



CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: APRIL 25, 2024

██████████ Owner
Deneane Smith
142 Fairview Avenue
Confluence, Pennsylvania 15424

RE: Deneane's Personal Care Home
142 Fairview Avenue
Confluence, Pennsylvania 15424
License #: 321520

Dear ██████████:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on December 5-6, 2023 and March 20, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) and 55 Pa. Code §20.71(a)(2);(4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal

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

[REDACTED]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: [REDACTED]

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

Sincerely,



Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

[REDACTED]

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

Facility Information

Name: *DENEANE'S PERSONAL CARE HOME* License #: *32152* License Expiration: *02/28/2023*
Address: *142 FAIRVIEW AVENUE, CONFLUENCE, PA 15424*
County: *SOMERSET* Region: *CENTRAL*

Administrator

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

Legal Entity

Name: *DENEANE SMITH*
Address: *142 FAIRVIEW AVENUE, CONFLUENCE, PA, 15424*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *02/08/1999* Issued By: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *19* Waking Staff: *14*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint* Exit Conference Date: *12/06/2023*

Inspection Dates and Department Representative

12/05/2023 - On-Site: [REDACTED]
12/06/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *18* Residents Served: *18*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *17* Are 60 Years of Age or Older: *16*
Diagnosed with Mental Illness: *16* Diagnosed with Intellectual Disability: *4*
Have Mobility Need: *1* Have Physical Disability: *0*

Inspections / Reviews

12/05/2023 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/28/2023*

01/09/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/26/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 01/26/2024

04/16/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/26/2024

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

3c - Post Current License

1. Requirements

2600.

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

Description of Violation

On 12/5/2023, the home did not have the current license or regulations posted in a public or conspicuous place. The license that was posted in the home was from 2/28/2022-2/28/2023.

Repeated Violation - 12/8/2022

Plan of Correction

Directed (█) - 01/03/2024

The Administrator has applied for a renewal certificate. The certificate will be submitted as soon as it is received. On December 6, 2023 the Administrator printed and posted a copy of this chapter in the resident dining room. Beginning January, 2024, the Administrator will check monthly to ensure this chapter continues to be hung in the resident dining room. Staff were asked to notify the Administrator if they notice this chapter missing from the resident dining room. Please see attached checklist.

Proposed Overall Completion Date: 02/29/2024

(Directed)

- The Administrator applied for a renewal certificate by 12/28/2023 which will be posted in a public and conspicuous place in the home once received.
- On 12/6/2023, the Administrator printed and posted a copy of the regulations in the resident dining room.
- Staff will receive education to notify the Administrator if the regulations or current license is observed to be missing from the resident dining room by 1/20/2024.
- Beginning no later than 1/20/2024, monthly audits will be completed by the Administrator or designee to ensure the current license and regulations are posted in a public and conspicuous place in the home.
- Documentation of staff education and completed monthly audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Not Implemented (█) - 03/27/2024

5a1 - DHS Access

2. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

1. Agents of the Department.

Description of Violation

On 12/5/2023 at approximately 10:15 AM, an agent of the Department requested access to the administrator's record including staff training documentation, as well as furnace cleaning, quality management meeting minutes and annual fire safety inspection/supervised drill documentation. Staff person A stated that the administrator would not be in today that no one else has access to those records. At approximately 11:15 AM, the licensing representative asked for the 2023 Staff Training Plan, annual training records for direct care staff, background checks, diplomas, training and

5a1 - DHS Access (continued)

direct care certification for staff members. Staff person A stated that they did not have access to those documents and that the administrator would have them. On 12/6/2023 at approximately 9:15 AM, the administrator indicated that [REDACTED] did not bring the requested annual training records for the staff members requested. The administrator also did not produce the quality management meeting records or annual fire safety inspection documents. The licensing representatives did not have access to the information for the following regulations: 26(a), 65(f), 65(g), 65(e), 132(b) and 132(d).

Repeated Violation - 7/12/2022, et al.

Plan of Correction

Directed ([REDACTED] - 01/03/2024)

The administrator educated [REDACTED] designee, Administrator Assistant, Staff Person A, on December 7, 2023 as to the location of all records. Staff person A will have access to all records at all times beginning December 7, 2023. All records will be kept safely and securely in the office area of the facility so that the designee will have immediate access to them in order to provide all records to Agents of the Department upon their request.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- A written policy regarding record storage and access will be reviewed and updates will be made, as necessary, by 1/20/2024.
- The administrator or designee will provide education to all staff who have access to resident records on the policy by 1/20/2024.
- Quarterly audits of the home's resident and staff records, policies and procedures, quality management meeting minutes, and fire safety documents will be completed by the administrator or designee starting 1/20/2024 to ensure the records are present, accurate and readily available.
- Documentation of education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Implemented ([REDACTED] - 03/27/2024)

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

According to the Influenza Awareness Act (NH 1785), residences must post the required influenza information in a public place in the residence year-round. On 12/5/2023, the home did not have the flu awareness poster posted in the home.

According to the Care Facility Carbon Monoxide Alarm Standards Act, if the Carbon Monoxide (CO) alarm operates by a battery, the battery must be labelled with the date of installation and be replaced at least once annually. On

18 - Compliance With Laws (continued)

12/5/2023, the CO alarm on the second floor had a label indicating that the battery had not been changed since 4/12/2019, and the home does not keep a log or any documentation showing when the batteries are changed.

Repeated Violation - 7/12/2022, et al

Plan of Correction

Directed (█) - 01/03/2024)

On December 6, 2023 the Administrator printed and posted a Influenza Awareness Act poster in the resident dining room. Beginning January, 2024, the Administrator will check monthly to ensure this chapter continues to be hung in the resident dining room. Staff were asked to notify the Administrator if they notice this poster missing from the resident dining room. Please see attached checklist.

On December 6, 2023 the battery in the CO Alarm was dated and changed. Administrator will continue to check all CO Alarms to ensure the batteries installed in them are not more than one year old. Please see attached checklist.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- On 12/6/2023, the Administrator printed and posted a copy of the Influenza Awareness poster in the resident dining room.
- Staff will receive education to notify the Administrator if the poster is observed to be missing from the resident dining room by 1/20/2024.
- Beginning no later than 1/20/2024, monthly audits will be completed by the Administrator or designee to ensure the Influenza Awareness poster remains posted in a public and conspicuous place in the home.
- On December 6, 2023 the battery in the carbon monoxide alarm was dated and changed by the Administrator or designee.
- Beginning no later than 1/20/2024, monthly audits of all carbon monoxide alarms will be completed by the Administrator or designee to ensure the batteries are labeled with the date of installation and replaced at least once annually or at such time as the carbon monoxide alarm signals a drained or failing battery, whichever is sooner.
- Documentation of staff education and completed monthly audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Not Implemented (█) - 03/27/2024)

20b6 - Interest Bearing Account

4. Requirements

2600.

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

- 6. If a home is holding more than \$200 for a resident for more than 2 consecutive months, the administrator shall notify the resident and offer assistance in establishing an interest-bearing account in the resident's name at a local Federally-insured financial institution. This does not include security deposits.

20b6 - Interest Bearing Account (continued)

Description of Violation

The home held money for residents #1 and #2, from at least 1/1/2023 through 12/1/2023, during which time the monthly balance of those funds did not fall below \$1,000.00. The home has not notified the residents nor offered assistance in establishing an interest-bearing account in the resident's name at a local Federally-insured financial institution.

Plan of Correction

Directed (█) - 01/03/2024

Resident #1 did have a signed refusal for an interest bearing account, however, the department representative would not accept it. Interest bearing accounts for Resident #1 and #2 were offered on December 7, 2023 and were refused. The Administrator offered all residents who the home is payee for interest bearing accounts on December 7, 2023. The Administrator will offer interest bearing accounts to all residents who monthly balances are over \$200.00 for 2 consecutive months.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- Interest bearing accounts for Resident #1 and #2 were offered on December 7, 2023 and were refused.
- The Administrator offered all residents who the home is rep payee for interest bearing accounts on December 7, 2023.
- The Administrator or designee will receive education on regulation 2600.20(b)(6) by 1/20/2024. Documentation of the education provided will be kept by the home.
- Beginning no later than 1/20/2024, the Administrator or designee will complete monthly audits of resident accounts. If a resident's account has more than \$200 for more than two consecutive months, the Administrator or designee will offer the resident assistance in establishing an interest bearing account.
- Documentation of the notice and offer will be kept by the home and will be available for review by the Department.

Directed Completion Date: 01/20/2024

Implemented (█) - 03/27/2024

20b8 - Quarterly Account

5. Requirements

2600.

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

- 8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

Residents #1 and #2 have not received a quarterly itemized account of financial transactions made on the resident's behalf since at least January 2023.

Plan of Correction

Directed (█) - 01/03/2024

The home DID give residents #1 and #2 a quarterly itemized account of financial transactions. The itemized account, did not include the total income and room and board fees. The itemized account DID show the deposit of their \$85.00 monthly spending allowance and all of the transactions coming out of their monthly spending allowance, Beginning January, 2024 the home will include the residents monthly income and monthly room and

20b8 - Quarterly Account (continued)

board fees in their itemized account. The home will do this for all residents in which the home is payee for.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- The Administrator or designee will receive education on regulation 2600.20(b)(8) by 1/20/2024. Documentation of the education provided will be kept by the home.
- All residents of the home for whom the home provides financial assistance will receive an itemized account of financial transactions by 1/22/2024 and quarterly thereafter.
- A copy of the itemized account will be provided to the resident's designated person, if applicable, by the Administrator or designee no later than 1/22/2024 and quarterly thereafter.
- Documentation of the itemized account being provided to the resident and designated person will be kept by the home for review by the Department.

Directed Completion Date: 01/22/2024

Implemented (█) - 03/27/2024)

52 - Hiring Staff

7. 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

Staff Person B, hired █, did not have a criminal history / background check completed as of 12/5/2023, in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102).

Plan of Correction

Directed (█) - 01/03/2024)

Administrator will ensure that all staff persons have a completed criminal history/background check in accordance with the Older Adult Protective Services Act. All staff files were audited to ensure that they all have this documentation. A monthly staff file review will take place to ensure all staff have this completed.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- The home will complete a background check for Staff Member B by 1/20/2024. The completed background check will be filed in Staff Member B's employee file by the Administrator or designee upon receipt of the document.
- Staff Member B will not provide unsupervised care to the residents in the home until the background check is obtained.
- The Administrator or designee completed an audit of all staff member files by 12/28/2023 to ensure each staff member has the background check completed.
- Beginning no later than 1/20/2024, monthly audits of employee records will be completed by the Administrator or designee.
- The Administrator or designee will receive education by 1/20/2024 on the required timelines to complete

52 - Hiring Staff (continued)

background checks for all new hires.

- The home will keep documentation of all audits and education which will be available for review by the Department.

Directed Completion Date: 01/20/2024

Implemented (█) - 03/27/2024)

63a - First Aid/CPR Training

8. 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 11/26/2023, 18 residents were in the home. From 2:00 PM through 6:00 AM on 11/27/2023, there were no staff in the home trained in first aid.

On 12/3/2023, from 2:00 PM through 6:00 AM on 12/4/2023, there were 18 residents in the home and no staff who were trained in first aid.

On 12/4/2023, from 2:00 PM through 6:00 AM on 12/5/2023, there were 18 residents in the home and no staff who were trained in first aid.

Plan of Correction

Directed (█) - 01/03/2024)

All staff were trained in CPR. The Administrator assumed that First Aid was included. First Aid was also given in this training, therefore, the Administrator did not review the certificates/cards. The Administrator will be more mindful and check all certificates of completed training to ensure the home remains compliant. A First Aid/CPR class is scheduled for ALL staff on January 18th, 2024.

Proposed Overall Completion Date: 01/18/2024

(Directed)

- First Aid/CPR education will be completed by all staff on 1/18/2024. Copies of the certification for each staff member will be kept by the home.
- Beginning 1/18/2024, the Administrator or designee will complete an audit of the staff schedule at least one week in advance to ensure at least one staff person for every 50 residents who is trained in first aid and CPR is scheduled to be present in the home at all times.
- Beginning 1/20/2024, the Administrator or designee will complete quarterly audits of all staff records to ensure first aid and CPR certifications are current.
- Documentation of certifications and audits will be kept by the home for review by the Department.

Directed Completion Date: 01/20/2024

Implemented (█) - 03/27/2024)

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.

Description of Violation

Staff Person C received only nine (9) hours of annual training for training year 2022.

Staff Person D received only eight (8) hours of annual training for the training year 2022.

Staff Person E received zero (0) hours of annual training for training year 2022.

Plan of Correction

Directed () - 01/04/2024)

All staff files were audited for review of their 2022 annual trainings. Certificates of all staff trainings will be inserted into the staff files. The Administrator will follow the Annual Staff Training Schedule and audit all staff records quarterly to ensure that all staff have received the scheduled trainings per the annual staff training plan which will be 12 hours or more.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- The Administrator or designee will audit all direct care staff training records for the 2023 training year by 1/20/2024 to ensure 12 hours of annual training has been provided and supporting documentation is filed in their record(s).
- The Administrator or designee will review the 2024 staff training plan and update, as necessary, to ensure the courses planned for the upcoming year includes 12 hours of training content by 1/20/2024.

Directed Completion Date: 01/20/2024

Implemented () - 03/27/2024)

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

Staff Person C did not receive annual training in the areas of infection control, instructions on meeting the needs of the resident, or medication self-administration in training year 2022.

Staff Person D did not receive annual training in the areas of infection control, instructions on meeting the needs of the resident, or medication self-administration in training year 2022.

65f - Training Topics (continued)

Staff Person E did not receive annual training in the areas of infection control, instructions on meeting the needs of the resident, medication self-administration, care for residents with Dementia and cognitive impairment, personal care service needs, safe management techniques or care for residents with mental health or intellectual disabilities in training year 2022.

Plan of Correction**Directed (█ - 01/05/2024)**

All staff persons were trained on all topics included in regulation 65.f. All staff files were audited for review of their 2022 annual trainings. Certificates of all staff trainings will be inserted into the staff files. The Administrator will follow the Annual Staff Training Schedule, which will include the training topics required per regulation 65.f. An audit of all staff records quarterly will be completed to ensure that all staff have received the scheduled trainings per the annual staff training plan.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- The Administrator or designee will audit all direct care staff training records for the 2023 training year by 1/20/2024 to ensure staff received training on the topics required in 2600.65(f). Supporting documentation will be filed in the staff record(s).
- The Administrator or designee will review the 2024 staff training plan and update, as necessary, to ensure the courses planned for the upcoming year includes the required training topics in 2600.65(f) by 1/20/2024.

Directed Completion Date: 01/20/2024

Implemented (█ - 03/27/2024)**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.

Description of Violation

Staff Person C did not have annual training in emergency preparedness procedures or The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) for training year 2022.

Staff person D did not have annual training in emergency preparedness procedures, resident rights, nor The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102) for training year 2022.

65g - Annual Training Content (continued)

Staff person E did not have annual training in the areas of fire safety, emergency preparedness procedures, resident rights, The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), or falls and accident prevention for training year 2022.

Plan of Correction

Directed (█ - 01/05/2024)

All staff files were audited for review of their 2022 annual trainings. Certificates of all staff trainings will be inserted into the staff files. The Administrator will follow the Annual Staff Training Schedule, which will include the training topics required per regulation 65.f. An audit of all staff records quarterly will be completed to ensure that all staff have received the scheduled trainings per the annual staff training plan.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- The Administrator or designee will audit all direct care staff training records for the 2023 training year by 1/20/2024 to ensure staff received training on the topics required in 2600.65(g). Supporting documentation will be filed in the staff record(s).
- The Administrator or designee will review the 2024 staff training plan and update, as necessary, to ensure the courses planned for the upcoming year includes the required training topics in 2600.65(g) by 1/20/2024.

Directed Completion Date: 01/20/2024

Implemented (█ - 03/27/2024)

82a - Poisonous Materials

12. Requirements

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 12/5/2023 at 9:09 AM, a clear spray bottle was on the kitchen counter next to the microwave containing a green liquid. The bottle was labeled with black marker as "multipurpose cleaner". This liquid was not in its original container, nor marked with a manufacturer's label.

Repeated Violation - 12/8/2022

Plan of Correction

Directed (█ - 01/03/2024)

The spray bottle was immediately disposed of. Staff were educated and reminded that they could not have unlabeled materials and that all materials should remain in their original containers with the manufacturer's label.

Administrator will be in January 2024 to check all areas of the home monthly to ensure that all materials are in their original, labeled containers.

Proposed Overall Completion Date: 12/27/2023

(Directed)

82a - Poisonous Materials (continued)

- The spray bottle was disposed of on 12/5/2023 by the Office Manager.
- Education was provided to all staff by 12/28/2023 on the use of unlabeled materials and the requirement for materials to remain in their original containers with the manufacturer's label.
- Starting no later than 1/20/2024, the Administrator or designee will complete monthly audits in the home to ensure all poisonous materials are stored in their original, labeled containers.
- Documentation of education and completed audits will be kept by the home for review by the Department.

Directed Completion Date: 01/20/2024

Implemented (█) - 03/27/2024)

87 - Lighting

13. Requirements

2600.

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

Description of Violation

On 12/5/2023, there were no lights in the second-floor hallway leading to the exit with the fire escape of the building. There is a fixture in the hallway, but there were no light bulbs in the fixture.

Repeated Violation - 7/12/2022, et al

Plan of Correction

Directed (█) - 01/03/2024)

On December 5, 2023 a light bulb was inserted into the fixture. Administrator will continue to check all lights to ensure that the lightbulbs installed in them are in working order. Please see attached checklist.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- On December 5, 2023 a light bulb was inserted into the fixture.
- Education will be provided to all staff by 1/20/2024 on regulation 2600.87 and notifying the Administrator or designee when a light is observed to be non-operable.
- By 1/20/2024, the Administrator or designee will begin monthly audits of the homes interior and exterior areas to ensure areas of the home are lighted properly.
- Documentation of education and completed audits will be kept by the home for review by the Department.

Directed Completion Date: 01/20/2024

Implemented (█) - 03/27/2024)

88a - Surfaces

14. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 12/5/2023, the following were observed:

88a - Surfaces (continued)

There is a hole with broken drywall measuring approximately 16 inches wide by 22 inches high at the bottom of the staircase on the first floor.

There is a hole in the floor of the office area beside the side exit measuring approximately 4 inches deep, 6 inches wide and 6 inches long.

The door to resident room #7 at the top of the staircase is broken. The bottom section of the door does is not connected to the hinge.

The door to resident room #5 on the first floor is broken. The door is a hollow-core door, and the bottom quarter of the panel has been broken off.

The vinyl flooring on the first-floor hallway between the bathroom and room #5 is covered in tape. However, the tape is frayed and lifting in pieces. The flooring is lifted from the ground now causing a tripping hazard.

On 12/6/2023, the second-floor bathroom faucet was leaking through the handle and dripping onto the floor creating a pool of water - thus causing a slipping hazard.

Repeated Violation - 7/12/2022, et al

Plan of Correction

Directed (█) - 01/03/2024

The Administrator will ensure all items listed above will be completed on or before January 31, 2024. The work will be completed by a private individual. The Administrator will continue to check all areas of the home at least monthly to ensure that all areas of the home are in good repair and free of hazards.

Proposed Overall Completion Date: 01/31/2024

(Directed)

- The Administrator will ensure all items listed above will be completed on or before January 20, 2024. The work will be completed by a private individual.
- Beginning 1/20/2024, the Administrator or designee will conduct a walkthrough of all interior and exterior areas of the building on a weekly basis to identify areas where maintenance is required. Repairs will be completed within one week of an issue being discovered. Documentation of the weekly walkthroughs will be retained by the home for review by the Department, and the documentation must include any issues found.

Directed Completion Date: 01/20/2024

Not Implemented (█) - 03/27/2024

93a - Handrails

15. Requirements

2600.

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

93a - Handrails (continued)

Description of Violation

On 12/5/2023, the handrail on the exterior fire escape was observed to be loose and wobbly due to it not being secured to the building.

Plan of Correction

Directed (█ - 01/03/2024)

The handrail was fixed and secured on 12/08/23. The Administrator will continue to check all areas of the home at least monthly to ensure that all areas of the home are in good repair and have well secured hand rails.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- The handrail was fixed and secured on 12/08/2023.
- An audit of each ramp, interior stairway and outside steps will be audited for a well-secured handrail by 1/20/2024. Repairs will be completed within 1 week, if necessary.
- Beginning 1/22/2024, the Administrator or designee will complete weekly walkthroughs of all interior and exterior areas of the building to ensure handrails are properly secured. Repairs will be completed within one week of an issue being discovered.
- Documentation of the weekly walkthroughs will be retained by the home for review by the Department, and the documentation must include any issues found.

Directed Completion Date: 01/22/2024

Implemented (█ - 03/27/2024)

95 - Furniture and Equipment

16. Requirements

2600.

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

Description of Violation

On 12/5/2023 at approximately 9:20 AM, the smoke detector located at the top of the stairwell on the second floor was dangling by exposed wires, and an open hole in the wall was observed.

On 12/5/2023 at approximately 9:11 AM, the exterior light outside the side entrance to the home was dangling with exposed wires.

On 12/5/2023, the dresser and chest of drawers in resident room #9 were broken and missing drawers.

Plan of Correction

Directed (█ - 01/03/2024)

The exterior light was fixed on 12/08/23. The smoke detector and chest of drawers will be repaired or replaced by 01/31/24. The Administrator will continue to check all areas of the home at least monthly to ensure that all areas of the home are in good repair, clean and free of hazards.

Proposed Overall Completion Date: 01/31/2024

(Directed)

- The exterior light was fixed on 12/08/2023. The smoke detector and chest of drawers will be repaired or

95 - Furniture and Equipment (continued)

replaced by 01/20/2024.

- Beginning no later than 1/20/2024, the Administrator or designee will complete weekly audits of the home's furniture and equipment to ensure they are in good repair and free of hazards. Repairs will be completed within 1 week of a hazard being discovered.
- Documentation of the weekly audits will be retained by the home for review by the Department; documentation must include any issues found.

Directed Completion Date: 01/20/2024

Not Implemented (█ - 03/27/2024)

100a - Exterior - Free of Hazards

17. Requirements

2600.

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

Description of Violation

On 12/5/2023, there was a large accumulation of lint on the ground outside of the dryer vent. Much of this lint was resting against both cable and electrical wires causing a potential fire hazard.

Plan of Correction

Directed (█ - 01/03/2024)

On December 5, 2023 the lint was cleaned and removed. It was raining outside, therefore, causing the lint to stick. The lines outside are cable and telephone lines which are no longer in use without power to them, therefore, it does not cause a fire hazard. The Administrator will check monthly to ensure that this area is free of hazards.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- On December 5, 2023 the lint was cleaned and removed.
- Beginning 1/20/2024, the Administrator or designee will complete weekly audits of the exterior of the building to ensure the building and building grounds or yard is in good repair and free of hazards. Repairs will be completed within 1 week of a hazard being discovered.
- Documentation of the weekly audits will be retained by the home for review by the Department; the documentation must include any issues found.

Directed Completion Date: 01/20/2024

Implemented (█ - 03/27/2024)

101j1 - Mattress Fire Retardant

18. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

On 12/6/2023, one of the mattresses in resident room #9 was observed to be threadbare with numerous rips and

101j1 - Mattress Fire Retardant (continued)

tears in the fabric; the mattress was not in good repair.

Plan of Correction

Directed () - 01/03/2024

The Administrator will check all mattresses in the home and will replace mattresses, (including resident #9's mattress) that are not in good repair on or before January 31, 2024. Administrator will continue to check all mattresses monthly to ensure they are in good repair.

Proposed Overall Completion Date: 01/31/2024

(Directed)

- The Administrator will check all mattresses in the home and will replace mattresses, (including resident #9's mattress) that are not in good repair on or before January 20, 2024.
- Beginning 1/20/2024, the Administrator or designee will audit all mattresses monthly to ensure they are in good repair, clean and supports the resident.
- Documentation of audits will be retained by the home and will include any concerns noted. Mattress replacements, cleanings, repairs will also be documented and kept by the home for review by the Department.

Directed Completion Date: 01/20/2024

Implemented () - 03/27/2024

101j2 - Bedroom Chairs

19. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

2. A chair for each resident that meets the resident's needs.

Description of Violation

Resident room #9 is occupied by three residents; however, on 12/6/2023, there was only one chair in this room.

Resident room #6 had no chairs in the room on 12/6/2023.

Plan of Correction

Directed () - 01/03/2024

The Administrator will check all bedrooms in the home and will ensure each resident has a chair. Chairs have been ordered and will be placed in the home on or before January 10, 2024. Administrator will continue to check all bedrooms monthly to ensure each resident has a chair.

Proposed Overall Completion Date: 01/10/2024

(Directed)

- The Administrator will check all bedrooms in the home and will ensure each resident has a chair available.
- Chairs have been ordered by the Administrator or designee and will be placed in the home on or before January 10, 2024.
- Beginning no later than 1/20/2024, the Administrator or designee will complete monthly audits of each resident room to ensure a chair is available and meets the needs of the rooms' occupants.
- Education will be provided to all staff on the requirement of regulation 2600.101(j)(2) by 1/20/2024 to ensure staff are not removing chairs from the resident's rooms.

101j2 - Bedroom Chairs (continued)

- Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Implemented (█) - 03/27/2024

101j6 - Mirror

20. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

- 6. A mirror.

Description of Violation

On 12/6/2023, there was no mirror present in resident rooms #5 and #8.

Plan of Correction

Directed (█) - 01/03/2024

The Administrator will check all bedrooms in the home and will ensure each bedroom has a mirror. Mirrors have been installed. Administrator will continue to check all bedrooms monthly to ensure each bedroom has a mirror.

Proposed Overall Completion Date: 12/28/2023

(Directed)

- The Administrator or designee will place mirrors in resident rooms #5 and #8 by 1/20/2024.
- The Administrator or designee will complete an initial audit of all resident rooms by 1/20/2024 to ensure each room has a mirror present. Monthly audits will be completed following the initial audit by the Administrator or designee.
- Education will be provided to all staff on regulation 2600.101(j)(6) and will notify the Administrator or designee if a mirror is missing or needs replaced by 1/20/2024.
- Documentation of education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Implemented (█) - 03/27/2024

101j7 - Lighting/Operable Lamp

21. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

There is no source of light present at bedside in resident rooms #5, #7 nor 8. The lamps in resident room #6 are not reachable at bedside.

Repeated Violation - 7/12/2022, et al

101j7 - Lighting/Operable Lamp (continued)

Plan of Correction

Directed (█ - 01/03/2024)

The Administrator will check all bedrooms in the home and will ensure each resident has a bedside light. Lamps have been placed in Resident #5, #7 & #8 bedrooms Administrator will continue to check all bedrooms monthly to ensure each resident had a bedside reachable light.

Proposed Overall Completion Date: 01/10/2024

(Directed)

- The Administrator or designee placed lamps in resident rooms #5, #7 and #8 by 12/28/2023.
- An initial audit will be completed no later than 1/20/2024 to ensure each resident has an operable lamp or other source of lighting that can be turned on at bedside.
- Education will be provided to all staff on regulation 2600.101(j)(7) and to ensure lamps remain accessible at bedside by 1/20/2024.
- The Administrator or designee will complete monthly audits beginning no later than 1/20/2024 to ensure residents have an operable source of bedside lighting.
- Documentation of education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Not Implemented (█ - 03/27/2024)

102c - Tub/Shower - 10 users

22. Requirements

2600.

102.c. There shall be at least one bathtub or shower for every ten or fewer users, including residents, staff persons and household members.

Description of Violation

The home has a shower on the first floor and a bathtub/shower on the 2nd floor; both had water pressure. However, the diverter from the tub to the shower does not work and the bathtub did not have a stopper installed or available for use. Therefore, on 12/5/2023, the home served 18 residents with only one bathtub or shower.

Plan of Correction

Directed (█ - 01/03/2024)

The faucet on the tub/shower was replaced on December 11, 2023. The tub/shower is in proper working order. The Administrator will continue to check the tub/shower units in the home monthly to ensure they are all in working order at all times.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- The faucet on the tub/shower was replaced on December 11, 2023 and is in proper, working order.
- Residents and staff will be informed that the 2nd floor shower/tub is available for use by 1/20/2024.
- Starting no later than 1/20/2024, monthly audits will be completed by the Administrator or designee to ensure there is at least one working bathtub or shower for every ten or fewer users.
- Documentation of the repair and completed audits will be kept by the home and available for review by the Department.

102c - Tub/Shower - 10 users (continued)

Directed Completion Date: 01/20/2024

Implemented (█) - 03/27/2024

102i - Soap Dispenser

23. Requirements

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On both 12/5/2023 and 12/6/2023, there were soap dispensers available in the first-floor and second-floor bathroom. However, they were both empty and had no soap available to the residents.

On 12/5/2023, there was an unlabeled, used bar of soap at the bathroom sink in the second-floor bathroom.

Repeat Violation - 12/8/2022, 7/12/2022, et al

Plan of Correction

Directed (█) - 01/03/2024

Liquid soap was placed in both bathrooms on December 6, 2023 by the Administrators Assistant. All staff were reminded that liquid soap is required in all bathrooms at all times. Liquid soap needs to be filled as it gets low to ensure the bathrooms do not run out. The Administrator will check all bathrooms monthly to ensure that they have liquid soap available.

The bar of soap was removed at the time of inspection. All residents were reminded that they are not permitted to keep bars of soap in the bathroom. If they wish to use the bar of soap, they must keep it in a labeled container and store it in their bedroom with their personal belongings. Administrator will randomly check bathrooms to ensure that there is not any bar soap in the resident bathrooms.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- Liquid soap was placed in both bathrooms on December 6, 2023 by the Administrators Assistant.*
- Education was provided to all staff by 12/28/2023 that liquid soap is required in all bathrooms at all times. Liquid soap needs to be filled as it gets low to ensure the bathrooms do not run out.*
- The bar of soap was removed from the 2nd floor bathroom sink on 12/5/2023.*
- All residents were reminded that they are not permitted to keep bars of soap in the bathroom by 12/28/2023. If they wish to use the bar of soap, they must keep it in a labeled container and store it in their bedroom with their personal belongings.*
- Beginning no later than 1/20/2024, the Administrator or designee will complete weekly audits of the bathrooms to ensure a dispenser with soap is provided within reach of each bathroom sink and a bar of soap is not present unless it is clearly labeled for each resident who shares a bathroom.*
- Documentation of education and completed audits will be kept by the home and available for review by the Department.*

102i - Soap Dispenser (continued)

Directed Completion Date: 01/20/2024

Implemented (█) - 03/27/2024)

107c - Food/Water 3 Day Supply

24. Requirements

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 12/5/2023, the home served 18 residents. The home did not maintain at least a 3-day supply of nonperishable food in the event of an emergency as confirmed by Staff Person A for 18 residents.

Plan of Correction

Directed (█) - 01/04/2024)

The home is disputing this violation. Staff person A did not confirm or agree. At the time of inspection our food storage was low, however we DID have a 3 day supply. The home is in a very rural area therefore the home makes a monthly grocery run at the beginning of each month. Staff was on it's way to purchase the monthly groceries when the state representative showed up on December 5, therefore, staff came back to the home to be with the departments representatives and then a smaller order of groceries were purchased on the evening of December 5, 2023. We knew the state would be back the next day, so we made a smaller run until we had the time to go for the larger grocery purchase. When the homes grocery supply was checked on December 5, 2023, the following items were in the home PRIOR to any grocery purchases: 10 pound ham, sausage patties, 10 pound pork loin, 10 pound hamburger, 2-4 pound packages of chicken legs, 2- 4 to 5 pound packs of chicken breast, chicken patties, bag of meatballs, canned shredded chicken, canned tuna, eggs, milk, bread, cold cereal, oatmeal, 3-32oz. bags of frozen broccoli, 2-2 pound bags of frozen California blend, cans of chili, black beans, black eyed peas, canned green beans, canned corn, canned spinach, peanut butter, macaroni and cheese, spaghetti noodles.....among other odds and ends and condiments.

This is more than enough for a 3 day supply. I understand that we have food in several locations and it was spread out, therefore, looking like there was not as much as there actually was, however, there was a sufficient amount for a 3 day supply.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- The Administrator and or designee will receive education on regulation 2600.107(c) by 1/20/2024 including the sample menus provided in the Regulatory Compliance Guide.
- The Administrator or designee will purchase items to ensure a three-day food supply is maintained which requires no refrigeration, minimal or no preparation or cooking and little to no water for the current census by 1/20/2024.
- Beginning 1/20/2024, the Administrator or designee will take inventory of the food supply to review expiration dates and ensure sufficient stock is maintained; inventory will be completed on a quarterly basis.

107c - Food/Water 3 Day Supply (continued)

- Documentation of education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Implemented (█) - 03/27/2024)

109b - Rabies Vaccination

25. Requirements

2600.

109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On 12/5/2023, there were two yorkie dogs present in the home. The home does not have a current certificate of rabies vaccination from a licensed veterinarian.

Plan of Correction

Directed (█) - 01/03/2024)

Staff person A is a neighbor to the home. The residents continue to allow the small dogs in the home. The residents and staff were all informed that the dogs could not be in the home or on it's property until the home secures proof of a rabies vaccination. Administrator will continue to remind staff and residents of this regulation. The dogs will be scheduled in January to obtain a rabies vaccination so if a resident would happen to still allow the dogs in the home they will be vaccinated.

Proposed Overall Completion Date: 01/31/2024

(Directed)

- The owner of the dogs was notified by the Administrator and the dogs are unable to visit the home until a current certificate of rabies vaccination is received from a licensed veterinarian.
- Education will be provided to all staff in the home on the requirement of regulation 2600.109(b) to ensure all visiting pets have a current vaccination record on file prior to coming into the home. Education will be provided by the Administrator no later than 1/20/2024.
- Starting no later than 1/20/2024, the Administrator will audit all visiting pet vaccination records on a quarterly basis to ensure their certificate of rabies vaccination remains current.
- Documentation of education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Not Implemented (█) - 03/27/2024)

123b - Emergency Procedures Posted

26. 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 12/5/2023, the home's emergency procedures were not posted in a conspicuous and public place in the home.

123b - Emergency Procedures Posted (continued)

Repeated Violation - 7/12/2022, et al

Plan of Correction

Directed () - 01/03/2024

A copy of the Emergency Procedures were posted back in the resident dining room. The Administrator will check the dining room monthly to ensure all required posting are available for review.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- A copy of the Emergency Procedures were posted in the resident dining room by the Administrator or designee by 12/28/2023.
- Education will be provided to designated staff members on this regulation and to inform the Administrator or designee if the procedures are no longer posted so a new copy can be provided.
- Beginning no later than 1/20/2024, the Administrator or designee will complete monthly audits to ensure the Emergency Procedures remain posted in a public and conspicuous place in the home.
- Documentation of education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Implemented () - 03/27/2024

132b - Safety Inspection/Fire Drill

27. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection and fire drill conducted by a fire safety expert was conducted on 9/5/22.

Repeat Violation - 7/12/2022, et al

Plan of Correction

Directed () - 01/03/2024

The homes Fire Safety Inspection & Drill was conducted with the Confluence Volunteer Fire Department on 07/10/23. The documents were not filed correctly and could not be found at the time of inspection. Please see attached. The Administrator will be more mindful with filing documentation to ensure it is available and is easily accessed.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- The homes Fire Safety Inspection and Drill was conducted with the Confluence Volunteer Fire Department on 07/10/2023. The documents were not filed correctly and could not be found at the time of inspection.
- The Administrator or designee will file the annual fire safety inspection and fire drill conducted by a fire safety expert in the home no later than 1/20/2024.
- The Administrator will complete quarterly audits starting no later than 1/20/2024 to ensure the

132b - Safety Inspection/Fire Drill (continued)

documentation is filed at the home and readily available.

- Documentation of the audit will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Implemented () - 03/27/2024)

161b - Well-Balanced Meals

29. Requirements

2600.

161.b. At least three nutritionally well-balanced meals shall be offered daily to the resident. Each meal shall include an alternative food and drink item from which the resident may choose.

Description of Violation

The posted weekly meal menu for the week of 12/4/2023 through 12/10/2023 does not provide at least three nutritionally well-balanced meals daily. On 12/5/2023, the menu for dinner was ham and cheese sandwich with coleslaw. Per resident interviews on 12/6/2023, residents received a sandwich with ham and white bread with no offered vegetables, fruit, or alternative. On 12/6/2023, residents received cold cereal, coffee and water.

Plan of Correction

Directed () - 01/03/2024)

The Administrator and Administrator Assistant have been working on creating new menu's with nutritionally well-balanced meals. Staff have been informed that they are to offer nutritious meals and alternatives if the residents do like what is being served. On 12/06/23 for breakfast, the residents also received 2 pieces of toast with their meal. The Administrator will conduct resident interviews to ensure that the they are receiving the food items that are on the menu.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- The Administrator and or designee will receive education on meeting the recommended dietary allowances established by the United States Department of Agriculture by 1/20/2024. Documentation of education will be kept by the home.
- By 1/20/2024, the Administrator or designee will create menus which will consist of at least three nutritionally well-balanced meals per day. Past menus of meals that were served, including changes, will be kept for at least 1 month to be available for review by the Department.
- Starting no later than 1/20/2024, the Administrator or designee will conduct weekly resident interviews to ensure the residents are receiving the food items on the menu. The Administrator will also complete random audits of each meal at least once a month to ensure nutritionally well-balanced meals are being served. Documentation of the resident interviews and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Implemented () - 03/27/2024)

161c - Additional Portions

30. Requirements

2600.

161.c. Additional portions of meals and beverages at mealtimes shall be available for the resident.

Description of Violation

Per resident and staff interviews, residents are not consistently provided additional portions of meals or alternatives upon resident request.

Plan of Correction

Directed (█ - 01/03/2024)

Staff have been informed that they are to offer additional portions and alternatives if the residents are still hungry after they have ate their meal. The Administrator will conduct resident interviews to ensure that the they are receiving extra portions if they are still hungry.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- Education was provided to staff that they are to offer additional portions and alternatives if the residents are still hungry after they have consumed their meal by 12/28/2023.*
- Residents will be informed no later than 1/20/2024 that additional portions of meals and beverages at mealtimes will be made available for the residents; documentation will be kept.*
- Beginning no later than 1/20/2024, the Administrator or designee will conduct weekly resident and staff interviews to ensure additional portions of meals and beverages at mealtimes are being made available.*
- Documentation of education and interviews will be kept by the home and available for review by the Department.*

Directed Completion Date: 01/20/2024

Implemented (█ - 03/27/2024)

162c - Menus Posted

31. Requirements

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

As of 12/5/2023, the home's menu for the current week was posted. However, the home did not have a menu completed or posted 1 week in advance.

Repeated Violation - 7/12/2022, et al

Plan of Correction

Directed (█ - 01/03/2024)

Menu's were updated and hung in the resident dining room by the Administrator Assistant on December 18, 2023. Beginning January 2024 the Administrator will check monthly to ensure menu's continue to be hung in the resident dining room. All staff were informed that menus must be posted one week in advance and hung in the resident dining room.

Proposed Overall Completion Date: 12/27/2023

162c - Menus Posted (continued)

(Directed)

- Menu's were updated and hung in the resident dining room by the Administrator Assistant on December 18, 2023.
- All staff were informed that menus must be posted one week in advance and hung in the resident dining room by 12/28/2023.
- Beginning no later than 1/20/2024, the Administrator or designee will complete weekly audits to ensure a current weekly menu and a menu for 1 week in advance are posted in a public and conspicuous place in the home.
- Documentation of the education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Implemented (█) - 03/27/2024)

183b - Meds and Syringes Locked

32. 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 12/5/2023 at 10:20 AM, a bottle of Nystatin Topical Powder, USP 15g was observed unlocked, unattended and accessible on a bureau in room #█ This bottle had a prescription label for Resident #3 who has not been assessed to self-administer medications.

On 12/6/23, a used tube of Hemorrhoidal ointment was found unlocked, and accessible in the room of Resident #4. This resident has not been assessed to self-administer medications.

Repeated Violation -12/8/2022

Plan of Correction

Directed (█) - 01/03/2024)

Both medications were immediately placed in the locked medication cart. All staff were reminded that all medication must be kept in the locked medication cart. Beginning January 2024 the Administrator will check all medications monthly while doing audits of the Med Cart to ensure all medications in the facility are locked and inaccessible.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- Medications were removed from the residents' rooms and secured in the locked medication cart.
- Education was provided to all staff that all medication must be kept in the locked medication cart by 12/28/2023.
- An initial audit of all resident rooms will be completed by 1/20/2024 to ensure medications are not

183b - Meds and Syringes Locked (continued)

unlocked, unattended and accessible by the Administrator or designee.

- Beginning 1/22/2024, the Administrator will complete weekly audits of all resident bedrooms to ensure medications are kept in an area or container that is locked.
- Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 01/22/2024

Not Implemented () - 03/27/2024)

183e - Storing Medications

33. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

The following loose pills were found in the medication cart on 12/6/2023:

- 2nd drawer – one loose round orange pill with identifier MX32 (possibly citalopram) stuck to a package with other medications.
- 3rd drawer – one small white round pill with identifier 17 (possibly furosemide) – loose in drawer.

Repeated Violation - 12/8/2022

Plan of Correction

Directed () - 01/03/2024)

The loose pills were immediately disposed of by the Administrator's Assistant. On 12/07/23 an audit was conducted of the Med Cart to ensure that all medications were stored in an organized manner and that there were not any loose pills within the Med Cart by the Administrator. Staff were educated on being mindful and to make sure that there are not any loose pills within the Med Cart. January 2024 Administrator will check the Med Cart by performing monthly audits. The home has also recently switched to a new pharmacy and the pharmacy will be performing monthly Med Cart Audits as well.

ensure all medications within the Med Cart are stored in an organized manner.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- The loose pills were immediately disposed of by the Administrator's Assistant on 12/6/2023.
- On 12/07/23 an audit was conducted of the Med Cart to ensure that all medications were stored in an organized manner and that there were not any loose pills within the Med Cart by the Administrator.
- By 1/20/2024, the Administrator will check the Med Cart by performing monthly audits to ensure all medications within the Med Cart are stored in an organized manner. The home has also recently switched to a new pharmacy and the pharmacy will be performing monthly Med Cart Audits as well.
- Documentation of education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

183e - Storing Medications (*continued*)*Implemented (█ - 03/27/2024)*

185a - Implement Storage Procedures

34. 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 Acetaminophen 325mg as needed. On 12/6/23, this medication was not available in the home.

Resident #4 is prescribed Albuterol Sulfate 90mcg as needed. On 12/6/23, this medication was not available in the home.

Resident #5 is prescribed Cyclobenzaprine 10mg as needed. On 12/6/23, this medication was not available in the home.

Repeat Violation - 7/12/2022, et al

Plan of Correction*Directed (█ - 01/03/2024)*

The home shall review its procedures for ordering medications. Changes will be implemented to ensure that prescriptions are ordered/reordered in a timely manner so that residents do not go without their medications.

On 12/06/23 Residents #2 and #4 missing medications were ordered from the pharmacy and delivered on 12/07/23.

After speaking with Resident #5's physician, the physician decided to discontinue that medication.

On 12/07/23 an audit was conducted of the entire Med Cart to ensure that all medications were available. Staff were educated on being mindful and to make sure that they are ordering medication when it is getting low so that it is always available for the residents. January 2024 Administrator will check the Med Cart by performing monthly audits. The home has also recently switched to a new pharmacy and the pharmacy will also be performing monthly Med Cart Audits.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- On 12/06/2023, Residents #2 and #4 missing medications were ordered from the pharmacy and delivered on 12/07/2023. After speaking with Resident #5's physician, the physician decided to discontinue that medication by 12/28/2023.*
- On 12/07/2023 an audit was conducted of the entire Med Cart to ensure that all medications were available.*
- Staff were educated on being mindful and to make sure that they are ordering medication when it is getting low so that it is always available for the residents by 12/28/2023.*
- The Administrator will review the home's current policies and procedures for ordering medications. The*

185a - Implement Storage Procedures (continued)

policy will be updated by 1/20/2024 to ensure that prescriptions are ordered/reordered in a timely manner so that residents do not go without their medications. All staff administering medications will be educated on the updated policy by 1/22/2024.

- By 1/20/2024, the Administrator or designee will complete monthly audits of the medication cart to ensure medications are available as ordered by the physician. The home has also recently switched to a new pharmacy and the pharmacy will also be performing monthly Med Cart Audits.
- Documentation of education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/22/2024

Not Implemented () - 03/27/2024)

187a - Medication Record

35. 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 #4 is prescribed Amiodarone HCL 100mg, Xarelto 15mg, Tramadol HCL 50mg, Pregabalin 150mg. However, the resident's medication administration record does not indicate a diagnosis nor purpose for these medications.

Repeated Violation 12/8/2022, 7/12/2022, et al.

Plan of Correction

Directed () - 01/03/2024)

On 12/07/23 an audit was conducted of the resident MARS to ensure that all medications had a diagnosis. Staff were educated on being mindful and to make sure that they are seeing a diagnosis on the MARS for each medication. January 2024 Administrator will check the MARS by performing monthly audits. The home has also recently switched to a new pharmacy and the pharmacy will also be performing monthly Med Cart Audits.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- On 12/07/2023 an audit was conducted of the resident MARs to ensure that all medications had a diagnosis.
- Education was provided to staff on being mindful and to make sure that they are seeing a diagnosis on the MARs for each medication by 12/28/2023.
- By 1/20/2024, the Administrator will complete monthly audits on resident MARs to ensure each medication has a diagnosis or purpose.
- Documentation of education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Implemented () - 03/27/2024)

187c - Refusal of Medication

36. Requirements

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 11/4/23 and 11/5/23 at 8:00 am, resident #6 refused to take the scheduled doses of Aspirin 81mg, Atorvastatin 20mg, blood glucose, Clonazepam .5mg, Divalproex 500mg, Docusate Sod 100mg, Levothyroxine 75mcg, Loratadine 10mg, Metformin 500mg, Metoprolol 25mg, Mineral Tablet, Omega 3 cap, Topiramate 100mg, Tradjenta 5mg, Vitamin D 400iu and Xarelto 20mg. There is no indication that the provider was notified within 24 hours as required.

Plan of Correction

Directed ([redacted] - 01/03/2024)

Staff were re-educated on informing the Administrator or Administrators Assistant when a resident refuses a medication. If a resident refuses a medication, the Administrator or Assistant will immediately notify the prescriber and follow the prescribers orders. Monthly audits will completed of the MARS to review all medication refusals and to ensure that they are being reported to the prescriber.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- Staff were re-educated on informing the Administrator or Administrators Assistant when a resident refuses a medication by 12/28/2023.
- If a resident refuses a medication, the Administrator or Assistant will immediately notify the prescriber and follow the prescribers orders. Documentation of prescriber notification of residents' refusal to take a medication and the prescriber's response will be kept by the home.
- Beginning no later than 1/20/2024, the Administrator or designee will complete monthly audits of residents' Medication Administration Records to review all medication refusals and to ensure that they are being reported to the prescriber.
- Documentation of education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Implemented ([redacted] - 03/27/2024)

187d - Follow Prescriber's Orders

37. Requirements

2600.

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

Description of Violation

Resident #2 is prescribed Disulfiram 250mg ([redacted]) one daily, Folic Acid 1mg one daily, Sertraline 100mg ([redacted]) once daily and Vitamin B1 100mg once daily. On 11/6/23 and 11/21/23, Resident #2 did not receive these medications at 8:00 AM as ordered by the physician per the resident's Medication Administration Record (MAR).

187d - Follow Prescriber's Orders (continued)

Resident #4 is prescribed Levothyroxine 125 mcg once a day. Resident #4 did not receive this medication as ordered by the physician on 11/17/ 2023, 11/24/2023, 11/25/2023 or 11/27/2023 per the resident's MAR.

Resident # 5 is prescribed Midodrine 5mg 3X/day. Resident #5 did not receive this medication as ordered at 12:00 PM on 11/8/2023, 11/9/2023, 11/10/1023, 11/13/2023, 11/14/2023, 11/15/2023, 11/16/2023, 11/17/2023, 11/21/2023, 11/22/2023, 11/23/2023, 11/28/2023, 11/29/2023 or 11/30/2023 per the resident's MAR.

Resident #6 is prescribed a blood sugar check three times per day. However, neither the Medication Administration Record (MAR) nor the glucometer show that Resident #6 has had any blood sugar checks in November 2023.

Plan of Correction

Directed (████ - 01/03/2024)

All resident MARS were reviewed to ensure that all medications are being given and indicated as so on the MARS. The Administrator will continue to check the MARS monthly to ensure that all medications are being given and documented correctly. Administrator spoke with all staff members to review the procedures for documenting medication and giving it as ordered.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- Education will be provided to all staff who administer medications to administer medications per the physician's orders. Education will be provided by the Administrator or designee no later than 1/20/2024.
- Starting no later than 1/20/2024, the Administrator or designee will complete weekly resident MAR reviews to ensure medications are administered per the physician's orders and documented accordingly on the residents' MARS.
- Starting no later than 1/20/2024, Resident #6's blood glucose levels will be reviewed weekly by the Administrator or designee to ensure blood glucose levels are being checked per the physician's orders.
- Documentation of education and completed weekly audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Implemented (████ - 03/27/2024)

190a - Completion Medication Course

38. Requirements

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person E was certified in medication administration on ██████████. Annual practicums were not completed until 2023 when Staff person E had two medication record reviews and only one medication observation completed. Staff person E administered medications to Resident #5 on 11/24/2023, 11/25/2023, 11/27/2023, and administered

190a - Completion Medication Course (continued)

medications to Resident #2 on 11/20/2023, 11/24/2023, 11/25/2023 and 11/27/2023.

Repeated Violation - 7/12/2022, et al

Plan of Correction

Directed (█ - 01/03/2024)

Staff person E was re-trained and completed the entire Medication Administration Course on 12/08/23. All staff records were audited to ensure that all staff were compliant with their annual practicums. Administrator will review staff files monthly to ensure that all staff are current with their annual practicums.

Proposed Overall Completion Date: 12/27/2023

(Directed)

- Staff person E was re-trained and completed the entire Medication Administration Course on 12/08/23. Documentation of the completed course will be filed in the employee record.
- The Administrator or designee completed an audit on all staff records to ensure staff are current in medication administration training by 12/28/2023.
- Beginning no later than 1/20/2024, the Administrator or designee will complete monthly staff record audits to ensure medication administration certification remains current and available.
- Documentation of the training and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 01/20/2024

Not Implemented (█ - 03/27/2024)

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

Facility Information

Name: *DENEANE'S PERSONAL CARE HOME* License #: *32152* License Expiration: *02/28/2023*
Address: *142 FAIRVIEW AVENUE, CONFLUENCE, PA 15424*
County: *SOMERSET* Region: *CENTRAL*

Administrator

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

Legal Entity

Name: *DENEANE SMITH*
Address: *142 FAIRVIEW AVENUE, CONFLUENCE, PA, 15424*
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *02/08/1999* Issued By: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *21* Waking Staff: *16*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Interim* Exit Conference Date: *03/20/2024*

Inspection Dates and Department Representative

03/20/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *18* Residents Served: *18*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *16* Are 60 Years of Age or Older: *15*
Diagnosed with Mental Illness: *8* Diagnosed with Intellectual Disability: *4*
Have Mobility Need: *3* Have Physical Disability: *0*

Inspections / Reviews

03/20/2024 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/05/2024*

Inspections / Reviews *(continued)*

04/17/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/15/2024

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

3c - Post Current License

1. Requirements

2600.

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

Description of Violation

During the inspection on 3/20/2024, the home did not have a current license posted in a public or conspicuous place. The license that was posted in the home was from 2/28/2022-2/28/2023.

Plan of Correction

Directed (█) - 04/16/2024)

The Administrator applied for a renewal certificate. Once received, the new license will be posted in the resident dining area. Monthly audits will be continued to ensure that the current license is hung in the resident dining area. Staff will also be reminded monthly to notify the Administrator if the current license is missing from the dining area.

(Directed)

- The Administrator started the process to apply for a renewal certificate on 4/10/2024. Once received, the new license will be posted in the resident dining area.
- Once the new license is received and posted in the home, monthly audits will be continued to ensure that the current license is hung in the resident dining area.
- Staff will receive education on the requirement of this posting by 5/15/2024 and will be be reminded monthly to notify the Administrator if the current license is missing from the dining area.
- Documentation of completed monthly audits and training will be kept by the home and available for review by the Department.

Directed Completion Date: 05/15/2024

18 - Compliance With Laws

2. 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

According to the Care Facility Carbon Monoxide Alarm Standards Act, if the Carbon Monoxide (CO) alarm operates by a battery, the battery must be labelled with the date of installation and be replaced at least once annually. On 3/20/2024, the CO alarm on the second floor did not have a label indicating the date the battery had been installed. . The CO alarm on the 1st floor had a label dated 2/24/2023 however there was no battery in the device.

Plan of Correction

Directed (█) - 04/16/2024)

New batteries were labeled and installed into both carbon monoxide meters. The Administrator will continue to perform monthly audits checking all Carbon Monoxide Alarms to ensure that they all have batteries installed and dated within the last 12 months.

18 - Compliance With Laws (continued)

(Directed)

- New batteries were labeled and installed into both carbon monoxide meters by 4/15/2024.
- The Administrator or designee will audit all carbon monoxide alarms in the home by 5/15/2024 to ensure they contain a battery and that they are labeled with the date of battery installation.
- Starting 5/15/2024, the Administrator or designee will complete quarterly audits of all carbon monoxide alarms in the home to ensure the batteries have dates of battery installation and that the batteries have been replaced at least once annually.
- Documentation of completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 05/15/2024

85a - Sanitary Conditions

3. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

Resident room # [REDACTED] is occupied by four residents. Staff state that three (3) of the four (4) residents urinate on the carpeted floor on a regular basis. On 3/20/2024, the room smelled strongly of urine, and a pungent odor could be smelled from down the hall.

On 3/20/2024 at approximately 9:30 AM, the resident bathroom on the first floor was observed to have an accumulation of urine around the base of the toilet.

Plan of Correction

Directed ([REDACTED] - 04/16/2024)

Staff routine is to go thru the home and begin cleaning the bedrooms and bathrooms after breakfast time. Staff routinely cleans the carpets in Resident Room # [REDACTED] because of the problem with residents urinating on the floor. Staff will continue to clean the carpets on a regular basis. The Administrator is planning on replacing the carpeting in Resident Room # [REDACTED] this summer. Administrator will continue checking all areas of the home weekly to ensure the home is free of odors and urine is not present on the floor.

(Directed)

- Staff routine is to go thru the home and begin cleaning the bedrooms and bathrooms after breakfast time. Staff routinely cleans the carpets in Resident Room # [REDACTED] because of the problem with residents urinating on the floor. .
- The carpeting in Resident room # [REDACTED] will be replaced by 7/1/2024. Until the carpeting is replaced, staff will clean the carpets at least once daily.

85a - Sanitary Conditions (continued)

- Staff will receive education on checking the bedrooms and bathrooms each shift for urine or odor. Areas identified to have urine or an odor will be cleaned immediately. Education to be completed no later than 5/15/2024 by the Administrator or designee.
- The Administrator or designee will check all areas of the home at least weekly to ensure the home is free of odors and areas covered in urine beginning no later than 5/15/2024.
- Documentation of education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 07/01/2024

88a - Surfaces**4. Requirements**

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 3/20/2024, a hole was observed at the bottom of the wall at the bottom of the stairs on the first floor showing the area behind the drywall.

On 3/20/2024, the vinyl flooring on the first-floor hallway between the bathroom and room #5 is covered in tape. However, the tape is frayed and lifting from the ground, causing a potential tripping hazard.

On 3/20/2024, a faceplate was observed to be missing from a light switch in the dining room near the kitchen, exposing the wiring for the switch.

Plan of Correction

Directed (████) - 04/16/2024)

The "hole" at the bottom of the stairway has always been a part of the structure of the home. Behind the wall is a radiator used for heating the downstairs of the facility. There are rungs at the bottom of the wall to allow the heat to enter the stairway. The area you are seeing behind the drywall is the actual heater. Again, this structure has been part of the building since the home opened in 2001.

The tape in the hallway has been removed and new tape has been placed over the area. The administrator will replace the vinyl flooring this summer.

A new faceplate was installed and placed in the dining room over the light switch.

The Administrator will continue to monitor these areas of the home monthly to ensure all all surfaces are clean, in good repair and free of hazards.

Proposed Overall Completion Date: 08/15/2024

88a - Surfaces (continued)

(Directed)

- The "hole" at the bottom of the stairway has always been a part of the structure of the home. Behind the wall is a radiator used for heating the downstairs of the facility.
- The tape in the hallway has been removed and new tape has been placed over the area by 4/15/2024. The administrator will replace the vinyl flooring by 7/1/2024.
- A new faceplate was installed and placed in the dining room over the light switch by 4/15/2024.
- Beginning 5/15/2024, the Administrator or designee will conduct a walkthrough of all interior areas of the building on a weekly basis to identify areas where maintenance is required. Repairs will be completed within one week of an issue being discovered.
- Documentation of the weekly walkthroughs will be retained by the home for review by the Department, and the documentation must include any issues found.

Directed Completion Date: 07/01/2024

95 - Furniture and Equipment

5. Requirements

2600.

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

Description of Violation

On 3/20/2024, the toilet in the 1st floor bathroom beside room #5 did not have a handle to flush the waste.

Plan of Correction

Directed (████) - 04/16/2024)

The handle on the first floor bathroom toilet had broken within two days prior to 03/20/24. The toilet was still operable and able to be flushed. A new handle was installed and the toilet was fixed on 03/22/2024. The Administrator will continue to check the entire home performing weekly audits to ensure all furniture and equipment are in good repair, clean and free of hazards.

(Directed)

- A new handle was installed and the toilet was fixed on 03/22/2024.
- Beginning no later than 5/15/2024, the Administrator or designee will complete weekly audits of the home's furniture and equipment to ensure they are in good repair and free of hazards. Repairs will be completed within 1 week of being discovered.
- Documentation of the weekly audits will be retained by the home for review by the Department; documentation must include any issues found.

Directed Completion Date: 05/15/2024

101j3 - Bed/Linens/Pillows/Blankets

6. 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 3/20/2024 at approximately 9:30 AM, one of the resident's in bedroom #9 had a pillow that had multiple brown and yellow-ish stains.

Plan of Correction

Directed () - 04/16/2024)

The Administrator will check all pillows in the home and will clean or replace all pillows that are not in good repair on or before April 30, 2024. The pillow in bedroom #9 was replaced on 03/22/24. The Administrator will continue to perform monthly audits checking all pillows to ensure they are all clean and in good repair.

(Directed)

- The pillow in bedroom #9 was replaced on 03/22/24.
- The Administrator will check all pillows in the home and will clean or replace all pillows that are not in good repair on or before April 30, 2024.
- Education will be provided to all staff on regulation 2600.101(j)(3) by 5/15/2024 by the Administrator.
- Beginning no later than 5/15/2024, the Administrator will perform monthly audits checking all pillows to ensure they are all clean and in good repair.
- Documentation of education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 05/15/2024

101j7 - Lighting/Operable Lamp

7. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Three (3) residents share bedroom #9. On 3/20/2024, this room was observed to be without access to a source of light that can be turned on/off at bedside for any of the residents.

Plan of Correction

Directed () - 04/16/2024)

Lamps were placed in a location accessible to residents at bedside. The Administrator will continue to perform monthly audits to ensure that all residents have accessible bedside lighting.

(Directed)

- Lamps were placed in a location accessible to residents at bedside by 4/15/2024.
- All staff will receive education on regulation 2600.101(j)(7) by 5/15/2024 by the Administrator or designee. Staff will ensure lighting remains within reach of bedside during their shift.
- Beginning no later than 5/15/2024, the Administrator or designee will perform monthly audits to ensure that all residents have accessible bedside lighting.
- Documentation of education and monthly audits will be kept by the home and available for review by the Department.

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

Directed Completion Date: 05/15/2024

101r - Bedroom - shades/drapes/window covering

8. Requirements

2600.

101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

On 3/20/2024, resident bedrooms #7 and #8 did not have shades, blinds, or any coverings on the bedroom windows.

Plan of Correction

Directed (█) - 04/16/2024

Window coverings were installed on the windows in resident bedrooms #7 and #8. The Administrator will continue to perform monthly audits to ensure that all windows have coverings.

(Directed)

- Window coverings were installed on the windows in resident bedrooms #7 and #8 by 4/15/2024.
- Education will be provided to all staff no later than 5/15/2024 on regulation 2600.101(r) and will notify the Administrator or designee if window coverings are missing from a resident's bedroom.
- Beginning no later than 5/15/2024, the Administrator will complete monthly audits to ensure that all windows have coverings.
- Documentation of education and monthly audits will be kept by the home and available for review by the Department.

Directed Completion Date: 05/15/2024

109b - Rabies Vaccination

9. Requirements

2600.

109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On 3/20/2024, a yorkie entered the home on two separate occasions around 4:00 PM. Residents were observed to open the front door so the canine could enter the home. The home does not have a current certificate of rabies vaccination from a licensed veterinarian for this canine.

Plan of Correction

Directed (█) - 04/16/2024

The neighbor no longer owns the yorkie. Staff and residents have been and will continue to be educated on the requirement of regulation 2600.109(b) to ensure all visiting pets have a current vaccination record on file prior to coming into the home. If a pet begins to visit the home the Administrator will complete quarterly vaccination records.

(Directed)

- Education will be provided to all staff in the home on the requirement of regulation 2600.109(b) to ensure all visiting pets have a current vaccination record on file prior to coming into the home. Education will be provided by the Administrator no later than 5/15/2024.
- Staff will be instructed to notify the Administrator prior to a pet entering the home to ensure the proper

109b - Rabies Vaccination (continued)

records have been obtained and are on file.

- The Administrator or designee will inform all residents by 5/15/2024 not to allow pets in the home without first notifying staff.
- If a pet begins to visit the home, the Administrator will file vaccination records in the home and complete quarterly vaccination records.
- Documentation of staff and resident education will be kept by the home and available for review by the Department.

Directed Completion Date: 05/15/2024

130g - Smoke Detector Repair

11. Requirements

2600.

130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

On 3/20/2024, the hardwired smoke detector located in the back hallway on the first floor was not properly installed and therefore inoperative; there was no battery in the device at the time of the inspection.

Plan of Correction

Directed () - 04/16/2024)

A battery was installed into the smoke detector. This alarm is not one of the smoke detectors that is hard wired.

(Directed)

- A battery was installed into the smoke detector by 4/15/2024.
- The Administrator or designee will complete an audit of all smoke detectors in the home to ensure they have batteries and are working properly by 5/15/2024.
- The Administrator or designee will complete monthly testing for operability on all smoke detectors and fire alarms in the home beginning no later than 5/15/2024. A written record of the monthly testing will be kept by the home.

Directed Completion Date: 05/15/2024

183b - Meds and Syringes Locked

12. 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 3/20/2024, at approximately 9:06 AM, three inhalant medications were unlocked, unattended and accessible on top of the medication cart in the dining room. There were no staff in the immediate area or in the dining room at the time.

183b - Meds and Syringes Locked (continued)

Plan of Correction

Directed () - 04/16/2024

Medications were immediately placed back into the medication cart and the cart was locked. Education was provided once again to all staff that all medication must be kept in the locked medication cart. Administrator will continue to complete weekly audits to ensure that there are not any medications unlocked in the facility.

Proposed Overall Completion Date: 04/15/2024

(Directed)

- Medications were immediately placed back into the medication cart and the cart was locked.
- Education was provided to all staff that all medication must be kept in the locked medication cart by 4/15/2024.
- Beginning 5/15/2024, the Administrator or designee will complete audits each shift to ensure medications have been locked in the medication cart for 2 weeks followed by daily audits for 2 weeks and then on-going weekly audits.
- Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 05/15/2024

185a - Implement Storage Procedures

13. 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 as needed for diabetic monitoring This resident has an Agamatrix Amp glucometer. On 3/20/2024 at approximately 1:50 PM, this glucometer reads 00-00 00:00, indicating no date and time. There are readings saved in the glucometer as follows: 172, 263, 145, 137, 134, 132, 138, etc. Since the glucometer is not calibrated, there is no indication of the date/time those readings were taken and there are no documented blood glucose levels on the resident's March 2024 Medication Administration Record.

Resident #1 is prescribed Naproxen 250mg-give 1 tablet by mouth every 12 hours as needed for pain. On 3/20/2024 at approximately 2:05 PM, this medication was not available in the home.

Plan of Correction

Directed () - 04/16/2024

A new glucometer was ordered for Resident #3. Resident #3 is ordered blood glucose checks as needed and it is extremely seldom that needs checked. However, we do have a new meter if needs them checked.

Naproxen was ordered and is available in the home for Resident #1.

On 03/22/24 an audit of the entire med cart was performed to ensure that all medications are available for each

185a - Implement Storage Procedures (continued)

resident. Staff were educated on being mindful and to make sure they are reordering medication as it is being used by each resident.

(Directed)

- A new glucometer was ordered for Resident #3. Resident #3 is ordered blood glucose checks as needed and it is extremely seldom that it needs checked.
- Staff will receive education by 5/15/2024 on the proper documentation protocol for PRN blood glucose checks as well as proper calibration of any glucometer in the home.
- Beginning 5/15/2024, the home will implement weekly checks to be completed by the Administrator or designee to ensure all glucometers in the home remain calibrated to the correct date/time. Additionally, the glucometers will be checked weekly to ensure any readings that may have been taken PRN are documented appropriately in the resident's record.
- Naproxen was ordered by 4/15/2024 and is available in the home for Resident #1.
- On 03/22/24 an audit of the entire med cart was performed to ensure that all medications are available for each resident.
- Staff were educated on being mindful and to make sure they are reordering medication as it is being used by each resident by 4/15/2024.
- Starting no later than 5/15/2024, the Administrator or designee will complete monthly medication cart audits to ensure medications are available as ordered by the physician.
- Documentation of education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 05/15/2024

190a - Completion Medication Course**14. Requirements**

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Member A did not complete the annual practicum requirements for medication administration as only one of two medication administration observations were completed. The annual practicum documentation does not include the staff member's signature, the date of the recertification or if the staff member was recertified. This staff member administered medications to residents to include the following:

On 3/3/2024 to Resident #1 at 8:00 AM

On 3/9/2024 to Resident #1 at 8:00 AM

On 3/17/2024 to Resident #1 at 8:00 PM

On 3/19/2024 to Resident #1 at 8:00 PM

190a - Completion Medication Course (continued)

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

Staff person A original qualification date was ██████████ Staff person A Medication reviews were 03/02/24 and 03/26/24. Staff person A had a MAR Review 03/27/24. It was our understanding that the annual practicum was to be completed withing the same month each year, not by the exact day. Please advise us where we can find these regulations to ensure we are completing the annual practicums in a timely manner.

(Directed)

- Due to Staff Member A only completing one medication administration observation for med practicum year 2023, Staff Member A will complete two additional medication administration observations by 7/1/2024.
- The Administrator or designee will audit all med tech's documentation for training year 2023 and complete remediation as per ODP Medication Administration requirements. Audit will be completed by 5/15/2024.
- Beginning no later than 5/15/2024, the Administrator or designee will complete quarterly audits of staff's medication administration training to ensure required observations and MAR reviews are completed timely and the documentation is completed in its entirety.

Directed Completion Date: 05/15/2024