reading of 114, however, it was not recorded on the MAR

On 1/4/24, resident #8's glucometer did not have a reading; however, the resident's January 2024 MAR indicated a blood sugar reading of 107.

Repeat violation: 10/13/23 and 4/6/23 et al

Plan of Correction

Accept [REDACTED] - 04/17/2024)

DHS med techs will be retrained on 2600.185.a by administrator within 1 week of accepted plan of correction. documentation of retraining will be kept.

Administrator to audit each diabetic residents glucose meter minimally of once per week x 8 weeks, then monthly thereafter to ensure compliance is being maintained. Documentation of audits will be kept. Audits to begin within 7 days of accepted plan of correction.

Licensee's Proposed Overall Completion Date: 03/28/2024

Not Implemented [REDACTED] - 07/01/2024)

186a - Authorized Prescriber**27. Requirements**

2600.

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

Description of Violation

On 1/18/24, there was a tube of Betamethasone/Clotrimazole topical cream (Lotrisone) prescribed to resident #4 on the medication cart. However, the home does not have a written prescription from an authorized prescriber.

Plan of Correction

Accept [REDACTED] - 04/17/2024)

Resident #4's Betamethasone/Clotrimazole was disposed of by med tech on 01/18/2024 while inspectors were on site.

DHS med techs will be retrained on 2600.186.a by administrator within 1 week of accepted plan of correction. documentation of retraining will be kept.

Administrator or designated person(s) to conduct a complete med audit on all resident's completed by 04/30/2024 then monthly there after x 6 months to ensure compliance with 2600.186.a. documentation of med audits will be kept. Audits to begin within 7 days of the accepted plan of correction.

186a - Authorized Prescriber (*continued*)

Licensee's Proposed Overall Completion Date: 03/28/2024

Implemented [REDACTED] - 07/01/2024)

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

Facility Information

Name: *ARK MANOR* License #: *44686* License Expiration: *03/26/2024*
Address: *105 SANDRA DRIVE, DELMONT, PA 15626*
County: *WESTMORELAND* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *ARK MANOR LLC*
Address: [REDACTED].COM

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *06/23/2006* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *40* Waking Staff: *30*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Provisional, Monitoring* Exit Conference Date: *05/09/2024*

Inspection Dates and Department Representative

05/09/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *70* Residents Served: *36*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *16* Are 60 Years of Age or Older: *31*
Diagnosed with Mental Illness: *13* Diagnosed with Intellectual Disability: *3*
Have Mobility Need: *4* Have Physical Disability: *0*

Inspections / Reviews

05/09/2024 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *06/02/2024*

Inspections / Reviews (continued)

06/04/2024 - POC Submission

Submitted By: [REDACTED] Submitted: 06/27/2024
Reviewer: [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED]

Submitted By: [REDACTED] Date Submitted: 06/27/2024
Reviewer: [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED]

Submitted By: [REDACTED] Date Submitted: 06/27/2024
Reviewer: [REDACTED] Follow-Up Type: *Enforcement*

82a - Poisonous Materials

1. Requirements

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

There were 2 bottles of unlabeled poisons on the housekeeping cart. According to staff person A, the light purple liquid in a 32-ounce spray bottle was Fabuloso and the light-yellow liquid in a 32-ounce spray bottle was Pine-Sol. Original product labeling at the home indicated if ingested "Call a poison control center or doctor immediately."

Plan of Correction

Accept [REDACTED] - 06/04/2024)

The unlabeled poisons have been removed from the facility. All staff will be re educated on 2600.82.a within one week of the accepted plan of correction. Documentation will be kept. Beginning the week of 06/01/2024, administrator will conduct a weekly check of all poisonous materials to ensure they are being stored in their original, labeled containers x 4 weeks. Documentation of checks will be kept.

Licensee's Proposed Overall Completion Date: 06/02/2024

Not Implemented [REDACTED] - 07/01/2024)

82c - Locking Poisonous Materials

2. Requirements

2600.

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

Description of Violation

At 10:09 a.m., there were four 1-gallon jugs of germicidal bleach, five 1-quart spray bottles of Spic and Span and three 1.32 gallons of Fabuloso cleaner with manufacturers' labels indicating "Immediately call a poison control center or doctor."

Not all residents of the home, including resident #1, have been assessed capable of recognizing and using poisons safely.

Repeat Violation: 6/1/23 et al

Plan of Correction

Directed [REDACTED] - 06/12/2024)

All staff will be re educated on 2600.82.c within one week of the accepted plan of correction. Documentation will be kept. Beginning the week of 06/01/2024, administrator will conduct daily check of all poisonous materials to ensure they are being kept locked and inaccessible to residents, designated staff will complete daily checks when administrator is not in the home. Documentation of checks will be kept [REDACTED] - DIRECTED: Documentation shall be kept.

Directed Completion Date: 06/10/2024

Not Implemented [REDACTED] - 07/01/2024)

90a - Landline Telephone

3. Requirements

2600.

90.a. The home shall have a working, noncoin operated, landline telephone that is accessible in emergencies and accessible to individuals with disabilities.

Description of Violation

According to staff person B, the administrator, the home has not had a working, non-coin operated landline telephone for approximately the past 3 weeks.

Plan of Correction

Accepted [redacted] - 06/04/2024)

On 05//31/2024 the landline telephones were repaired in the facility. To ensure compliance a new, updated telephone system was installed.

Licensee's Proposed Overall Completion Date: 06/02/2024

Not Implemented [redacted] - 07/01/2024)

121a - Unobstructed Egress

4. 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

At approximately 10:21 a.m., the exit door in TV room to the rear deck (near the blue wing) was difficult to open. An agent of the Department had to use much force to push the crash bar and get door to open.

Plan of Correction

Accepted [redacted] - 06/04/2024)

Repairs to push bar to rear deck will be completed within 2 weeks of accepted plan of correction by maintenance. All other door will be checked to ensure routes from rooms and from building are unlocked and unobstructed by maintenance within 2 weeks of accepted plan of correction then monthly there after. All staff will be reeducated on 2600.121.a within 2 weeks of accepted plan of correction to ensure compliance. Documentation of education will be kept.

Licensee's Proposed Overall Completion Date: 06/02/2024

Not Implemented [redacted] - 07/01/2024)

144c1 - Smoking Area Guidelines

5. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

There was a large, plastic coffee container that was approximately ¾ full of cigarette butts, an empty cigarette pack and numerous cigarette butts scattered on the ground between the home and the garage. There were cigarette butts stuck into the recesses of several bricks on the wall of the left side of the home and two chairs with vinyl seats and a blanket lying on the ground.

144c1 - Smoking Area Guidelines (continued)

Plan of Correction

Accept [REDACTED] - 06/12/2024)

On 5/10/2024 the administrator, [REDACTED], removed the plastic coffee container, discarded it and replaced it with an appropriate, firesafe, butt-tainer. At this time she cleaned the trash and other debris, including butts in brick. All seating removed from this area except for a metal bench. Within 2 weeks of the accepted plan of correction all staff will be retrained on 2600.144.c. documentation of training will be kept. Administrator will monitor smoking areas Within 7 calendar days of receipt of the plan of correction - The administrator or a designee will monitor the smoking area and other exterior areas, including the garage, daily and on all shifts, to ensure no one is smoking outside the designated smoking area. documentation will be kept.

Licensee's Proposed Overall Completion Date: 06/10/2024

Not Implemented [REDACTED] - 07/01/2024)

183b - Meds and Syringes Locked

6. Requirements

2600.

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

Description of Violation

At approximately 9:50 a.m., a small cup containing six medications prescribed to resident #2 was unlocked and accessible to residents on the residents bedside table in room 405. Resident #2 has been in the hospital since [REDACTED]/24. Also, resident #2's roommate, resident #3, was present in the room. Medications in the cup were identified by staff person B, as Synthroid, Eliquis Metoprolol, Lasix and Potassium.

Repeat Violation: 6/1/23 et al

Plan of Correction

Accept [REDACTED] - 06/12/2024)

The medication on the bedside table of resident #2 was removed when inspectors were on site. All DHS med techs will be re educated on 2600.183.b to ensure compliance within 2 weeks of the accepted plan of correction. documentation will be kept. Administrator will monitor facility minimally of twice per week and daily monitoring by a staff person designated by the administrator. to ensure compliance to begin within week of the accepted plan of correction. Documentation of checks will be kept.

Licensee's Proposed Overall Completion Date: 06/10/2024

Not Implemented [REDACTED] 07/01/2024)

183e - Storing Medications

7. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #4's Lispro injection Kwik pen was not dated when opened. According to manufacturer's instructions, the medication is to be discarded after 28 days.

183e - Storing Medications (continued)

Repeat Violation: 10/13/23 and 6/1/23 et al

Plan of Correction

Accept [REDACTED] - 06/12/2024)

DHS med techs discarded resident #4's Lispro 28 days after fill date to ensure it was discarded within the manufacturer's instructions. DHS med techs will be retrained on 2600.183.e within 2 weeks of accepted plan of correction. Documentation of education will be kept. Once re education is complete administrator A designated staff person who is med trained should review meds daily to ensure they are dated when opened. Documentation of checks will be kept for 6 weeks.

Licensee's Proposed Overall Completion Date: 06/10/2024

Not Implemented [REDACTED] /01/2024)

184a - Resident's Meds Labeled

8. Requirements

2600.

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

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #4 is ordered Lantus Solostar insulin. The Lantus Solostar insulin pen was stored in a pink box in the medication cart; however there was no medication label on the pen or in the box.

Repeat Violation: 10/13/23 and 6/1/23 et al

Plan of Correction

Accept [REDACTED] - 06/12/2024)

resident #4 insulin was returned to pharmacy labeled bag on 5/10/2024. DHS med techs will be re-educated on 2600.184.a within 2 weeks of the accepted plan of correction. Documentation of education will be kept. After re-education is complete, administrator or designee will begin daily checks to ensure compliance is being maintained. administrator or designee to complete full med audit on all residents within 30 days of the accepted plan of correction. Documentation will be kept x6 weeks.

Licensee's Proposed Overall Completion Date: 06/10/2024

Not Implemented [REDACTED] - 07/01/2024)

187b - Date/Time of Medication Admin.

9. Requirements

2600.

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

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

Description of Violation

Resident #4 is ordered Tiotropium Bromide, inhale contents of 1 capsule via inhaler once daily (2 puffs per cap) for obstructive sleep apnea. On 5/9/24, staff person C did not administer this medication; however, staff person C initialed the medication administration record, (MAR), as having administered the medication.

Repeat Violation: 6/1/23 et al

Plan of Correction

Accept [REDACTED] 06/12/2024)

DHS med techs will be re-educated on 2600.187.b within 2 weeks of accepted plan of correction. Documentation of education will be kept. After re-education is complete, the administrator or designated person will begin weekly checks to ensure compliance is being maintained. Documentation of checks will be kept x 6 weeks. administrator and/or designee to complete full med audit on all residents within 30 days of the accepted plan of correction to ensure compliance is being maintained.

Licensee's Proposed Overall Completion Date: 06/10/2024

Not Implemented [REDACTED] - 07/01/2024)

187d - Follow Prescriber's Orders

10. Requirements

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

Description of Violation

Resident #4 is ordered Furosemide 20mg, 2 times per day, one in the morning, one in the evening. On multiple dates, including 5/1/24 through 5/8/24, resident #4 was administered Furosemide 20 mg 2 times per day, one in the morning and two in the evening.

Resident #4 is ordered Tiotropium Bromide, inhale contents of 1 capsule via inhaler once daily (2 puffs per cap) for obstructive sleep apnea; however, staff person C indicated she only administers it to the resident if the resident asks for it. On 5/8/24. the resident did not ask for it, and the medication was not administered.

Repeat Violation: 6/1/23 et al

Plan of Correction

Accept [REDACTED] - 06/12/2024)

On 06/09/24, while inspectors were on site, administrator requested med order confirmation from PCP while he was at facility for rounds. Within 2 weeks of accepted plan of correction DHS med techs will be re educated on 2600.187.d. documentation of re education will be kept. After re education is complete, the administrator weekly and daily by designated med trained employee monitoring to ensure compliance is being maintained. documentation of monitoring will be kept x 6 weeks.

Licensee's Proposed Overall Completion Date: 06/10/2024

Not Implemented [REDACTED] - 07/01/2024)