pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **FAIR OAKS OPCO LLC**
LEGAL ENTITY

To operate **FAIR OAKS SENIOR LIVING**
NAME OF FACILITY OR AGENCY

Located at **2200 WEST LIBERTY AVENUE, PITTSBURGH, PA 15226**
(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 **100** (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 **March 26, 2024** until **September 26, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **452863**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

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

[redacted]
Fair Oaks OPCO LLC
2200 West Liberty Avenue
Pittsburgh, Pennsylvania 15226

RE: Fair Oaks Senior Living
License/COC #: 452863

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on August 17, 2023, August 18, 2023, August 29, 2023, October 4, 2023, October 5, 2023, October 12, 2023, January 11, 2024, and January 12, 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), mistreatment or abuse of residents being cared for in the facility, 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 THIRD PROVISIONAL license to operate the above facility. A THIRD PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your THIRD PROVISIONAL license is enclosed and is valid from March 26, 2024 to September 26, 2024.

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

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
101(j)(7)	II	87	$3	$261	15 calendar days from mailing date of this letter
185(a)	II	87	$3	$261	15 calendar days from mailing date of this letter
187(d)	II	87	$5	$435	5 calendar days from mailing date of this letter
225(a)	II	87	$5	$435	5 calendar days from mailing date of this letter
227(d)	II	87	$5	$435	5 calendar days from mailing date of this letter
81(b)	II	87	$5	$435	5 calendar days from mailing date of this letter

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

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

If you disagree with the decision to issue a 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:

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

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

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *FAIR OAKS SENIOR LIVING* **License #:** *45286* **License Expiration:** *10/14/2023*

Address: *2200 WEST LIBERTY AVENUE, PITTSBURGH, PA 15226*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *FAIR OAKS OPCO LLC*

Address: *2200 WEST LIBERTY AVENUE, PITTSBURGH, PA, 15226*

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

Certificate(s) of Occupancy

Type: *Other* **Date:** *01/16/2017* **Issued By:** *City of Pittsburgh*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *105* **Waking Staff:** *79*

Inspection Information

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

Reason: *Renewal, Complaint, Provisional, Incident* **Exit Conference Date:** *08/29/2023*

Inspection Dates and Department Representative

08/17/2023 - On-Site: [redacted]
08/18/2023 - On-Site:
08/29/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served:** *78*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *76*
Diagnosed with Mental Illness: *1*
Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *27*
Have Physical Disability: *1*

Inspections / Reviews

08/17/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/25/2023*

12/06/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/03/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/13/2023*

12/27/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/03/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/03/2024*

03/06/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *01/03/2024*

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

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 8/17/23, the violation reports dated 6/23/22 and 11/15/22 were not posted in the home. The only violation report posted was dated 5/3/23.

Plan of Correction ***Accept (- 12/01/2023)***

Immediately on 8/7/23 the missing summaries dated 6/23/22 and 11/15/22 were added to the binder and posted in a public and conspicuous place in the lobby of the home.
Going forward to ensure continued compliance the Administrator will check the survey binder to assure all current and PRN inspection summaries are posted in a conspicuous place. An audit was created for the Administrator to sign after she checks the binder and contents at the beginning and each of each month.

Licensee's Proposed Overall Completion Date: *09/26/2023*

Implemented - 03/06/2024)

15a - Resident Abuse Report

2. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 8/26/23 at approximately 10:42 p.m., there was a resident-to-resident abuse incident when resident #1 was alleged to have hit resident #2 in the the head. The incident was not reported to the local area agency on aging until 8/27/23 at 2:05 p.m.

Plan of Correction ***Accept - 12/01/2023)***

An inservice about Abuse Reporting was held 9/20/23 and another one is scheduled 10/4/23 regarding staff's responsibility to "immediately" report any suspected abuse or neglect. Staff was trained to directly report suspected abuse in the absence of the Administrator and DRS. The phone numbers of the departments are posted in the DRS office and in the med room. Copies of the form and phone numbers of the Administrator and DRS are posted with the Agency numbers for staff to notify. The home will continue to provide education on the community's policy regarding Abuse and Neglect at employee orientation. Training will also be provided on an individual basis if needed.
The DRS Assistant /Designee will review orientation and annual training monthly for 2 months then quarterly thereafter.

Licensee's Proposed Overall Completion Date: *10/04/2023*

Implemented - 03/06/2024)

17 - Record Confidentiality

3. Requirements

2600.

17 - Record Confidentiality *(continued)*

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

Description of Violation

On 8/17/23 at 1:00 p.m., there was a list of the names, dates of birth, and mobility needs of all residents in the home, and the records of 8 residents unlocked, unattended and accessible in the Lemon Lounge, including residents #3, #4, #5, #6, #7, #8, #9, and #10.

Repeat violation: 5/3/23

Plan of Correction ***Accept [redacted] - 12/26/2023)***

Fair Oaks Senior Living immediately locked the door when this concern was brought to the attention of the Administrator. The Administrator/ Designee will be responsible for handling and moving records. No resident records will be left in a room without the ability to lock door. Administrator/Designee will read RCG 2600.17 Record Confidentiality. AS print out from the RCG 2600.17 Record Confidentiality will be read and discussed during Quality Assurance Committee.
Admin/designee will do daily walk through of home for 6 weeks and weekly thereafter to ensure all records are in a locked area. Starting on 12/13/23. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *12/13/2023*

Implemented [redacted] - 03/06/2024)

42b - Abuse

4. Requirements

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

Description of Violation

Resident #1, admitted to the home on [redacted]23, is diagnosed with a major neurocognitive disorder with behavioral disturbances, The resident was admitted to the home after a hospital stay, where, according to hospital discharge records, the resident was receiving a psychiatric evaluation and treatment for "behavioral dysregulation including yelling, not eating, and physical aggression toward others." The resident's medical evaluation, dated 5/26/23, indicates the resident requires a secured dementia care unit (SDCU). The home does not have an SDCU. Also, the assessment for resident #1, dated [redacted]/23, indicates the resident requires total supervision.

On 8/26/23 at approximately 10:42 p.m., resident #1 entered resident #2's room, sat down next to [redacted] on the bed and hit resident #2 in the head. Resident #2 was upset by the incident, screamed for resident #2 to leave [redacted] bedroom, and remains fearful someone will hit[redacted]. The home failed to supervise resident #1, and admitted resident #2 when the medical evaluation indicated the resident required a secured dementia care unit (SDCU).

Plan of Correction ***Accept [redacted] - 12/26/2023)***

Fair Oaks has implemented a "Move In Committee", in which the team will review all documentation of the potential resident. Discussion will include, history, medical needs, Doctor, family concerns, behaviors, ADL's and can we meet their needs. If a physician deems the resident needs a SDCU then the home will not accept said resident.
Training for staff on Altered Mental Status will be on 12/18/23. Documentation will be kept.

42b - Abuse (continued)

Audit of RASPS will be completed by October30, 2023 by DRS/Designee
Inservice on Dementia (scheduling in October, do not have verification of exact date)- on redirecting techniques for residents exhibiting behaviors on the unit.
All residents will be one a 2-hour check. Documentation will be kept. Any resident showing signs of altered mental status will be placed on a 15-minute check for 3 days. After 3 days resident will be reassessed. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Not Implemented [redacted] 03/06/2024)

54a - Direct Care Staff

5. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:

Description of Violation

Direct care staff person A, hired [redacted]23, does not have a high school diploma, GED diploma, or active registration status on the Pennsylvania nurse aide registry.

Repeat violation: 11/15/22 et al

Plan of Correction ***Accept [redacted] - 12/26/2023)***

Direct care staff has a diploma from Haiti, GED diploma, but does have the direct care registry. W waiver was applied for on 8/30/23 via email. On 9/14/23 response from Scholaro Inc. indicates that staff member A diploma is as high as 9th grade. However, Staff member A is enrolled in a GED program (Essential Education). Documentation will be provided. Ongoing all out of country diplomas will be sent to Scholaro for review.

All employee files will be audited by DRS Assistant/ Designee by October 25, 2023, to assure that all diplomas or GED confirmation is present.

A hire check sheet will be completed by DRS Assistant/Designee. Audit and documentation to be presented at Quarterly QA meeting.

Proposed Overall Completion Date: 12/18/2023

Licensee's Proposed Overall Completion Date: *12/18/2023*

Not Implemented [redacted] - 03/06/2024)

65f - Training Topics

6. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
3. Care for residents with dementia and cognitive impairments.

Description of Violation

Direct care staff person B, hired [redacted]7, did not receive training in care for residents with dementia and cognitive

65f - Training Topics (continued)

impairment during the 2022 training year.

Plan of Correction ***Accept [redacted] - 12/01/2023)***

All staff will receive 6 hours of Dementia Training. Dementia training is being scheduled in October. The Training binder was reviewed and all staff that had missed inservices will receive the trainings. A system is n place for the year 2023. The DRS is responsible for maintaining compliance. Training topics for the year of 2022 and 2023 will be audited again for completion and compliance with Make Up trainings offered and completed by 1/1/2024. Ongoing the DRS will continue to be responsible for trainings, the DRS Assistannt will also review binder quarterly to ensure all trainings are completed.

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

Implemented [redacted] - 03/06/2024)

65i - Training Record

7. 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

The home's record of 2022 annual direct care staff training did not include the location, content of course, date and training source for multiple trainings, including:
- Personal Care Needs & Self Medication Administration
- Meeting the Needs of Resident on PCH forms
- Infection Control
- Safe Management Techniques
- Care for Resident with Mental Illness and Mental Retardation
- Fire Safety
- Emergency Preparedness
- Resident Rights / Abuse
- HIPPA
- Wound Care

The home's record of 2022 annual direct care staff training for Fall and Accident Prevention did not include the content of the course, date, and training source.

The home's record of 2022 annual direct care staff training for Resident Rights/Abuse and Emergency Preparedness did not include the length of courses.

Plan of Correction ***Accept [redacted] - 12/01/2023)***

The DRS and Administrator reviewed the 2022 training results mentioned in the exit interview. The DRS was educated on proper completion of training records. The DRS will be responsible for ensuring training records are completed correctly in its entirety to ensure compliance with regulation. The Administrator will preform monthly audits starting on 10/6/2023 and the beginning of each month thereafter.

Licensee's Proposed Overall Completion Date: *10/30/2023*

Implemented [redacted] - 03/06/2024)

65i - Training Record *(continued)*

81a - Accomodation

8. Requirements

2600.
81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Description of Violation

Resident #3 has a hearing impairment. The closed-captioning telephone belonging to the resident has not been set up, therefore is not available for the resident to use. The phone has been in the resident's bedroom for approximately 3 months.

Plan of Correction ***Accept ([redacted] - 12/26/2023)***

After further investigation, resident #3 has no desire for this telephone. The cost is not something [redacted] cares to have. Resident #3 uses a regular phone when [redacted] needs to make a phone call. Resident #3 has a cochlear implant that [redacted] wears continuously which provides [redacted] with the ability to hear on the phone. This phone was provided by an outside agency for the hearing impaired. Unfortunately, it come at a monthly cost which cannot be met by resident #3. Moving forward, any special accommodations needed by a resident will be addressed within 24 hours of request. This will be monitored by admin/designee by using HSL work orders.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented [redacted] - 03/06/2024)

82c - Locking Poisonous Materials

9. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 8/17/23, a spray bottle of Comet Cleaner with Bleach with a manufacturer's label indicating "If swallowed drink a glass of water. Call a physician immediately." was unlocked and unattended in the cabinet under the kitchen sink in the 2nd floor dining room.

On 8/17/23, a can of Claire disinfectant spray Q with a manufacturer's label indicating "Call a poison control center or doctor for treatment advice" was unlocked and unattended in the 4th floor laundry room closet.

Not all residents of the home, including resident #4, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] 12/26/2023)***

Immediately all poisonous materials were removed from unsafe areas. Inservice was held 9/20/23 educating all staff of the importance of keeping all poisonous materials locked. Documentation will be kept. All poisonous materials will be kept in locked areas moving forward.
A weekly walk thru of all common areas will be done by admin/designee moving forward. Documentation will be

82c - Locking Poisonous Materials (continued)

kept. All housekeepers responsible for common areas will monitor areas daily for poisonous material and ensure they are removed and kept locked. One staff member per shift will be assigned and monitor all areas and removing any poisonous items and put finding in a shift report.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented [redacted] - 03/06/2024)

86b - Bathroom

10. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

On 8/17/23, the bathroom located in room 104 did not have an operable window and the exhaust fan for ventilation was inoperable.

Plan of Correction ***Accept [redacted] - 12/01/2023)***

The Maintenance Director checked the fan and discovered the vent door was inoperative. Maintenance cleaned and adjusted the vent, and it is no working.
Audits will be completed by Maintenance /Designee for checking the exhaust fans throughout the home weekly for 8 weeks, then monthly thereafter.

Licensee's Proposed Overall Completion Date: *09/26/2023*

Implemented [redacted] - 03/06/2024)

89b - Hot Water Temperature

11. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 8/17/23 at 10:48 a.m., the water temperature at the sink in the lower-level activities room measured 125.6 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 12/26/2023)***

Immediately the Maintenance Director (Under the sink there is a tankless water heater adjusted the knobs. Maintenance checked again in an hour and the temperature was correct at 120 degrees. The water temperatures will be taken at different locations and times throughout the home weekly moving forward. Documentation will be kept. Training for staff was on 9/20/2023. Staff will report any water temperatures being too hot and immediately report it to Maintenance.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented [redacted] - 03/06/2024)

92 - Windows

12. Requirements

2600.

92 - Windows *(continued)*

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

Description of Violation

There was a tear approximately 3"x1" in the right emergency exit door screen located in the basement.

The screen was detached approximately 20" from the bottom of the frame on the screen door leading from the 3rd floor lobby to the balcony.

Plan of Correction ***Accept [redacted] - 12/01/2023)***

The entire screen for the tear in the screen door in basement was replaced on 9/5/2023. The screen detached from the 3rd floor was also entirely replaced on 9/5/2023. All staff were educated on 9/20/2023 for checking the screens weekly for tears, holes, or missing screens. This was added to the housekeeping check list. If they discover an issue, they are to notify Maintenance. Maintenance and the Administrator will evaluate the screen for repair or replacement.

Licensee's Proposed Overall Completion Date: *09/26/2023*

Implemented [redacted] - 03/06/2024)

93a - Handrails

13. Requirements

2600.
93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

There is no handrail for the 5" step leading from the laundry room emergency exit of the home.

Plan of Correction ***Accept [redacted] 12/26/2023)***

A grab bar has been added to each door. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *12/13/2023*

Implemented [redacted] - 03/06/2024)

95 - Furniture and Equipment

14. Requirements

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

Description of Violation

On 8/17/23, the toilet was not in working order in the lower-level women's common bathroom.

On 8/17/23, the water drained extremely slow in the sink located in the lower-level women's common bathroom.

Plan of Correction ***Accept [redacted] 10/03/2023)***

The missing part that had been order to fix the toilet had been delivered on August 31. Maintenance fixed the toilet that day. Maintenance also unclogged the drain in which the water now runs down faster. Decision to have extra toilet parts on hand to prevent waiting time to have something repaired was made.

95 - Furniture and Equipment (continued)

Maintenance when making rounds will randomly check the flow of the water and toilets are in working condition. Staff was reminded that if they find something not in working order to fill out a maintenance slip at the front desk.

Licensee's Proposed Overall Completion Date: *09/26/2023*

Implemented [redacted] - 03/06/2024)

101j7 - Lighting/Operable Lamp

15. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 8/17/23, resident #5's bedside lamp was not within reach of the bed and the tap light next to the bed was not in working order.

Repeat violation: 11/15/22 et al

Plan of Correction ***Accept [redacted] - 12/01/2023)***

Security immediately replaced the batteries to the push light. Added to housekeeping checklist will be - housekeepers will check lamps and push lights are in working order when they do weekly cleaning and dusting. Housekeepers will keep new light bulbs and batteries on their cart and will immediately change bulbs and batteries when needed. Procedure and checklist will be monitored by Maintenance weekly. Housekeeping will be inserviced on new procedure by 10/3/2023. Maintenance/ Designee will randomly audit rooms monthly for appropriate lighting for 3 months and quarterly thereafter. Maintenance will review audit results with Administrator to determine if compliance is maintained or additional actions may need to be taken.

Licensee's Proposed Overall Completion Date: *10/03/2023*

Not Implemented [redacted] - 03/06/2024)

121a - Unobstructed Egress

16. 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

The 2nd floor north emergency exit door leading to the patio is locked with an electronic keypad; however, no code was posted. Also, the door cannot be unlocked without entering a code, and not all residents of the home can use the code to open the door without staff assistance. The home does not have a secured dementia care unit.

On 8/17/23, the laundry room emergency exit screen doors were locked with slide locks at the top of each door.

Plan of Correction ***Accept [redacted] - 12/27/2023)***

After speaking with [redacted] on 12/13/23, we have agreed to install a panic bar on 2nd floor north

[redacted]

emergency exit door leading to the patio. We are currently getting estimates for the install from our locksmith. This estimate and install will be completed by 2/1/23. Documentation and receipts will be provided before or by 2/1/23.

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

Not Implemented [redacted] - 03/06/2024)

123c - Evacuation Diagrams

17. Requirements

2600.
123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

On 8/17/23, the 1st floor evacuation diagram was not depicted correctly. The building was renovated during the summer of 2022 and the evacuation diagram is no longer accurate to the building's current structure.

Plan of Correction ***Accept ([redacted] 12/01/2023)***

The evacuation diagram was immediately removed and corrected. The correct one was immediately put in its place. The Administrator and Maintenance did a walk through the building and reviewed the other evacuation signs to ensure each diagram shows correct passage to exit doors.

Licensee's Proposed Overall Completion Date: *09/26/2023*

Implemented [redacted] - 03/06/2024)

141a - Medical Evaluation

[redacted]

VIOLATION WITHDRAWN JD 3/14/24

[redacted]

[redacted]

184a - Resident's Meds Labeled

19. 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 #3 is ordered Sennosides 8.6mg, 2 tablets at bedtime, however, the medication label indicates Geri-Kot 8.6mg.

Resident #7 is ordered Novolog 100 units/ml KwikPen, inject subcutaneously before meals and at bedtime per sliding scale:
70-140 = 0 units; 141-180 = 1 unit; 181-220 = 2 units; 221-260 = 3 units; 261-300 = 4 units; 301-340 – 5 units; 341-400 = 6 units
>400 call MD
However, the medication label does not include the entire dosage instructions and only indicates:
70-140 = 0 units;; 141-180 = 1 unit; 181-220 = 2 units

Resident #8 is ordered Albuterol Sulfate HFA 90mcg, inhale 2 puffs every 4 hours as needed; however, the label was partially missing and did not include:
- Date prescription was issued
- The prescribed dosage and instructions for administration
- The name and title of the prescriber

Plan of Correction ***Accept [redacted] - 12/27/2023)***

The DRS called the pharmacy indicating that resident #3 ordered Sennosides but the label read Geri-kot. Pharmacy sent Sennosides with the correct label to match the order, Pharmacy was also notified of label partially gone on resident #8 medication and resident #7 did not state the proper information. Both labels are now correct. Staff has been retrained on the procedure of labels not being able to read and that medication need to match the MAR. DRS Assistant will do med cart audits twice a week till compliance is understood and met then once a week thereafter.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Not Implemented [redacted] - 03/06/2024)

185a - Implement Storage Procedures

20. 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 #7 is ordered blood glucose check 4 times a day before meals and at bedtime.
On 8/16/23, resident had a blood sugar reading of 211 at 19:35, however, staff person C did not record this blood sugar reading on the August 2023 medication administration record (MAR).

Repeat violation: 5/3/23 et al, 11/15/22 et al

Plan of Correction ***Accept [redacted] - 12/01/2023)***

An inservice was held on 9/20/2023 to review the proper procedure and importance of documentation. We also have implemented a procedure that checks all the accucheck readings on the MAR for accuracy. An audit sheet is is kept in the 3 med cart's narcotic book, and after each narcotic count at the change of shift the Med Tech will go to the audit sheet and the diabetic resident accucheck machine will check it against the MAR reading accuracy, The DRS will double check at the end of each month. This will ensure signature and readings are documented properly.

Licensee's Proposed Overall Completion Date: *11/06/2023*

Not Implemented ([redacted] - 03/06/2024)

187a - Medication Record

21. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #3 is ordered Ondansetron HCL 8mg, one-half tablet every 8 hours as needed. However, the medication is not indicated on the August 2023 medication administration record (MAR).

Repeat violation: 5/3/23 et al

Plan of Correction ***Accept [redacted] - 12/26/2023)***

Resident #3 is a veteran and receives [redacted] medication from the VA. Ondansetron HCL 8 mf was ordered by the VA. When they are ordered from the VA Fair Oaks receives a script which is faxed to the pharmacy for it to be profiled and put on the MAR. The Medical Evaluation in May had this medication on it, however the medical evaluation in September did not. So, the medication would not be on the MAR for August. A DC order has been obtained for resident #3. A complete MAR audit will be conducted on 9/29/23. The DRS/Designee will conduct monthly MAR audits. Ongoing all new orders will be verified by the DRS Assistant and will sign off monthly that all orders are correct and match the MAR.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Implemented [redacted] - 03/06/2024)

187d - Follow Prescriber's Orders

22. Requirements

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

Description of Violation

Resident #7 is ordered Acetaminophen 500mg, 2 tablets (1000 mg) every 8 hours, Amantadine 100mg 1 capsule daily, and B-12 1000mcg daily. However, these medications were not administered at 8:00 a.m. on 8/16/23. The medications were found on 8/18/23 at approximately 10:22 a.m., in a roll pack on the medication cart. The roll pack containing these medications was marked "8/16/23 8:00 am."

Resident #7 is ordered Carbidopa-Levo ER 50-200 TA 1 tablet four times daily, Metformin HCL 500 mg 1 tablet twice daily, Sertraline Hcl 50mg, 1 tablet daily. However, these medications were not administered at 8:00 a.m. on 8/18/23. The medications were found on 8/18/23 at approximately 10:22 a.m., in a roll pack on the medication cart. The roll pack containing these medications was marked "8/18/23, 8:00 a.m."

The roll pack containing these medications was marked "8/16/23 8:00 am."

Repeat violation: 5/3/23 et al

Plan of Correction ***Accept[redacted] - 12/27/2023)***

The Med Tech and DRS Assistant reviewed resident #7 MAR to ensure accuracy in accordance with the prescriber's order. A Med tech re-education training (with emphasis on checking the MAR against the med and signing off the medication) scheduled for 10/5/2023 and 10/10 2023. To ensure all Med techs attend this training a sign off sheet will be used to track this. Monthly audits of 10% of census charts of medication will be preformed by DRS/ Designee. Audits will be reviewed and signed off by the Administrator. Audits will be continued monthly till completion.
All medication technicians will be observed doing a medication pass by the administrator by 1/1/24. If counseling is needed, it will be done immediately. Documentation will be kept.

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

Not Implemented[redacted] - 03/06/2024)

225a - Assessment 15 Days

23. 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

The assessment, dated [redacted]/23, or resident #1, admitted to the home on [redacted]/23, indicates the resident has no problem with judgment and aggression. The resident is diagnosed with a major neurocognitive disorder with behavioral disturbances, and according to hospital records, the resident was receiving a psychiatric evaluation and treatment after being admitted on an involuntary 302 petition from another senior living facility for "behavioral dysregulation including yelling, not eating, and physical aggression toward others." On 8/26/23 at approximately 10:42 p.m., resident #1 entered resident #2's room and sat down next to [redacted] on the bed and hit resident #2 in the head.

225a - Assessment 15 Days (continued)

The assessment, dated [redacted]/22, for resident #6 does not include the diagnoses of constipation, restlessness and agitation, benign prostatic hyperplasia (BPH), anemia, and hyperlipidemia that are indicated on the medical evaluation, dated 7/14/23.

Repeat violation: 11/15/22 et al and 6/3/22 et al

Plan of Correction ***Accept ([redacted] - 12/27/2023)***

We have implemented a "Preadmission Overview Team" are managers who deal with the move in, evaluates and discussed any concerns. In the discussion will be all the diagnosis, medications, history, behavioral issues, psychological, social, and physical concerns and needs. And can we meet their needs. Notes will be taken at the meeting and will be reviewed at the QA meetings. Once a month the DRS/ Administrator will review recent move in charts to ensure all documentation is present and matches.
Resident #1 no longer resides in the home. Resident #6 assessment has been updated to reflect the diagnoses of constipation, restlessness and agitation, benign prostatic hyperplasia (BPH), anemia, and hyperlipidemia.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Not Implemented [redacted] - 03/06/2024)

[redacted]

227d - Support Plan Medical/Dental

25. Requirements

227d - Support Plan Medical/Dental *(continued)*

2600.

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

Description of Violation

Resident #5 has bilateral half-length bedrails at the top of his bed; however, the support plan, dated 1/18/23, does not address the need for the bedrails or a plan to protect the resident from the potential dangers of the bedrails.

Repeat violation: 11/15/22 et al

Plan of Correction ***Accept[redacted] 12/27/2023)***

Immediately the present siderails were securely covered. Maintenace will do a daily check on all enable bars and admin/designee will do bi-weekly checks. Documentation will be kept. The DRS updated the support plan to address the need for bedrails and a plan to protect the resident. The DRS will track residents who have enablers. During Morning Meeting, we will review any changes with our residents and the DRS will be responsible for putting changes on the support plan. On 9/18/23 the Administrator trained the DRS on proper documentation required for enablers. DRS and Administrator will review all new move-in support plans/RASPS to ensure all current residents have a support plan which accurately shows each resident's individuality and care needs.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Not Implemented[redacted] - 03/06/2024)

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

Facility Information

Name: *FAIR OAKS SENIOR LIVING* **License #:** *45286* **License Expiration:** *10/14/2023*

Address: *2200 WEST LIBERTY AVENUE, PITTSBURGH, PA 15226*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *FAIR OAKS OPCO LLC*

Address: *2200 WEST LIBERTY AVENUE, PITTSBURGH, PA, 15226*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date:** *01/16/2017* **Issued By:** *City of Pittsburgh*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *101* **Waking Staff:** *76*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *11/22/2023*

Inspection Dates and Department Representative

10/04/2023 - On-Site: [redacted]
10/05/2023 - Off-Site:
10/12/2023 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served:** *83*

Secured Dementia Care Unit

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

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *69*
Diagnosed with Mental Illness: *1*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *18*
Have Physical Disability: *0*

Inspections / Reviews

10/04/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/16/2023*

12/27/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/15/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/03/2024*

01/09/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/15/2024*

[redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/15/2024*

03/06/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *01/15/2024*

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

42b - Abuse

1. Requirements

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

Description of Violation

Resident #1 has a diagnosis of Alzheimer's disease and resided on the memory care unit of the home and utilized a wanderguard for safety. According to the resident's assessment, dated 8/15/23, the resident required extensive supervision and was not to leave the home unattended.

On 9/13/23 at approximately 11:00 a.m. – 11:30 a.m., resident #1 removed [redacted] wanderguard and walked out of the home. Staff indicated the resident had exit-seeking behavior and removed the wanderguard device several times prior to this incident. According to staff person A, the administrator, and staff person B, the hospital called the home and told them the resident was transported there via ambulance after the resident fell and broker her arm.

The home failed to ensure that the resident's wanderguard remained in place and that the resident did not leave the home unattended which resulted in the resident breaking her arm.

Plan of Correction ***Directed ([redacted] 01/09/2024)***

Wander guards are no longer being used at the home. Moving forward if a possible resident has or needs a wander guard, said resident will not be accepted.
Fair Oaks has implemented a "Move In Committee", in which the team will review all documentation of the potential resident. Discussion will include, history, diagnoses (dementia/Alzheimer disease), medical needs, Doctor, family concerns, behaviors, ADLs, and can we meet their needs. If a physician deems the resident needs a SDCU or a wander guard, then the home will not accept said resident.
Training for staff on Altered Mental Status will be on 12/18/23. Documentation will be kept. All residents will be one a 2-hour check. Documentation will be kept. Any resident showing signs of altered mental status will be placed on a 15-minute check for 3 days. After 3 days resident will be reassessed. Documentation will be kept.

Mock elopement drills have been completed. Additional trainings will be completed regarding elopements and the staff will be retrained on our elopement prevention policies. Risk assessments are also in place by our Move-In Committee to make sure a potential resident is not an elopement risk.

DIRECTED: Within 30 days of receipt of this plan of correction (POC) – The home will develop written elopement prevention policies to include elopement risk evaluations. The written policies will be submitted to the Western Regional Office. Within 60 days of receipt of this POC, all staff persons will be trained on the elopement prevention policies. Documentation of training will be kept. [redacted] 1/8/24

DIRECTED: Within 60 days of receipt of this plan of correction – The administrator will ensure that Elopement Risk Assessments are completed, including a facility-specific elopement risk assessment, and a resident elopement risk assessment for each resident. Resident support plans will incorporate elopement risk into the plan of care with individualized interventions. [redacted] 8/24

DIRECTED: Mock elopement drills will be conducted at least two times within 90 days of receipt of this POC and a

42b - Abuse (continued)

least every 6 months thereafter. Mock elopement drills will be documented to include date, time, name of the person conducting the drill. Documentation will be kept. [redacted] 1/8/24

Directed Completion Date: *01/31/2024*

Not Implemented [redacted] - 03/06/2024)

225a - Assessment 15 Days

2. 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

The assessment, dated [redacted] 23, for resident #1 does not include the diagnoses of hyperlipidemia, Vitamin B12 deficiency, insomnia, and GERD that are indicated on the medical evaluation, dated 8/7/23.

Repeat violation: 11/15/22.

Plan of Correction ***Accept ([redacted] 01/09/2024)***

Resident #1 never returned to the home. Moving forward all assessments will be previewed by administrator and signed off that it is accurate. A complete chart audit will be completed by administrator within 30 days of acceptance of POC. Documentation will be kept.

All assessments will be reviewed within 30 days to ensure all diagnoses are included. Additional training will also be completed so that all staff involved in assessments and support plan completion include all diagnoses, including diagnoses on the medication list.

Licensee's Proposed Overall Completion Date: *01/22/2024*

Not Implemented ([redacted] - 03/06/2024)

225c - Additional Assessment

3. Requirements

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

Description of Violation

The assessment, dated [redacted] /23, for resident #2 does not include the diagnosis of polyneuropathy that is indicated on the medical evaluation, dated 6/20/23.

Repeat violation: 11/15/22.

Plan of Correction ***Accept ([redacted] 01/09/2024)***

Immediately on [redacted] 23 a new assessment, classified as a department request, was done with all correct diagnoses for resident #2. Moving forward all assessments will be previewed by administrator and signed off that it is

225c - Additional Assessment (continued)

accurate. A complete chart audit will be completed by administrator within 30 days of acceptance of POC. Documentation will be kept.

All assessments will be reviewed within 30 days to ensure all diagnoses are included. Additional training will also be completed so that all staff involved in assessments and support plan completion include all diagnoses, including diagnoses on the medication list.

Licensee's Proposed Overall Completion Date: *01/22/2024*

Implemented [redacted] - 03/06/2024)

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

Facility Information

Name: *FAIR OAKS SENIOR LIVING* **License #:** *45286* **License Expiration:** *10/14/2023*

Address: *2200 WEST LIBERTY AVENUE, PITTSBURGH, PA 15226*

County: *ALLEGHENY* **Region:** *WESTERN*

Administrator

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

Legal Entity

Name: *FAIR OAKS OPCO LLC*

Address: *2200 WEST LIBERTY AVENUE, PITTSBURGH, PA, 15226*

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

Certificate(s) of Occupancy

Type: *Other* **Date:** *01/16/2017* **Issued By:** *City of Pittsburgh*

Type: *I-2* **Date:** *05/09/1997* **Issued By:** *City of Pittsburgh*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *120* **Waking Staff:** *90*

Inspection Information

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

Reason: *Complaint, Provisional, Monitoring* **Exit Conference Date:** *01/12/2024*

Inspection Dates and Department Representative

01/11/2024 - On-Site: [redacted]

01/12/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served:** *87*

Secured Dementia Care Unit

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

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *86*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *33* **Have Physical Disability:** *2*

Inspections / Reviews

01/11/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/24/2024*

02/26/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/24/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/28/2024*

03/05/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/28/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/06/2024*

03/07/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *03/06/2024*

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

54a - Direct Care Staff

1. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Staff person A, hired [redacted]/23, does not have a high school diploma, GED diploma, or active registration status on the Pennsylvania nurse aide registry.

Repeat Violation: 11/15/22 et al

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

Immediately documentation was provided from Scholaro showing that the employee's education is equivalent to that of a GED in the United States of America. The staff member has also completed the Direct Care Staff Training and Competency Test for Personal Care Homes (PCH) and Assisted Living Residences (ALR).

Waivers requests are also being sent to [redacted] with the proper documentation. Any new hire will also follow this same process. Documentation will be kept.

Direct care staff will be required to provide proof of education prior to employment, and if need be, a waiver request will be sent prior to employment in direct care.

DIRECTED: All direct care staff will have proof of high school diploma, GED diploma or active status on the PA Nurse Aide registry. Any staff person who has a non-US diploma will have their credentials submitted to the Department with a waiver request to ensure the diploma is equivalent to a US high school diploma. No staff will work in direct care prior to receipt of an approved waiver. [redacted]29/24

Directed Completion Date: *03/01/2024*

Not Implemented [redacted] - 03/12/2024)

81b - Resident Personal Equipment

2. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 1/11/24, the bedside mobility device on resident #1's bed in room [redacted] was not well-secured, and the device could be moved in both directions toward the head and foot of the bed and lifted from the box spring, and there was an open area measuring approximately 10½" by 5¾", all posing an entrapment and fall hazard. Also, there were openings on the headboard and footboard of the bed: six openings measuring 6" by 24½" on the headboard and six openings measuring 6" by 16½" footboard, posing an entrapment hazard.

On 1/11/24, there were six openings measuring 6" by 24½" on the headboard and six openings measuring 6" by 16½" footboard, on the bed directly across from the door in room 601, posing an entrapment hazard.

81b - Resident Personal Equipment (continued)

Repeat violation: 5/3/23 et al

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

Immediately the bedside mobility device was secured. After further review and discussion with the resident, [redacted] advised the bedside mobility device was useless to [redacted] and we received doctors orders to remove it from [redacted] bed.

We also ordered new sleigh beds with no openings for both room [redacted] and room [redacted] They were delivered and installed on 2/20/2024. All other beds at Fair Oaks with openings that could be considered entrapment hazards have been removed and replaced by new sleigh beds. A total of 17 beds were replaced.

A monitoring process is in place for all bedside mobility devices, we will complete an audit daily to make sure the mobility devices are being safely used. DIRECTED: Direct care staff will complete an audit daily and the administrator will complete the audit at least once per week. Documentation will be kept. - [redacted] 2/29/24

Administrator and DRS will educate all direct care staff on safe bedside mobility device/bedrail usage. Staff will be instructed to monitor bedrail safety, including checking covers on openings, daily and on each shift as part of their regular daily duties. DIRECTED: Education will be completed by 3/11/24. Documentation will be kept. - [redacted] 29/24

An in-service will also be held on safe bedside mobility device/bedrail usage on 2/28/2024. DIRECTED: In-service will be completed by 3/11/24. Documentation will be kept. [redacted] 2/29/24

Proposed Overall Completion Date: 03/11/2024

Directed Completion Date: *03/11/2024*

Not Implemented [redacted] 03/12/2024)

101j7 - Lighting/Operable Lamp

3. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 1/11/24, resident #2's bedside lamp was approximately 3' from the resident's bed and was unable to be turned off/on at bedside.

Repeat violation: 11/15/22 et al

Plan of Correction ***Accept [redacted] - 02/26/2024)***

Immediately a push light was installed on the wall beside the resident's bed. [redacted] did not [redacted] furniture moved; everything was where [redacted] wanted it. Moving forward audits will be conducte[redacted] weekly to ensure residents have a bedside lamp within their reach or an operating push light that can be easily accessed from their bed. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *03/11/2024*

101j7 - Lighting/Operable Lamp *(continued)*

Not Implemented [redacted] - 03/12/2024)

101o - Walls, Floors, Ceilings

4. Requirements

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

Description of Violation

The carpeting in bedroom [redacted] was in disrepair in several areas in the hall and in front of and around the bathroom door posing trip/fall hazards in the following areas:

-Bathroom entrance - The tacking strip was taped down with electrical tape that was lifting up in the middle, exposing approximately 7" of a sharp edge.
- Hallway - The carpeting was was taped with electrical and duct tape at the edges and the tacking strip along the wall was taped and the tape was lifting up. The carpeting was loose in the corner of the hall near the living area
- The carpeting was frayed and lifting up approximately 3' along the kitchen area

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

Immediately the carpet was removed and the sharp edges that were exposed were covered. The resident uses an electric wheelchair which caused the damage to the wall and floor. A long-term correction is currently under way, using laminate or some other material that will not get damaged by his wheelchair. Will provide details of the exact plan as soon as possible.

The administrator/designee or DRS will complete a walk-through/audit of the building bi-weekly to ensure all floors are in good repair. DIRECTED: The walk-throughs will begin by 3/7/2024.[redacted] 2/29/24

Proposed Overall Completion Date: 03/11/2024

Directed Completion Date: *03/11/2024*

Not Implemented ([redacted] - 03/12/2024)

183d - Prescription Current

5. 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

Resident #3's order for Meclizine 12.5mg was discontinued on 12/4/23; however, on 1/12/24, the medication was on

183d - Prescription Current (continued)

the medication cart.

Plan of Correction ***Accept [redacted] - 02/26/2024)***

Immediately the medication was removed from the medication cart. Moving forward audits of the carts will be performed weekly by the DRS or designee to ensure that no discontinued medications remain in any med carts. Documentation will be kept.

Licensee's Proposed Overall Completion Date: *03/11/2024*

Not Implemented [redacted] - 03/12/2024)

185a - Implement Storage Procedures

6. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 1/12/24, resident #4's glucometer was not calibrated to the current date and time. The medication administration record (MAR) indicated on 1/10/24 at 4:00 p.m., the resident had a blood sugar reading of 233. The glucometer indicated the date and time as 9/4 8:42 and no a.m. or p.m. was included.

Repeat violation: 11/15/22 et al

Plan of Correction ***Accept [redacted] - 02/26/2024)***

Immediately the glucometer was calibrated correctly, showing the correct date and time. An in-service is being planned to be conducted to review the proper procedure and importance of documentation. We also have implemented a procedure that checks all the accu-check readings on the MAR for accuracy. An audit sheet is kept in the 3 med cart's narcotic book, and after each narcotic count at the change of shift, the Med Tech will go to the audit sheet and the diabetic resident accu-check machine will check it against the MAR reading accuracy, The DRS will double check at the end of each month. This will ensure signature and readings are documented properly.

Licensee's Proposed Overall Completion Date: *03/11/2024*

Not Implemented [redacted] - 03/12/2024)

187d - Follow Prescriber's Orders

7. Requirements

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

Description of Violation

Resident #3 is ordered Furosemide 40mg, 1 tablet daily, except Mondays and Fridays.
The resident was administered the medication on Friday, 1/12/23. Also, the medication label indicates 1 tablet only on Mondays and Fridays.

187d - Follow Prescriber's Orders (continued)

Repeat violation: 5/3/23 et al

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

Immediately the DRS and Med tech reviewed the MAR to ensure accuracy with the prescribers orders. It was discovered that we received the incorrect medication from the pharmacy, the pharmacy was contacted, they admitted fault and corrected the issue. A Med tech re-education training (with emphasis on checking the MAR against the med and signing off the medication) will be completed shortly. To ensure all med techs attend this training a sign off sheet
will be used to track this. Monthly audits of 10% of census charts of medication will be performed by DRS/ Designee. Documentation will be kept.

In-Service training is scheduled to be completed on 3/4/2024 and chart audits have begun on 2/28/24.

Licensee's Proposed Overall Completion Date: *03/11/2024*

Not Implemented[redacted] - 03/12/2024)

227d - Support Plan Medical/Dental

8. Requirements

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

Description of Violation

The support plan, dated, [redacted]/23, for resident #5 does not indicate the resident has a bed cane bedside mobility device. It was ordered on 12/6/23, to assist the resident with turning and repositioning.

The support plan, dated [redacted]/23, for resident #6 does not indicate the resident uses a Sit-to-Stand mechanical device for transfers. The resident was ordered the device on 10/13/23.

The support plan, dated 3[redacted]/23, for resident #7 does not indicate the resident uses a wanderguard for safety.

Repeat violation: 11/15/22 et al

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

Immediately the support plan for resident #5 was updated to show the resident has a bed cane bedside mobility device.

Immediately the support plan for resident #6 was updated to show the resident uses a Sit-To-Stand mechanical device for transfers.

Immediately the support plan for resident #7 was updated to show that the resident uses a wanderguard for safety.

Moving forward the audits will be conducted weekly by the Resident Care Coordinator or designee to ensure the support plans are up-to-date and correct. DIRECTED: Audits to commence no later than 3/5/24. [redacted]2/29/24

227d - Support Plan Medical/Dental (continued)

Maintenace will do a daily check on all enable bars and admin/designee will do bi-weekly checks. Documentation will be kept. The DRS updated the support plan to address the need for bedrails and a plan to protect the resident. The DRS will track residents who have enablers. During Morning Meeting, we will review any changes with our residents and the DRS will be responsible for putting changes
on the support plan. We will continue to educate staff regarding the use of bedside mobility devices and proper documentation. DRS and Administrator will review all new move-in support plans/RASPS to ensure all current residents have a support plan which accurately shows each resident's individuality and care needs.

Bedside mobility device training will be completed on 2/28/24. Audits of support plan are underway and will be completed by the Administrator/designee after every new move-in.

DIRECTED: The administrator will develop a system to ensure support plans are updated when residents' needs change, including mobility needs such as bedside mobility devices are used and wanderguards installed. - [redacted] 2/29/24

Proposed Overall Completion Date: 03/11/2024

Directed Completion Date: *03/11/2024*

Not Implemented[redacted] - 03/12/2024)