pennsylvania
DEPARTMENT OF HUMAN SERVICES

# CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **TITHONUS MT. LEBANON LP**
LEGAL ENTITY

To operate **THE PINES OF MT. LEBANON**
NAME OF FACILITY OR AGENCY

Located at **1537 WASHINGTON ROAD, PITTSBURGH, PA 15228**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **112**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 18**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

**55 Pa.Code Chapter 2600: Personal Care Homes**
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **September 18, 2024** until **September 18, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **433610**

ISSUING OFFICER

DEPUTY SECRETARY

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

HS 628 – 04/23

Emailing Date: September 18, 2024

Tithonus Mt. Lebanon LP

RE: The Pines of Mt. Lebanon
1537 Washington Road
Pittsburgh, Pennsylvania 15228
License #: 433610

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on March 18th, 2024, March 19th, 2024, April 18th, 2024, April 25th, 2024, July 11th, 2024, July 12th, 2024 and July 15th, 2024, and the corrections you have made after our inspections, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

### Facility Information

**Name**: *THE PINES OF MT. LEBANON* **License #**: *43361* **License Expiration**: *06/28/2024*

**Address**: *1537 WASHINGTON ROAD, PITTSBURGH, PA 15228*

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

### Administrator

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

### Legal Entity

**Name**: *TITHONUS MT. LEBANON LP*

**Address**:

### Certificate(s) of Occupancy

**Type**: *C-2 LP* **Date**: *06/05/1990* **Issued By**: *Labor and Industry*

### Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *70* **Waking Staff**: *53*

### Inspection Information

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

**Reason**: *Renewal, Provisional* **Exit Conference Date**: *03/19/2024*

### Inspection Dates and Department Representative

*03/18/2024 - On-Site:*

*03/19/2024 - On-Site:*

### Resident Demographic Data as of Inspection Dates

#### General Information

**License Capacity**: *112* **Residents Served**: *54*

#### Secured Dementia Care Unit

**In Home**: *Yes* **Area**: *1st Floor Memory Care* **Capacity**: *18* **Residents Served**: *8*

#### Hospice

**Current Residents**: *13*

#### Number of Residents Who:

**Receive Supplemental Security Income**: *0* **Are 60 Years of Age or Older**: *54*

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

**Have Mobility Need**: *16* **Have Physical Disability**: *1*

## Inspections / Reviews

### 03/18/2024 - Full

**Lead Inspector**: *Ashley Roser* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/07/2024*

**04/08/2024 - POC Submission**

**Submitted By**: [redacted] **Date Submitted**: *05/21/2024*

**Reviewer**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/12/2024*

**04/16/2024 - POC Submission**

**Submitted By**: [redacted] **Date Submitted**: *05/21/2024*

**Reviewer**: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/15/2024*

**09/09/2024 - Document Submission**

**Submitted By**: [redacted] **Date Submitted**: *05/21/2024*

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

## 3c - Post Current License

### 1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

**Description of Violation**

*On [redacted], the most recent license inspection summaries, dated 3/27/23 et. al., 8/14/23 et. al., 8/23/23, 9/19/23, 10/16/23 et. al. and 1/18/24 were not posted in a public and conspicuous place in the home.*

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

*3c- The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy if this chapter in a conspicuous and public place in the personal care home.*
*- a copy of the most recent license inspection summaries, dated 3/27/2023,8/14/2023,8/23/2023,9/19/2023,10/16/2023, and 1/8/2024 were posted in public and conspicuous place on 3/18/2024 by the EOO.*
*-a copy of the current license inspection summary issued by the Department dated March 29, 2024, has been posted in a public and conspicuous place by the EOO on April 7, 2024.*
*- The EOO will monitor at the beginning of each month to ensure that the current license inspection summary issued by the Department is posted in a public and conspicuous place and continue with this monitoring beginning April 8, 2024, and continuing indefinitely.*
*- The next quality management review meeting is April 16, 2024*
*- 2600.3c has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*
*-The homes current license is always hung in the bulletin board in the main lobby.*

**Licensee's Proposed Overall Completion Date:** *12/31/2024*

***Implemented ([redacted] - 09/09/2024)***

## 17 - Record Confidentiality

### 2. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident’s designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident’s power of attorney for health care or health care proxy or a resident’s designated person, or if a court orders disclosure.

**Description of Violation**

*On [redacted] at [redacted], assessment and support plans for numerous residents, including residents #1 and #2, were unlocked, unattended and accessible on top of the medication cart labeled, "233-259".*

*On [redacted] at [redacted], hospice binders for numerous residents, including residents #3 and #4, were unlocked, unattended and accessible in the wellness center waiting area.*

*On [redacted] at [redacted], the wellness center was unlocked, unattended and accessible, which contained numerous resident records, including the records for residents #1 and #2.*

## 17 - Record Confidentiality (continued)

*REPEAT VIOLATION: 8/14/2023, et. al; 3/27/2023, et. al.*

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

*2600.17.*
*Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.*
*- The assessment support and plans for numerous residents, the hospice binders noted in the violation, were all moved to the Wellness office on 3/18/2024 by the RWD.*
*The wellness door was immediately closed by SME on 3/18/2024 while doing walk thru with inspectors.*
*-All Nurses and Med Techs will be in serviced on keeping Resident information confidential and never leaving Resident information unattended on the med cart. This education will be completed by April 20,2024. (DIRECTED: By 4/20/24: All current staff persons shall receive the education that all resident records and information shall be kept in an area that is locked. (█ 4/16/24). Documentation of staff education will be kept in accordance with 2600.65i.*
*- The EOO/RWD/MOD will audit the top of medication carts and entire home for compliance daily for 2 months beginning 4-16-2024 and ending 6/30/2024. (DIRECTED: Documentation of the daily audits shall be kept. (█ 4/16/24). The EOO/RWD/ MOD will then audit the top of medication carts and entire home every 2 weeks starting July 1, 2024, to ensure all residents records and information is being kept in an area that is locked.*
*- The next quality management review meeting is April 16, 2024*
*- 2600.17 has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *05/01/2024*

***Implemented (█ - 09/09/2024)***

## 18 - Compliance With Laws

**3. Requirements**

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

**Description of Violation**

*On 3/18/24, there was no influenza poster posted in a public place in accordance with the Influenza Awareness Act, enacted in July, 2016.*

## 18 - Compliance With Laws *(continued)*

**Plan of Correction** ***Accept [redacted] - 04/08/2024)***

*2600.*
*18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.*
*- The influenza poster was immediately rehung on 3/18/2024 in a public place.*
*-The EOO will monitor at the beginning of each month beginning April 8, 2024, to ensure the influenza poster is in a public place in accordance with the Influenza Awareness Act and will continue to monitor monthly indefinitely.*

**Licensee's Proposed Overall Completion Date:** *12/31/2024*

***Implemented ([redacted] - 09/09/2024)***

## 26b - Quality Management Plan Content

**4. Requirements**

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.

**Description of Violation**

*The home's most recent quality management review, completed on 1/30/24, did not include a review of staff person training or licensing violations and plans of correction.*

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

*2600.26.b. The quality management plan shall address the periodic review and evaluation of the following:*
*3. Staff person training.*
*4. Licensing violations and plans of correction, if applicable.*
*- The quality management plan shall include staff person training and License violations and plans of correction, if applicable beginning the Month of April 2024 and continuing monthly indefinitely.*
*- The next quality management review meeting is April 16, 2024 (DIRECTED: The quality management review shall include a review of all items specified in 2600.25b. [redacted] 4/16/24).*

*- 2600.26b has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely. (DIRECTED: The administrator shall ensure all items specified in 2600.26b are reviewed during each of the home's quality management reviews.[redacted]/16/24).*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *04/16/2024*

***Implemented [redacted] - 09/09/2024)***

## 63a - First Aid/CPR Training

### 5. 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 [redacted] from approximately 2:00pm through 10:30pm, there were 54 residents present in the home; however, there was only 1 staff person present in the home who was trained in first aid and certified in obstructed airway techniques and CPR.*

*On [redacted] from approximately 10:30pm through 6:30am on 3/12/24, there were 54 residents present in the home; however, there was only 1 staff person present in the home who was trained in first aid and certified in obstructed airway techniques and CPR.*

*On [redacted] from approximately 2:00pm through 10:30pm, there were 53 residents present in the home; however, there was only 1 staff person present in the home who was trained in first aid and certified in obstructed airway techniques and CPR.*

*On [redacted] from approximately 10:30pm through 6:30am on 3/15/24, there were 53 residents present in the home; however, there was only 1 staff person present in the home who was trained in first aid and certified in obstructed airway techniques and CPR.*

*On [redacted] from approximately 2:00pm through 10:30pm, there were 53 residents present in the home; however, there was only 1 staff person present in the home who was trained in first aid and certified in obstructed airway techniques and CPR.*

*On [redacted] from approximately 10:30pm through 6:30am on 3/17/24, there were 53 residents present in the home; however, there was only 1 staff person present in the home who was trained in first aid and certified in obstructed airway techniques and CPR.*

*REPEAT VIOLATION: 3/27/2023, et. al.*

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

*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.*
*- Staff will be trained in first aid and certified in obstructive airway techniques and CPR, these classes will be offered monthly beginning April 2024 and ending December 2024. The next class is scheduled April 29,2024 at 1pm. (DIRECTED: Documentation of the training shall be kept. [redacted] 4/16/24).*
*- The EOO/ASD will maintain a tickler beginning April 8th, 2024, with all staff names and who was trained in first aid and certified in obstructed airway techniques and CPR.*
*- The EOO will ensure based on the schedule that the proper number of staff working each shift, were trained in first aid and certified in obstructed airway techniques and CPR. This will be monitored daily starting April 16, 2024, and compared to the daily schedule to ensure compliance with this regulation.*

## *63a - First Aid/CPR Training (continued)*

*- The next quality management review meeting is April 16, 2024. (DIRECTED: Documentation of the quality management reviews shall be kept. ██ 4/16/24)*

*- 2600.63a has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *04/29/2024*

***Implemented ██ - 09/09/2024)***

## 65e - 12 Hours Annual Training

**9. Requirements**

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

**Description of Violation**

*Direct care staff person A, hired on ██, did not receive any annual training during the 2023 training year.*

*REPEAT VIOLATION: 3/27/2023, et. al.*

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

*2600.65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.*
*1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.*
*2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.*
*- The next quality management review meeting is April 16, 2024 (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. ██ 4/16/24).*
*- 2600.65e has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. ██ 4/16/24).*

*DIRECTED: By 5/10/24: Direct care staff person A shall receive at least 12 hours of training related to their job duties. Documentation of the trainings shall be kept in accordance with 2600.65i. ██ 4/16/24*

## 65e - 12 Hours Annual Training (continued)

*DIRECTED: Beginning on 4/22/24: The administrator/designee shall review the home's current staff training plan and all training documents on a monthly basis to ensure all direct care staff persons receive at least 12 hours of annual training during each training year. The monthly review shall also include ensuring documentation of all trainings is present in accordance with 2600.65i. Documentation of the monthly reviews shall be kept for 6 months. [redacted] 4/16/24*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *05/10/2024*

***Implemented [redacted] - 09/09/2024)***

## 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 A, hired on [redacted], did not receive training on any of the topics specified in 2600.65(f) during the 2023 training year.*

*REPEAT VIOLATION: 3/27/2023, et. al.*

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

*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*

## 65f - Training Topics (continued)

*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.*
*- Employee A completed 12 hours of training for 2023 from April1-April 12,2024 and will complete 2024 training between April 1, 2024, and December 31, 2024. the trainings shall be kept in accordance with 2600.65i.*
*- the trainings included but were not limited to medication, abuse, resident rights, emergency preparedness, fire, dementia, infection control, meeting the needs of the resident, etc.*
*- The next quality management review meeting is April 16, 2024. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. ██ 4/16/24).*

*- 2600.65f has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. ██ 4/16/24).*

*DIRECTED: By 5/10/24: Direct care staff person A shall receive training on all topics specified in 2600.65f. Documentation of the trainings shall be kept in accordance with 2600.65i.██ 4/16/24*

*DIRECTED: Beginning on 4/22/24: The administrator/designee shall review the home's current staff training plan and all training documents on a monthly basis to ensure all direct care staff persons receive training on all topics specified in 2600.65f during each training year. The monthly review shall also include ensuring documentation of all trainings is present in accordance with 2600.65i. Documentation of the monthly reviews shall be kept for 6 months. ██ 4/16/24*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *05/10/2024*

***Implemented ██ - 09/09/2024)***

## 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.

## 65g - Annual Training Content *(continued)*

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**

*Direct care staff person A, hired on [redacted], did not receive training on any of the topics specified in 2600.65(g) during the 2023 training year.*

*REPEAT VIOLATION: 3/27/2023, et. al.*

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

*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.*
*- The next quality management review meeting is April 16, 2024. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. [redacted] 4/16/24).*
*- 2600.65g has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. [redacted] 4/16/24).*

*DIRECTED: By 5/10/24: Direct care staff person A shall receive training on all topics specified in 2600.65g. Documentation of the trainings shall be kept in accordance with 2600.65i. [redacted] 4/16/24*

*DIRECTED: Beginning on 4/22/24: The administrator/designee shall review the home's current staff training plan and all training documents on a monthly basis to ensure all direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers receive training on all topics specified in 2600.65g during each training year. The monthly review shall also include ensuring documentation of all trainings is present in accordance with 2600.65i. Documentation of the monthly reviews shall be kept for 6 months. [redacted] 4/16/24*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *05/10/2024*

## 65g - Annual Training Content *(continued)*

***Implemented ██ - 09/09/2024)***

## 84 - Heat Sources

**12. Requirements**

2600.

84. Heat Sources - Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120° F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from comin in contact with the heat source.

**Description of Violation**

*On 3/18/24 at 10:42 am, the fireplace in the home's special needs kitchen was on and in-use and measured 152 degrees Fahrenheit on the glass protective guard.*

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

*2600.84.*
*On 3/18/24 at 10:42 am, the fireplace in the home's special needs kitchen was on and in-use and measured 152 degrees Fahrenheit on the glass protective guard.*
*- New fireplace safety protectant screens have been ordered to be permanently installed in front of fireplaces.*
*-The power and gas have been turned off the units until the screens arrive and are installed.*
*- Proof of purchase and install will be maintained by the EOO.*
*- Installation is to be completed by May 15, 2024. (DIRECTED: The fireplace in the home's special needs kitchen shall not be operable until the safety protector is added. ██ 4/16/24).*
*-The home has heat pumps throughout the whole building as the main source of heat.*
*-Once the new protectant screens arrive and are installed the monitoring for compliance will begin.*
*-The SME will check the temperature of both fireplaces 3x a week using a calibrated digital infrared thermometer. (DIRECTED: The weekly checks shall begin on 4/22/24. ██ 4/16/24).*
*- The next quality management review meeting is April 16, 2024*

*- 2600.84 has been added to the quality review meeting checklist on April 12,2024. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. LM 4/16/24).*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. ██ 4/16/24).*

*DIRECTED: By 5/1/24: All staff persons shall be educated that all heat sources exceeding 120° Fahrenheit that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from comin in contact with the heat source. Documentation of the education shall be kept in accordance with 2600.65i. ██ 4/16/24).*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *05/15/2024*

***Implemented (██ - 09/09/2024)***

## 84 - Heat Sources *(continued)*

## 86b - Bathroom

**13. Requirements**

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

**Description of Violation**

*On 3/19/24, no operable, outside windows or exhaust fans were present in the bathrooms of bedrooms #154 and #229.*

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

*2600.86.b.*
*On 3/19/24, no operable, outside windows or exhaust fans were present in the bathrooms of bedrooms #154 and #229.*
*-Unit 229, the mechanical exhaust unit for this room was fixed on 4/9/2024.*
*-Unit 156, ductwork balancing work will be done by April 30,2024.*
*-on 4-8-2024 all bathrooms were checked for proper operation.*
*-All bathrooms will be checked weekly for proper exhaust 2x a week for two months by the SME beginning 4-8-2024 and ending 6-9-2024. Then every other week for 2 months beginning 6-10-24 and ending 8-10-2024. Then monthly for 2 months beginning 8-11-2024 and ending 10-11-2024. This will be maintained by the SME in TELS and a copy printed out monthly for the EOO's binder*
*- The next quality management review meeting is April 16, 2024. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. 4/16/24).*
*- 2600.86b has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. 4/16/24).*

*DIRECTED: By 5/1/24: The administrator shall ensure the exhaust fan in the bathroom of bedroom #154 is repaired. 4/16/24*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *05/01/2024*

***Implemented ( - 09/09/2024)***

## 103d - Storing Food Off Floor

**14. Requirements**

2600.
103.d. Food shall be stored off the floor.

## 103d - Storing Food Off Floor *(continued)*

**Description of Violation**

*On 3/18/24, approximately 137 gallons of emergency water was stored on the kitchen storage room floor.*

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

*2600.103.d. Food shall be stored off the floor.*
*-This was corrected immediately upon State Surveyors noting citation.*
*-Dietary, housekeeping and Maintenance Employees will be in serviced by April 20 ,2024 to ensure that all food is stored off the floor, including emergency water (drinking water) is stored properly according to 2600.103.d.*
*-The DED will do a monthly audit beginning April 16, 2024, and continuing indefinitely, to ensure that all food is stored off the floor, including emergency(drinking) water is stored properly.*
*- The next quality management review meeting is April 16, 2024. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. 4/16/24).*
*- 2600.103d has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. 4/16/24).*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *04/20/2024*

***Implemented 09/09/2024)***

## 103f - Refrigerator/Freezer Temps

**15. Requirements**

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

**Description of Violation**

*On 3/18/24 at 10:39 am, there was no thermometer present in the special needs kitchen drink refrigerator.*

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

*2600.103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.*
*-Thermometer was placed in the special need's refrigerator on 3/18/2024 by the SME.*
*-Dietary staff will be in serviced by April 20, 2024, on proper procedures for refrigerator temps in special needs refrigerator. (DIRECTED: The staff education shall also include the requirement that operable thermometers shall be present in all refrigerators and freezers. Documentation of the staff education shall be kept in accordance with 2600.65i. 4/16/24).*
*- DED will monitor weekly beginning April 8,2024 to ensure refrigerator temps are recorded completely on the*

## 103f - Refrigerator/Freezer Temps (continued)

*temperature recording sheet and that thermometer is present in refrigerator in special needs and all refrigerators and freezers in kitchen and wellness, etc. (DIRECTED: Documentation of the weekly temperatures of all refrigerators and freezers shall be kept. 4/16/24).*
*-DED will save in a file, the completed monthly refrigerator temperatures for the special need's refrigerator and other refrigerators and freezers indefinitely.*
*- The next quality management review meeting is April 16, 2024. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. 4/16/24).*
*- 2600.103f has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. 4/16/24).*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *04/20/2024*

***Implemented - 09/09/2024)***

## 103g - Storing Food

**16. Requirements**

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

**Description of Violation**

*On 3/18/24 at 10:36 am, the following open and unsealed items were present in the home's walk-in freezer:*

- *A bag of frozen carrots*
- *A box of Otis Spunkmeyer muffins*

*REPEAT VIOLATION: 3/27/2023, et. al.*

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

*2600.*
*103.g. Food shall be stored in closed or sealed containers.*
*- By April 20, 2024, all dietary personnel will be in-serviced on the proper storage procedures for storing food. (DIRECTED: Documentation of the staff education shall be kept in accordance with 2600.65i. LM 4/16/24).*
*- The DED will monitor weekly beginning April 16, 2024, to ensure that all food is stored in closed or sealed containers, in all food storage areas in the home, this monitoring will continue indefinitely.*
*-The carrots and Otis Spunkmeyer muffins were discarded for safety by the EOO on 3/18/2024 @ noon due to not*

## *103g - Storing Food (continued)*

*being stored properly.*
*- The next quality management review meeting is April 16, 2024. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. ██ 4/16/24).*

*- 2600.103g has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely- (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. ██ 4/16/24).*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *04/20/2024*

***Implemented (██ - 09/09/2024)***

## 123b - Emergency Procedures Posted

**17. Requirements**

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

**Description of Violation**

*On 3/18/24, the home's and municipality's emergency preparedness plans were not posted in a conspicuous and public place in the home.*

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

*2600.*
*123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.*
*-a copy of the home's and municipality's emergency preparedness plans were located by the EOO on 3/18/2024.*
*- A sign was posted on the bulletin board in the lobby stating the Emergency Preparedness binder can be found located in the cabinet by the elevator on 3/18/2024. (DIRECTED: By 4/18/24: The administrator shall ensure the cabinet by the elevator is unlocked. ██ 4/16/24). There was a sign posted there previously but a new one was made.*

*- The EOO will monitor at the beginning of each month starting April 2024 to ensure that the municipality's emergency preparedness plans are located in the cabinet by the elevator and continue with this monitoring indefinitely. (DIRECTED: The first monthly audit shall be conducted on 4/20/24. ██ 4/16/24).*
*- The next quality management review meeting is April 16, 2024. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. ██ 4/16/24).*

*- 2600.123b has been added to the quality review meeting checklist on April 12,2024.*

## *123b - Emergency Procedures Posted (continued)*

*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *04/20/2024*

***Implemented (█ - 09/09/2024)***

## 130e - Hearing Impairment

**18. Requirements**

2600.
130.e. If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

**Description of Violation**

*Residents #7 and #9 are unable to hear the fire alarm system. Residents #7 and #9 each have a signaling device in their bedrooms; however, there is no signaling device approved by a fire safety expert to alert residents #7 and #9 of the fire alarm system in numerous common areas of the home, to include the home's living room, main dining room, sunroom, spa area, hair dresser area, activities room and theater room.*

*REPEAT VIOLATION: 3/27/2023, et. al.*

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

*2600.130.e.*
*Residents #7 and #9 are unable to hear the fire alarm system. Residents #7 and #9 each have a signaling device in their bedrooms; however, there is no signaling device approved by a fire safety expert to alert residents #7 and #9 of the fire alarm system in numerous common areas of the home, to include the home's living room, main dining room, sunroom, spa area, hairdresser area, activities room and theater room.*
*- on 4/4/2024 the EOO and Maintenace director reached out to our fire safety expert consultant asking for his guidance on which type of personal body alarm to purchase. One that vibrates and notifies our disabled residents when our fire alarm goes off. We got the ok today (4-15-2024) from Fire Fighters to purchase these enabling products. The signaling device to be purchased is the silent call- these will be ordered on April 16,2024 and expect delivery by the week of April 29, 2024. We will also receive a letter stating they are approved by a fire safety expert after we receive and activate the device. We will put in place a procedure for checking batteries in the devices and ensuring the residents are wearing the devices when not asleep, when the devices are received. (DIRECTED: The policies shall include ensure all signaling devices for individuals who cannot hear the home's fire alarm system are checked during each of the home's monthly fire drills. Documentation of the policies shall be kept.*

## *130e - Hearing Impairment (continued)*

*Documentation of the monthly checks shall be kept on the home's fire drill records. 4/16/24).*
*- Once the devices are received and installed a training will be provided to all staff on proper usage and who will be responsible for checking functioning of the device when fire alarm goes off. (DIRECTED: All staff persons shall receive training on the devices by 5/5/24. 4/16/24). All documentation of training will be kept in accordance with 2600.65i.*
*- Prior to admission of any hearing-impaired residents a bed shaker and body device will be purchased to ensure residents safety in accordance with 2600.130e.*
*- The next quality management review meeting is April 16, 2024. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. 4/16/24).*

*DIRECTED: By 5/1/24: The administrator shall ensure resident #7 and #9's support plans are updated to include the use of signaling devices so the residents are alerted of the activation of the home's fire alarm. 4/16/24*

*- 2600.130e has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely- The EOO will audit 8 resident support plans monthly beginning April 16, 2024, and will continue indefinitely to ensure preparer signature and residents signatures were completed. A copy of the signed support plan reviewed and signed off on by the EOO will be uploaded into the resident's electronic chart and a log of the 3 support plans audited monthly will be maintained in the EOO's office.-The EOO and Maintenance Director reached out to our Fire safety expert on April 4, 2024, and received his approval for the use of the signaling device in the bedrooms. We are awaiting a letter confirming this information.*
*- Beginning April 8th with each monthly fire drill the devices will be tested for proper functioning and this will be documented on the fire drill documentation log. There will be no end date as this will continue monthly as long, we have a resident or staff member with a hearing impairment in the community.*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *05/05/2024*

***Implemented ( - 09/09/2024)***

## 183a - Original Containers and Injections

### 19. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

### Description of Violation

*Resident #6 is prescribed (0.5mg) by mouth twice a day as needed. On there were tablets, which were cut in 1/2 and repackaged into small bags using silent knight packaging.*

## *183a - Original Containers and Injections (continued)*

*Each of the bags contained 10 of the 1/2 Alprazolam tablets and were stapled closed.*

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

*2600.183.a. Resident #6 is prescribed by mouth twice a day as needed. On , there were tablets, which were cut in 1/2 and repackaged into small bags using silent knight packaging. Each of the bags contained 10 of and were stapled closed.*
*- All nurses and med techs will be in serviced by April 15, 2024, on 183a original containers and injections. The training is a power point created by corporate nurses who are train the trainers for medication administration (not removing medications from their original containers). The training covers: medication errors, mediation administration, documentation, allergies, med cart audits, refusals, prn medication, Documentation of the training will be kept will be kept in accordance with 2600.65i.*
*- The RWD will audit the med carts every two weeks starting April 8,2024 and ending June 1, 2024, to ensure proper compliance with 183 a - original containers and injections. After June 11, 2024, the RWD will audit medication carts monthly thru December 31,2024 to ensure compliance with 183 a- original containers and injections.*
*- The next quality management review meeting is April 16, 2024. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. 4/16/24).*
*- 2600.183a has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. 4/16/24).*

*DIRECTED: By 4/18/24: The administrator shall ensure resident #6's which were cut in 1/2 and repackaged, are disposed of in accordance with the home's policy and in accordance with 2600.183f. The administrator shall also ensure resident #6's Alprazolam is delivered to the home in packaging consistent with the current prescriber order. 4/16/24*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *04/18/2024*

***Implemented - 09/09/2024)***

## 223a - Description of Service

**20. Requirements**

2600.
223.a. The home shall have a current written description of services and activities that the home provides including the following:
1. The scope and general description of the services and activities that the home provides.
2. The criteria for admission and discharge.
3. Specific services that the home does not provide, but will arrange or coordinate.

## 223a - Description of Service *(continued)*

**Description of Violation**

*The home's current written description of services indicates that the home provides transportation; however, the home no longer provides transportation.*

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

*2600.*
*223.a. The home's current written description of services indicates that the home provides transportation; however, the home no longer provides transportation.*
*-Upon Surveyors noting the citation a letter was immediately drafted and sent the same day to all Residents and families stating a 30-day notice that the home does not provide transportation any longer.*

*DIRECTED: By 4/18/24: The administrator shall ensure a copy of the home's updated description of services is kept. ███ 4/16/24*

*-By April 25, 2024, the EOO will ensure a signed copy has been returned for the 30-day notice of no longer providing transportation has been received by all Resident POA's.*
*-The home's blank resident-home agreement contract was updated for future admissions to ensure the resident - home contract indicates the home does not provide transportation on 4/15/2024.*
*- Yearly the EOO/CRD/AGM will review the description of services for accuracy.*
*- The next quality management review meeting is April 16, 2024. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. ███ 4/16/24).*

*- 2600.223a has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. ███ 4/16/24).*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *04/25/2024*

***Implemented ███ - 09/09/2024)***

## 224a - Preadmission Screen Form

**21. Requirements**

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

## 224a - Preadmission Screen Form *(continued)*

**Description of Violation**

*Resident #5 was admitted to the home on [redacted] however, the resident's preadmission screening was completed on [redacted]*

*Resident #6's preadmission screening, dated [redacted], does not include the signature of the person who completed the form.*

*Resident #8 was admitted to the home on [redacted] however, no preadmission screening was completed.*

*REPEAT VIOLATION: 3/27/2023, et. al.*

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

*2600.224.a.*
*Resident #5 was admitted to the home on [redacted] however, the resident's preadmission screening was completed on [redacted]*
*Resident #6's preadmission screening, dated [redacted], does not include the signature of the person who completed the form.*
*Resident #8 was admitted to the home on [redacted]; however, no preadmission screening was completed.*
*-Resident #5,6 and 7 received a new prescreen on [redacted] to correct citation errors. (DIRECTED: Copies of the completed preadmission screenings shall be kept in each resident's record. [redacted] 4/16/24).*

*DIRECTED: By 4/18/24: The administrator shall complete a preadmission screening for resident #8 and place the completed preadmission screening in resident #8's record. [redacted] 4/16/24*

*- All new admits prescreens will be reviewed- the day before or the morning of admission by the EOO prior to admission starting April 16,2024.*
*- A new admit check list will be started as soon as we are notified of a move in and will be completed by the ASD by the end of the move in date. (DIRECTED: The new admission checklist shall be implemented by 4/18/24 and used for all future admissions to ensure a preadmission screening is completed within 30 days prior to admission for all new admissions. Copies of the completed new admission checklists shall be kept in each resident's record. [redacted] 4/16/24).*
*- The EOO within 3 days of move in will review all new admits and sign off on the new admit check list beginning April 16,2024.*
*- All residents charts will be reviewed by April 20, 2024, to ensure they have a prescreen completed. This will be done by the EOO/ASD.*
*- The EOO will review with the CRD, Receptionist and ASD the new admit checklist and proper way to complete the checklist. This training will be done on April 16, 2024. The documentation of the education, date and who presented the training will be kept in accordance with 2600.65i.*
*- The next quality management review meeting is April 16, 2024. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. [redacted] 4/16/24).*

*- 2600.224a has been added to the quality review meeting checklist on April 12,2024.*

## 224a - Preadmission Screen Form (continued)

*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. 4/16/24).*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *04/20/2024*

***Implemented ( - 09/09/2024)***

## 227g -Support Plan Signatures

**22. Requirements**

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

**Description of Violation**

*Resident #7's support plan, dated is not signed by the resident and does not indicate the resident was unable to participate, declined to participate, refused to sign or was unable to sign.*

*REPEAT VIOLATION: 10/16/2023; 9/19/2023; 8/23/2023*

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

*2600.227.g.*
*Resident #7's support plan, dated , is not signed by the resident and does not indicate the resident was unable to participate, declined to participate, refused to sign or was unable to sign.*
*- Resident # 7's support plan was signed by the resident on*
*- A tickler has been made, on to include all support plan dates, prepares signature completed, residents signature completed, and dates completed. The RWD will maintain the tickler for support plan signatures weekly beginning April 15, 2024.*
*- All residents current support plans will be audited by the EOO/RWD beginning April 15,2024 to ensure they have prepares signature and residents signature- This will be completed by April 30,2024.*
*-All resident wellness employees will be educated by April 30,2024 on regulatory requirements for generating*

## 227g -Support Plan Signatures (continued)

*resident support plans. This will be presented by the EOO. All documentation of the education will be kept in accordance with 2600.65i.*
*- The next quality management review meeting is April 16, 2024. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. 4/16/24).*

*- 2600.227g has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely.*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. 4/16/24). The EOO will audit 8 resident support plans monthly beginning April 16, 2024, and will continue indefinitely to ensure preparer signature and residents signatures were completed. A copy of the signed support plan reviewed and signed off on by the EOO will be uploaded into the resident's electronic chart and a log of the ~~3 support plans~~ (UNACCEPTABLE PORTION OF PLAN OF CORRECTION. DIRECTED: The monthly audits shall include a review of at least 8 resident support plans per month to ensure compliance with 2600.227g. Documentation of the audits shall be kept. 4/16/24). audited monthly will be maintained in the EOO's office.*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *04/30/2024*

***Implemented - 09/09/2024)***

## 231b - Medical Evaluation

**23. Requirements**

2600.
231.b. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident’s diagnosis of Alzheimer’s disease or other dementia and the need for the resident to be served in a secured dementia care unit.

**Description of Violation**

*Resident #6 was admitted to the secured dementia care unit (SDCU) on ; however, resident #6’s medical evaluation was completed on .*

*REPEAT VIOLATION: 8/14/2023, et. al; 3/27/2023, et. al.*

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

*2600.231.b.*
*Resident #6 was admitted to the secured dementia care unit (SDCU) on however, resident #6’s medical evaluation was completed on*
*- Resident # 6 will receive a new medical evaluation on , when the MD is in the community.*
*- Beginning all resident moving into the SDCU will have a medical evaluation prior to being admitted.*

## *231b - Medical Evaluation (continued)*

*- All resident's currently residing in the SDCU charts will be reviewed by April 20,2024 by the EOO to ensure they have a completed DME.*
*- A new admit check list will be started as soon as we are notified of a move in and will be completed by the ASD by the end of the move in date. (DIRECTED: The new admission checklist shall be implemented by 4/18/24 and used for all future admissions to the home's SDCU to ensure a medical evaluation is completed in its entirety within 60 days prior to admission for all new SDCU admissions. Copies of the completed new admission checklists shall be kept in each resident's record. ██ 4/16/24).*
*- The EOO will review with the CRD, Receptionist and ASD the new admit checklist and proper way to complete the checklist. This training will be done on April 16, 2024. The documentation of the education, date and who presented the training will be kept in accordance with 2600.65i.*
*- The EOO prior to admission will review the DME and within 3 days of move in will review all new admits and sign off on the new admit check list. (DIRECTED: The EOO audit of new admission medical evaluations shall begin on 4/18/24. Documentation of the audits shall be kept for 2 months. ██ 4/16/24).*
*- The next quality management review meeting is April 16, 2024. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. ██ 4/16/24).*

*- 2600.231b has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. ██ 4/16/24).*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely- The EOO will audit 8 resident support plans monthly beginning April 16, 2024, and will continue indefinitely to ensure preparer signature and residents signatures were completed. A copy of the signed support plan reviewed and signed off on by the EOO will be uploaded into the resident's electronic chart and a log of the 3 support plans audited monthly will be maintained in the EOO's office.*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *04/20/2024*

***Implemented ██ - 09/09/2024)***

## 233c - Key-Locking Devices

### 25. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

**Description of Violation**

*On 3/18/24, no directions for operating the home's locking mechanism were present near the SDCU exit door across*

## *233c - Key-Locking Devices (continued)*

*from bedroom #158a.*

*REPEAT VIOLATION: 3/27/2023, et. al.*

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

*2600.233.c.*
*On 3/18/24, no directions for operating the home's locking mechanism were present near the SDCU exit door across from bedroom #158a.*
*- The directions for operating the locking mechanism near the SDCU exit door across from bedroom #158a is continuously removed by a resident. - The SME on 4/1/2024 after many attempts at reposting the instructions, placed the instructions in a frame and screwed the frame to the wall- he also placed the instructions in frames and screwed them to the wall at all other doors in the SDCU.*
*- Beginning April 8,2024 the SME/EOO will ensure weekly that the directions are in place by the SDCU exit door across from bedroom #158a and all other doors in the SDCU and will continue weekly checks indefinitely.*
*- The next quality management review meeting is April 16, 2024. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. 4/16/24).*
*- 2600.233c has been added to the quality review meeting checklist on April 12,2024.*
*-All monthly quality management review meeting notes will be maintained in a binder in the EOO's office and this will continue indefinitely. (DIRECTED: Documentation of the quality management reviews shall be kept and include a review of all items specified in 2600.26b. 4/16/24).*
*-The EOO will ensure the staff training and License violations and plans of correction, if applicable are discussed monthly during the quality management plan monthly meeting beginning April 2024 and continuing monthly indefinitely- The EOO will audit 8 resident support plans monthly beginning April 16, 2024, and will continue indefinitely to ensure preparer signature and residents signatures were completed. A copy of the signed support plan reviewed and signed off on by the EOO will be uploaded into the resident's electronic chart and a log of the 3 support plans audited monthly will be maintained in the EOO's office.*

*Proposed Overall Completion Date: 12/31/2024*

**Directed Completion Date:** *04/16/2024*

***Implemented - 09/09/2024)***

## 253c - Records Log

**26. Requirements**

2600.
253.c. The home shall keep a log of resident records destroyed on or after October 24, 2005. This log must include the resident’s name, record number, birth date, admission date and discharge date.

**Description of Violation**

*The home's log of resident records that were destroyed, dated 2016-present, does not include the birthdates and admission dates of the resident records that were destroyed.*

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

### Facility Information

**Name**: *THE PINES OF MT. LEBANON* **License #**: *43361* **License Expiration**: *06/28/2024*

**Address**: *1537 WASHINGTON ROAD, PITTSBURGH, PA 15228*

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

### Administrator

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

### Legal Entity

**Name**: *TITHONUS MT. LEBANON LP*

**Address**:

### Certificate(s) of Occupancy

**Type**: *C-2 LP* **Date**: *06/05/1990* **Issued By**: *Labor and Industry*

### Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *67* **Waking Staff**: *50*

### Inspection Information

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

**Reason**: *Complaint, Incident* **Exit Conference Date**: *04/25/2024*

### Inspection Dates and Department Representative

*04/18/2024 - On-Site:*

*04/25/2024 - On-Site:*

### Resident Demographic Data as of Inspection Dates

General Information

**License Capacity**: *112* **Residents Served**: *51*

Secured Dementia Care Unit

**In Home**: *Yes* **Area**: *1st Floor, Life Stories* **Capacity**: *18* **Residents Served**: *5*

Hospice

**Current Residents**: *7*

Number of Residents Who:

**Receive Supplemental Security Income**: *0* **Are 60 Years of Age or Older**: *51*

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

**Have Mobility Need**: *16* **Have Physical Disability**: *4*

## Inspections / Reviews

### 04/18/2024 - Partial

**Lead Inspector**: *Ashley Roser* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/16/2024*

**05/21/2024 - POC Submission**

**Submitted By**: [redacted] **Date Submitted**: *06/11/2024*

**Reviewer**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/27/2024*

**05/21/2024 - POC Submission**

**Submitted By**: [redacted] **Date Submitted**: *06/11/2024*

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

**09/09/2024 - Document Submission**

**Submitted By**: [redacted] **Date Submitted**: *06/11/2024*

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

## 23a - Activities of Daily Living Assistance

### 1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

**Description of Violation**

*According to resident #1's most recent assessment and support plan, dated [redacted], resident #1 requires physical assistance of 2 staff persons to transfer in/out of bed/chair with the use of a Hoyer lift; however, from approximately the morning of [redacted] through the afternoon of 4/6/24, resident #1 was not transferred in/out of bed, because resident #1's Hoyer lift was inoperable.*

*REPEAT VIOLATION: 10/16/2023, et. al.; 9/19/2023*

**Plan of Correction** ***Accept [redacted] - 05/21/2024)***

*23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.*
*The RWD resigned after not following thru with ensuring the Hoyer was repaired.*
*1. Immediate Assessment and Repair of Hoyer Lifts:*
*Goal: Ensure all Hoyer lifts are in good working condition to safely meet the needs of residents.*
*-Action: Conduct an immediate inspection of all Hoyer lifts to identify and repair any that are non-functional. Contract certified technicians if necessary and expedite the repair process. - EOO on 4/18/2024 verified both Hoyer lifts in the community were in working order. No issues with either Hoyer.*
*2. Notification and Documentation Protocol:*
*- Goal: Establish clear communication channels for reporting equipment malfunctions to ensure quick resolution and prevent service disruptions.*
*-Action: Implement a standardized protocol for staff to report equipment issues immediately to the maintenance department and document these reports in a maintenance log, accessible to management at all times.*
*- Completion Date: Protocol implementation - on 4/20/2024 EOO added to the MOD weekend paperwork Hoyer Lifts functioning properly. Every sat and sun the manager on duty checks to ensure Hoyer's for residents are functioning properly and document- In the event a Hoyer is not functioning properly a call is to me made to the EOO for immediate plans for a resolution.*
*-between 4/20/2024 and 4/30/2024 all Wellness staff were educated on the protocol for reporting a malfunctioning Hoyer.*
*-Starting 4/20/2024 the EOO checks any Hoyer in the community weekly to ensure they are working properly and will continue for 6 months ending 10/31/2024.*
*-all new wellness staff hired after 5/1/2024 will be educated on the protocol for reporting a Hoyer malfunction immediately and will complete a Hoyer competency for proper use.*
*3. Staff Training on Equipment Handling and Reporting:*
*Goal: Enhance staff competency in using Hoyer lifts and in reporting any issues promptly and effectively.*
*- Action: Provide immediate training for all caregiving staff on the correct use of Hoyer lifts, focusing on safety procedures, troubleshooting minor issues, and the importance of immediate reporting of malfunctions.*
*- Completion Date: Between 4/20/2024 and4/30/2024 and then with every new wellness employee. This is being done by the EOO/RWD.*
*4. Quality Assurance Reviews:*

## 23a - Activities of Daily Living Assistance (continued)

*-Goal: Ensure the effectiveness of the new protocols and maintenance programs.*
*- Action: Incorporate equipment management into the facility's regular quality assurance reviews to monitor adherence to the maintenance program, effectiveness of staff training, and timeliness of issue reporting and resolution.*
*- Completion Date: Reviews to begin with the next quality assurance meeting on 5/28/2024- This citation will be added to the quality assurance log for all monthly meetings.*
*5. Regular Staff Refresher Trainings:*
*-Goal: Keep all staff updated on best practices for equipment use and maintenance.*
*-Action: Schedule semi-annual refresher training sessions for all staff on the use of Hoyer lifts and the proper procedures for reporting equipment issues.*
*-Completion Date: This will be reviewed during the 1st and 4th quarter meeting annually by the EOO/SMD.*

*Documentation and Submission:*
*• Evidence of Compliance: Include repair or replacement invoices, staff training records, updated maintenance logs, and quality assurance review summaries will be maintained in a binder in the EOO's office.*

**Licensee's Proposed Overall Completion Date:** *05/30/2024*

***Implemented - 09/09/2024)***

## 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 or around the morning of , staff person A was providing housekeeping services in resident #2's bedroom. As staff person A was leaving resident #2's bedroom, staff person A kissed resident #2 on right cheek. Staff person A then asked to kiss resident #2 on the lips and resident #2 said, "No. Get away". Staff person A then told resident resident #2, "Oh come on, your sister lets me kiss on the lips". Resident #2 again told staff person A, "No. Get away". At that time, staff person A left resident #2's bedroom. This incident made resident #2 feel "scared and disgusted".*

*REPEAT VIOLATION: 9/19/2023*

**Plan of Correction** ***Accept - 05/21/2024)***

*42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.*
*-Upon receiving notification of the abuse by Resident #2's sister- Resident was immediately interviewed. Staff person A was interviewed and immediately suspended per investigation. APS was called by the EOO and State report*

## 42b - Abuse (continued)

*done by EOO. APS arrived at the community and interviewed resident and spoke with EOO and substantiated the claim.*
*-Staff person A was terminated.*
*2. Support and Counseling for the Affected Resident:*
*- Goal: To provide immediate support and reassurance to the resident involved.*
*-Action: Arrange for the resident to receive counseling from a qualified professional to help cope with the trauma of the incident. Ensure the resident is comfortable in her environment and reassure her of her safety.*
*Completion Date: Resident refused counseling at the time and has now on 5/20/2024 ask for counseling. - Resident would like virtual visit with a counselor and EOO is setting that up - Resident requested a female counselor. EOO will schedule visit to be done by 5/31/2024.*
*By 5/31/2024 EOO will interview all residents - they will be asked how are they? Do they feel safe? and is there anything I can help them with. Then the EOO will continue interviewing 2 residents a week starting June1, 2024 and continuing indefinitely. The documentation will be maintained in the EOO office.*
*Abuse is already a part of the quality assurance meeting, but this specific citation will be added starting with the next meeting on 5/28/2024 and documentation will be maintained by the EOO.*
*- All staff get abuse training when they are hired and yearly- All Staff being reeducated on abuse beginning 5/1/2024 and completing by 5/30/2024. This training is being done by the EOO via a PowerPoint done by a certified trainer with Gateway Hospice.*
*EOO will discuss safety with Residents monthly at the Resident council meetings starting 6/2024 and continuing indefinitely.*
*EOO will continue to report any abuse claims to APS and State immediately.*

*The next Resident Council meeting is Wednesday June 5 10:30am to 11:00am and then the first Wednesday of every month 10:30am to 11:00am .*

**Licensee's Proposed Overall Completion Date:** *06/05/2024*

***Implemented ([redacted] - 09/09/2024)***

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

### Legal Entity

**Name**: *TITHONUS MT. LEBANON LP*

**Address**:

### Certificate(s) of Occupancy

### Staffing Hours

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

### Inspection Information

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

**Reason**: *Complaint, Provisional, Monitoring* **Exit Conference Date**: *07/15/2024*

### Inspection Dates and Department Representative

*07/11/2024 - On-Site*
*07/12/2024 - On-Site*
*07/15/2024 - On-Site*

### Resident Demographic Data as of Inspection Dates

General Information

**License Capacity**: *112* **Residents Served**: *50*

Secured Dementia Care Unit

**In Home**: *Yes* **Area**: *1st Floor Memory Care* **Capacity**: *18* **Residents Served**: *7*

Hospice

**Current Residents**: *9*

Number of Residents Who:

**Receive Supplemental Security Income**: *0* **Are 60 Years of Age or Older**: *50*

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

**Have Mobility Need**: *16* **Have Physical Disability**: *2*

## Inspections / Reviews

### 07/11/2024 - Partial

**Lead Inspector**: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/15/2024*

## 65g - Annual Training Content

**1. 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.

**Description of Violation**

*Direct care staff person A, hired on [redacted] did not receive fire safety training conducted by a fire safety expert during the 2023 training year.*

*Direct care staff person B, hired on [redacted], did not receive fire safety training conducted by a fire safety expert during the 2023 training year.*

*REPEAT VIOLATION: 3/27/2023, et. al.*

**Plan of Correction** ***Directed [redacted] - 08/23/2024)***

*2600.65g Annual Fire Safety Training.*
*-All staff going forward will be trained yearly in fire safety training conducted by a fire safety expert or by a staff person trained by a fire safety expert. All yearly training will be monitored on a tickler system maintained by the EOO and all staff will be given a certificate of completion, for their file when their training is completed. (DIRECTED: Beginning on 9/1/24: The EOO/administrator shall review the tickler system monthly to ensure all staff persons receive training on all topics specified in 2600.65g during each training year. [redacted] 8/23/24).*
*-The EOO will be trained by a fire safety expert to conduct the training as a backup by September 30, 2024. (DIRECTED: Documentation of the training shall be kept. [redacted] 23/24).*
*-The Annual Fire Safety training will be added to the monthly QI Meeting and a list will be kept monthly Starting August 20, 2024, and will continue every month to ensure everyone has the annual fire safety training yearly. This list will be maintained as part of the monthly QI meeting.*
*- The Fire Safety training for 2024 will be conducted August 27-29, 2024, and then --monthly to ensure all employees have completed their fire safety training specific to the Pines each year.*
*-The SMD/EOO will be responsible for ensuring all staff has the training yearly and documentation of the training will be kept in accordance with 2600.65i.*
*-Staff Person A & B will receive their annual fire safety training by August 30, 2024. Eric Ambrose, SMD will be doing the training and documentation of the education will be kept in accordance education with 2600.65i.*
*-documentation of all the education will be kept in accordance with 2600.65i.*

*Proposed Overall Completion Date: 09/30/2024*

**Directed Completion Date:** *08/30/2024*

***Implemented ([redacted] - 09/09/2024)***

## 82c - Locking Poisonous Materials

**2. Requirements**

2600.

## 82c - Locking Poisonous Materials *(continued)*

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

**Description of Violation**

*On [redacted] at [redacted], the following poisonous materials were unlocked, unattended and accessible in a storage room behind the kitchen in the secured dementia care unit (SDCU):*

- *A 3.75oz Tube of [redacted] with a manufacturer's label indicating, "In case of accidental ingestion, contact a physician or Poison Control Center right away"*
- *A 3.5oz [redacted] ointment with a manufacturer's label indicating, "In case of accidental ingestion contact a physician or PCCC right away"*

*None of the residents who reside in the home's SDCU are assessed as safe to be around poisonous materials.*

**Plan of Correction** ***Directed ([redacted] - 08/23/2024)***

*2600.82c Poisonous materials*
*Poisonous material left unlocked, unattended and accessible in storage room behind the kitchen in the SDCU.*
*-During the surveyor walk -thru, the poisonous material was immediately secured by the SME walking with the surveyor on July 11, 2024.*
*-2600.82c Will be added to the Monthly QI report*
*-EOO/HSS/SMD Beginning August 15, 2024, will check the storage room behind the kitchen in the SDCU and the entire home, fives time a week for 2 months ending October 31, 2024, to ensure all poisonous materials are locked away.*
*-EOO/HSS Beginning November 1,2024 will check the storage room behind the kitchen in the SDCU and the entire home twice a week until January 31,2025 and then once a month indefinitely thereafter to ensure all poisonous materials are locked away.*
*- RWA/MED TECH/LPN will check the storage room behind the kitchen in the SDCU nightly beginning 8/15/2024 indefinitely to ensure all poisonous materials are locked away.*
*-All staff person will be educated on 2600.82c poisonous materials shall be kept in an area that is locked by August 31, 2024. This training will be done by the EOO, and documentation of the education will be kept in accordance with 2600.65i.*

*Proposed Overall Completion Date: 12/30/2024*

**Directed Completion Date:** *08/31/2024*

***Implemented [redacted] - 09/09/2024)***

## 85a - Sanitary Conditions

**3. Requirements**

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

**Description of Violation**

*On 7/11/24 at 11:25am, there was a red sticky substance on the bottom of the freezer drawer in the SDCU kitchen.*

*REPEAT VIOLATION: 3/27/2023, et. al.*

## 85a - Sanitary Conditions *(continued)*

**Plan of Correction** ***Accept [redacted] - 08/23/2024)***

*2600.85 Sanitary conditions shall be maintained. - Red sticky substance on the bottom of the freezer in the SDCU kitchen.*
*-2600.85 Will be added to the Monthly QI report*
*- On July 11, 2024, the HSS cleaned the red sticky substance located on the bottom of the freezer drawer in the SDCU kitchen.*
*-EOO/HSS Beginning August 15, 2024, will check the refrigerators /freezers in the entire facility fives time a week for 2 months ending October 31, 2024, to ensure safety conditions are maintained and no spills are present.*
*-EOO/HSS Beginning November 1,2024 will check the refrigerators/freezers in the entire facility twice a week until January 31,2025 and then once a month indefinitely thereafter to ensure safety conditions are maintained and no spills are present.*
*- RWA/MED TECH/LPN will check the refrigerator/freezer in the SDCU nightly beginning 8/15/2024 and continuing indefinitely to ensure safety conditions are maintained and no spills are present.*
*- The EOO will educate all staff on sanitary conditions, including education on ensuring all refrigerators and freezers are clean. This education will be completed by August 31, 2024. Documentation of the education will be kept in accordance with 2600.65i.*

**Licensee's Proposed Overall Completion Date:** *08/31/2024*

***Implemented [redacted] - 09/09/2024)***

## 103g - Storing Food

**4. Requirements**

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

**Description of Violation**

*On 7/11/24 at 1:25pm, there was an open and unsealed bag containing 7 hot dogs present in the home's walk-in cooler.*

*On 7/11/24 at 1:30pm, the following items were open and unsealed in the home's walk-in freezer:*

- *A 30 lb. box of corn kernels*
- *A bag of cookie pieces, approximately 1/2 full*

*On 7/11/24 at 1:35pm, there was an open and unsealed 25 lb. bag of sugar present in the home's dry storage pantry.*

*REPEAT VIOLATION: 3/27/2023, et. al.*

**Plan of Correction** ***Accept [redacted] - 08/23/2024)***

*2600.103g Food shall be stored in closed sealed containers.*
*-2600.103.g will be added to the monthly QI report.*
*-July 11, 2024 at 3pm the DED/EOO discarded the cited items found earlier in the day. The EOO immediately upon discarding the items informed the surveyors that the had been discarded.*
*-DED/HSS/SMD beginning 8/15/2024 will check the walk-in cooler/freezer and the dry storage pantry and any other food storage area in the facility five times a week to ensure all items are closed and sealed. This will continue for two months ending October 31,2024.*
*-DED/HSS/SMD beginning 11/1/2024 will check the walk-in cooler/freezer and the dry storage pantry and any*

*103g - Storing Food (continued)*

*other food storage area in the facility, three times a week to ensure all items are closed and sealed. This will continue for two months ending December 31,2024.*
*-DED/HSS/SMD beginning 1/1/2025 will check the walk-in cooler/freezer and the dry storage pantry and any other food storage area in the facility, two times a week to ensure all items are closed and sealed. This will continue indefinitely.*
*-EOO beginning August 19,2024 will check the walk -in cooler/freezer and the dry storage pantry and any other food storage area, two times a week to ensure all items are closed and sealed until December 31, 2024.*
*-EOO will do an in-service between August 19, 2024, and August 31, 2024, for all Dietary staff to ensure compliance with 2600.103g and the in-service will be maintained in the training binder located in the EOO office in accordance with 2600.65i.*

*Plan of Correction*

**Licensee's Proposed Overall Completion Date:** *08/31/2024*

***Implemented [redacted] - 09/09/2024)***