CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: AUGUST 2, 2024

[redacted], Administrator
Hotel Lebanon Corporation
23-25 South Ninth Street
Lebanon, Pennsylvania 17042

RE: American House T/A Hotel Lebanon
23-25 South Ninth Street
Lebanon, Pennsylvania 17042
License #: 344043

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on December 19, 2023, February 27, 2024 and May 14-15, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summaries (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your license to operate the above facility. The decision to REVOKE your license is based on the violations attached to this notice and your failure to comply with the Department's regulations, gross incompetence, negligence and failure to submit an acceptable plan to correct noncompliance items and is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code §20.71(a)(2);(3);(5);(6) (relating to conditions for denial, nonrenewal or revocation).

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

55 Pa. Code Chapter 2600:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
2600.57(b)	II	54	$5	$270	5 calendar days from mailing date of this letter
2600.57(d)	II	54	$5	$270	5 calendar days from mailing date of this letter
2600.60(a)	II	54	$5	$270	5 calendar days from mailing date of this letter
2600.132(d)	II	54	$5	$270	5 calendar days from mailing date of this letter
2600.141(a)	II	54	$5	$270	5 calendar days from mailing date of this letter
2600.144(c)1	II	54	$5	$270	5 calendar days from mailing date of this letter
2600.185(a)	II	54	$5	$270	5 calendar days from mailing date of this letter
2600.187(a)	II	54	$5	$270	5 calendar days from mailing date of this letter
2600.187(d)	II	54	$5	$270	5 calendar days from mailing date of this letter
2600.191	II	54	$5	$270	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has

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

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

If you disagree with the decision to REVOKE your license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120

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 Summaries

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

Facility Information

Name: *AMERICAN HOUSE T/A HOTEL LEBANON* **License #**: *34404* **License Expiration**: *09/14/2023*

Address: *23-25 SOUTH NINTH STREET, LEBANON, PA 17042*

County: *LEBANON* **Region**: *CENTRAL*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *HOTEL LEBANON CORPORATION*

Address: *23-25 SOUTH NINTH STREET, LEBANON, PA, 17042*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/15/1987* **Issued By**: *Department of Labor and Industry*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *66* **Waking Staff**: *50*

Inspection Information

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

Reason: *Complaint, Fine* **Exit Conference Date**: *12/19/2023*

Inspection Dates and Department Representative

12/19/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *74* **Residents Served**: *55*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *unknown* **Are 60 Years of Age or Older**: *35*

Diagnosed with Mental Illness: *17* **Diagnosed with Intellectual Disability**: *3*

Have Mobility Need: *11* **Have Physical Disability**: *0*

Inspections / Reviews

12/19/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/14/2024*

01/19/2024 - POC Submission

Submitted By: [redacted] *dez* **Date Submitted**: *02/17/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/27/2024*

02/08/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/17/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/15/2024*

07/17/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *02/17/2024*

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

65b - Rights/Abuse 40 Hours

1. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Staff Person A, hired on [redacted] and Staff Person B, hired on [redacted], did not complete training in the following topics:

1. Resident rights.

2. Emergency medical plan.

3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

4. Reporting of reportable incidents and conditions.

Repeated Violation-7/26/23, et al and 1/10/23, et al

Plan of Correction ***Accept (- 02/07/2024)***

The administrator verified both staff files on 1/3/24 and staff B is no longer an employee as of [redacted].
Administrator will train Staff A will complete the missing training by 01/16/2024.
The administrator will improve on reviewing employee files every month starting February 6, 2024, to ensure no new hire is missing any of the required trainings. Any missing training will be addressed within 2 days of hiring to comply with training requirements.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Implemented (- 07/17/2024)

132d - Evacuation

2. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

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

9/28/23, 11:00PM - evacuation time: 5 minutes, 12 seconds

10/11/23, 3:00PM - evacuation time: 3 minutes, 48 seconds

11/9/23, 11:15PM - evacuation time: 4 minutes, 58 seconds

Repeated Violation-7/26/23, et al, 5/2/23 and 1/10/23, et al

132d - Evacuation *(continued)*

Plan of Correction ***Accept (█ - 02/08/2024)***

The administrator will email the Fire Chief with the Lebanon Fire Dept. to meet and discuss the evacuation time specific for our facility based on the structure of the building before 01/19/2024. Until the safe time is determined monthly fire drills will continue to be done with the 2 minutes and 30 seconds that are in placed at this time.
Email was sent on 1/23/2024 and we are waiting a response.
The administrator will continue to be in contact with the fire dept for any updates on the process.

Licensee's Proposed Overall Completion Date: *01/26/2024*

Not Implemented (█ - 07/17/2024)

141a 1-10 Medical Evaluation Information

3. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. 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 1's most recent medical evaluation (DME), dated █, did not include the following: medication regimen, body position/movement or cognitive function.

Repeated Violation-7/26/23, et al and 1/10/23, et al

Plan of Correction ***Directed (█ - 02/08/2024)***

Resident 1 was scheduled with an DME appointment on 2/13/2024 by the administrator.
DME report will be done monthly starting February 15 to ensure all new residents have a DME on file.
DME missing will be addressed with the Med Tech Supervisor and this will be done with quarterly starting April 2nd, 2024.
Med Tech Supervisor will be trained by Administrator by February 1st to ensure all steps are followed in the DME compliance.

Proposed Overall Completion Date: 02/13/2024

[Directed]

- *The administrator or designee will complete an initial audit of all current resident DMEs will be completed to*

141a 1-10 Medical Evaluation Information (continued)

ensure all current DMEs are completed. This audit will be completed 2/26/24. Documentation of audit should be kept and available for review by the Department.

Directed Completion Date: *02/26/2024*

Not Implemented (- 07/17/2024)

141b1 - Annual Medical Evaluation

4. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident 1's most recent medical evaluation (DME) was completed on

Plan of Correction ***Directed (- 02/08/2024)***

Resident 1 was schedule by the administrator for an appointment on 2/13/2024 with an DME appointment.
DME report will be done monthly starting February 15 to ensure all new residents have a DME on file.
DME missing will be addressed with the Med Tech Supervisor and this will be done with quarterly starting April 2nd, 2024.

Proposed Overall Completion Date: 02/13/2024

[Directed]

- *The administrator or designee will complete an initial audit of all current resident DMEs will be completed to ensure all current annual DMEs are completed. This audit will be completed 2/26/24. Documentation of audit should be kept and available for review by the Department.*

Directed Completion Date: *02/26/2024*

Not Implemented (- 07/17/2024)

183b - Meds and Syringes Locked

5. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 12/19/23 at approximately 10:18AM, Resident 2's Breztri 160 mcg/9mcg inhaler was unattended, unlocked and accessible on resident's nightstand in shared resident room .

Repeated Violation-7/26/23, et al

183b - Meds and Syringes Locked *(continued)*

Plan of Correction ***Accept (█ - 02/07/2024)***

Resident 2 will have a lock box in █ room by 1/31/2024.
The administrator will meet with med techs and direct care staff to discuss that no medications should be unattended at any time and the process to proper storage by 01/17/2023.
The administrator will monitor alternating 10 rooms bi-weekly starting February 1st. Any medications found will be removed or placed in lock box if applicable.
The administrator will coordinate to start educating the residents by February 15 in regards of self-administer medications and the importance of having them in a lock box.

Licensee's Proposed Overall Completion Date: *02/15/2024*

Implemented (█ - 07/17/2024)

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

Resident 3 is prescribed blood glucose checks 4 times a day. The blood glucose checks on the glucometer did not match the numbers transcribed on the Mediation Administration Record (MAR) as follows:
On 12/1/23, the number documented in the MAR states blood glucose was 279. However, there was no reading in the glucometer for this date and time.
Glucometer reading on 12/8/23 at 8:00PM was 240. The number documented in the MAR states blood glucose was 220.
Glucometer reading on 12/13/23 at 7:00AM was 125. The number documented in the MAR states the blood glucose was 129.
Glucometer reading on 12/16/23 at 8:00PM was 288. The number documented in the MAR states the blood glucose was 247.

Repeated Violation-7/26/23, et al

Plan of Correction ***Accept (█ - 02/07/2024)***

The administrator will meet and train the med techs to discuss proper documentation of Blood Sugar checks on the Residents' MARs by February 1, 2024.
Med Tech Supervisor will verify the records of blood sugar and compare to the glucometer starting March 1st, this will be done randomly at least twice in the month.
Med Tech Supervisor will meet with med tech and discuss the findings to ensure there is improvement on the errors. Staff will be written up following the handbook policy.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented (█ - 07/17/2024)

187a - Medication Record

7. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident 1 is prescribed Folic Acid 1mg tablet, Buspirone 30mg tablet and Amiodarone 200mg tablet. However, resident's December 2023 medication administration record (MAR) does not indicate a diagnosis or purpose for these medications.

Resident 4 is prescribed Steglatro 15mg tablet. However, resident's December 2023 MAR does not indicate a diagnosis or purpose for this medication.

Repeated Violation-7/26/23, et al

Plan of Correction ***Accept (█ - 02/07/2024)***

Med Tech Supervisor corrected Resident 1 and 4 Mars information.
The administrator will meet with all med techs by January 26th to explain how to document prescribing orders.
The administrator will review the information on the mars monthly to ensure proper documentation and any missing information will be corrected by Med Tech Supervisor at the time of finding.
Med Tech Supervisor will audit of all Resident MAR's to ensure each resident's Medication has a diagnosis or purpose recorded on the MAR starting March 1st.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented (█ - 07/17/2024)

187d - Follow Prescriber's Orders

8. Requirements

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

Description of Violation

Resident 4 has an order for blood glucose checks 3 times a day per doctor's order and resident's December 2023 medication administration record (MAR). However, the home is only checking resident's blood glucose levels 2 times a day.

Also, Resident 4 did not have blood glucose testing completed on the following dates and times: 12/1/23 at 7:00AM and 8:00PM, 12/2/23 at 7:00AM, 12/3/23 at 7:00AM and 8:00PM, 12/4/23 at 7:00AM and 8:00PM, 12/5/23 at 7:00AM and 8:00PM, 12/6/23 at 7:00AM, 12/7/23 at 7:00AM and 8:00PM, 12/8/23 at 8:00PM, 12/9/23 at 8:00PM, 12/10/23 at 8:00PM, 12/11/23 at 8:00PM, 12/13/23 at 8:00PM, 12/14/23 at 8:00PM, 12/15/23 at 8:00PM and 12/18/23 at 8:00PM.

Resident 5 has an order for Erythromycin 0.5% eye ointment that started on 12/11/23 at 12:00PM. The order states to apply ½ inches to affected eyes four times a day for 7 days. As of 12/19/23 at 12:00PM, the medication was still being administered to the resident.

Repeated Violation-7/26/23, et al

187d - Follow Prescriber's Orders (continued)

Plan of Correction ***Accept (- 02/07/2024)***

Resident 4 glucometer was secured, and blood sugar has been monitored since 12/20/2023.
Resident 5 stopped on medication on 12/20/2023 and was destroyed.
Med Tech Supervisor will audit of all Resident MAR's to ensure each resident's Medication has a diagnosis or purpose recorded on the MAR starting March 1st.
The administrator will meet with all med techs by January 26th to explain how to document prescribing orders.
The administrator will review the information on the mars monthly to ensure proper documentation.

Licensee's Proposed Overall Completion Date: *03/01/2024*

Not Implemented (- 07/17/2024)

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

Facility Information

Name: *AMERICAN HOUSE T/A HOTEL LEBANON* **License #**: *34404* **License Expiration**: *05/28/2024*

Address: *23-25 SOUTH NINTH STREET, LEBANON, PA 17042*

County: *LEBANON* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *HOTEL LEBANON CORPORATION*

Address: *23-25 SOUTH NINTH STREET, LEBANON, PA, 17042*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/15/1987* **Issued By**: *DL&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *55* **Waking Staff**: *41*

Inspection Information

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

Reason: *Provisional* **Exit Conference Date**: *02/28/2024*

Inspection Dates and Department Representative

02/27/2024 - On-Site: [redacted]

02/28/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *74* **Residents Served**: *55*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older**: *33*

Diagnosed with Mental Illness: *12* **Diagnosed with Intellectual Disability**: *3*

Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

02/27/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/30/2024*

04/17/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/09/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/06/2024*

07/17/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *05/09/2024*

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

51 - Criminal Background Check

1. Requirements

2600.

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

Description of Violation

Staff Person A, hired [redacted] did not have a criminal history check completed in accordance with the Older Adult Protective Services Act and 6 Pa. Code Chapter 15.

Staff Person C, hired [redacted] did not have a criminal history check completed in accordance with the Older Adult Protective Services Act and 6 Pa. Code Chapter 15.

Plan of Correction ***Accept ([redacted] - 04/15/2024)***

Staff Member A was let go and no longer works at the facility as of [redacted]. Staff Member C was hired on [redacted] and the criminal background was completed on [redacted]

Administrator will audit by 4/03/2024 all staff files in home's software (Tabula) to ensure all staff profile and documents are complete in accordance to the employee checklist. Administrator will be educated on the employee checklist and entering all information into Tabula.

Monthly reviews will be done of employees files by Administrator to ensure compliance with regulations. Reviews will start on 04/03/2024 for all employee files on Tabula.

Licensee's Proposed Overall Completion Date: *04/03/2024*

Not Implemented ([redacted] - 07/17/2024)

54a - Direct Care Staff

2. Requirements

2600.

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

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

Description of Violation

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

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

Repeated Violation - 7/26/23, et al

Plan of Correction ***Accept ([redacted] - 04/15/2024)***

Staff Member A was let go and no longer works at the facility as of [redacted] Staff Member C was hired on

54a - Direct Care Staff (continued)

and the high school diploma or GED was requested to be handed to administration by 04/05/2024.

Administrator will audit by 4/03/2024 all staff files in home's software (Tabula) to ensure all staff profile and documents are complete in accordance to the employee checklist. Administrator will be educated on the employee checklist and entering all information into Tabula.

Monthly reviews will be done of employees files by Administrator to ensure compliance with regulations. Reviews will start on 04/03/2024 for all employee files on Tabula.

Licensee's Proposed Overall Completion Date: *04/03/2024*

Implemented (- 07/17/2024)

57b - 1 Hour/Day

3. Requirements

2600.
57.b. Direct care staff persons shall be available to provide at least 1 hour per day of personal care services to each mobile resident.

Description of Violation

On 2/21/24 there were 55 residents in the home, requiring a minimum of 55 hours of direct care service. On this day, only 54 hours of direct care staffing were provided.

On 2/24/24 there were 55 residents in the home, requiring a minimum of 55 hours of direct care service. On this day, only 48 hours of direct care staffing were provided.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Accept (- 04/15/2024)***

The home as of 03/01/2024 has been actively hiring and posting job positions to fulfill the need of direct care staff. We have been successful in acquiring some staff but we are continue to look for ideal candidates to complete staffing personnel.

Administrator will continue to hire until staff starting 03/01/2024 meets regulatory compliance and work on staff schedules to ensure all personal care hours are meet for each resident.

Weekly checks of the schedules are going to be done by Administrator as of 04/05/2024 to ensure that staffing hours are up to regulation to ensure that residents are all receiving at least one hour of personal care service.

Licensee's Proposed Overall Completion Date: *04/05/2024*

Not Implemented (- 07/17/2024)

57d - Waking Hours

4. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 2/21/24, a total of 41.25 hours of direct care was required during waking hours. However, only 36 of the required hours were provided during waking hours.

On 2/24/24, a total of 41.25 hours of direct care was required during waking hours. However, only 30 of the required hours were provided during waking hours.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Accept (█ - 04/15/2024)***

The home as of 03/01/2024 has been actively hiring and posting job positions to fulfill the need of direct care staff. We have been successful in acquiring some staff but we are continue to look for ideal candidates to complete staffing personnel.

Administrator will continue to hire until staff starting 03/01/2024 meets regulatory compliance and work on staff schedules to ensure at least 75% of personal care hours are meet for each resident during waking hours.

Weekly checks of the schedules are going to be done by Administrator as of 04/05/2024 to ensure that staffing hours are up to regulation to ensure that residents are all receiving at least one hour of personal care service.

Licensee's Proposed Overall Completion Date: *04/05/2024*

Not Implemented (█ - 07/17/2024)

60a - Staff/Support Plan

5. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home had no certified medication technicians available during overnight shifts from 10pm to 6:30am on 2/19/24, 2/21/24, and 2/24/24. As a result, the home was unable to provide medication administration services during this time. There are several residents who have medications scheduled pro re nata (PRN), including the following residents:
Resident #1: Nitroglycerin 0.4mg as needed for chest pain
Resident #3: Acetaminophen 500 mg as needed for pain, Hydroxyzine 50 mg as needed for anxiety and Naloxone 4mg nasal spray as needed for suspected overdose

Repeated Violation - 7/26/23, et al

60a - Staff/Support Plan (continued)

Plan of Correction ***Accept (█ - 04/15/2024)***

The home as of 03/01/2024 has been actively hiring and posting job positions to fulfill the need of direct care staff. We have been successful in acquiring some staff but we are continue to look for ideal candidates to complete med technicians staffing personnel.

Administrator will continue to hire until staff starting 03/01/2024 meets regulatory compliance and work on staff schedules to ensure we have med technician staff for all shifts.

Weekly checks of the schedules are going to be done by Administrator as of 04/05/2024 to ensure that staffing hours are up to regulation to ensure that the home is meeting the needs of the residents by having medication certified staff available.

Licensee's Proposed Overall Completion Date: *04/05/2024*

Not Implemented (█ - 07/17/2024)

63a - First Aid/CPR Training

6. Requirements

2600.

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

Description of Violation

On 2/19/24 and 2/24/24, during the hours of 10:00pm to 6:30am, 55 residents were present in the home. During this time only 1 staff person was present in the home who was certified in CPR and first aid.

On 2/21/24, during the hours of 6:00am to 2:30pm, 55 residents were present in the home. During this time, no staff person was present in the home who was certified in CPR and first aid.

On 2/24/24, during the hours of 6:00am to 10:30pm, 55 residents were present in the home. During this time, only 1 staff person was present in the home who was certified in CPR and first aid.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Accept (█ - 04/15/2024)***

The home as of 03/01/2024 has been actively hiring and posting job positions to fulfill the need of direct care staff. We have been successful in acquiring some staff but we are working on getting staff to be CPR certified.

63a - First Aid/CPR Training (continued)

Administrator has contacted the CPR trainer to set up a date for training to be completed. The goal is to have CPR training completed by 04/30/2024 to have enough staff to cover.

Weekly checks of the schedules are going to be done by Administrator as of 04/05/2024 to ensure that staffing hours are up to regulation to ensure that the home is meeting the needs of the residents by having CPR certified staff scheduled.

Licensee's Proposed Overall Completion Date: *04/05/2024*

Implemented (█ - 07/17/2024)

65a - FS Orientation 1st Day

7. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Person A, whose first day of work was █ did not receive orientation on the following topics:

1. Evacuation procedures.

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.

4. Smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable.

5. The location and use of fire extinguishers.

6. Smoke detectors and fire alarms.

7. Telephone use and notification of emergency services.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (█ - 04/15/2024)***

Staff Member A was let go and no longer works at the facility as of █.

Administrator will be reviewing the employee checklist to make sure every staff member has all necessary paperwork. New staff members are to be filling out orientation in general fire safety and emergency preparedness form latest first day of employment or prior to employment.

65a - FS Orientation 1st Day (continued)

Monthly reviews of employee files are going to be completed by Administrator from 04/26/2024 in accordance to the checklist and regulations to ensure compliance with orientation in general fire safety and emergency preparedness.

Proposed Overall Completion Date: 04/26/2024

[Directed]

- *Administrator and/or designee will audit all current staff files by 4/26/24 to ensure all staff have completed the first day trainings. Documentation of this audit should be kept and available for review by the Department. Following initial audit, administrator will complete monthly reviews of employee files. Documentation of these audits should be kept and available for review by the Department.*

Directed Completion Date: *04/26/2024*

Implemented (- 07/17/2024)

65b - Rights/Abuse 40 Hours

8. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Person A completed 40th scheduled work hour; however, this staff person did not complete training in the following topics:

1. Resident rights.

2. Emergency medical plan.

3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

4. Reporting of reportable incidents and conditions

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (- 04/15/2024)***

Staff Member A was let go and no longer works at the facility as of

Administrator will be reviewing the employee checklist to make sure every staff member has all necessary paperwork. New staff members are to be filling out orientation on Rights and Abuse training with first day of employment or with in 40 hours of employment.

Monthly reviews of employee files are going to be completed by Administrator from 04/26/2024 in accordance to the checklist and regulations to ensure compliance with orientation on Rights and Abuse training.

65b - Rights/Abuse 40 Hours (continued)

Proposed Overall Completion Date: 04/26/2024

[Directed]

- *Administrator and/or designee will audit all current staff files by 4/26/24 to ensure all staff have completed the first 40-hour trainings. Documentation of this audit should be kept and available for review by the Department. Following initial audit, administrator will complete monthly reviews of employee files. Documentation of these audits should be kept and available for review by the Department.*

Directed Completion Date: *04/26/2024*

Implemented (- 07/17/2024)

65d - Initial Direct Care Training

9. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.
   - x. Staff person supervision, if applicable.
   - xi. Care and needs of residents with special emphasis on the residents being served in the home.
   - xii. Safety management and hazard prevention.
   - xiii. Universal precautions.
   - xiv. The requirements of this chapter.
   - xv. Infection control.
   - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Staff person A, who was hired did not complete the Department-approved direct care training course nor pass of the competency test.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (- 04/15/2024)***

Staff Member A was let go and no longer works at the facility as of

65d - Initial Direct Care Training (continued)

Administrator will be reviewing the employee checklist to make sure every staff member has all necessary paperwork. New staff members are to be taking the department approved direct care staff training at being hired.

Monthly reviews of employee files are going to be completed by Administrator from 04/26/2024 in accordance to the checklist and regulations to ensure compliance with taking the department approved direct care staff training.

Proposed Overall Completion Date: 04/26/2024

[Directed}

- *Administrator and/or designee will audit all current staff files by 4/26/24 to ensure all staff have completed direct care certification. Documentation of this audit should be kept and available for review by the Department. Following initial audit, administrator will complete monthly reviews of employee files. Documentation of these audits should be kept and available for review by the Department.*

Directed Completion Date: *04/26/2024*

Implemented (█ - 07/17/2024)

65f - Training Topics

10. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

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

Description of Violation

Direct care staff person B did not receive training in the following topics during training year 2023:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

65f - Training Topics (continued)

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (█ - 04/15/2024)***

All staff members are taking trainings in 2024 to cover all training topics included in regulation 65 f.

Administrator will be creating a binder by 04/30/2024 to cover all training topics included in 65 f. Also in the binder will be including the training schedule for what topics the home will be giving each month. Training sign in sheets will be used for staff members to sign off confirming there attendance to the training.

Monthly reviews of the binder starting 04/30/2024 will be done by Administrator to ensure all the training topics in regulation 65 f are being completed.

Proposed Overall Completion Date: 04/30/2024

[Directed]

- *Administrator and/or designee will audit all current staff files by 4/30/24 to ensure all direct care staff have completed all the required trainings so far for the 2024 training year. Documentation of this audit should be kept and available for review by the Department. Following initial audit, administrator will complete monthly reviews of employee files to ensure all direct care staff have completed the required training(s) for each month. Documentation of these audits should be kept and available for review by the Department.*

Directed Completion Date: *04/30/2024*

Implemented (█ - 07/17/2024)

65g - Annual Training Content

11. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

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

Description of Violation

Staff Person B did not receive training in the following topics during training year 2023:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

65g - Annual Training Content (continued)

3. Resident rights.
4. The Older Adult Protective Services Act
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (█ - 04/15/2024)***

All staff members are taking trainings in 2024 to cover all training topics included in regulation 65 g.

Administrator will be creating a binder by 04/30/2024 to cover all training topics included in 65 g. Also in the binder will be including the training schedule for what topics the home will be giving each month. Training sign in sheets will be used for staff members to sign off confirming there attendance to the training.

Monthly reviews of the binder starting 04/30/2024 will be done by Administrator to ensure all the training topics in regulation 65 g are being completed.

Proposed Overall Completion Date: 04/30/2024

[Directed}

- *Administrator and/or designee will audit all current staff files by 4/30/24 to ensure all staff have completed all the required trainings so far for the 2024 training year. Documentation of this audit should be kept and available for review by the Department. Following initial audit, administrator will complete monthly reviews of employee files to ensure all staff have completed the required training(s) for each month. Documentation of these audits should be kept and available for review by the Department.*

Directed Completion Date: *04/30/2024*

Implemented (█ - 07/17/2024)

85a - Sanitary Conditions

12. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 2/28/24 at approximately 9:45am, room #107, which is shared by 3 residents, had strong urine and body odors.

Plan of Correction ***Accept (█ - 04/16/2024)***

Room 107 was cleaned that same day immediately to ensure the resident was clean and the whole room was up to sanitary standards.

85a - Sanitary Conditions (continued)

Administrator with team leads will be creating a list scheduled room and shower list by 04/30/2024 to help ensure all residents and receiving the attention that they need. As are residents should be receiving 1 hour of care everyday.

Monthly reviews will be completed starting 05/17/2024 by Administrator to ensure schedules are being followed. Also team leads will be doing daily checks of staff to make sure schedules are being followed in accordance to regulation 85 a.

Proposed Overall Completion Date: 05/17/2024

Licensee's Proposed Overall Completion Date: *05/17/2024*

Not Implemented (█ - 07/17/2024)

89b - Hot Water Temperature

13. Requirements

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

Description of Violation

On 2/28/24 at 9:50am, the hot water temperature in the second-floor bathroom across from room #212 measured at 124.2 degrees Fahrenheit.

On 2/28/24 at 9:55am, the hot water temperature in the third-floor bathroom to the left of the hallway measured at 128.9 degrees Fahrenheit.

Plan of Correction ***Accept (█ - 04/15/2024)***

Maintenance adjusted water temperatures on 02/28/2024 so the hot water does not exceed a temperature of 120 degrees F.

Administrator had a meeting with maintenance on 04/05/2024 to inform on regulation 89 b where hot water temperature in areas accessible to the resident may not exceed 120°F.A facility checklist is going to be updated to for use of the facility walk through.

Administrator and Maintenance will be doing bi weekly walk throughs starting of 05/01/2024 the facility. To help ensure compliance with hot water temperature in areas accessible to the resident may not exceed 120°F.

Licensee's Proposed Overall Completion Date: *05/01/2024*

Not Implemented (█ - 07/17/2024)

101j3 - Bed/Linens/Pillows/Blankets

14. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
3. Pillows, bed linens and blankets that are clean and in good repair.

101j3 - Bed/Linens/Pillows/Blankets *(continued)*

Description of Violation

On 2/28/24, Resident #8 was in ██ room, lying on a soiled pillowcase and bed linens. The resident indicated the linens were not changed the previous day.

On 2/28/24, Resident #7's bed linens were soiled.

Plan of Correction ***Accept (██ - 04/16/2024)***

Resident #7 and #8 was cleaned that same day immediately to ensure the resident was clean and the whole room was up to sanitary standards.

Administrator with team leads will be creating a list scheduled room and shower list by 04/30/2024 to help ensure all residents and receiving the attention that they need. As are residents should be receiving 1 hour of care everyday.

Monthly reviews will be completed starting 05/17/2024 by Administrator to ensure schedules are being followed. Also team leads will be doing daily checks of staff to make sure schedules are being followed in accordance to regulation 101 j 3.

Proposed Overall Completion Date: 05/17/2024

Licensee's Proposed Overall Completion Date: *05/17/2024*

Implemented (██ - 07/17/2024)

132d - Evacuation

15. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the drill on 1/11/24 at 4:00pm. The drill took 4 minutes and 3 seconds.

Repeated Violation - 7/26/23, et al, 5/2/23

Plan of Correction ***Directed (██ - 04/15/2024)***

Administrator got in contact with a fire safety expert company and was able to set a date to get inspected on 04/17/2024. The company is called Fire and Life Safety Solutions and they will be helping to evaluated our facility setting an adequate time for evacuation. The company stated to the home that we could have this all resolved by the end of April.

Administrator and/or Med Supervisor will be conducting the fire drill keeping record of all the drill in the home. Making sure that we are following and compliant with the time and procedures set by the fire safety experts.

Administrator will be doing monthly checks starting 04/30/2024 to ensure fire drill evacuation is up to fire safety

132d - Evacuation (continued)

expert standard to be compliant with regulation.

Proposed Overall Completion Date: 04/30/2024

[Directed]

- *Administrator educate team leads and residents on this violation and any changes to evacuation time by 4/30/24. Documentation of this education should be kept and available for review by the Department.*

Directed Completion Date: *04/30/2024*

Not Implemented (- 07/17/2024)

141b1 - Annual Medical Evaluation

16. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's most recent medical evaluation was completed on ; the resident has no current annual medical evaluation.

Resident #3's most recent medical evaluation was completed on ; the resident has no current annual medical evaluation.

Plan of Correction ***Directed (- 04/15/2024)***

Resident #2 and #3 were bot schedule for DME apointments with their primary doctors. Resident #2 has an appointment on 04/23/2024 and resident #3 has an appointment on 04/16/2024.

Administrator has a meeting scheduled on 04/26/2024 with Med Supervisor about how to access resident profiles and DME. Explaining the importance of having current medical evaluation and they are done annually.

Administrator and Med Supervisor will be doing quarterly reviews starting 05/03/2024 to review DME to ensure that all information is up to date in accordance with resident most recent medical evaluation done annually. Reminders when entering in Tabula Pro will be set to help ensure that dates are current for medical evaluations.

Proposed Overall Completion Date: 05/03/2024

[Directed]

- *Administrator and/or designee will audit all current resident records by 5/3/24 to all residents have a current medical evaluation. Documentation of this audit should be kept and available for review by the Department. Following the initial audit, administrator and med supervisor will complete quarterly reviews to review upcoming medical evaluation due dates, ensuring those medical evaluations get scheduled and ensuring the medical evaluation document is completed within the required time frame. Documentation of these audits should be kept and available for review by the Department.*

141b1 - Annual Medical Evaluation *(continued)*

Directed Completion Date: *05/03/2024*

Not Implemented (█ - 07/17/2024)

144c1 - Smoking Area Guidelines

17. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

A large number of cigarette butts were observed on the ground in the following areas:
designated smoking area on the deck (over 10 butts), the side entrance designated smoking area (over 20 butts), the back entrance to the left of the stairs (over 50 butts) and near the dumpsters (over 50 butts).

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (█ - 04/15/2024)***

The home immediately cleaned the perimeter of the building to make sure there was no cigarette but in our designated areas.

A facility checklist is going to be updated to for use of the facility walk through. This includes inside and outside the building to ensure that smoking procedures are being followed on proper disposal of cigarettes.

Administrator and Maintenance will be doing bi weekly walk throughs starting of 05/01/2024 the facility. To help ensure compliance with smoking procedures in regulation 144 c 1.

Proposed Overall Completion Date: 05/01/2024

[Directed]

- *Administrator educate team leads, staff and residents on this violation by 4/30/24. Documentation of this education should be kept and available for review by the Department.*
- *Administrator will update facility checklist to include reviewing the inside and outside of the building for proper disposal of cigarette butts by 5/1/24.*

Directed Completion Date: *05/01/2024*

Not Implemented (█ - 07/17/2024)

161d - Dietary Needs

18. Requirements

2600.
161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

161d - Dietary Needs *(continued)*

Description of Violation

Resident #5 and Resident #6 are prescribed mechanical soft diets. However, on 2/27/24 and 2/28/24, these residents were served and observed eating bread during lunch. Dietary and medication technician staff were interviewed and were not aware that these residents were ordered a mechanical soft diet.

Plan of Correction ***Directed (█ - 04/15/2024)***

Staff members were informed of this information and resident #5 and #6 have been being served mechanical soft foods. Also residents were informed on how they should have their food served in a mechanical soft diet.

Administrator has a meeting scheduled on 04/26/2024 all staff about how to access resident profiles and RASP in order to understand each residents needs. Also that the needs stated in their profiles needs to be followed accordingly.

Administrator and Med Supervisor will be doing quarterly reviews starting 05/03/2024 with the staff to remind them to take time to review resident profiles and RASP to be informed on each residents needs.

Proposed Overall Completion Date: 05/03/2024

[Directed]

- *Administrator will educate staff and residents on prescribed diets by 4/30/24. Documentation of this education should be kept and available for review by the Department. Documentation of this educate should be kept and available for review by the Department.*
- *Administrator and med supervisor will complete an initial audit of all resident RASPs by 5/3/24 to ensure all current resident RASPs contain residents' correct diets and how the home will meet the residents' diets. Documentation of this audit should be kept and available for review by the Department. Following initial audit, administrator and med supervisor will complete quarterly reviews of resident RASPs to ensure compliance. Documentation of these audits should be kept and available for review by the Department.*
- *Starting 5/3/24, administrator and/or designee will ensure a list of all residents with special diets is posted in the kitchen for staff to refer to during mealtimes.*
- *Starting on 5/3/24, administrator and/or designee will be completing weekly meal observations to ensure special diets are being followed. Documentation of this audit should be kept and available for review by the Department.*

Directed Completion Date: *05/03/2024*

Not Implemented (█ - 07/17/2024)

162e - Menu Changes

19. Requirements

2600.
162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

162e - Menu Changes *(continued)*

Description of Violation

On 2/27/24, tuna sandwiches were listed on the menu for the lunch meal. However, residents were served broccoli cheese soup, a slice of bread, and pears instead. No notice was provided to the residents in advance of the meal.

Plan of Correction ***Accept (- 04/15/2024)***

Resident menus are being followed as posted on the dining room bulletin board to ensure accessibility to resident knowing what the meal will be for the day. Menus are being made sure to be posted 2 weeks prior to date to ensure home can have necessary products to follow established menu.

Administrator has informed cook on proper notice policy when changing the menu and also the importance of residents having the accessibility to knowing what meal they will be having.

Administrator will be doing bi weekly reviews of menu starting 04/19/2024 to make sure it is being followed as posted and if a change is made that it is posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal.

Licensee's Proposed Overall Completion Date: *04/19/2024*

Implemented (- 07/17/2024)

183b - Meds and Syringes Locked

20. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 2/2/24 at approximately 9:45am, Resident #5's fluticasone nasal spray Breo Ellipta and albuterol sulfate inhaler were observed unlocked, unattended, and accessible on the resident's bedside table and drawer.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Accept (- 04/15/2024)***

Resident's medications were immediately secure in the lock box and a meeting with the resident was held informing of the responsibility of keeping medication secure in a lock box when being a self administrating resident. If this is something that continued not following correct storage procedures they would have to go in the medication room to be administered by staff for safety reasons.

Administrator and Med Supervisor has a meeting with medication technicians and staff on 04/26/2024 to inform on the importance of proper medication storage with residents that self administer.

Med Supervisor will do bi weekly walk throughs of the building starting 04/19/2024 to ensure all rooms with residents that self administer are securing medication in a locked box.

Licensee's Proposed Overall Completion Date: *04/19/2024*

183b - Meds and Syringes Locked *(continued)*

Implemented (- 07/17/2024)

VIOLATION WITHDRAWN - NSC, 7/17/24

)

184b - Labeling OTC/CAM

22. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident’s name.

Description of Violation

On 2/28/24, a bottle of low dose aspirin and a bottle of fish oil tablets belonging to Resident #4, were observed in the medication cart with the resident's prescription medications but were not labeled with the resident's name.

Plan of Correction ***Directed (- 04/16/2024)***

Resident #4 prescription medication bottles were labeled with their name and left in the cart. As they are still current prescribed medications.

Administrator and Med Supervisor has a meeting with medication technicians on 04/26/2024 to inform on the importance of having OTC medications and CAM belong to the resident, they shall be identified with the resident’s name.

Med Supervisor will do weekly checks throughs of the med carts starting 04/19/2024 to ensure all med carts have

184b - Labeling OTC/CAM (continued)

current medication of residents that are present in the home and with label.

Proposed Overall Completion Date: 04/19/2024

[Directed]

- *Med supervisor will audit all current medications in the home by 4/26/24 to all medications are properly labeled. Documentation of this audit should be kept and available for review by the Department. Following the initial audit, med supervisor will complete weekly reviews to ensure compliance. Documentation of these audits should be kept and available for review by the Department.*

Directed Completion Date: *04/26/2024*

Implemented (█ - 07/17/2024)

185a - Implement Storage Procedures

23. 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 #2 is prescribed Xiidra 5% eye drops as needed. On 2/28/24, Resident #2's xiidra eyedrops were not available in the home.

On 2/28/24, during a review of Resident #3's One Touch Vero Flex glucometer and resident's medication administration record (MAR), the following discrepancies were observed:
On 2/17/24 5:00pm, the blood sugar reading in the MAR is documented as 250; however, this reading was not in the resident's glucometer.
On 2/8/24 5:00pm, the blood sugar reading in the MAR is documented as 306; however, this reading was not in the resident's glucometer.
On 2/4/24 7:00pm, the blood sugar reading in the MAR is documented as 220; however, the reading in the resident's glucometer is 137.
On 2/11/24 11:00am, the MAR is marked blank; however, the blood sugar reading in the resident's glucometer is 295.
On 2/2/24, the resident's glucometer has blood sugar readings of 61 at 7:08pm and 87 at 7:35pm. However, the MAR is marked as if the resident refused.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (█ - 04/15/2024)***

Carts we organized 02/29/2024 were all diabetic supplies and glucometers are labeled to a resident. Each resident has their own small bin labeled with their name and all the items in it.

Administrator and Med Supervisor has a meeting with medication technicians on 04/26/2024 to inform on the importance of implementing procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

185a - Implement Storage Procedures (continued)

Med Supervisor will do weekly checks throughs of the med carts starting 04/19/2024 to ensure all med carts have labeled medications and medical equipment with a residents name. To also be organized accordingly to keep better accountability and organization.

Proposed Overall Completion Date: 04/19/2024

[Directed]

- *Med supervisor will audit all current PRN medications in the home by 4/26/24 to ensure all PRN medication is available in the home. Documentation of this audit should be kept and available for review by the Department. Following the initial audit, med supervisor will complete weekly review to ensure all PRN medications are available on-site and review resident glucometer readings with documented readings on the MARs to ensure compliance. Documentation of this audit should be kept and available for review by the Department.*

Directed Completion Date: *04/26/2024*

Not Implemented (█ - 07/17/2024)

187a - Medication Record

24. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #2 is prescribed Xiidra. However, Resident #2's medication administration record (MAR) does not indicate the diagnosis or purpose for this medication.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (█ - 04/16/2024)***

Resident #2 diagnosis or purpose was added according to prescribers orders on the medication Xiidra.

Administrator has a meeting with Med Supervisor and medication technicians on 04/26/2024 to inform on the importance of all residents having diagnosis or purpose for the medication, including pro re nata (PRN) on the MAR.

Med Supervisor will do bi weekly checks of MARs starting 04/24/2024 to ensure all current medications are on the MAR stating their diagnosis or purpose for the medication, including pro re nata (PRN).

Proposed Overall Completion Date: 04/24/2024

[Directed]

- *Med supervisor will audit all current resident MARs by 4/26/24 to ensure all MARS have diagnoses or*

187a - Medication Record (continued)

purposes for each medication. Documentation of this audit should be kept and available for review by the Department. Following the initial audit, med supervisor will bi-weekly review of MARs to ensure compliance. Documentation of these audits should be kept and available for review by the Department.

Directed Completion Date: *04/26/2024*

Not Implemented (- 07/17/2024)

187d - Follow Prescriber's Orders

25. Requirements

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

Description of Violation

Resident #3 is ordered 34 units to be injected insulin glargine solostar under the skin 2 times a day for diabetes. On the following days, the resident was only given 30 units:
7:00AM dose on 2/1 through 2/10/24
8:00PM dose on 2/3 through 2/7/24

Resident #3 is prescribed 3 blood glucose checks daily. However, only 2 blood glucose checks were completed on 2/10 through 2/16/24.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Accept (- 04/15/2024)***

Resident #3 med staff was informed the importance of following the prescribed orders of the doctor and any issues were to be informed to doctor if changes need to be made.

Administrator and Med Supervisor has a meeting with medication technicians on 04/26/2024 to inform on the home shall follow the directions of the prescriber for each resident.

Med Supervisor will do bi weekly checks of MARs starting 04/26/2024 to ensure all the home is following the prescribers orders.

Licensee's Proposed Overall Completion Date: *04/26/2024*

Not Implemented (- 07/17/2024)

191 - Resident Right to Refuse

26. Requirements

2600.

191 - Resident Right to Refuse *(continued)*

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #2 admitted [redacted] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident #3 admitted [redacted] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident #6 admitted [redacted], has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed ([redacted] - 04/16/2024)***

Residents #2, #3 and #6 met with the administrator and signed the form " Right to Refuse Medications" on 04/05/2024

Administrator and Med Supervisor will be trained on the information for residents right to refuse medications on 04/22/2024. As administration staff the home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Administrator and Med Supervisor will do quarterly reviews starting 05/03/2024 of resident files to ensure all residents have been educated on the right to question or refuse a medication if the resident believes there may be a medication error.

Proposed Overall Completion Date: 05/03/2024

[Directed]

- *Administrator and med supervisor will complete an initial audit of all resident records by 5/3/24 to ensure all current residents have been educated on their right to refuse medication if the resident believes there may have been a medication error. Documentation of this audit should be kept and available for review by the Department. Following initial audit, administrator and med supervisor will complete quarterly reviews of new resident records to ensure compliance. Documentation of these audits should be kept and available for review by the Department.*

Directed Completion Date: *05/03/2024*

Not Implemented ([redacted] - 07/17/2024)

VIOLATION WITHDRAWN - NSC, 7/17/24

227e - Self Administer Medication

28. Requirements

2600.
227.e. The resident's support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident #5's current medical evaluation, dated , states resident can self-administer medications but needs assistance with remembering the schedule. However, resident's current assessment, dated , states resident cannot self-administer medications.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (- 04/16/2024)***

Resident #5 RASP was fixed to correlate to their most current medical evaluation on 04/04/2024.

227e - Self Administer Medication (continued)

Administrator has a meeting scheduled on 04/26/2024 with Med Supervisor about how to access resident profiles and RASP in order to understand each residents needs. Also resident RASP stay current with resident's most recent medical evaluation on medication administration and fix accordingly.

Administrator and Med Supervisor will be doing quarterly reviews starting 05/03/2024 to review RASP to ensure that all information is up to date in accordance with resident most recent medical evaluation of medication administration.

Proposed Overall Completion Date: 05/03/2024

[Directed]

- *Administrator and med supervisor will complete an initial audit of all resident RASPs and DMES by 5/3/24 to ensure all current resident RASPs match current medical evaluations' self-administration information. Documentation of this audit should be kept and available for review by the Department. Following initial audit, administrator and med supervisor will complete quarterly reviews of resident RASPs and medical evaluations to ensure compliance. Documentation of these audits should be kept and available for review by the Department.*

Directed Completion Date: *05/03/2024*

Not Implemented (- 07/17/2024)

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

Facility Information

Name: *AMERICAN HOUSE T/A HOTEL LEBANON* **License #**: *34404* **License Expiration**: *05/28/2024*

Address: *23-25 SOUTH NINTH STREET, LEBANON, PA 17042*

County: *LEBANON* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *HOTEL LEBANON CORPORATION*

Address: *23-25 SOUTH NINTH STREET, LEBANON, PA, 17042*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/15/1987* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *54* **Waking Staff**: *41*

Inspection Information

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**: *0*

Reason: *Complaint, Interim* **Exit Conference Date**: *05/15/2024*

Inspection Dates and Department Representative

05/14/2024 - On-Site: [redacted]

05/15/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *74* **Residents Served**: *54*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *29* **Are 60 Years of Age or Older**: *50*

Diagnosed with Mental Illness: *15* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

05/14/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/07/2024*

07/08/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/15/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/15/2024*

07/17/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *07/15/2024*

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 4/11/24, 4/22/24 and 5/11/24, Resident 6 did not receive medication as prescribed by the physician. The home did not report this incident to the Department.

On 4/28/24, Resident 7 experienced a fall at the home, sustaining serious bodily injury requiring treatment at a hospital or medical facility. The home did not report this incident to the Department.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (█ - 06/14/2024)***

Plan of Correction
To address these violations and prevent future occurrences, we will implement the following corrective actions:
• Staff Training:
o All staff will receive mandatory retraining on medication administration procedures, adherence to physician orders, and resident care protocols.
o Training will specifically emphasize the importance of reporting any missed medications or errors immediately, including blood glucose checks and falls with serious injury.
o This staff training is going to be completed by 06/21/2024.

• Documentation Review and Revision:
o A binder will be created for the Med Office with procedures to ensure they clearly capture all interactions with residents, including missed medications and falls. This binder will be completed by 06/21/2024
o Implement the system (Tabula Pro) for flagging missed medications or errors and ensuring timely reporting to the supervisor and Department by 06/19/2024

• Communication and Reporting Procedures:
o Establish clear communication protocols for reporting medication errors, missed checks, and resident falls to the Department within 24 hours.
o The Administrator is responsible for reporting, clear documentation of reporting actions, and designated phone numbers or online reporting platforms.

16c - Written Incident Report (continued)

• Incident Review and Follow-up:
o Implement a system (Tabula Pro) for reviewing incidents thoroughly to identify root causes and corrective actions.
o Conduct follow-up audits to ensure the effectiveness of corrective actions starting 06/28/2024 and on a weekly basis after that.
o Daily reviews of Tabula Pro notifications will be done to ensure all reportable incidents are being reported.

We will report these incidents to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours of this report. The report will detail the incidents, corrective actions taken, and preventive measures implemented to prevent future occurrences.

Proposed Overall Completion Date: 06/28/2024

[Directed]

- *Administrator or designee will complete incident reports for the identified incidents listed in the violation and send these incident reports to DHS by 7/10/24.*
- *The administrator or designee will educate all staff on this regulation by 7/10/24. Documentation of this education will be kept and available for review by the Department.*
- *Beginning no later than 7/10/24, the administrator or designee will complete daily reviews of Tabula Pro notifications to review missed medications and ensure all medication errors are reported within 24 hours of incident occurring.*
- *Beginning no later than 7/10/24, the administrator will implement a documentation system for direct care staff to document any concerning behaviors or incidents, such as falls, during each shift. Administrator will review this documentation daily and complete incident reports as required.*
- *Beginning no later than 7/10/24, the administrator or designee will file all completed and reported incident reports in a binder. This binder will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented ([redacted] - 07/17/2024)

42b - Abuse

2. 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

On [redacted], Resident 1 was transported to the hospital [redacted] [redacted] Through interviews with staff members and review of the resident's record, there were concerns mentioned such as pain in [redacted] legs, difficulty ambulating, lack of personal hygiene that were ongoing, prior to contacting 911 for transport [redacted]

On [redacted], Resident 2's [redacted]

42b - Abuse (continued)

Resident 3 is prescribed Haloperidol (2mg) 2 tablets twice daily and Prazosin (5mg) 2 tablets at bedtime. During the period of 5/1/24 to 5/13/24, Resident 3 has not received either medication due to a bill payment issue with the prescriber. The home made no attempt during this period to seek a resolution with the prescriber to have Resident 3's medications refilled.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (- 06/14/2024)***

On 911 was called and EMT came to assessed resident 1. was admitted treated, transferred to and moved to a higher level of care.

On resident 2 was scheduled for a podiatry appointment to have feet assessed. Front office supervisor called multiple locations as many did not take insurance and did schedule resident 2 for a but resident 2 refused to go to such appointment. Since resident 2 is resident 2 became agreeable to having staff care for during ongoing weekly self-care activity which Administrator has implemented to 3 times per month. Resident 2 nails have been trimmed and has been rescheduled scheduled for to be seen by a podiatrist.

Resident 3's rep payee Advocacy Alliance has been notified and have been connected with resident 3's provider. Resident 3 continues to refuse to take any ownership to make any form of partial payment towards balance of previous obtained services.

Administrator will be creating a resident evaluation form that will screen residents' holistic state. Administrator will train all management staff on 06/18/2024 on the information and steps to be taken when filling out the resident evaluation form. Which is to be completed with in the month.

Administrator and Supervisor will complete a resident evaluation form to screen all resident present in the home by 06/30/2024. Then will be continued to be completed on a monthly basis as of 07/01/2024.

Proposed Overall Completion Date: 07/01/2024

[Directed]

- *Beginning no later than 7/10/24, staff will observe each resident per shift on a daily basis. Medical, medication or hygienic concerns observed by staff or discussed with residents will be documented and will be reported to the administrator or designee.*
- *Beginning no later than 7/10/24, the home will follow up with medical care as needed. If a resident refuses medical care, the refusal and the continued attempts to educate and inform the resident about the need for health care shall be documented in the resident's record. Administrator or designee will be responsible for completing and filing this information in the residents' record.*
- *The administrator or designee will educate all staff this regulation as well as documenting and reporting medical and hygienic concerns. Education will be provided no later than 7/10/24. Documentation of*

42b - Abuse (continued)

education will be kept and available to the Department.

- *The administrator or designee will educate all med techs of this regulation as well as review the procedure for administering medications, including when a resident is out of the home. Education will be provided no later than 7/10/24. Documentation of education will be kept and available to the Department.*
- *Beginning no later than 7/10/24, the administrator or designee will complete weekly reviews of staff documentation to ensure all resident medical, medication and hygienic needs are being met.*
- *Beginning no later than 7/10/24, the administrator or designee will update resident assessment and support plans to reflect residents' current needs.*

Directed Completion Date: *07/10/2024*

Not Implemented (- 07/17/2024)

42s - Privacy

3. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

Staff Member B was terminated from the home due to sharing information about the home and residents to family member. This information was shared on the family member's social media. Also, Staff Member B allowed family member to come into the home and take pictures.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (- 06/14/2024)***

Staff Member B was terminated from the American House due to sharing information about the home and residents to a family member. Staff was termination due to breach of confidentiality agreement.

The Administrator will reeducate on 06/19/2024 for all staff on the importance of HIPPA compliance and remind all staff that upon their hiring staff signed a document adhering to protecting the confidentiality of all residents. All staff records will be audited to make sure confidentiality agreement form has been signed by 06/30/2024.

Proposed Overall Completion Date: 06/30/2024

[Directed]

- *The administrator or designee will audit all current staff records for completed confidentiality agreements by 6/30/24. Documentation of this audit will be kept and available for review by the Department.*
- *Beginning no later than 7/10/24, the administrator or designee will complete a sample of staff and resident interviews to ensure resident confidentiality is being maintained. Documentation of these interviews will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented (- 07/17/2024)

51 - Criminal Background Check

4. Requirements

2600.

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

Description of Violation

Staff Member A, hired on [redacted], has resided in Pennsylvania for less than 2 years. An FBI background check was not completed for Staff Member A.

Plan of Correction ***Directed ([redacted] - 06/14/2024)***

Staff member A has been instructed to go (IdentoGO) for [redacted] FBI check. The facility has received the record as staff member a being eligible to work as of 06/03/2024.

Moving forward upon hire a criminal check will be processed and if staff has been out of the state of PA for more then two years an FBI check will also be processed. The Administrator will be using the current employee checklist to ensure compliance with staff files.

Administration will audit staff files by June 30, 2024. and quarterly review will be done going forward starting in September 2024.

Proposed Overall Completion Date: 06/30/2024

[Directed]

- *Beginning no later than 7/10/24, the administrator or designee will implement a new employee checklist, including completing an FBI criminal background check for new employees who have lived in PA for less than 2 years.*
- *The administrator or designee will educate all staff involved with the hiring process on this regulation. Education will be completed no later than 7/10/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented ([redacted] - 07/17/2024)

52 - Hiring Staff

5. Requirements

2600.

52. Staff Hiring, Retention and Utilization - Hiring, retention and utilization of staff persons shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults) and other applicable regulations.

Description of Violation

The PA criminal history background check for Staff Member B, hired on [redacted], was not completed until [redacted]

52 - Hiring Staff *(continued)*

Plan of Correction ***Directed (- 06/14/2024)***

The PA criminal history background check for Staff Member B, hired on , was completed

For Staff member B a criminal check was completed. Moving forward upon hire a criminal check will be processed and if staff is from out of PA with in 2 years staff a FBI check will also be processed. The employee checklist will include this to be followed accordingly.

Administration will audit staff files by June 30, 2024. and quarterly review will be done going forward starting in September 2024.

Proposed Overall Completion Date: 06/30/2024

[Directed]

- *Beginning no later than 7/10/24, the administrator or designee will implement a new employee checklist, including completing a criminal background check for new employees.*
- *The administrator or designee will educate all staff involved with the hiring process on this regulation. Education will be completed no later than 7/10/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *06/30/2024*

Not Implemented (- 07/17/2024)

57b - 1 Hour/Day

6. Requirements

2600.
57.b. Direct care staff persons shall be available to provide at least 1 hour per day of personal care services to each mobile resident.

Description of Violation

On 5/5/24 and 5/11/24, there were 54 residents in the home, requiring a minimum of 54 hours of direct care service. On this day, only 46 hours of direct care staffing were provided.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (- 06/14/2024)***

The Administrator continues to seek qualifying staff and search employment agencies to become fully staffed for all shifts

The home will contine to seek new candidates for DCS position as of 06/01/2024 to be able fulfill the state requirments about staff care hours.The Admninistrator is using job posting in indeed, reaching out to local employment facilities, and using in person applications to try to get qualified candiates to fill the positions.

The home will continue to use these outlets untils all necesary staff is aquired to comply with state regulations.

57b - 1 Hour/Day (continued)

Proposed Overall Completion Date: 06/13/2024

[Directed]

- *Beginning no later than 7/10/24, the administrator or designee review all work schedules prior to the schedules being posted to ensure the number of required direct care service hours are being met.*
- *Beginning no later than 7/10/24, the administrator or designee will put a plan in place to address maintaining the required number of direct care service hours when call offs occur.*
- *The administrator or designee will educate all staff involved with the scheduling process on this regulation. Education will be completed no later than 7/10/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented ([redacted] - 07/17/2024)

57d - Waking Hours

7. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 5/5/24 and 5/11/24, a total of 40.5 hours of direct care was required. However, only 30 of the required hours were provided during waking hours.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed ([redacted] - 06/14/2024)***

The Administrator continues to seek qualifying staff and search employment agencies to become fully staffed for all shifts

The home will contine to seek new candidates for DCS position as of 06/01/2024 to be able fulfill the state requirments about staff care hours.The Admninistrator is using job posting in indeed, reaching out to local employment facilities, and using in person applications to try to get qualified candiates to fill the positions.

The home will continue to use these outlets untils all necesary staff is aquired to comply with state regulations.

Proposed Overall Completion Date: 06/13/2024

[Directed]

- *Beginning no later than 7/10/24, the administrator or designee review all work schedules prior to the schedules being posted to ensure the number of required direct care service hours provided during waking hours are being met.*

57d - Waking Hours (continued)

- *Beginning no later than 7/10/24, the administrator or designee will put a plan in place to address maintaining the required number of direct care service hours during waking hours when call offs occur.*
- *The administrator or designee will educate all staff involved with the scheduling process on this regulation. Education will be completed no later than 7/10/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented (- 07/17/2024)

60a - Staff/Support Plan

8. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

There are several residents who have medications scheduled as needed (PRN), including Resident 3, who is prescribed Hydroxyzine (25 mg) for anxiety and Mirtazapine (15 mg) to aid with sleep. The home had no certified medication technicians available during overnight shifts from 10:00 pm to 6:30 am the week of 5/5/24. As a result, the home was unable to provide medication administration services during this time.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (- 06/14/2024)***

The Administrator scheduled staff members to be trained for Medication Administration Certification on 06/17/2024 at 8 a.m.

By 06/17/2024 Administration will assure that all residents will have access to someone who will be able to administer medication on a Pro Re Nata PRN basis during overnight shifts.
The Administrator will continue to review schedules to ensure that a med tech can be available at all hours to administer medications.

Proposed Overall Completion Date: 06/17/2024

[Directed]

- *Beginning no later than 7/10/24, the administrator or designee review all work schedules prior to the schedules being posted to ensure there is always a med tech on duty.*
- *The administrator or designee will educate all staff involved with the scheduling process on this regulation. Education will be completed no later than 7/10/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented (- 07/17/2024)

85a - Sanitary Conditions

9. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 5/14/24, a pungent bodily odor was detected upon entry into bedroom ███ which is shared by 3 residents.

On 5/14/24, the third-floor communal bathrooms of the home did not contain any hand-drying options.

Plan of Correction ***Accept (██ - 06/14/2024)***

Administrator has developed and implemented a new room cleaning schedule for each staff to follow. Room ███ has been thoroughly cleaned immediately on 05/14/2024. Hand-drying options were placed in the 3rd floor bathroom on 5/14/2024.

Administrator will be creating a daily walk-thru list by 06/21/2024 to be completed daily to ensure necessary daily items are available and up to sanitary standards.

Administrator has developed Daily task list by 06/21/2024 to be completed on each shift by each staff member.

Administrator will review the implementation of the task list with staff members on 06/19/24 during monthly staff meeting. Also will be filing paperwork of all the completed daily walkthroughs and daily checklist starting 06/24/2024

Proposed Overall Completion Date: 06/24/2024

Licensee's Proposed Overall Completion Date: *06/24/2024*

Not Implemented (██ - 07/17/2024)

85d - Trash Receptacles

10. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 5/14/24 at 9:40 am, there was a full, uncovered and unattended trash can in the kitchen.

Plan of Correction ***Accept (██ - 06/14/2024)***

On 5/14/24 the lid to the trash was placed back on the trash can. On 05/13/2024 there was a sign posted in the kitchen to maintain the trash cans covered when not in use.

Staff members during their shifts are to inspect trash cans to ensure they are all covered to continue compliance with state regulations. Administrator will be creating a daily walk-thru list by 06/21/2024 to be completed daily to ensure necessary daily items are available and up to sanitary standards. Administrator has developed Daily task list by 06/21/2024 to be completed on each shift by each staff member.

Administrator will review the implementation of the task list with staff members on 06/19/24 during monthly staff

85d - Trash Receptacles (continued)

meeting. Also will be filing paperwork of all the completed daily walkthroughs and daily checklist starting 06/24/2024

Licensee's Proposed Overall Completion Date: *06/24/2024*

Not Implemented (█ - 07/17/2024)

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 5/14/24, the hot water temperatures in both third-floor bathrooms measured 124.1 degrees and 123 degrees Fahrenheit.

Plan of Correction ***Directed (█ - 06/14/2024)***

The Administrator instructed the Maintenance staff on 5/15/24 to lower the water temperature and to retest water temperatures to make sure water temperature do not exceed 120 degrees.

On 5/16/24 a water thermometer was used by Maintenance staff to record, and it showed temperature below 120 degrees.

The Administrator and Maintenance will be completely a biweekly facility checklist to ensure water temperatures are with in compliance. Facility checklist are to begin on 06/17/2024 and stores into Tabula Pro.

Proposed Overall Completion Date: 06/17/2024

[Directed]

- *Education will be provided to staff on this regulation by the administrator or designee. Education will be provided by 7/10/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented (█ - 07/17/2024)

92 - Windows

12. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 5/14/24, there was an open window with no screen in the third-floor bathroom that overlooks the alley.

Plan of Correction ***Directed (█ - 06/14/2024)***

On 5/15/24 Maintenance staff was shown the gap on the window, which he adjusted. Window is a Florida style

92 - Windows (continued)

window which has a glass panel on the interior and calls for no screen.

The Administrator and Maintenance will be completely a biweekly facility checklist to ensure water temperatures are with in compliance. Facility checklist are to begin on 06/17/2024 and stores into Tabula Pro.

Proposed Overall Completion Date: 06/17/2024

[Directed]

- *Beginning no later 7/10/24, the administrator or designee will add reviewing the windows in the building to the bi-weekly facility checklist.*
- *Education will be provided to staff on this regulation by the administrator or designee. Education will be provided by 7/10/24. Documentation of this education will be kept and available for review by the Department.*
- *Beginning no later 7/10/24, the administrator or maintenance staff will complete an initial audit of all windows in the building to ensure compliance. Then the administrator or maintenance staff will complete bi-weekly reviews of the home's windows to ensure on-going compliance. Documentation of these audits will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented (- 07/17/2024)

102h - Toilet Paper

13. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 5/14/24, there was no toilet paper for either bathroom located on the third floor.

Plan of Correction ***Accept (- 06/14/2024)***

On 5/14/24 Toilet paper was supplied to all bathrooms.

Administrator will be creating a daily walk-thru list by 06/21/2024 to be completed daily to ensure necessary daily items are available and up to sanitary standards.

Administrator has developed Daily task list by 06/21/2024 to be completed on each shift by each staff member.

Administrator will review the implementation of the task list with staff members on 06/19/24 during monthly staff meeting. Also will be filing paperwork of all the completed daily walkthroughs and daily checklist starting 06/24/2024

Proposed Overall Completion Date: 06/24/2024

Licensee's Proposed Overall Completion Date: *06/24/2024*

102h - Toilet Paper *(continued)*

Not Implemented (█ - 07/17/2024)

127a - Portable Space Heaters

14. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

On 5/14/24, a portable space heater was observed under the desk in the home's medication office.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (█ - 06/14/2024)***

Administrator instructed maintenance staff to remove heater and to never bring a portable heater into building.

Admistrator will retrain maintenance on 06/17/2024 any siting of portable space heaters are to be removed immeadiately regarless of the situation.

The Administrator and Maintenance will be completely a biweekly facility checklist to ensure water temperatures are with in compliance. Facility checklist are to begin on 06/17/2024 and stores into Tabula Pro.

Proposed Overall Completion Date: 06/17/2024

[Directed]

- *Education will be provided to all staff on this regulation by the administrator or designee. Education will be provided by 7/10/24. Documentation of this education will be kept and available for review by the Department.*
- *Beginning no later than 7/10/24, the administrator and/or maintenance staff will complete a weekly walkthrough of the home to ensure there are no portable space heaters in the home. Documentation of this walkthroughs will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented (█ - 07/17/2024)

132d - Evacuation

15. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills:
On 3/15/24 at 3:00 pm, the evacuation time was 4 minutes and 30 seconds.
On 4/17/24 at 2:00 pm, the evacuation time was 6 minutes and 35 seconds.

132d - Evacuation (continued)

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (- 06/14/2024)***

The administrator is continuing to work on getting a fire company inspector to give us a letter for fire evacution time based on structural reasons. The home is trying to find the blueprints to the bluilding to be able to provide them to the fire inspection company. An architect is going to be contracted to make blueprints of the builing by 08/31/2024

The home will continue to do fire drills monthly and record all the information in Tabula Pro.

Proposed Overall Completion Date: 08/31/2024

[Directed]

- *The home will obtain a letter from a fire safety expert that includes the maximum time the home has to evacuate based on the structure of the building. The home will obtain this letter no later than 7/10/24.*
- *The administrator will develop a system by 7/10/24 to obtain this letter annually and will review monthly fire drill records upon completion to ensure residents are able to evacuate within the designated time.*

Directed Completion Date: *08/31/2024*

141a 1-10 Medical Evaluation Information

16. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. 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 most recent medical evaluation, dated did not include section 4 (the needs addendum) or section 7 (the medication addendum).

Plan of Correction ***Directed (- 06/14/2024)***

Resident # 2 had a medical appointment with PCP on 4/26/24 and a new DME has been faxed to Dr.

141a 1-10 Medical Evaluation Information (continued)

[redacted] office to be completed. Resident #2 has been educated on the importance of regulations regarding medical guidelines.

To address this violation and ensure a complete medical evaluation for Resident 2, we will take the following actions:

Review and Update Resident Care Plan:
Upon receiving the completed medical evaluation, we will review and update Resident 2's care plan to reflect their specific needs, dietary requirements, medication regimen, allergies, and self-administration abilities. This ensures all staff caring for Resident 2 have access to this critical information.
Staff Training:
We will conduct staff training on 06/20/2024 to emphasize the importance of complete medical evaluations for residents. The training will cover the required content of the evaluation forms (including Needs and Medication Addenda) and the process for ensuring complete documentation upon admission or within 30 days.

Review Admission Procedures:
We will review our admission procedures with Tabula Pro software to ensure staff thoroughly verify the completeness of the medical evaluation forms before finalizing Resident admission.
Communication with Physicians:
We will establish clearer communication protocols with physicians' offices to ensure they understand the specific information required in the medical evaluation forms for Personal Care Home admissions.

by 06/28/2024 the Home will have requested a DME or schedule a DME appoinment with PCP

Proposed Overall Completion Date: 06/28/2024

[Directed]

- *The administrator or designee will complete staff education on this regulation on 6/20/24. Documentation of this education will be kept and available for review by the Department.*
- *The administrator or designee will complete an initial audit of all current medical evaluations to ensure the medical evaluations have all required information. This audit will be completed by 7/10/24. Documentation of this audit will be kept and available for review by the Department.*
- *Beginning no later than 7/10/24, the administrator or designee will review all newly completed medical evaluations within 48 hours of receiving the medical evaluations to ensure all required information is documented.*
- *Beginning no later than 7/10/24 the administrator or designee will complete quarterly audits of current medical evaluations for compliance. Documentation of these audits will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented ([redacted] - 07/17/2024)

141b1 - Annual Medical Evaluation

17. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident 2's most recent medical evaluation was completed on [redacted]

Plan of Correction

Directed ([redacted] - 06/14/2024)

Resident # 2 had a medical appointment with [redacted] PCP on [redacted] and a new DME has been faxed to Dr. [redacted] [redacted] office to be completed. Resident #2 has been educated on the importance of regulations regarding medical guidelines.

To address this violation and ensure a complete medical evaluation for Resident 2, we will take the following actions:

Review and Update Resident Care Plan:
Upon receiving the completed medical evaluation, we will review and update Resident 2's care plan to reflect their specific needs, dietary requirements, medication regimen, allergies, and self-administration abilities. This ensures all staff caring for Resident 2 have access to this critical information.
Staff Training:
We will conduct staff training on 06/20/2024 to emphasize the importance of complete medical evaluations for residents. The training will cover the required content of the evaluation forms (including Needs and Medication Addenda) and the process for ensuring complete documentation upon admission or within 30 days.

Review Admission Procedures:
We will review our admission procedures with Tabula Pro software to ensure staff thoroughly verify the completeness of the medical evaluation forms before finalizing Resident admission.
Communication with Physicians:
We will establish clearer communication protocols with physicians' offices to ensure they understand the specific information required in the medical evaluation forms for Personal Care Home admissions.

by 06/28/2024 the Home will have requested a DME or schedule a DME appoinment with PCP

Proposed Overall Completion Date: 06/28/2024

[Directed]

- *The administrator or designee will obtain and file Resident 2's new medical evaluation by 7/10/24.*
- *Beginning no later than 7/10/24, the administrator or designee will complete an initial audit of all current resident medical evaluations to identify any overdue medical evaluations and upcoming evaluations that need scheduled. Documentation of this audit will be kept and available for review by the Department.*
- *The administrator or designee will complete staff education on this regulation on 6/20/24. Documentation of this education will be kept and available for review by the Department.*
- *Beginning no later than 7/10/24, the administrator or designee will keep a schedule of when each resident's new medical evaluation is due and will schedule medical evaluations ahead of these dates to ensure compliance.*
- *Beginning no later than 7/10/24, the administrator or designee will complete quarterly audit sof all current resident medical evaluations to ensure all medical evaluations are being completed within the required timeframe. Documentation of this audit will be kept and available for review by the Department.*

141b1 - Annual Medical Evaluation *(continued)*

Directed Completion Date: *07/10/2024*

Not Implemented (- 07/17/2024)

144c1 - Smoking Area Guidelines

18. Requirements

2600.

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

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

Description of Violation

On 5/14/24, there were multiple cigarette butts on the ground near trash cans, and 1 fresh-looking cigarette butt on the steps of the first-floor rear stairwell inside the building.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (- 06/14/2024)***

The administrator has relocated smoking zones to the back of the home.
All residents have been instructed to not smoke out of the smoking zones.

Staff have been instructed to redirect residents to designated smoking areas.
All residents are being reminded on an ongoing basis to throw their cigarettes butts inside smoking containers oppose to the interior basement floors.

Administrator will be creating a daily walk-thru list by 06/21/2024 to be completed daily to ensure necessary daily items are available and up to sanitary standards. Also will be filing paperwork of all the completed daily walkthroughs and daily checklist starting 06/24/2024

Proposed Overall Completion Date: 06/24/2024

[Directed]

- *The administrator or designee will relocate the designated smoking areas to the back of the home no later than 7/10/24.*
- *The administrator or designee will educate all residents and staff about this violation. Education to be completed by 7/10/24. Documentation of this education will be kept and available for review by the Department.*
- *Beginning no later than 7/10/24, the administrator or designee will be completing daily reviews of the exterior of the home to ensure compliance. Documentation of these reviews will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

144c1 - Smoking Area Guidelines *(continued)*

Not Implemented (█ - 07/17/2024)

161d - Dietary Needs

19. Requirements

2600.
161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

Resident 4 is prescribed a mechanical diet. However, on 5/14/24 during lunch time, the resident was served a cheese steak sandwich and chips.

Plan of Correction ***Directed (█ - 06/14/2024)***

Resident 4 buys █ own meals at times which are not soft mechanical.
█ has been seen observed eating without difficulty despite being on a soft mechanical and at times will █ refuse to eat soft food and buys non mechanical soft foods.

Administrator has reached out to █ PCP to inform PCP that resident 4 has not been following through with the soft mechanical diet as evidence of eating all sorts of foods and to specify if resident if to continue on being on such a diet. Administrator request resident be scheduled for an eating assessment to rule out any swallowing and/or chewing abnormality.

Administrator is waiting for a response from resident's #4 █ PCP. Administrator or Supervisor will be reaching out again to doctor to get a definitive answer in writing by 06/21/2024

A review will be completed by 07/05/2024 of resident dietary needs to be placed into a special diet list to ensure all residents are getting required diestary needs met. The list will be posted in kitchen and information updated into Tabula Pro by 07/05/2024.

Proposed Overall Completion Date: 07/05/2024

[Directed]

- *Beginning no later than 7/10/24, the administrator or designee will complete an initial audit of all current resident special diets to identify all current special diets. This information will be updated into Tabula Pro, the resident's RASP and will be posted in the kitchen by 7/10/24.*
- *The administrator or designee will educate all staff on the current special diets. Education will be completed by 7/10/24. Documentation of the education will be kept and available for review by the Department.*
- *Beginning no later than 7/10/24, the administrator or designee will observe at least 3 mealtimes per week to ensure residents are receiving the appropriate diet. Documentation of these observations will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented (█ - 07/17/2024)

184a - Resident's Meds Labeled

20. 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.
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

On 5/15/24, there was an unlabeled tube of GenTeal tears ointment that does not include the resident's name, the name and title of the prescriber, the prescribed dosage and instructions for administration or the date the prescription was issued.

Plan of Correction ***Directed (█ - 06/14/2024)***

Administrator has removed all unidentified items from the medical room and med cart on 05/17/2024

All medical trained staff have been reminded that under no circumstances is the med chart to hold any medication without being labeled, current and prescribed by a physician. No store bought over the counter (OTC) is to be stored inside the medical room without any written orders for each OTC.
All staff have been clearly advised on this per
Corrective Actions
To address this violation and ensure proper medication labeling, we will take the following actions:
Medication Identification:
We will attempt to identify the resident to whom the unlabeled medication belongs. This may involve reviewing medication administration records or consulting with Med administration staff.
Verification and Documentation:
If the resident is identified, we will verify the medication order with the physician and ensure the medicine is not expired. The pharmacy label will be properly completed with the resident's name, prescriber information, dosage instructions, and date of prescription.
Discarding Unidentified Medication:
If the resident cannot be identified or the medication is expired, we will safely dispose of the unlabeled medication according to federal and state regulations. Medication will be disposed properly.
Staff Training:
We will conduct mandatory training for all staff involved in medication handling and administration. The training will emphasize the importance of proper medication labeling according to Pennsylvania regulations and best practices for medication storage and management, on 06/19/2024.

Conclusion
We take medication safety very seriously. By implementing this Plan of Correction, we aim to ensure all medications are properly labeled, stored securely, and administered according to physician orders. We will continue to monitor our procedures and strive for continuous improvement in medication management practices, staring on 06/25/2024

184a - Resident's Meds Labeled (continued)

Proposed Overall Completion Date: 06/25/2024

[Directed]

- *The administrator or designee will complete an initial audit of all current medication on-site to ensure all medication is properly labeled. This audit will be completed no later than 7/10/24. Documentation of the audit will be kept and available for review by the Department.*
- *Beginning no later than 7/10/24, the administrator or designee will complete monthly audits of current medications on-site to ensure all medication is properly labeled. Documentation of the audit will be kept and available for review by the Department.*
- *The administrator or designee will educate all med techs on this regulation on 6/19/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented (█ - 07/17/2024)

185a - Implement Storage Procedures

21. 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 5 is prescribed blood glucose checks 3 times a day. The blood glucose checks on the glucometer used for the resident did not match the numbers transcribed on the medication administration record (MAR) including the following:
On 5/11/24 at 7:00 pm, the MAR documents a blood glucose level of 160. This reading was not found in the glucometer.
The glucometer reading on 5/9/24 at 6:17 pm was 170. The MAR documents that the resident refused the 7:00 pm reading.
The glucometer reading on 5/7/24 at 6:03 pm was 262. The number documented in the MAR on 5/7/24 at 5:00 pm 190.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (█ - 06/14/2024)***

Administrator shall make sure all glucometers are with new batteries, calibrated with date and time. Staff instructed to make sure to document the sugar levels at once.

185a - Implement Storage Procedures (continued)

Administrator has created a list with names of all diabetics to help staff with documenting while in the process of collecting blood droplets.

Administrator also has been requesting on an ongoing basis all diabetic PCP's to prescribe Libre 2 system which will make collecting and documenting blood sugar levels.

Staff Training:
We will conduct mandatory retraining on 06/19/2024 for all staff involved in blood glucose monitoring. The training will emphasize the importance of accurate readings, proper use of the glucometer, documentation procedures, and troubleshooting potential issues. This may include proper calibration, test strip handling, and hygiene practices.

We will review and update our documentation procedures for blood glucose readings. This may involve standardizing the format for recording readings on the MAR, including timestamps and clear indications of refused checks. weekly review of glucometers will be compare to the MARS to ensure there is no discrepency starting on 07/01/2024.

Proposed Overall Completion Date: 07/01/2024

[Directed]

- *The administrator or designee will educate all med techs on this regulation by 7/10/24. Documentation of this education will be kept and available for review by the Department.*
- *Beginning no later than 7/10/24, the administrator or designee will complete weekly reviews of the glucometer readings and documented MAR readings for all current residents who are prescribed blood sugar testing. Documentation of these audits will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented (- 07/17/2024)

187a - Medication Record

22. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident 3 is prescribed Quetiapine (300mg). However, Resident 3's medication administration record (MAR) does not indicate diagnosis or purpose for the medication.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (- 06/14/2024)***

Administrator has reviewed MARS and resident # 3 diagnosis has been added.

187a - Medication Record (continued)

Staff Training:
We will conduct mandatory training for all staff involved in medication administration. The training will emphasize the importance of complete and accurate medication records, including documenting the diagnosis or purpose for each medication administered, on 06/19/2024.

Review Process:
We will implement a system on Tabula Pro Software for reviewing medication administration records for completeness before medication administration. This may involve a designated staff member responsible for verifying all required information is documented, starting on 07/01/2024.

Proposed Overall Completion Date: 07/01/2024

[Directed]

- *The administrator or designee will complete an initial audit of all current resident MARs to ensure all required information is listed. This audit will be completed by 7/10/24. Documentation of the audit will be kept and available for review by the Department.*
- *Beginning no later than 7/10/24, the administrator or designee will complete monthly audits of resident MARS to ensure all required information is listed. Documentation of the audit will be kept and available for review by the Department.*
- *The administrator or designee will educate all med techs on this regulation by 7/10/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented (- 07/17/2024)

187b - Date/Time of Medication Admin.

23. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident 3 is prescribed Famotidine, Haloperidol, Atorvastatin, Prazosin and Quetiapine. Resident 3's medication administration record (MAR) does not include the initials of the staff person who administered these medications on 5/14/24 at 8:00 pm.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (- 06/14/2024)***

Resident 3 is prescribed Famotidine, Haloperidol, Atorvastatin, Prazosin and Quetiapine. Resident 3's medication administration record (MAR) does not include the initials of the staff person who administered these medications on 5/14/24 at 8:00 pm.
Administrator has viewed (MAR) and medication administration staff's initials have been added on to the MAR.

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

Staff Training:
We will conduct mandatory training for all staff involved in medication administration. The training will emphasize the importance of complete and accurate medication records, including documenting the date/time of Medication Admin for each medication administered, on 06/19/2024.

Review Process:
We will implement a system on Tabula Pro Software for reviewing medication administration records for completeness before medication administration. This may involve a designated staff member responsible for verifying all required information is documented, starting on 07/01/2024.

Proposed Overall Completion Date: 07/01/2024

[Directed]

- *The administrator or designee will have the staff who administered these medications, document a note in Resident 3's MAR regarding the medications not initialed on 5/14/24 at 8pm. This will be completed no later than 7/10/24.*
- *Beginning no later than 7/10/24, the administrator or designee will complete monthly audits of resident MARS for completion. Documentation of the audit will be kept and available for review by the Department.*
- *The administrator or designee will educate all med techs on this regulation by 7/10/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented ([redacted] - 07/17/2024)

187d - Follow Prescriber's Orders

24. Requirements

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

Description of Violation

Resident 3 is prescribed Haloperidol (2mg) 2 tablets twice a day and Prazoin (5mg) 2 capsules at bedtime. However, these medications were not administered to Resident 3 during the period of 5/1/24 to 5/13/24 due to the medications not being available in the home.

Resident 5 is prescribed blood glucose checks at 7:00 am, 5:00 pm and 7:00 pm. However, on 5/12/24, the resident's 7:00 pm blood glucose check was not done.

Resident 6 is prescribed Clonazepam (1mg) 1 tablet three times a day and Methylprednisolone (4mg) 1 tablet three times a day. However, on 5/11/24 at 12:00 pm, this medication was not administered.

Repeated Violation - 7/26/23, et al

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction ***Directed (- 06/14/2024)***

Resident 3 is prescribed Haloperidol (2mg) 2 tablets twice a day and Prazoin (5mg) 2 capsules at bedtime. However, these medications were not administered to Resident 3 during the period of 5/1/24 to 5/13/24 due to the medications not being available in the home.

Staff Training:
We will conduct mandatory training for all staff involved in medication administration. The training will emphasize the importance of complete and accurate medication records, including following the directions of the prescriber for each medication administered, on 06/19/2024.

Review Process:
We will implement a system on Tabula Pro Software for reviewing medication administration records for completeness before medication administration. This may involve a designated staff member responsible for verifying all required information is documented, starting on 07/01/2024.

Proposed Overall Completion Date: 07/01/2024

[Directed]

- *The administrator or designee will complete an initial audit of all current resident medications to ensure all routine medications are available on-site. This audit will be completed by 7/10/24. Documentation of this audit will be kept and available for review by the Department.*
- *Beginning no later than 7/10/24, the administrator or designee will complete weekly audits of current resident medication and resident MARS to identify any medications that need reordered and order them as well as ensure MARs are being initialed by staff. Documentation of these audits will be kept and available for review by the Department.*
- *The administrator or designee will educate all med techs on this regulation by 7/10/24. Documentation of this education will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented (- 07/17/2024)

191 - Resident Right to Refuse

25. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident 6, admitted on and Resident 7, admitted on have not been educated on the resident's right to refuse medication if the resident believes that there may be a medication error.

Repeated Violation - 7/26/23, et al

191 - Resident Right to Refuse *(continued)*

Plan of Correction ***Directed (- 06/14/2024)***

Administrator has met with the residents 04/30/2024 and has educated all residents that they have the right to refuse medication.

The resident checklist has been updated to the one used by Tabula Pro to include documentation of "right to refuse medications".
Resident files will be reviewed for this document by 06/28/2024 to ensure everyone has knowledge of this right.

Administration will audit resident files by June 28, 2024. and quarterly review will be done going forward starting in September 2024.

Proposed Overall Completion Date: 06/28/2024

[Directed]

- *The administrator or designee will educate all staff involved the admission process on this regulation. Education will be completed no later than 7/10/24. Documentation of this education will be kept and available for review by the Department.*
- *The administrator or designee will create a new admission checklist, including reviewing and documenting resident on their right to refuse medication if they feel there is a medication error. This will be completed by 7/10/24.*
- *The administrator or designee will complete an initial audit to ensure all current resident records included documentation resident was educated on their right to refuse medication if they feel there is a medication error. This will be completed by 7/10/24.*
- *Beginning 7/10/24, the administrator or designee will complete quarterly audits of all new resident records for on-going compliance. Documentation of these audits will be kept and available for review by the Department.*

Directed Completion Date: *06/28/2024*

Not Implemented (- 07/17/2024)

227d - Support Plan Medical/Dental

26. 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 current assessment for Resident 6, dated indicates the resident needs assistance with laundry, transportation and medical appointments. However, the resident's current support plan, dated , does not document how these needs will be met.

Plan of Correction ***Directed (- 06/14/2024)***

Resident 6's RASP has been updated by 05/21/2024 having the descriptions of how the needs assistance with laundry, transportation and medical appointments are going to be met by the home.

227d - Support Plan Medical/Dental (continued)

Resident files will be reviewed for this document by 06/28/2024 to ensure all resident have a RASP. Tabula Pro alerts have been activated to notify when RASP are expiring so administration staff can complete forms.

Administration will audit resident files by June 28, 2024. and quarterly review will be done going forward starting in September 2024.

Proposed Overall Completion Date: 06/28/2024

[Directed]

- *The administrator or designee will educate all staff involved with RASP process on this regulation. Education will be completed no later than 7/10/24. Documentation of this education will be kept and available for review by the Department.*
- *The administrator or designee will complete an initial audit of all current RASPs to ensure there is a plan documented for the home to meet all resident needs. This audit will be completed by 7/10/24. Documentation of this audit will be kept and available for review by the Department.*
- *Beginning no later than 7/10/24, the administrator or designee will complete quarterly audits to ensure on-going compliance. Documentation of these audits will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented (- 07/17/2024)

227e - Self Administer Medication

27. Requirements

2600.
227.e. The resident's support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident 6's assessment, dated does not address the resident's ability to self-administer medications.

Repeated Violation - 7/26/23, et al

Plan of Correction ***Directed (- 06/14/2024)***

Administrator has viewed resident's 6 DME and found that Medical Evaluation dated 10/11/23 indicated she is not able to self administer under supervision. RASP was fix to be according to documentation that resident can not self administer medication.

Resident files will be reviewed for this document by 06/28/2024 to ensure all resident RASP have the correct self ability to medicate. Tabula Pro will be used to update this information into the RASP and ensure all information is coherent

.

Administration will audit resident files by June 28, 2024. and quarterly review will be done going forward starting in September 2024.

227e - Self Administer Medication (continued)

Proposed Overall Completion Date: 06/28/2024

[Directed]

- *The administrator or designee will educate all staff involved with RASP process on this regulation. Education will be completed no later than 7/10/24. Documentation of this education will be kept and available for review by the Department.*
- *The administrator or designee will complete an initial audit of all current RASPs and current DMEs to ensure all current RASPs match self-administer determination on the DMEs. This audit will be completed by 7/10/24. Documentation of this audit will be kept and available for review by the Department.*
- *Beginning no later than 7/10/24, the administrator or designee will complete quarterly audits to ensure on-going compliance. Documentation of these audits will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented (█ - 07/17/2024)

252 - Record Content

28. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
 3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident 1's record does not include a photograph of the resident that is no more than 2 years old.

Plan of Correction ***Directed (█ - 06/14/2024)***

Photographs of all residents have been taken by 06/13/2024 and all residents will have new photos downloaded into the tabula pro system.

Alerts have been set up in Tabula Pro to notify when a picture is going to expire to help maintain compliance.

Administration will audit resident files by June 28, 2024. and quarterly review will be done going forward starting in September 2024.

Proposed Overall Completion Date: 06/28/2024

[Directed]

- *The administrator or designee will educate all staff involved with maintaining resident records on this regulation. Education will be completed no later than 7/10/24. Documentation of this education will be kept and available for review by the Department.*
- *Beginning no later than 7/10/24, the administrator or designee will set up alerts in Tabula Pro to notify staff when a resident's picture is going to expire.*
- *The administrator or designee will complete an initial audit of all current resident files to make sure all*

252 - Record Content (continued)

resident records have an up-to-date picture of the resident. This audit will be completed by 7/10/24. Documentation of this audit will be kept and available for review by the Department.

- *Beginning no later than 7/10/24, the administrator or designee will complete quarterly audits to ensure on-going compliance. Documentation of these audits will be kept and available for review by the Department.*

Directed Completion Date: *07/10/2024*

Not Implemented ([redacted] - 07/17/2024)