

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

May 20, 2024

[REDACTED], DIRECTOR  
ABODE CARE OF ALLENTOWN LLC  
[REDACTED]  
[REDACTED]

RE: ABODE CARE OF ALLENTOWN  
2232 29TH STREET SW  
ALLENTOWN, PA, 18103  
LICENSE/COC#: 23039

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/17/2024, 01/23/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED]  
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

**Name:** ABODE CARE OF ALLENTOWN **License #:** 23039 **License Expiration:** 12/09/2024  
**Address:** 2232 29TH STREET SW, ALLENTOWN, PA 18103  
**County:** LEHIGH **Region:** NORTHEAST

**Administrator**

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

**Legal Entity**

**Name:** ABODE CARE OF ALLENTOWN LLC  
**Address:** [REDACTED]

**Certificate(s) of Occupancy**

**Type:** C-2 LP **Date:** 08/04/2012 **Issued By:** L & I

**Staffing Hours**

**Resident Support Staff:** 0 **Total Daily Staff:** 82 **Waking Staff:** 62

**Inspection Information**

**Type:** Full **Notice:** Unannounced **BHA Docket #:**  
**Reason:** Renewal **Exit Conference Date:** 01/23/2024

**Inspection Dates and Department Representative**

01/17/2024 - On-Site: [REDACTED]  
01/23/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information			
<b>License Capacity:</b> 150	<b>Residents Served:</b> 76		
Secured Dementia Care Unit			
<b>In Home:</b> No	<b>Area:</b>	<b>Capacity:</b>	<b>Residents Served:</b>
Hospice			
<b>Current Residents:</b> 13			
Number of Residents Who:			
<b>Receive Supplemental Security Income:</b> 0	<b>Are 60 Years of Age or Older:</b> 73		
<b>Diagnosed with Mental Illness:</b> 2	<b>Diagnosed with Intellectual Disability:</b> 1		
<b>Have Mobility Need:</b> 6	<b>Have Physical Disability:</b> 4		

**Inspections / Reviews**

01/17/2024 Full		
<b>Lead Inspector:</b> [REDACTED]	<b>Follow-Up Type:</b> POC Submission	<b>Follow-Up Date:</b> 02/22/2024
03/07/2024 - POC Submission		
<b>Submitted By:</b> [REDACTED]	<b>Date Submitted:</b> 03/21/2024	
<b>Reviewer:</b> [REDACTED]	<b>Follow-Up Type:</b> POC Submission	<b>Follow-Up Date:</b> 03/14/2024

Inspections / Reviews *(continued)*

03/14/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/21/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 03/22/2024

05/20/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/21/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

18 - Compliance With Laws

1. Requirements

2600.

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

Description of Violation

The home did not change and date the batteries in the homes CO2 monitor on an annual basis. The Homes carbon monoxide detector located on the 2nd floor was dated 12/21/22. The Pennsylvania care facility carbon monoxide alarm standard act indicated that carbon monoxide detector batteries are to be checked annually and dated when that occurs

Plan of Correction

Accept [redacted] - 03/14/2024)

Building Maintenance Superintendent replaced all the CO2 batteries throughout the building on 1/25/24 immediately following the inspection. [redacted] also created a log to ensure that all batteries are tested on a monthly basis as well as, replaced on an annual basis every January. DHS stated log is acceptable form of tracking. Executive Director and Building Maintenance Superintendent will ensure this is followed up on and completed monthly/annually.

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

Implemented [redacted] - 05/19/2024)

20b1 - Financial Records

2. Requirements

2600.

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

- 1. The home shall keep a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance.

Description of Violation

Resident #7 has a resident account that was opened on [redacted] with an amount of [redacted]. On [redacted] another deposit of [redacted] was made. On [redacted], the balance was [redacted]. These transactions did not contain the signature of the resident or withdrawal amounts.

Plan of Correction

Accept [redacted] - 03/07/2024)

On [redacted] the resident and POA signed the entire [redacted] balance out of the safe (see attached) and transferred it to her outstanding beauty/barber shop balance.

Executive Director retrained Community Life Director on 1/23/2024 regarding procedure needing resident signatures on all account transactions (see attached).

Executive Director and Community Life Director will continue to be responsible to manage safe and funds log.

Licensee's Proposed Overall Completion Date: 02/21/2024

Implemented [redacted] - 05/19/2024)

65e - 12 Hours Annual Training

3. Requirements

2600.

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

65e - 12 Hours Annual Training (continued)

**Description of Violation**

*There is no documentation that Staff Person B had 12 hours of annual training in the year 2023. Only .5 hours were documented for the training year.*

**Plan of Correction**

**Accept** ( ) - 03/07/2024)

*Direct care staff person B did complete all team trainings in 2023, however proper documentation couldn't be produced. Staff person B is currently working on retaking all the required training for 2023 on Relias to ensure the proper documentation and will have completed by March 15th.*

*Executive Director as of 9/30/23 will ensure that all annual training hours be properly assigned via Relias including monthly all team meetings with training hours, topics, and sign in sheets. The Executive Director will ensure ongoing compliance and be reviewed during our leadership quality compliance meetings.*

**Licensee's Proposed Overall Completion Date: 03/15/2024**

**Implemented** ( ) - 05/19/2024)

65f - Training Topics

**4. Requirements**

2600.

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

**Description of Violation**

*There is no documentation that Staff Member B had training on medication self-administration, Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, Care for residents with dementia and cognitive impairments, Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, Personal care service needs of the resident, and Safe management techniques in the year 2023*

**Plan of Correction**

**Accept** ( ) - 03/07/2024)

*Direct care staff person B did complete the required topic in 2023, however proper documentation couldn't be produced. Staff person B is currently working on retaking all the required training on Relias to ensure the proper documentation and will have completed by February 29th.*

*Executive Director as of 9/30/23 will ensure that all annual training hours be properly assigned via Relias including monthly all team meetings with training hours, topics, and sign in sheets. The Executive Director will ensure ongoing compliance and be reviewed during our leadership quality compliance meetings.*

**Licensee's Proposed Overall Completion Date: 02/29/2024**

**Implemented** ( ) - 05/19/2024)

65g - Annual Training Content

**5. Requirements**

2600.

65g Annual Training Content (continued)

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

Description of Violation

There is no documentation that staff member A had annual training on fire safety by a fire safety expert or a staff person trained by a fire safety expert, and resident rights.

There is no documentation that Staff Member B had training on fire safety by a fire safety expert or staff person trained as a fire safety expert, emergency preparedness, resident rights, The Older Adult Protective Services Act, and falls and accident prevention in the year 2023.

Plan of Correction

Accept ( ) - 03/07/2024)

Direct care staff person A did complete the required topics in 2023 via all team meeting trainings, however proper documentation couldn't be produced. Staff person A retook both required trainings on Relias already on 2/13/2024 to ensure the proper documentation (see attached). Please note that the Relias Fire Safety video was created by a Fire Safety Expert.

Executive Director as of 9/30/23 will ensure that all annual training hours be properly assigned via Relias including monthly all team meetings with training hours, topics, and sign in sheets. The Executive Director will ensure ongoing compliance and be reviewed during our leadership quality compliance meetings.

Licensee's Proposed Overall Completion Date: 02/21/2024

Implemented ( ) - 05/19/2024)

81b - Resident Personal Equipment

6. 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

The bed enabler located in room 415 has an opening of 9 x 5 and it was not covered upon initial walk through.

Plan of Correction

Accept ( ) - 03/14/2024)

Apartment 415 has been vacant. On 1/17/2024 bed enabler in apartment 402 was secured fully with a proper cover (pillow case) leaving no holes by the Building Maintenance Superintendent, this was verified on our second visit inspection on 1/23/2024. All other bed enablers in the community were checked and verified by the Director of Wellness that they already had proper coverings on them.

Resident, staff and family all notified of risk of injury and that bed enabler must be covered at all times. It will be reviewed again at all team meeting on 3/21/2024. Director of Wellness and Executive Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: 03/21/2024

Implemented ( ) - 05/19/2024)

82c - Locking Poisonous Materials

7. Requirements

82c - Locking Poisonous Materials (continued)

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

Virex II and Alpha HP multi purpose cleaners were store in an unlocked storage closet in stairwell closet to room 131. Residents of the home, including residents [REDACTED] have not been assessed capable of recognizing and using poisons safely

Plan of Correction

Accept [REDACTED] - 03/14/2024)

Closet was immediately locked on 1/17/2023 by Building Maintenance Superintendent and all staff was notified to keep poisonous materials secured and locked at all times throughout the entire community. We will be reviewing again at all team meeting on 3/21/2024. Building Maintenace Superintendent and Executive Director will ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 03/21/2024

Implemented [REDACTED] - 05/19/2024)

85d - Trash Receptacles

9. Requirements

2600.

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

Description of Violation

The large gray garbage can located in the kitchen of the home was found to be uncovered.

Plan of Correction

Accept [REDACTED] - 03/14/2024)

The garbage can cover was immediately placed back on during the inspection by Building Maintenance Superintendent on 1/17/24 and all staff was informed that all garbage cans must have lids on all times. This will be reviewed again at our all staff meeting on 3/21/24. Executive Director walked the community and verified all garbage cans had lids on. Our Director of Dining, Building Maintenance Superintendent and Executive Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: 03/21/2024

Implemented [REDACTED] - 05/19/2024)

85e - Trash Outside Home

10. 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

The lid of the dumpster located outside the home was open and inoperable.

Plan of Correction

Accept [REDACTED] - 03/14/2024)

Gusty winds on the day of inspection of 1/17/24 blew the lid open due to lid curvature. The lid was immediately flipped back on by Building Maintenance Superintendent during inspection on 1/17/24. [REDACTED] also called the garbage company and scheduled repair. Garbage lid was replaced on 1/31/2024. It will be reviewed with all staff at all team meeting on 3/21/2024 that those lids must stay on and that if they blow open, they must be flipped back on.

85e - Trash Outside Home (continued)

*Building Maintenance Superintendent and Executive Director will be responsible for ongoing compliance.*

**Licensee's Proposed Overall Completion Date: 03/21/2024**

**Implemented (█) - 05/19/2024)**

87 - Lighting

11. Requirements

2600.

87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

**Description of Violation**

*The stairway leading to the 2nd floor by room 131 was not properly lit due to the ceiling fixture being inoperable.*

**Plan of Correction**

**Accept (█) - 03/07/2024)**

*On 1/23/24 all lights were operational and fixed by Building Maintenance Superintendent as it was already previously in progress. We are completing monthly inspections and have a log created and in place as of 1/25/24 (see attached). Building Maintenance Superintendent and Executive Director will oversee compliance.*

**Licensee's Proposed Overall Completion Date: 02/21/2024**

**Implemented (█) - 05/19/2024)**

91 - Telephone Numbers

12. Requirements

2600.

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

**Description of Violation**

*The telephone numbers required by this regulation were not posted by the phones located by room 205.*

**Plan of Correction**

**Accept (█) - 03/14/2024)**

*Required Telephone numbers were posted by the telephone near apartment 205 by Executive Director on 1/17/24 on the date of inspection.*

*Executive Director walked community and verified that all other telephones had emergency numbers posted by them.*

*Executive Director will do monthly checks to ensure all numbers are posted where necessary.*

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

**Implemented (█) - 05/19/2024)**

96a - First Aid Kit

13. Requirements

2600.

96a - First Aid Kit (continued)

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

Description of Violation

First aid kit located in 400 med room did not have antiseptic.

Plan of Correction

Accept ( ) - 03/14/2024

Antiseptic was inserted by the Director of Wellness in the 400 med room first aid kit on 1/23/24 after inspection (picture attached).

Director of Wellness verified that all other first aid kits had all necessary supplies.

Monthly checks will be conducted by Director of Wellness and Assistant Director of Wellness to ensure all first aid kits are up to date and for ongoing compliance.

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

Implemented ( ) - 05/19/2024

100a - Exterior - Free of Hazards

14. Requirements

2600.

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

Description of Violation

A black plastic crinkled drainage pipe was found lying across the sidewalk outside the exit near room 101.

Plan of Correction

Accept ( ) - 03/14/2024

The snow removal company had just been out the morning of 1/17/24 and scraped the plastic drainage pipe out of the concrete hours prior. A spike was used to fix drainage pipe outside on 1/17/24 the day of inspection (see attached) by Building Maintenance Superintendent. The rest of the grounds were walked by both Building Maintenance Superintendent and Executive Director on 1/17/2024 to ensure the grounds were free from hazards.

Building Maintenance Superintendent and Executive Director will ensure ongoing compliance.

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

Implemented ( ) - 05/19/2024

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

Residents in rooms 110, 339, didn't have a light within reach of the bed.

Repeated Violation 12-20-22

101j7 Lighting/Operable Lamp (continued)

Plan of Correction

Accept ( ) - 03/14/2024)

Immediately following the inspection, lights were placed at the bedside within reach of each resident's apartment (110/339) by Building Maintenance Superintendent on 1/17/2024. All other apartments in the community were walked to ensure lights were present and they were on 1/17/2024.

Procedures will be reviewed in our all team meeting on 3/21/24 and that the Director of Wellness, Building Maintenance Superintendent, and ED will ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 03/21/2024

Implemented ( ) - 05/19/2024)

103g - Storing Food

16. Requirements

2600.  
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

Butter located in kitchen prep refrigerator was not wrapped and securely closed.

Plan of Correction

Accept ( ) - 03/14/2024)

Butter was securely wrapped immediately on the spot on 1/23/24 by Director of Dining. Director of Dining checked to ensure all food was securely wrapped and it was on 1/23/24.

Director of Dining reminded chef that all food must be sealed completely and will be reviewed again at all team meeting on 3/21/24. Executive Director and Director of Dining will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: 03/21/2024

Implemented ( ) - 05/19/2024)

103i - Outdated Food

17. Requirements

2600.  
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

Sliced cake that was in the prep refrigerator was not dated.

A large #10 can of potatoes was dented and in with the cans of food to be used for food preparation.

Plan of Correction

Accept ( ) - 03/14/2024)

Director of Dining removed and discarded can immediately on the spot during the inspection on 1/23/24. Director of Dining checked entire dry storage for any other dented cans and verified there were not any on 1/23/24.

Dining team will be retrained again during all team meeting on 3/21/2024. Executive Director and Director of Dining will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: 03/21/2024

Implemented ( ) - 05/19/2024)

**105c Supply Linens/Towels**

**18. Requirements**

2600.

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

**Description of Violation**

*During inspection, inspectors noted that linen closets were on each floor, but none of the closet had sufficient linens to completely change all beds in the home.*

**Plan of Correction**

Accept (█) - 03/07/2024)

20 additional linens ordered on 1/22/24 to ensure compliance - receipt attached.

*Executive Director will do quarterly checks to ensure we have enough bed linens with fluctuating census. Executive Director will be responsible for ongoing Maintenance.*

**Licensee's Proposed Overall Completion Date:** 02/21/2024

Implemented (█) - 05/19/2024)

**121a Unobstructed Egress**

**19. 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**

*A resident's walker was found in front of the exit near mechanical room 1, preventing immediate egress in the event of an emergency.*

**Plan of Correction**

Accept (█) - 03/14/2024)

*The walker was removed immediately by Building Maintenance Superintendent on 1/17/23 and returned to the resident in the West End Activity Area. The resident just walked away from it moments before. Executive Director walked entire community to ensure there were no other blocked egress exits and there were not.*

*Personal Care Associates and all Directors will be retrained at all team meeting on 3/21/2024 to ensure that all egress exits remain clear and unblocked.*

**Licensee's Proposed Overall Completion Date:** 03/21/2024

Implemented (█) 05/19/2024)

**132a Monthly Fire Drill**

**20. Requirements**

2600.

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

**Description of Violation**

*The home did not maintain a fire drill record for drills held from January 2023 to September 2023. Therefore, it cannot be verified that fire drills were held.*

132a - Monthly Fire Drill (continued)

Plan of Correction

Accept ( ) - 03/07/2024)

Previous records/documentation were not found within community by new Executive Director that started in September and were not able to be produced, but staff reports corroborated that drills did happen monthly, and night drills did occur bi annually.

Current Executive Director started new records (please see attached) and has them in a locked office with new electronic key codes that only the Building Maintenance Superintendent and Executive Director has access to - they both will ensure drills occur as required on a monthly basis and sleeping hour drills happen once every 6 months.

Licensee's Proposed Overall Completion Date: 02/21/2024

Implemented ( ) - 05/19/2024)

132c - Fire Drill Records

21. 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.

Description of Violation

The home did not maintain a fire drill record for drills held from January 2023 to September 2023

Plan of Correction

Accept ( ) - 03/07/2024)

Previous records/documentation were not found within community by new Executive Director that started in September and were not able to be produced, but staff reports corroborated that drills did happen monthly, and night drills did occur bi annually.

Current Executive Director started new records and has them in a locked office with new electronic key codes that only the Building Maintenance Superintendent and Executive Director has access to - they both will ensure drills occur as required on a monthly basis and sleeping hour drills happen once every 6 months.

Licensee's Proposed Overall Completion Date: 02/21/2024

Implemented ( ) - 05/19/2024)

132d - Evacuation

22. Requirements

2600.

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

Description of Violation

The home exceeded maximum evacuation time determined by the fire expert of 5 minutes and 35 seconds during the fire drill conducted on 10/13/23/23 at 2:23pm, with a recorded time of 6 minutes 21 seconds and 11/28/23 at 1155pm, with a recorded time of 5 minutes and 42 seconds.

Plan of Correction

Accept ( ) - 03/14/2024)

We had training with staff on 2/15/2024 presented by Building Maintenance Superintendent to go over Fire Safety

**132d - Evacuation (continued)**

*procedures and process to improve times.  
Our Jan. 25, 2024 fire drill had a time of 4:54 which showed vast improvement.*

*We will always redo a fire drill if our times ever exceed the allotted time. Building Maintenance Superintendent and Executive Director will oversee ongoing compliance.*

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

**Implemented (█) - 05/19/2024)**

**132e - Fire Drill Sleeping Hours**

**23. Requirements**

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

**Description of Violation**

*The home conducted a sleeping hour drill on November 28, 2023, at 11:55pm. The home did not conduct a sleeping drill every six (6) months as required.*

*Repeated Violation 12-20-22*

**Plan of Correction**

**Accept (█) - 03/07/2024)**

*Previous records/documentation were not found within community by new Executive Director that started 9/30/2023 and were not able to be produced, but staff reports corroborated that drills did happen monthly, and night drills did occur bi annually.*

*Current Executive Director started new records and has them in a locked office with new electronic key codes that only the Building Maintenance Superintendent and Executive Director Has access to - they both will ensure drills occur as required on a monthly basis and sleeping hour drills happen once every 6 months. We already did complete one. Executive Director and Building Maintenance Superintendent will maintain ongoing compliance.*

**Licensee's Proposed Overall Completion Date: 04/17/2024**

**Implemented (█) - 05/19/2024)**

**141a 1-10 Medical Evaluation Information**

**24. Requirements**

2600.

141a 1-10 Medical Evaluation Information (continued)

- 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. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
  2. Medical diagnosis including physical or mental disabilities of the resident, if any.
  3. Medical information pertinent to diagnosis and treatment in case of an emergency.
  4. Special health or dietary needs of the resident.
  5. Allergies.
  6. Immunization history.
  7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
  8. Body positioning and movement stimulation for residents, if appropriate.
  9. Health status.
  10. Mobility assessment, updated annually or at the Department's request.

**Description of Violation**

Resident #2's initial medical evaluation was completed on [REDACTED]. The medical evaluation indicated that the resident needed a secured dementia care unit.

**Plan of Correction**

Accept [REDACTED] - 03/14/2024)

Please note that we had available and produced a newer version of the DME on the date of inspection (1/23/2024) that was dated [REDACTED] for a status change that stated none. Director of Wellness and Wellness Nurse ensured that all of our Memory Lane residents don't have this listed on their DME as we only have the Wander Guard bracelet system in place at this time.

Director of Wellness does regular annual audits or as needed for ongoing compliance.

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

Implemented [REDACTED] - 05/19/2024)

183d - Prescription Current

**25. 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 #5 had a prescription for [REDACTED] tablets. The prescription was discontinued but was still found in the medication cart.

**Plan of Correction**

Accept [REDACTED] - 03/14/2024)

Director of Wellness immediately disposed via drug buster the Ibuprofen 200mg tablets on 1/23/2024. Director of Wellness conducted thorough medication cart audits on all carts to ensure that we didn't have any other discontinued medications on the carts (and there were no others found) on 1/24/2024.

Director of Wellness will continue to conduct bi-weekly medication cart audits as well as a quarterly audit by Health Direct pharmacy to ensure medication carts are current.

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

Implemented [REDACTED] - 05/19/2024)

185a - Implement Storage Procedures

26. Requirements

2600.

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

Description of Violation

Resident #1's glucometer was not calibrated to the correct date and time

Plan of Correction

Accept (█ - 03/14/2024)

Resident #1's glucometer was calibrated on █ with dates and times by Health Direct Pharmacy. All other glucometers were checked to ensure proper calibrations on █ by Director of Wellness.

Director of Wellness scheduled a diabetic training on █ to retrain on diabetes and insulin competencies (see attached). Yearly training will continue, and Director of Wellness and Executive Director will ensure ongoing compliance.

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

Implemented (█ - 05/19/2024)

187a - Medication Record

27. 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 #6 has a prescription for █ tablets. The medication label states to give 1/2 tablet by mouth daily. The Medication Administration Record lists instructions to give 1 tablet daily. As per interviews with staff, the medication label is correct.

Plan of Correction

Accept (█ - 03/14/2024)

Executive Director confirmed with Director of Wellness, Wellness Nurse, Assistant Director of Wellness, and med techs that that the MAR is correct of 1 tablet daily as of 11/28/20 when the original order was signed. All med techs confirmed they had been giving him 1 tablet daily according to the MAR. Attached is proof of order sent to get this revised again on 12/20/23. All bottled medications throughout all med carts were cross checked with the MAR to ensure directions matched on 1/23/24.

On 1/23/2024 Wellness Director placed a sticker "Directions changed refer to chart" on the prescription bottle.

Director of Wellness will continue to conduct weekly medication cart audits as well as a quarterly audit by Health Direct pharmacy to ensure medication carts are current.

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

Implemented (█ - 05/19/2024)

227d - Support Plan Medical/Dental

28. Requirements

2600.

227d Support Plan Medical/Dental (continued)

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 # 3's Resident Assessment and Support Plan (RASP) dated [redacted] was not updated to include when the resident began PT/OT services and what those services were doing for the resident. Additionally, an addendum was added to the residents RASP indicating a change in the resident's diet to mechanical soft. However, the addendum was not dated when this change went into effect.

Resident #4's initial Documentation of Medical Evaluation (DME) dated [redacted], indicated the resident was on a mechanical soft diet. Resident #4 was admitted to hospice on [redacted] and a DME was completed on [redacted]. The DME indicated "NA" for special diet. However, the RASP indicated the Resident #4's diet was mechanical soft as previously indicated by the doctor.

Repeat Violation 7 7 23, 4 6 23

Plan of Correction

Accept [redacted] - 03/14/2024)

Resident's #3 RASP was immediately updated with the proper information on [redacted] with the following information: date resident began PT/OT services with Fox and reason along with fixed addendum with date diet went into effect (see attached).

Resident #4 DME that was completed on [redacted] is correct of N/A for special diet is correct. On [redacted] the family signed a consent requesting resident to have a regular diet even after being briefed on all of the risks involved with aspiration and against Dr. and Speech therapists' recommendations (see signed consent order attached). And updated RASP attached.

New Director of Wellness, has actively taken the initiative to review all current DMEs and RASPs for compliance and will have complete by 4/15/2024.

Licensee's Proposed Overall Completion Date: 04/15/2024

Implemented [redacted] - 05/19/2024)