



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: MAY 3, 2024

[REDACTED]
BCB Holdings Fund
[REDACTED]

RE: Victoria Manor Personal Care Home
100 Rose Court
Oakdale, Pennsylvania 15071
License/COC #: 446424

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 January 9, 2024, and February 29, 2024, of the above facility, the citations specified on the enclosed Licensing Inspection Summaries (LISs) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby **REVOKES** your certificate of compliance (license number 446424) to operate the above facility. The Department's decision to revoke your license is based on the violations attached to this notice and your failure to comply with the Department's regulations, failure to submit an acceptable plan to correct noncompliance items and failure to comply with the acceptable plan to correct noncompliance items, and 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).

In accordance with 55 Pa. Code § 2600.269 (b) (relating to ban on admissions) no new resident admissions are permitted after the date of this letter.

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 violations 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>					
51	II	32	\$5	\$160	5 calendar days from mailing date of this letter
65(i)	III	32	\$3	\$96	15 calendar days from mailing date of this letter
141(a)	II	32	\$5	\$160	5 calendar days from mailing date of this letter
225(a)	II	32	\$5	\$160	5 calendar days from mailing date of this letter
227(a)	II	32	\$5	\$160	5 calendar days from mailing date of this letter
17	III	32	\$3	\$96	15 calendar days from mailing date of this letter
65(e)	III	32	\$3	\$96	15 calendar days from mailing date of this letter
65(f)	III	32	\$3	\$96	15 calendar days from mailing date of this letter
65(g)	III	32	\$3	\$96	15 calendar days from mailing date of this letter
141(b)(1)	II	32	\$5	\$160	5 calendar days from mailing date of this letter
183(e)	II	32	\$5	\$160	5 calendar days from mailing date of this letter

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

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

If you disagree with the decision to REVOKE your 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. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

[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.

The enclosed violation reports specify plans of correction and dates by which corrections must be made. If you choose to appeal, an acceptable plan of correction must be followed during your operation pending your appeal. Victoria Manor Personal Care Home is required to remain in full compliance with all applicable statutes and regulations, including but not limited to Article X of the Human Services Code, 62 P.S. §§ 1001 et seq., and 55 Pa. Code Ch. 2600 (relating to Personal Care Homes)

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: *VICTORIA MANOR PERSONAL CARE HOME* License #: *44642* License Expiration: *06/19/2024*
Address: *100 ROSE COURT, OAKDALE, PA 15071*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *BCB HOLDINGS FUND*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *01/02/1996* Issued By: *L & I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *34* Waking Staff: *26*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Fine* Exit Conference Date: *01/09/2024*

Inspection Dates and Department Representative

01/09/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *38* Residents Served: *29*

Secured Dementia Care Unit

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

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *3* Are 60 Years of Age or Older: *28*
Diagnosed with Mental Illness: *5* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *5* Have Physical Disability: *1*

Inspections / Reviews

01/09/2024 - Partial

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

Inspections / Reviews (*continued*)

02/06/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/05/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 02/11/2024

02/29/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/05/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 03/07/2024

04/12/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/05/2024

Reviewer: [REDACTED]

Follow-Up Type: Exception

51 - Criminal Background Check

1. 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

The following staff did not have the criminal background check completed until 1/9/24, to include:

- * Direct care staff person A hired [redacted] 23.
- * Direct care staff person B hired [redacted] /23.
- * Direct care staff person C hired [redacted] /23.

Repeat Violation: 10/5/23, 7/6/23, 5/9/23.

Plan of Correction

Accept [redacted] - 02/29/2024)

The criminal background checks to staff A,B,C were completed on 2/5/2024 by the administrator. The administrator quit and a new Administrator is now in charge. The new administrator is doing an audit of all the staff records. This was started on 1/11/2024 and will be finished by 2/11/2024. Any and all criminal background checks will be completed. A training happened on 1/18/2024 and criminal backgrounds were checks were discussed to ensure all staff know they cannot be alone at any time if they do not have a background check completed and returned within the first 30 days of employment.

An audit will be conducted monthly by the administrator or designee. this will begin 3/1/2024 after the big audit to ensure all staff records have a PA state Police criminal background check is present. Documentation will be kept.

Licensee's Proposed Overall Completion Date: 02/28/2024

Not Implemented [redacted] -4/12/24)

Licensee's Proposed Date for POC Implementation

65i - Training Record

2. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

On 1/9/24, direct care staff person C, hired [redacted] /23, indicated receiving the required first day orientation and 40 working hours training. However, there was no documentation to support that direct care staff person C had completed the training.

Repeat Violation: 10/5/23.

Plan of Correction

Accept [redacted] - 02/29/2024)

On 1/12/2024 the training record for the first 40 hours was completed on staff C by tthe administrator. The administrator quit and a new Administrator is now in charge. The new administrator is doing an audit of all the staff records. This was started on 1/11/2024 and will be finished by 2/11/2024. Any and all training records will be completed. A training happened on 1/18/2024 and all mandatory trainings were discussed.

An audit will be conducted monthly by the administrator or designee. this will begin 3/1/2024 after the big audit to ensure all staff records and training requirements are completed. Documentation will be kept.

Licensee's Proposed Overall Completion Date: 02/28/2024

Not Implemented ([redacted] -4/12/24)

Licensee's Proposed Date for POC Implementation

141a - Medical Evaluation

3. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident #2 admitted [REDACTED]/23; however, the resident’s medical evaluation was completed on 8/1/23.

Resident #3 admitted [REDACTED]/23; however, the resident’s medical evaluation did not include the in-person evaluation date or date the form was completed. These sections were blank.

Repeat Violation: 7/6/23

Plan of Correction

Directed [REDACTED] 02/29/2024)

Resident number 2 and 3 medical evaluations were completed on 1/16/2024 by the PC and the administrator. The administrator quit and a new Administrator is now in charge. The new administrator is doing an audit of all the resident records. This was started on 1/11/2024 and will be finished by 2/11/2024. Any and all medical evaluation will be completed. A training happened on 1/18/2024 and medical evaluations were discussed to ensure staff know what they are and what needs to be documented on the Medical evaluation.

An audit will be conducted monthly by the administrator or designee. this will begin 3/1/2024 after the big audit to ensure all residents have a ME and that it is filled out properly. Documentation will be kept.

Proposed Overall Completion Date: 02/28/2024

DIRECTED

Within 1 calendar day of receipt of the plan of correction: The administrator shall insure any corrections of a DME upon discovering that the physician, physician's assistant or certified registered nurse practitioner has recorded inaccurate information or omitted information, if a registered nurse (RN) or licensed practical nurse (LPN) contacts the person who performed the evaluation, AND receives permission from that person to correct the DME, AND documents the date, time, and person spoken to on the DME next to the correction. 2/29/24 [REDACTED]

Directed Completion Date: 03/01/2024

Not Implemented [REDACTED]-4/12/24)

Licensee’s Proposed Date for POC Implementation

187a - Medication Record

4. Requirements

2600.

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

- 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.

187a - Medication Record (continued)

Description of Violation

Resident #2 was ordered Triamcinolone Acetonide 0.1% Topical Cream. Apply to body, arms, and legs BID (two times daily) for 2-3 weeks between and after scabies and treatment. On 1/9/24, review of resident #2's December 2023 Medication Administration Record (MAR) did not include the prescribed medication.

Resident #4 was ordered Permethrin 5% Topical Cream- Apply to entire body from neck down. Leave on for 10 hours then wash. Repeat in one week for scabies. The medication was not ordered until 12/21/23 and the December 2023 MAR indicates it was administered 12/27/23. The next treatment per the physician orders should have been administered on 1/3/24. However, the residents January 2024 MAR does not include the medication nor any indication the medication was administered.

Plan of Correction

Accept [redacted] 02/29/2024)

Resident number 2 and 3 both had the medications ordered on 1/9/2023 and back in the building that night. The administrator quit and a new Administrator is now in charge. The new administrator already did a full cart audit of the medication and the MAR to make sure all the medications are on the MAR are following the prescribed orders from the Doctor. There will be 2 cart audits a week starting on 1/28/2024. this will be done by the Administrator, designee and/or the Medication trainer.

A training happened on 1/18/2024 and Medication orders, MAR were discussed to ensure staff know what medication orders look like and who it is suppose to be on the MAR.

An audit will be conducted 2 times a week by the administrator or designee or medication trainer this will begin 1/28/2024 after the big audit to ensure all residents have the correct medication on the MAR. Documentation will be kept.

Licensee's Proposed Overall Completion Date: 02/28/2024

Not Implemented [redacted] -4/12/24)

Licensee's Proposed Date for POC Implementation

187d - Follow Prescriber's Orders

5. Requirements

2600.

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

Description of Violation

On 12/7/23, resident #2 was prescribed Permethrin 5% Topical Cream -Apply to entire body from neck down. Leave on for 10 hours then wash. Repeat in one week (12/14/23). The resident was also prescribed Triamcinolone Acetonide 0.1% Topical Cream. Apply to body, arms, and legs BID (two times daily) for 2-3 weeks between and after scabies and treatment. On 1/9/24, the resident's December 2023 MAR did not include either of the prescribed medications or that it was administered as prescribed. The resident's January 2024 MAR did not include the prescribed medication, Triamcinolone Acetonide 0.1% Topical Cream and there was no documentation the medication was administered, or the physician's orders followed.

On 12/21/23, resident #4 was ordered Permethrin 5% Topical Cream- Apply to entire body from neck down. Leave on for 10 hours then wash. Repeat in one week for scabies. The medication was not ordered until 12/21/23 and the December 2023 MAR indicates it was administered 12/27/23. The next treatment per the physician orders should have been on 1/3/24. However, the residents January 2024 MAR does not include the medication nor any indication the medication was administered.

187d - Follow Prescriber's Orders (continued)

Plan of Correction**Directed** [REDACTED] 02/29/2024)

Resident number 2 and 4 had the medication back in the building on 1/4/2024 and it matched the prescribers order. The administrator quit and a new Administrator is now in charge. The new administrator already did a full cart audit of the medication and the MAR to make sure all the medications are on the MAR are following the prescribed orders from the Doctor. There will be 2 cart audits a week starting on 1/28/2024. this will be done by the Administrator, designee and/or the Medication trainer.

A training happened on 1/18/2024 and Medication orders, MAR were discussed to ensure staff know what medication orders look like and who it is suppose to be on the MAR.

An audit will be conducted 2 times a week by the administrator or designee or medication trainer this will begin 1/28/2024 after the big audit to ensure all residents have the correct medication on the MAR. Documentation will be kept.

Proposed Overall Completion Date: 02/28/2024

DIRECTED

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall notify both residents and the resident's designated person of the medication errors for each resident. Documentation of the notifications shall be kept. 2/29/24 [REDACTED]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall notify both of the resident's prescribers of the medication errors for each resident. Documentation of the notifications shall be kept. 2/29/24 [REDACTED]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall file an incident report for the medication errors including who made (by title) the notification and the date when the notification was made. 2/29/24 [REDACTED]

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall document the medications errors were made part of the resident's permanent record. 2/29/24 [REDACTED]

Directed Completion Date: 03/01/2024

Not Implemented [REDACTED] -4/12/24)

Licensee's Proposed Date for POC Implementation
 225a - Assessment 15 Days
6. 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 #1's assessment, dated [REDACTED] 23, does not include an assessment need or degree for aggression. The section is blank.

Resident #3 was admitted [REDACTED] 23; however, there was no assessment completed.

225a - Assessment 15 Days (continued)

Resident #4 was admitted [REDACTED] 23; however, the resident's assessment was completed on 5/9/23. Also, the resident's assessment was not updated to include the diagnosis of scabies and the treatment.

REPEAT VIOLATION: 5/9/2023; 7/6/23; 10/5/23

Plan of Correction

Accept [REDACTED] 02/29/2024)

Resident 1,3 and 4 had their 15 day assessment complete to address everything above. This was done on 1/15/2024 by the administrator. The administrator quit and a new Administrator is now in charge. The new administrator is doing an audit of all the resident records. This was started on 1/11/2024 and will be finished by 2/11/2024. Any and all Assessment evaluation will be completed. A training happened on 1/18/2024 and assessments evaluations were discussed to ensure staff know what they are and what needs to be documented on the Assessment evaluation. An audit will be conducted monthly by the administrator or designee. this will begin 3/1/2024 after the big audit to ensure all residents have an assessment and that it is filled out properly. Documentation will be kept.

Licensee's Proposed Overall Completion Date: 02/28/2024

Not Implemented [REDACTED] 4/12/24)

Licensee's Proposed Date for POC Implementation

227a - Support Plan 30 Days

7. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #4 admitted [REDACTED] 23; however, the resident's support plan was completed on 5/9/23. Also, the resident's support plan was not updated to include the treatment of scabies.

Repeat Violation: 7/6/23,5/9/23,

Plan of Correction

Directed [REDACTED] - 02/29/2024)

Resident 1,3 and 4 had their 30 day assessment complete to address everything above. This was done on 1/15/2024 by the administrator. The administrator quit and a new Administrator is now in charge. The new administrator is doing an audit of all the resident records. This was started on 1/11/2024 and will be finished by 2/11/2024. Any and all Support plan evaluation will be completed. A training happened on 1/18/2024 and support plans evaluations were discussed to ensure staff know what they are and what needs to be documented on the Support plans evaluation and how staff use them to do care.

An audit will be conducted monthly by the administrator or designee. this will begin 3/1/2024 after the big audit to ensure all residents have an assessment and that it is filled out properly. Documentation will be kept.

Proposed Overall Completion Date: 02/28/2024

DIRECTED

Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall update Resident #4's Support plan. 2/29/24 [REDACTED]

Within 2 Calendar days of receipt of the accepted plan of correction: The administrator or designee shall conduct an audit of resident support plans monthly. Documentation will be kept. 2/29/24 [REDACTED]

Directed Completion Date: 03/01/2024

Not Implemented [REDACTED] -4/12/24)

Licensee's Proposed Date for POC Implementation

228e - Discharge and Transfer

8. Requirements

2600.

228.e. The date and reason for the discharge or transfer, and the destination of the resident, if known, shall be recorded in the resident record.

Description of Violation

Resident #1 was discharged on [REDACTED]/23; however, the date of discharge, reason and location was not included in the resident's record.

Plan of Correction**Accept [REDACTED]02/29/2024)**

on 1/9/2023 there was a discharge transfer paper put in the file. This was done by the administrator. The administrator quit and a new Administrator is now in charge. The new administrator is doing an audit of all the resident records. This was started on 1/11/2024 and will be finished by 2/11/2024. Any and all discharge evaluation will be completed. A training happened on 1/18/2024 and discharge evaluations were discussed to ensure staff know what they are and what needs to be documented on the discharge evaluation.

An audit will be conducted monthly by the administrator or designee. this will begin 2/1/2024 after the big audit to ensure all residents discharged have proper documentation. Documentation will be kept.

Licensee's Proposed Overall Completion Date: 02/28/2024

Not Implemented [REDACTED]-4/12/24)

Licensee's Proposed Date for POC Implementation

Facility Information

Name: VICTORIA MANOR PERSONAL CARE HOME License #: 44642 License Expiration: 06/19/2024
 Address: 100 ROSE COURT, OAKDALE, PA 15071
 County: ALLEGHENY Region: WESTERN

Administrator

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

Legal Entity

Name: BCB HOLDINGS FUND
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 01/02/1996 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 45 Waking Staff: 34

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Complaint, Provisional Exit Conference Date: 02/29/2024

Inspection Dates and Department Representative

02/29/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 38 Residents Served: 32

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 2 Are 60 Years of Age or Older: 32
 Diagnosed with Mental Illness: 5 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 13 Have Physical Disability: 1

Inspections / Reviews

02/29/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/21/2024

03/19/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 03/25/2024
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/26/2024

Inspections / Reviews (*continued*)

03/26/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/25/2024

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 04/02/2024

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 2/29/24, the most recent license inspection summaries posted in the home's binder labeled "Victoria Manor Violations reports" included the following dates: 10/5/23, 5/9/23, 1/11/23 et. al. However, the inspection summary from the inspection conducted on 7/6/23 and was not posted in a conspicuous and public place in the home.

On 2/29/24, the license that was posted in a public and conspicuous place indicated it shall remain in effect from 9/20/22 through 3/20/23. However, the home's current license is effective from 12/19/23 until 6/19/24.

Plan of Correction

Accept [REDACTED] - 03/19/2024)

These were corrected on 2/30/2024 by the administrator. The old Administrator left and the new Administrator is trying to get everything in order. A training took place on 3/13/2024 for all staff and this was addressed at the training. this training was conducted by the administrator.

Moving forward the Administrator or designee will check monthly to make sure all plan of corrections and the license is hung.

Documentation will be kept and signed off by the administrator or the designee. The documentation started on 3/1/2024 by the Administrator. (attached).

Licensee's Proposed Overall Completion Date: 03/13/2024
Licensee's Proposed Date for POC Implementation

Not Implemented ([REDACTED]-4/12/24)

16c - Written Incident Report

2. Requirements

2600.

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

Description of Violation

On date-of-death of resident #1, at approximately 12:13 a.m. resident #1 ceased to breathe. However, the resident's death was not reported to the Department's personal care home regional office or the Department's personal care home complaint hotline within 24 hours in a manner designated by the Department and was not reported to the Department until 2/28/24.

On date-of-death of resident #2, at approximately 12:25 a.m., resident #2 ceased to breathe. However, the resident's death was not reported to the Department's personal care home regional office or the Department's personal care home complaint hotline within 24 hours in a manner designated by the Department and was not reported to the Department until 2/29/24 at approximately 2:20 p.m.

Plan of Correction

Accept [REDACTED] 03/19/2024)

Both death reports were sent to the state on 2/28/2024 and 2/29/2024 by the designee. The new administrator is trying to get everything in order that was missed by the old administrator.

A training took place with all staff on 3/13/2024 and 16c was addressed. Staff were taught how to write a reportable and that they need to be faxed or called in within 24hours. This was completed by the Administrator.

Moving forward death paperwork will be completed within 24 hours. This will be checked by the administrator or designee Monday- Friday and staff will call the administrator immediately upon a death.

16c - Written Incident Report (continued)

Administrator will keep documentation with signatures.

These checks started on 3/1/2024.

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

Not Implemented [REDACTED]-4/12/24)

Licensee's Proposed Date for POC Implementation

17 - Record Confidentiality

3. Requirements

2600.

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

Description of Violation

On entrance to the home on 2/29/24 at 9:00 a.m., there were multiple binders unlocked, unattended, and accessible sitting on the countertop of the reception area adjacent to the dining room that included a binder that indicated "Every shift needs to be giving showers" which included resident first names and their home health or hospice agencies arranged in columns with residents to receive showers on Monday, Wednesday, and Friday in the left column, and residents to receive showers on Tuesday, Thursday, and Saturday in the right column and covered dates ranging from 1/1/24 to present day to include 2/24/24, 2/25/24, 2/27/24, 2/28/24, and 2/29/24 and all pages indicated the following:

Left Column:

- Resident #3 – H/H Amedisys
- Resident #4 – Hospice/Commonwealth
- Resident #5 – H/H Advance
- Resident #6 – Hospice/Commonwealth
- Resident #7 – H/H Gallagher

Right Column:

- Resident #8 – Hospice – Commonwealth
- Resident #9 – H/H – Concordia
- Resident #10 – H/H Advance
- Resident #11 – Hospice – Heritage
- Resident #12 – H/H – Advance

REPEAT VIOLATION 7/6/23

Plan of Correction

Accept [REDACTED] 03/19/2024)

Everything stated above was put away immediately by the designee on 2/29/2024.

A training took place on 3/13/2024 with all staff and 17 was talked about and discussed to ensure all staff know what confidential information is how it needs to be locked up. This training was conducted by the administrator. Moving forward 4 times a week the entire building will be checked to ensure that all confidential documents. This will be done by the Administrator and designee and signed off on. (attached). These checks started on 3/1/2024.

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

Not Implemented [REDACTED]-4/12/24)

Licensee's Proposed Date for POC Implementation

18 - Compliance With Laws

4. Requirements

18 - Compliance With Laws (continued)

2600.

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

Description of Violation

At 10:59 a.m., the carbon monoxide detector mounted above the doorway to the laundry room from the home's dining room had two AA batteries that were labeled with a date of 2/15/22. In accordance with the Care Facility Carbon Monoxide Alarm Standards Act enacted June 2016, if a carbon monoxide detector is battery operated, the batteries must be replaced at least once annually or at such time as the unit signals a drained or failing battery, whichever is sooner.

At 11:05 a.m., the carbon monoxide detector mounted above the doorway to the kitchen from the home's dining room had two AA batteries that were labeled with a date of 2/15/22. In accordance with the Care Facility Carbon Monoxide Alarm Standards Act enacted June 2016, if a carbon monoxide detector is battery operated, the batteries must be replaced at least once annually or at such time as the unit signals a drained or failing battery, whichever is sooner.

At 11:17 a.m., the carbon monoxide detector mounted above the doorway to the freezer storage room which contained a HydroJet gas fired hot water tank had two AA batteries that were labeled with a date of 2/15/22. In accordance with the Care Facility Carbon Monoxide Alarm Standards Act enacted June 2016, if a carbon monoxide detector is battery operated, the batteries must be replaced at least once annually or at such time as the unit signals a drained or failing battery, whichever is sooner.

Plan of Correction

Accept (████) 03/19/2024)

The batteries were changed on 3/2/2023 by the maintenance man. There was a training that was conducted on 3/13/2024 by the Administrator and 18 was discussed in detail.

Moving forward the batteries will be check monthly by the administrator or designee and ensure they are swapped out and changed every six month.

this will begin on 3/1/2024 by the administrator. documentation will be kept.

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

Not Implemented (████) -4/12/24)

Licensee's Proposed Date for POC Implementation

42s - Privacy**5. 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 2/29/24 at approximately 4:30 p.m. it was observed on the monitor in the home's office that the video monitoring system's cameras mounted behind the nurse's station captured the interior spaces of both the men's and women's common half bathrooms located on either side of the dining room.

Plan of Correction

Accept (████) 03/19/2024)

The cameras were changed on 3/1/2024 to ensure they were not capturing the interior space of the common bathrooms.

A training was conducted for all staff on 3/13/2024 and 42s was discussed in detail. the administrator conducted the training.

Moving forward the videos cameras will be checked weekly to ensure they are not in any privacy areas. This started on 3.1.2024 by the administrator. documentation will be kept.

42s - Privacy (continued)

Licensee's Proposed Overall Completion Date: 03/13/2024
Licensee's Proposed Date for POC Implementation

Not Implemented (█-4/12/24)

60a - Staff/Support Plan

6. Requirements

2600.

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

Description of Violation

On 2/21/24 there were twenty-eight residents in the home including resident #6 who interviews indicated is a two-person assist. However, on 2/21/24 direct care staff person A was the only staff person during the 11:00 p.m. to 7:00 a.m. shift and the home was not staffed adequately to evacuate all residents in the event of an emergency.

Plan of Correction

Accept (█- 03/19/2024)

All residents charts will be reviewed by 3/20/2024 by the administrator and updated if needed to make sure we know exactly how many 2 person assists we have. Moving forward there will be the number of staff needed to take care of the residents needs. The schedule was checked to make sure all shifts were covered. The DHS formula will be used for staffing as well as looking at all 2 person assists to ensure there is enough staff on shift this started immediately after DHS left.

There was a training on 3/13/2024 that the administrator conducted and 60 a was discussed to ensure everyone understand 2 people assists.

Schedule will be checked daily to ensure all staff models are correct. this will be done by the administrator or designee. this started on 3/1/2024. documentation will be kept.

Licensee's Proposed Overall Completion Date: 03/24/2024
Licensee's Proposed Date for POC Implementation

Not Implemented (█4/12/24)

65e - 12 Hours Annual Training

7. Requirements

2600.

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

Description of Violation

Direct care staff person A did not receive any training in 2023 training year [1/1/23 – 12/31/23].

Direct care staff person B did not receive any training in 2023 training year [1/1/23 – 12/31/23].

REPEAT VIOLATION 7/6/23

Plan of Correction

Accept (█03/19/2024)

Trainings were completed on for A and B during the week of 3/1/2-24 and completed 3/6/2024 The administrator signed off.

There was an all staff training on 3/13/2024 and 65e was discussed and taught.

All staff files were audited and will be completed by 3/24/2024 by the administrator and designee to ensure that all staff are up to date on all trainings. this started on 3/1/2024

Moving forward the Staff charts will be audited monthly by the administrator and or designee and to ensure all the staff trainings are up to date. A check list will be kept.

Licensee's Proposed Overall Completion Date: 03/24/2024
Licensee's Proposed Date for POC Implementation

Not Implemented (█-4/12/24)

65f - Training Topics

8. 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 A did not receive annual training in required topics for the 2023 training year to include:

- (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.*

Direct care staff person B did not receive annual training in required topics for the 2023 training year to include:

- (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.*

REPEAT VIOLATION 7/6/23

Plan of Correction

Accept [REDACTED] 03/19/2024)

Trainings were completed on for A and B during the week of 3/1/24 and completed 3/6/2024 The administrator signed off.

There was an all staff training on 3/13/2024 and 65f was discussed and taught.

All staff files were audited and will be completed by 3/24/2024 by the administrator and designee to ensure that all staff are up to date on all trainings. this started on 3/1/2024

Moving forward the Staff charts will be audited monthly by the administrator and or designee and to ensure all the staff trainings are up to date. A check list will be kept.

65f - Training Topics (continued)

Licensee's Proposed Overall Completion Date: 03/24/2024
Licensee's Proposed Date for POC Implementation

Not Implemented [redacted]-4/12/24)

65g - Annual Training Content

9. 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.

Description of Violation

Direct care staff person A did not receive required annual training for the 2023 training year to include:

- (1) Fire safety completed by a fire safety expert or by a 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.

Direct care staff person B did not receive required annual training for the 2023 training year to include:

- (1) Fire safety completed by a fire safety expert or by a 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.

REPEAT VIOLATION 7/6/23

Plan of Correction

Accept [redacted] - 03/19/2024)

Trainings were completed on for A and B during the week of 3/1/2-24 and completed 3/6/2024 The administrator signed off.

There was an all staff training on 3/13/2024 and 65g was discussed and taught.

All staff files were audited and will be completed by 3/24/2024 by the administrator and designee to ensure that all staff are up to date on all trainings. this started on 3/1/2024

Moving forward the Staff charts will be audited monthly by the administrator and or designee and to ensure all the staff trainings are up to date. A check list will be kept.

Licensee's Proposed Overall Completion Date: 03/24/2024
Licensee's Proposed Date for POC Implementation

Not Implemented [redacted]-4/12/24)

65i - Training Record

10. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

65i - Training Record (continued)

Description of Violation

The record of training for direct care staff person C's diabetic education, dated 12/18/23, did not include the content or length of the training.

REPEAT VIOLATION 10/5/23

Plan of Correction

Accept (redacted) - 03/19/2024)

The trainer who did the diabetic training was contacted on 3/6/2024 and a description of the content and length was received. There was an allstaff training on 3/13/2024 and 65i was discussed and taught.

All staff files were audited and will be completed by 3/24/2024 by the administrator and designee to ensure that all staff are up to date on all trainings. this started on 3/1/2024

Moving forward the Staff charts will be audited monthly by the administrator and or designee and to ensure all the staff trainings are up to date. A check list will be kept.

Licensee's Proposed Overall Completion Date: 03/24/2024

Not Implemented (redacted) -4/12/24)

Licensee's Proposed Date for POC Implementation

85a - Sanitary Conditions

11. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

At approximately 10:50 a.m. all the countertops in the home's kitchen had bits of unidentifiable food debris and an oily film coating the surface of the countertops that was pervasive on all the countertop surfaces in the kitchen.

At approximately 11:25 a.m. the ventilation fan in the bathroom of resident room (redacted) belonging to resident #13, was matted with dust and debris approximately one-eighth of an inch thick throughout the slats of the fan.

At approximately 11:30 a.m. the toilet bowl in resident room #14, belonging to resident (redacted) was splattered with what appeared to be dried fecal matter around the entire inside of the toilet bowl.

At approximately 11:36 a.m. the ventilation fan in the shared bathroom of resident room (redacted) belonging to resident #15 and resident #7, was matted with dust and debris approximately one-eighth of an inch thick throughout the slats of the fan.

At approximately 3:55 p.m. the underside of the rear of the toilet seat and back section of the toilet bowl of the shared bathroom in resident room (redacted) belonging to resident #16 and resident #5, was caked with what appeared to dried feces and the front rim of the toilet bowl was coated in flecks of a brown substance which may have also been dried feces and loose strands of pubic hair that was stuck to dried urine.

At approximately 3:55 p.m. the vanity sink next to the toilet in the shared bathroom in resident room #16, belonging to resident #16 and resident #5, was coated in a mixture of various substances that included what appeared to hair, mucus, saliva, blood and a dried unidentifiable brown liquid splatter.

85a - Sanitary Conditions (continued)

Plan of Correction

Accept [REDACTED] - 03/26/2024)

The countertop was cleaned immediately. Ventilation fan in room 18 and 4 were cleaned by the maintenance man on 3/1/2024, Resident 14, 16 and 5 toilets and sinks were all cleaned that day on 2/29/2024.

A training was conducted on 3/13/2024 by the administrator and 85a was discussed.

Moving forward a cleaning sign off sheet was created by the administrator on 3/4/2024 to begin and the bathroom and kitchen will be checked during each shift 7-3, 3-11 and 11-7 by the caregivers and signed off on that it was cleaned if needed. A deep clean of the kitchen was conducted on 3/2/2024 to ensure everything is clean. The administrator will check 3 times a week to ensure the sign off sheets are completed and rooms and kitchen are clean.

Licensee's Proposed Overall Completion Date: 03/24/2024
Licensee's Proposed Date for POC Implementation

Not Implemented ([REDACTED]-4/12/24)

85b - Infestation

12. Requirements

2600.

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

Description of Violation

At approximately 3:55 p.m. there was a swarm of gnats in the shared bathroom of resident room [REDACTED] belonging to resident #16 and resident #5, with as many as 9 gnats on the shower curtain and many more flying in the air.

Plan of Correction

Accept [REDACTED] 03/26/2024)

The bathroom of 16 and 5 was cleaned immediately.

A training was conducted on 3/13/2024 by the administrator and 85b was discussed.

Moving forward a cleaning sign off sheet was created by the administrator on 3/4/2024 to begin and the bathroom and kitchen will be checked during each shift 7-3, 3-11 and 11-7 by the caregivers and signed off on that it was cleaned if needed.. A deep clean of the kitchen was conducted on 3/2/2024 to ensure everything is clean. The administrator will check 3 times a week to ensure the sign off sheets are completed and rooms and kitchen are clean.

Licensee's Proposed Overall Completion Date: 03/24/2024
Licensee's Proposed Date for POC Implementation

Not Implemented ([REDACTED]-4/12/24)

85e - Trash Outside Home

13. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 11:45 a.m. there were as many as sixty-seven cigarette butts found on the ground, underneath chairs and outside of the ash cans placed at the edge of the home's parking lot in the designated smoking area.

Plan of Correction

Accept [REDACTED] - 03/19/2024)

cigarette butts were cleaned up immediately.

A training was conducted on 3/13/2024 by the administrator and 85e was discussed.

Moving forward a cleaning sign off sheet was created by the administrator on 3/4/2024 to begin and the smoking area will be swept daily and signed off on. The administrator will check 3 times a week to ensure the sign off sheets are completed and no cigarettes butts are on the ground.

Licensee's Proposed Overall Completion Date: 03/18/2024
Licensee's Proposed Date for POC Implementation

Not Implemented ([REDACTED]-4/12/24)

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

At approximately 10:55 a.m. the water temperature at the sink in the common men’s half bathroom from the main living room measured 122.9 degrees Fahrenheit. The temperature was measured again at approximately 5:25 p.m. and measured 123.4 degrees Fahrenheit.

At approximately 11:22 a.m. the water temperature at the sink in resident room #18’s full bathroom, belonging to resident #13, measured 152.7 degrees Fahrenheit. The temperature was measured again at approximately 5:30 p.m. and measured 137.8 degrees Fahrenheit.

At approximately 11:32 a.m. the water temperature at the sink in resident room #14’s full bathroom, belonging to resident #14, measured 149.3 degrees Fahrenheit. The temperature was measured again at approximately 5:28 p.m. and measured 135.1 degrees Fahrenheit.

At approximately 11:38 a.m. the water temperature at the sink in shared resident room #4’s full bathroom, belonging to resident #15 and resident #7, measured 159.6 degrees Fahrenheit. The temperature was measured again at approximately 5:32 p.m. and measured 113.1 degrees Fahrenheit.

Plan of Correction

Accept [redacted] 03/19/2024)

The maintenance [redacted] came in on 3/1/2024 and fixed the water heater. All the bathroom waters were tested several times throughout that day to make sure they are accurate. The maintenance [redacted] came in the next 5 days to make sure all temperatures are accurate.

A training on 3/13/2024 conducted by the administrator discussed 89b.

Moving forward the administrator or maintenance man will check the water 3 times a week and sign off. The administrator will check the sign off sheets to make sure the temperatures are being completed. This started on 3/7/2024.

Licensee's Proposed Overall Completion Date: 03/24/2024
Licensee’s Proposed Date for POC Implementation

Not Implemented [redacted] -4/12/24)

132c - Fire Drill Records

15. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Repeat Violation 5/9/23

Description of Violation

The home’s fire drill record indicated the alarm sounded for a drill on 11/16 but did not indicate the year of the drill.

The home’s fire drill record indicated the alarm sounded for a drill on 12/19 but did not indicate the year of the drill.

The home’s fire drill record indicated the alarm sounded for a drill on 1/15 but did not indicate the year of the drill.

The home’s fire drill record indicated the alarm sounded for a drill on 2/20 but did not indicate the year of the drill.

132c - Fire Drill Records (*continued*)**Plan of Correction**

Accept [REDACTED] 03/19/2024)

*this could not be fixed due to past drills.**Moving forward all fire drill will have an end date on each drill. A fire drill was conducted on 3/14/2024 and the date was placed on it.**A training was conducted and 132c was discussed**Moving forward the administrator will check monthly and sign off that all fire drills are completed and that the entire date with the year is on the drill. This started on 3/14/2024.*

Licensee's Proposed Overall Completion Date: 03/18/2024

Not Implemented [REDACTED] -4/12/24)

Licensee's Proposed Date for POC Implementation

132f - Alternate Exit Routes

16. Requirements

2600.

132.f. Alternate exit routes shall be used during fire drills.

Description of Violation*The home's fire drill record indicated the front door was the only evacuation route used for fire drills on dates to include:*

- 7/15/23 at 5:00 a.m.
- 8/14/23 at 11:00 a.m.
- 9/6/23 at 7:00 p.m.
- 10/18/23 at 10:00 a.m.
- 11/16 at 6:00 p.m.
- 12/19 at 5:30 a.m.
- 1/15 at 10:00 a.m.
- 2/20 at 7:00 p.m.

Plan of Correction

Accept [REDACTED] 03/19/2024)

*this could not be fixed due to past drills.**Moving forward all fire drill will have an alternative door that residents can all get out of and not only use one door especially if the fire is near the main door. A fire drill was conducted on 3/14/2024 and two other doors were used as alternative doors.**A training was conducted and 132f was discussed**Moving forward the administrator will check monthly and sign off that all fire drills are completed and that there is always an alternative door.. This started on 3/14/2024.*

Licensee's Proposed Overall Completion Date: 03/18/2024

Not Implemented [REDACTED] -4/12/24)

Licensee's Proposed Date for POC Implementation

141b1 - Annual Medical Evaluation

17. Requirements

2600.

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

Description of Violation*Resident #14's most recent medical evaluation was completed [REDACTED] 23.**Resident #6's annual medication evaluation, dated [REDACTED]/23, did not indicate the medical professional's license*

141b1 - Annual Medical Evaluation (continued)

number, that area was left blank.

REPEAT VIOLATION 10/5/23; 7/6/23

Plan of Correction

Accept [REDACTED] - 03/26/2024)

This was obtained on 3/07/2024 by the Doctor. Resident # 14 medical evaluation was completed by the administrator and Doctor on 3/7/2024. Resident # 6 correction to the medical evaluation was completed on 3/7/2024 by the administrator and Doctor.

There was an all staff training on 3/13/2024 and 141b1 was discussed and taught.

All resident files were audited and will be completed by 3/24/2024 by the administrator and designee to ensure that all annual medical evaluations are in there filled out correctly and up to date this started on 3/1/2024

Moving forward the residents charts will be audited monthly by the administrator and or designee and to ensure all the resident medical files are up to date. A check list will be kept.

Licensee's Proposed Overall Completion Date: 03/24/2024

Not Implemented [REDACTED] -4/12/24)

Licensee's Proposed Date for POC Implementation

183e - Storing Medications

18. 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 #6's Zinc 20/LIDO3/CLOTRIM1/TAO paste was found in the medication cart at approximately 3:17 p.m. and was labeled with an expiration date that indicated 2/6/24.

REPEAT VIOLATION 7/6/23

Plan of Correction

Accept [REDACTED] - 03/26/2024)

Resident # 6 medication Zinc was ordered on 3/1/2024 by the med tech and a new one was delivered on 3/2/2024. A med cart audit was conducted by the designee med tech was conducted on 3/1/2024 and all expired medications were ordered for new ones and taken out on 3/2/2024 when the new ones arrived.

A training was conducted on 3/13/2024 AND 183E was discussed.

moving forward a med cart audit will be conducted twice a week by the designated med tech and signed off on and the administrator will check the sign off sheets weekly. This started on 3/1/2024. the administrator will do a med cart audit monthly and the pharmacy was contacted and starting 4/20/2024 the pharmacy will do a monthly med cart audit.

Licensee's Proposed Overall Completion Date: 03/24/2024

Not Implemented [REDACTED] 4/12/24)

Licensee's Proposed Date for POC Implementation

187a - Medication Record

19. Requirements

2600.

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

6. Dose.

Description of Violation

Resident #13 is prescribed Humalog (Insulin Lispro) 100 unit/mL pen, inject four units subcutaneously three times

187a - Medication Record (continued)

daily in addition to sliding scale: 70-140=0 Units; 141-200=1 Unit, 201-260=2 Units; 261-320=3 Units; 321-400=4 Units; >400=6 Units, Call MD. However, resident #13's medication administration record for February 2024 did not include an area to document the sliding scale dosage of Insulin Lispro administered to resident #13.

Plan of Correction

Directed [REDACTED] - 03/26/2024)

Resident # 13 Humalog that did not have an area to document the sliding scale dosage had the documentation area added to the MAR on 3/1/2024 called in by the med tech and added by the pharmacy. med cart audit was conducted by the designee med tech was conducted on 3/1/2024 and area to document the humalog was added. the Doctor was involved in this discussion.

A training was conducted on 3/13/2024 AND 187a was discussed.

moving forward a med cart audit will be conducted twice a week by the designated med tech and signed off on. The med cart audit will consist of making sure the medications match the MAR and the doctors orders. Medications are check for expiration dates and all appropriate areas for documentation and the administrator will check the sign off sheets weekly. This started on 3/1/2024. the administrator will monitor the med cart audits and do a weekly audit

[REDACTED] This started on 3/11/2024. The pharmacy was contacted and starting 4/20/2024 the pharmacy will do a monthly med cart audit as well to make sure the MAR, the medication and the doctors orders all match.

A diabetic training will be conducted in next two months to have a refresher for all diabetic trained staff. A call was placed with the diabetic trainer.

Proposed Overall Completion Date: 04/24/2024

DIRECTED

Within five calendar days of receipt of the accepted plan of correction: The administrator shall have all of the steps indicated in the plan of correction implemented. 3/26/24 [REDACTED]

Directed Completion Date: 03/31/2024

Not Implemented [REDACTED] -4/12/24)

Licensee's Proposed Date for POC Implementation

187d - Follow Prescriber's Orders

20. Requirements

2600.

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

Description of Violation

Resident #14 is prescribed Potassium Cl ER 10 MEQ, take 1 tablet by mouth every day. However, on 2/20/24 the medication was not available in the home and was not administered to resident #14.

Resident #13 is prescribed Humalog (Insulin Lispro) 100 unit/mL pen, inject four units subcutaneously three times daily with meals. However, the medication was not administered three times on multiple dates to include:

- 2/2/24 at 12:00 p.m.
- 2/7/24 at 12:00 p.m.
- 2/9/24 at 12:00 p.m.
- 2/14/24 at 12:00 p.m. and 4:00 p.m.
- 2/25/24 at 12:00 p.m.
- 2/28/24 at 12:00 p.m.

Plan of Correction

Directed [REDACTED] - 03/26/2024)

med cart audit was conducted by the designee med tech was conducted on 3/1/2024 and area to document the

187d - Follow Prescriber's Orders (continued)

humalog was added. the Doctor was involved in this discussion.

The home's policy and procedure will be attached. The med tech needs to match the medication and the MAR to ensure they are administering the correct medication and they need to call 3-5 days before a medication is out to ensure it is in the building. The Medication Trainer who is certified by the state will provide the education on 4/12/2024. The training will be the approved Medication training by DHS.

The [redacted] was notified on 3/1/2024 of the medication error. The administrator notified the family.

The prescriber was notified on 3/1/2024 by the administrator. The home will follow the direction of the prescriber related to medication errors.

Moving forward all medication errors will be reported within 24 hours to DHS on a reportable incident report. The administrator or designee will file the report.

The medication error will be made part of the residents permanent record. The administrator put it in the residents file on 3/11/2024.

A training was conducted on 3/13/2024 AND 187a was discussed.

moving forward a med cart audit will be conducted twice a week by the designated med tech and signed off on and the administrator will check the sign off sheets weekly. This started on 3/1/2024. the administrator will do a med cart audit monthly and the pharmacy was contacted and starting 4/20/2024 the pharmacy will do a monthly med cart audit.

A diabetic training will be conducted in next two months to have a refresher for all diabetic trained staff. A call was placed with the diabetic trainer.

Please include education on the home's policy and procedures for administering medications and the process to order medications to ensure medications are available in the home for administration and Regulation 2600.187(d) including who will provide the education, who is being trained (by title), and the date the training was completed.

Please include the documentation of education will be in compliance with regulation 2600.65(i).

Please include notifying the resident and the resident's designated person of the medication errors for each resident. Including who made (by title) the notification and the date when the notification was made.

Please include notifying the prescriber of the medication errors for each resident. Including who made (by title) the notification and the date when the notification was made. Also indicate the home shall follow the direction of the prescriber related to the medication error.

Please include filing an incident report for the medication errors including who made (by title) the notification and the date when the notification was made.

Please indicate the medications errors were made part of the resident's permanent record errors including who made (by title) completed updating the resident's record and the date when the record was updated.

Proposed Overall Completion Date: 04/12/2024

DIRECTED

Within five calendar days of receipt of the accepted plan of correction: The administrator shall have all of the steps indicated in the plan of correction implemented. 3/26/24 [redacted]

Directed Completion Date: 04/12/2024

Not Implemented ([redacted]/12/24)

Licensee's Proposed Date for POC Implementation

224a - Preadmission Screen Form

21. Requirements

2600.

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

Description of Violation

Resident #7's preadmission screening form dated [REDACTED]/23 indicated "See attached" for medical, psychological, and behavioral diagnoses, however, there was nothing attached to resident #7's preadmission screening form.

Plan of Correction

Accept [REDACTED] 03/26/2024)

This was obtained on 3/07/2024 by the Doctor. Resident # 7 prescreening that indicated attached was completed on 3/7/2024 by the administrator. The medical, psychological and behavioral diagnosis were all completed.

There was an all staff training on 3/13/2024 and 224a was discussed and taught.

All resident files were audited and will be completed by 3/24/2024 by the administrator and designee to ensure that all staff are up to date with all preadmission screen forms. this started on 3/1/2024

Moving forward the residents charts will be audited monthly by the administrator and or designee and to ensure all the staff trainings are up to date. A check list will be kept.

Licensee's Proposed Overall Completion Date: 03/24/2024

Not Implemented ([REDACTED]-4/12/24)

Licensee's Proposed Date for POC Implementation

225a - Assessment 15 Days

22. 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 #6's initial assessment was not finalized until [REDACTED] 2023, however, resident #6 was admitted to the personal care home on [REDACTED] 23.

Resident #14's initial assessment was not finalized until [REDACTED]/23, however, resident # 14 was admitted to the home on [REDACTED]/23.

REPEAT VIOLATION 10/5/23; 7/6/23; 5/9/2023;

Plan of Correction

Accept [REDACTED] 03/26/2024)

This was completed on 3/07/2024 by the Administrator. Resident # 6 and # 14 had a new assessment completed on 3/7/2024 by the administrator.

There was an all staff training on 3/13/2024 and 225a was discussed and taught.

All resident files were audited and will be completed by 3/24/2024 by the administrator and designee to ensure all Assessments are completed up to date and all information is needed. this started on 3/1/2024

Moving forward the residents charts will be audited monthly by the administrator and or designee and to ensure all the resident files have assessments completed and filled out properly . A check list will be kept.

An audit of all newly admitted resident records (within 15 days of admission) to ensure each resident has a timely, complete, and accurate assessment completed and in the resident's record by the administrator or designee. This will be started with the next new resident and the audit will be completed within 14 days.

Licensee's Proposed Overall Completion Date: 03/24/2024

Not Implemented ([REDACTED]-4/12/24)

Licensee's Proposed Date for POC Implementation

225c - Additional Assessment

23. Requirements

2600.

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

- 1. Annually.
- 2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #6's initial assessment, dated [REDACTED] 23, indicated some physical assistance was required for transfers; however, resident #6 cannot go from sit to stand without being assisted, supervision and assist will be available for all transfers for optimal safety. The resident's assessment was not updated to include the use of a sit-to-stand lift for transferring. The resident does not have a current assessment completed.

Plan of Correction

Accept [REDACTED] 03/26/2024)

This was obtained on 3/07/2024 by the Doctor. An assessment for resident #6 was completed on 3/7/2024 by the administrator and the sit to stand was added to the new assessment.

There was an all staff training on 3/13/2024 and 225c was discussed and taught.

All resident files were audited and will be completed by 3/24/2024 by the administrator and designee to ensure that all staff are up to date on Assessments and additional assessments, this started on 3/1/2024

Moving forward the residents charts will be audited monthly by the administrator and or designee and to ensure all the resident files that need additional assessments are completed. A check list will be kept.

Licensee's Proposed Overall Completion Date: 03/24/2024

Not Implemented ([REDACTED]-4/12/24)

Licensee's Proposed Date for POC Implementation

227a - Support Plan 30 Days

24. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident #6's initial support plan was not finalized until [REDACTED] 2023, however, resident #6 was admitted to the personal care home on [REDACTED] 23.

REPEAT VIOLATION 7/6/23; 5/9/23

Plan of Correction

Accept [REDACTED] - 03/26/2024)

This was obtained on 3/07/2024 by the Doctor. A new support plan for # 6 was completed on 3/7/2024 by the administrator.

There was an all staff training on 3/13/2024 and 227a was discussed and taught.

All resident files were audited and will be completed by 3/24/2024 by the administrator and designee to ensure that all support plans are in there filled out correctly and up to date this started on 3/1/2024

An audit of all newly admitted resident records (within 15 days of admission) to ensure each resident has a timely, complete, and accurate assessment completed and in the resident's record by the administrator or designee. This will be started with the next new resident and the audit will be completed within 14 days.

Moving forward the residents charts will be audited monthly by the administrator and or designee and to ensure all the residents support plans are completed and up to date. . A check list will be kept.

Licensee's Proposed Overall Completion Date: 03/24/2024

Not Implemented ([REDACTED] 4/12/24)

Licensee's Proposed Date for POC Implementation