pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ALEXANDRIA MANOR OF ALLENTOWN INC**
LEGAL ENTITY

To operate **ALEXANDRIA MANOR**
NAME OF FACILITY OR AGENCY

Located at **7 SOUTH NEW STREET, NAZARETH, PA 18064**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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

The total number of persons which may be cared for at one time may not exceed **93**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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

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

and shall remain in effect from **July 9, 2024** until **July 9, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **210640**

ISSUING OFFICER

DEPUTY SECRETARY

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

HS 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: July 9, 2024

[redacted]
Alexandria Manor of Allentown Inc.
7 South New Street
Nazareth, Pennsylvania 18064

RE: Alexandria Manor
License #: 210640

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on April 11, 2024, April 16, 2024, and April 19, 2024, [and the corrections you have made after our inspection], we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

July 1, 2024

[redacted]
ALEXANDRIA MANOR OF ALLENTOWN INC
7 SOUTH NEW STREET
NAZARETH, PA, 18064

RE: ALEXANDRIA MANOR
7 SOUTH NEW STREET
NAZARETH, PA, 18064
LICENSE/COC#: 21064

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/11/2024, 04/16/2024, 04/19/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ALEXANDRIA MANOR* **License #**: *21064* **License Expiration**: *05/15/2024*

Address: *7 SOUTH NEW STREET, NAZARETH, PA 18064*

County: *NORTHAMPTON* **Region**: *NORTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *ALEXANDRIA MANOR OF ALLENTOWN INC*

Address: *7 SOUTH NEW STREET, NAZARETH, PA, 18064*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/17/1994* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *87* **Waking Staff**: *65*

Inspection Information

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

Reason: *Complaint, Provisional, Incident* **Exit Conference Date**: *04/19/2024*

Inspection Dates and Department Representative

04/11/2024 - On-Site: [redacted]
04/16/2024 - On-Site:
04/19/2024 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *93* **Residents Served**: *73*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *73*

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

Have Mobility Need: *14* **Have Physical Disability**: *0*

Inspections / Reviews

04/11/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/11/2024*

Inspections / Reviews *(continued)*

05/15/2024 - POC Submission

Submitte [redacted] **Date Submitted**: *06/04/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/20/2024*

05/29/2024 - POC Submission

Submitte [redacted] **Date Submitted**: *06/04/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/31/2024*

07/01/2024 - Document Submission

Submitted [redacted] **Date Submitted**: *06/04/2024*

Reviewer: [redacted] **Follow-Up Type**: *Not Required*

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

The home's Controlled Substance log containing confidential medical information was unlocked and accessible on top of a medication cart located in the lower level seating area at time of inspection.

Repeat violation - 9/26/23, et al.

Plan of Correction ***Do Not Accept ([redacted] 05/14/2024)***

Staff person responsible for the Controlled Substance Log received a written warning and re-education in Regulation 2600.17. All Med Tech's,, Administrator, and Assistant Administrator will be responsible for maintaining record confidentiality when not in use as applicable. Med Tech Supervisors, [redacted] will oversee compliance and maintain compliance while performing weekly audits of Medication Rooms/Carts.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Update: *05/14/2024*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date).
When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.
What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept[redacted] - 05/29/2024)***

Staff person responsible for the Controlled Substance Log at time of Inspection on 4/11/2024, received a written warning and re-education on Regulation 2600.17 on 4/11/2024 after ensuring said Controlled Substance Log was immediately locked up and secured as policy states. All Med Techs and potential med techs will receive re-education in Regulation 2600.17-Record Confidentiality with Emphasis on the Controlled Substance Log and securing of the same, including Medication Room Policies and Procedures on 5/21/2024 by Assistant Administrator/Medication Train the Trainer, [redacted] The Administrator, [redacted], Assistant Administrator, [redacted], and Med Tech Supervisors, [redacted], and [redacted] are responsible for fixing the problem and monitoring compliance. Starting 5/17/2024, Audits will be conducted by the Administrator, [redacted], daily Monday-Friday, alternating weekends with Med Tech Supervisors, [redacted] x two weeks, then

17 - Record Confidentiality (continued)

weekly x four weeks, then monthly x twelve by Assistant Administrator [redacted] will review all audits and take appropriate action upon any and all findings.

Licensee's Proposed Overall Completion Date: *05/22/2024*

Update: *05/29/2024*

Reviewed training with staff on 5/21/24, action taken with staff initially and daily audits.

Evidence of Completion ***Implemented ([redacted] - 06/07/2024)***

"Evidence of Completion" See attached documentation. [redacted] Administrator.

Update: *06/07/2024*

Onsite POC 6/6/24 [redacted]

42b - Abuse

2. Requirements

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

Description of Violation

On [redacted]/22/24, Staff Person A shoved Resident #4 to the ground, resulting in Resident #4 falling and being sent to the emergency room for evaluation. This was witnessed by Staff Person B and Resident #5.

Repeat violation - 9/26/23, et al.

Plan of Correction ***Do Not Accept [redacted] - 05/14/2024)***

Staff person A was immediately sent home upon incident and terminated on [redacted]/2024 after internal investigation complete. Administrator/Assistant Administrator will maintain ongoing compliance with initial trainings upon hire and ongoing trainings annually and as needed to maintain ongoing compliance with Regulation, with the incorporation of de-escalation techniques to all training for all staff. Administrator and Assistant Administrator also enrolled in May 2024 "Why Does Abuse Happen" Administrative continued education course through Temple University to incorporate more efficient hiring processes and ongoing education.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Update: *05/14/2024*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date).
When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.
What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.

42b - Abuse (continued)

Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] - 05/29/2024)***

Staff person A was immediately sent home upon incident on [redacted] 2024 and [redacted] /2024 via telephone by Administrator, [redacted] and Assistant Administrator, [redacted], after internal investigation completed by Assistant Administrator, [redacted] on [redacted] /2024. All staff will receive re-education in Regulation 2600.42b Abuse with emphasis on definitions of abuse, all staff expectations related to abuse and techniques and appropriate interventions to handle challenging resident situations and behaviors appropriately with the goal of de-escalation by the Administrator, [redacted], and Assistant Administrator, [redacted] on Tuesday, May 28, 2024 @ 9am. Starting 5/16/2024, staff-resident interaction audits will be performed by the Administrator, [redacted], and the Assistant Administrator [redacted], weekly x 4 and monthly thereafter. Both the Administrator and the Assistant Administrator will review and address any findings of all audits to maintain ongoing compliance. The Assistant Administrator, [redacted], completed continuing education: Why does abuse happen? Prevention, Reduction, and Elimination Strategies through Temple University on 5/18/2024 and the Administrator, [redacted], has completed the 3-hour prerequisite and will complete the same continuing education on 5/23/2024 by 4pm. The information obtained through our continuing education will be incorporated into our hiring processes, re-education on 5/28/2024, and annual and as needed ongoing education to maintain ongoing compliance with DHS regulations.

Licensee's Proposed Overall Completion Date: *05/28/2024*

Update: *05/29/2024*

Reviewed ass admin training, and audits. Please attach training with staff completed on 5/28/24

Evidence of Completion ***Implemented ([redacted] - 06/07/2024)***

"Evidence of Completion"-See attached documentation[redacted], Administrator.

Update: *06/07/2024*

Onsite POC 6/6/24 [redacted]

57c - 2 Hours/Day

3. Requirements

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 3/16/24 and 3/17/24, the home had a census of 73 residents in-house, with 14 of those residents having mobility needs. On 3/16/24 and 3/17/24 the home was required to have a minimum of 87 total direct care staffing hours per day. On 3/16/24 the home had 85.5 total hours of direct care staff scheduled. On 3/17/24 the home had 79 total hours of direct care staff scheduled. On both days, the home did not have enough direct care staffing hours to provide at least two hours per day of personal care services to each resident with mobility needs.

Repeat violation - 9/26/23, et al.

57c - 2 Hours/Day *(continued)*

Plan of Correction ***Do Not Accept ([redacted] - 05/14/2024)***

Administrator/Assistant Administrator have hired an additional two members at this time and are currently in the hiring process of others. The Administrator/Assistant Administrator are responsible to maintain ongoing staffing compliance and will cover shifts, with the assistance of current staff to maintain compliance with regulation.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Update: *05/14/2024*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date).
When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.
What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] - 05/29/2024)***

Unable to fix at time of inspection on 4/11/2024. The Administrator, [redacted] and the Assistant Administrator, [redacted] responsible to fix the issue and maintain ongoing compliance. Two additional dayshift PCA's have been hired with start dates of [redacted]/1/2024 and [redacted]23/2024, and two additional nightshift PCA's have been hired with start dates of[redacted]24/2024 and [redacted]/8/2024. We are also utilizing substitute personnel from Senior Solutions with a weekly schedule received every Friday, with the possibility of more assistance upon request. Starting 5/17/2024, schedule/staffing audits will be performed daily by the Administrator, [redacted] to assure hours assigned meet the 2 hour per day requirement related to resident's mobility needs. Staffing hour needs will be performed as residents are admitted; discharged; leave the facility for reasons of hospital admission, etc., a list of shifts needing overage will be posted in advance and the facility mandatory overtime policy will remain in full effect to ensure all staffing requirements are met to maintain ongoing compliance. The Administrator and the Assistant Administrator will be responsible to cover any shifts that do not meet requirement after all other avenues have been taken to maintain ongoing compliance with staffing regulations.

Licensee's Proposed Overall Completion Date: *05/22/2024*

Update: *05/29/2024*

Reviewed mandation policy, schedules, review of staffing hours needed based on census.

Evidence of Completion ***Implemented [redacted] - 06/07/2024)***

'Evidence Of Completion"- See attached Documentation-[redacted] Administrator

Update: *06/07/2024*

Onsite POC 6/6/24 [redacted]

60a - Staff/Support Plan

4. Requirements

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

Description of Violation

On 3/10/24, the home had a census of 73 residents in-house. 14 of those residents have mobility needs and require assistance evacuating in the event of an emergency. Of the 14 residents with mobility needs, two residents require two staff and the use of a Hoyer lift to transfer into a wheelchair, then can mobilize independently. Two residents require two staff hands-on assistance with transfers into a wheelchair; one can mobilize independently, while the other requires hands-on push assist. Eight residents require one staff to assist with sit to stand transfers to an assistive device, and then can mobilize independently. One resident requires continuous cuing to safely evacuate. One resident requires one staff to assist with hands-on transfers to a wheelchair and then requires hands-on push assist. A fire safety expert has granted the home a maximum of 13 minutes to evacuate residents outside or to their internal fire safe areas. On 3/10/24 there were only three staff members scheduled to work overnight. The home did not have sufficient staff to evacuate residents in the event of an overnight emergency.

Plan of Correction ***Do Not Accept [redacted] - 05/14/2024)***

The Administrator/Assistant Administrator is responsible to maintain ongoing compliance of Regulation. An additional hiring for overnight staff was completed and in process of training those individuals. The Administrator is responsible to cover overnight shifts where applicable to maintain a minimum of 4 staff on duty for the overnight shift.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Update: *05/14/2024*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date).
When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.
What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] - 05/29/2024)***

Unable to fix at time of inspection on 4/11/2024. The Administrator, [redacted], and the Assistant Administrator, [redacted] are responsible to fix the issue and maintain ongoing compliance. Two additional nightshift PCA's have been hired with start dates of [redacted]/24/2024 and [redacted]/8/2024. Starting 5/17/2024, schedule/staffing audits will be performed daily by the Admin [redacted] ensure the facility has sufficient staff on duty to safely

60a - Staff/Support Plan (continued)

evacuate residents in the event of an overnight emergency. Staffing hour needs will be performed as residents are admitted; discharged; leave the facility for reasons of hospital admission, etc., a list of shifts needing overage will be posted in advance and the facility mandatory overtime policy will remain in full effect to ensure all staffing requirements are met to maintain ongoing compliance. The Administrator and the Assistant Administrator will be responsible to cover any shifts that do not meet requirement after all other avenues have been taken to maintain ongoing compliance with staffing regulations.

Licensee's Proposed Overall Completion Date: *05/22/2024*

Evidence of Completion ***Implemented ([redacted] - 06/07/2024)***

'Evidence Of Completion"- See attached Documentation- [redacted] *Assistant Administrator*

Update: *06/07/2024*

Onsite POC 6/6/24 [redacted]

65f - Training Topics

5. Requirements

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

Description of Violation

Direct care staff person C did not receive training in the topic of Medication self-administration in training year 2023.

Direct care staff person D did not receive training in the following topics in training year 2023: Medication Self Administration; Instructions on meeting the resident's needs using the DME/RASP; Personal care service needs of residents; Safe management techniques; Infection control/cleanliness/immobility concerns; and Care for residents with MH/ID.

Repeat violation - 1/4/24, 9/26/23, et al.

Plan of Correction ***Do Not Accept [redacted] - 05/14/2024)***

The Administrator/Assistant Administrator is responsible to maintain ongoing annual education for all employees. Medication Self-Administration, Instructions on meeting the needs the residents needs using DME/RASP; Personal Care Service Needs of residents, Safe Management techniques, infection control/cleanliness/immobility/ and care for Residents with MH/ID is scheduled for June 5, 2024 for any all staff who did not previously complete. Infection Control class was scheduled for May 6, 2024.

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

Update: *05/14/2024*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date). When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.
What action that person will take to ensure the violation will not occur again, and when that action will happen

65f - Training Topics (continued)

- (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] 05/29/2024)***

The Administrator/Assistant Administrator is responsible to maintain ongoing annual education for all employees. Direct Care Staff Person C received training in Medication Self-Administration on 5/20/2024 given by Assistant Administrator, [redacted] to cover the 2023 training year. Direct Care Staff Person D received training in Medication Self-Administration; Instructions on Meeting the Residents Needs using DME/RASP; Personal Care Needs of Residents; Safe Management Techniques; Care of Residents w/Mental Health and ID; and Proper Documentation/HIPPA on 5/20/2024 given by Assistant Administrator, [redacted] to cover the 2023 training year. All staff will receive training specific to Regulation 2600.65f training topics with an emphasis on their responsibility to complete training in order to maintain ongoing compliance and employment. This education will be offered by the Administrator, [redacted], and/or the Assistant Administrator, [redacted] annually and completed by October 2024. A monthly audit will be completed by the Administrator, [redacted], to assure staff are completing the required in-service training on time. Any staff issues with non-compliance will be addressed by the Administrator, [redacted] in order to maintain ongoing compliance with DHS regulations.

Licensee's Proposed Overall Completion Date: *05/22/2024*

Update: *05/29/2024*

Reviewed staff C & D's training, upcoming memos for 2024.

Evidence of Completion ***Implemented ([redacted] - 06/07/2024)***

"Evidence of Completion"-See attached Documentation [redacted], Administrator.

Update: *06/07/2024*

Onsite POC 6/6/24 [redacted]

92 - Windows

6. Requirements

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

Description of Violation

The window across from the main stairwell and the window in sitting area were open and both had holes 4 inches in diameter.

The windows that open to the outside in the home's Sunshine room do not have screens.

Repeat violation - 1/4/24, 9/26/23, et al.

92 - Windows (continued)

Plan of Correction ***Do Not Accept ([redacted] - 05/14/2024)***

All screens have been fixed by the Maintenance Department and will be monitored for ongoing compliance during weekly audits by the Maintenance Department. The window's outside the sunshine room have been affixed with L brackets to ensure they cannot open without the screens until owner decides if screens can be placed on current windows.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Update: *05/14/2024*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date).
When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.
What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

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

[redacted], Maintenance Department, have been re-educated in Regulation 2600.92 by Administrator, [redacted] 17/2024. The windows identified across from the main stairwell and in the sitting area were repaired by [redacted], Maintenance Department on 5/8/2024. The windows located in the Sunshine Room have never had screens and have been affixed with "L" brackets to ensure they cannot be opened by [redacted], Maintenance Department on 5/8/2024. A meeting has been scheduled with the owner in order to discuss the possibility of having these windows affixed with screens on 5/29/2024. All facility windows with screens were assessed by [redacted] Maintenance Department, on 5/17/2024 and reviewed by Administrator, [redacted] on 5/17/2024. The screens in need of placement/repair were completed by 5/20/2024. Weekly audits will be maintained x 4 and monthly thereafter of all windows by the Maintenance Department. All audits will be reviewed by the Administrator, [redacted] and the Assistant Administrator, [redacted] weekly x4 then monthly thereafter to maintain compliance with DHS Regulations.

Licensee's Proposed Overall Completion Date: *05/22/2024*

Update: *05/29/2024*

Reviewed training and audit of all windows

Evidence of Completion ***Implemented ([redacted] - 06/07/2024)***

"Evidence of Completion"-See attached documentation-[redacted], Administrator.

92 - Windows *(continued)*

Update: *06/07/2024*

Onsite POC 6/6/24 [redacted]

103i - Outdated Food

7. Requirements

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

Description of Violation

A Quaker oats container and a packet of brown gravy mix were found open in the cupboard of the kitchen without an open date written on them.

2 cans of oranges and a can of mushrooms were found with dents in the downstairs pantry.

Plan of Correction ***Do Not Accept*** [redacted] ***- 05/14/2024)***

All were removed at time of Inspection. The kitchen staff will be responsible for ongoing compliance of all food/storage areas and will perform weekly audits and be responsible for removing any outdated/dented/unlabeled items moving forward.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Update: *05/14/2024*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date).
When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.
What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept*** [redacted] ***- 05/29/2024)***

All were removed at time of Inspection on 4/11/2024 by Administrator, [redacted]*. Food Service Cooks,* [redacted] *were re-educated in Regulation 2600.103i with emphasis on the need to date all items when opening and storing any food and the need to assess cans for denting and the removal of such if any are found by Administrator,* [redacted] *5/14/2024. Starting 5/20/20217, bi-weekly audits x 4, weekly, audits thereafter will be performed by the kitchen staff to assure compliance. These audits will be reviewed by Administrator,* [redacted] *and/or Assistant Administrator,* [redacted]*, and any findings will be addressed with kitchen staff in order to maintain ongoing compliance.*

103i - Outdated Food *(continued)*

Licensee's Proposed Overall Completion Date: *05/22/2024*

Update: *05/29/2024*

Reviewed training and audtis

Evidence of Completion ***Implemented [redacted] 06/07/2024)***

'Evidence Of Completion"- See attached Documentation- [redacted] *Assistant Administrator*

Update: *06/07/2024*

Onsite POC 6/6/24 [redacted]

144c2 - Smoking Area Distance

8. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

Approximately 3 cigarette butts were observed in the mulch of the smoking area. This poses a potential fire hazard.

Plan of Correction ***Do Not Accept [redacted] - 05/14/2024)***

All were removed at time of inspection. The smoking area will be monitored by the Administrator/Assistant Administrator daily to maintain ongoing compliance. All smokers will be responsible to follow current policies and procedures pertaining to the smoking area.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Update: *05/14/2024*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date).
When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.
What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

144c2 - Smoking Area Distance *(continued)*

Plan of Correction ***Accept[redacted] - 05/29/2024)***

All were removed at time of inspection on 4/11/2024 by Administrator,[redacted]. The designated smoking area has been affixed with signage related to the area and expectations on 5/20/2024 by [redacted], Maintenance Department. Residents and staff who use the designated smoking area have received re-education in Regulation 144c2, Alexandria Manor Policies, and expectations of the use of the smoking area on 5/17/2024 by Assistant Administrator, [redacted]. All smokers are responsible to follow policies, procedures, and regulations relating to the designated smoking area. Starting 5/16, the smoking area will be audited 2 x weekly x 4, then monthly x 4 by the Administrator, [redacted], and the Assistant Administrator, [redacted]. Findings will be reviewed and addressed to maintain compliance with DHS Regulations.

Licensee's Proposed Overall Completion Date: *05/23/2024*

Update: *05/29/2024*

Reviewed training, signage and audits.

Evidence of Completion ***Implemented [redacted] 06/07/2024)***

'Evidence Of Completion"- See attached Documentation-[redacted] Assistant Administrator

184a - Resident's Meds Labeled

9. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #6's Medication Administration Record and Prescriber's order indicates that the resident is prescribed Metformin 500mg, one tablet by mouth once daily in the morning. However, Resident #6''s pharmacy label reads, Metformin 500mg, one tablet twice daily in the morning. The medication label is incorrect.

Repeat violation - 9/26/23, et al.

Plan of Correction ***Do Not Accept [redacted] - 05/14/2024)***

Resident #6's MAR and medication label were fixed at time of inspection. Moving forward, all medication carts are assigned to specific med techs for weekly/monthly audits and will be maintained by those assigned for ongoing compliance.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Update: *05/14/2024*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date).
When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.
What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and

184a - Resident's Meds Labeled (continued)

do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] - 05/29/2024)***

Resident #6's MAR and medication label were fixed at time of inspection on 4/11/2024 by Med Tech, [redacted] The Med Tech responsible for specific Med cart received re-education in Regulation 2600.184a on 5/17/2024 by Administrator, [redacted]. All Med Techs and potential Med Techs received re-education in Regulation 184a with emphasis on physician order, MAR, pharmacy label matching and the five rights of medication administration on 5/21/2024 by Assistant Administrator and Medication Administration Train the Trainer, [redacted] Starting 5/18/24, audits of all medication carts will be performed by the Med Techs assigned to them bi-weekly x 4, then weekly thereafter. The audits will be reviewed by the Administrator, [redacted] the Assigned Med Tech and any findings will be addressed at that time in order to maintain compliance with DHS Regulations.

Licensee's Proposed Overall Completion Date: *05/23/2024*

Update: *05/29/2024*

Reviewed residents change of order sticker, training and audits

Evidence of Completion ***Implemented [redacted] - 06/07/2024)***

"Evidence of Completion"-See attached documentation. [redacted], Administrator.

Update: *06/07/2024*

Onsite POC 6/6/24 [redacted]

185a - Implement Storage Procedures

10. Requirements

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

Description of Violation

Resident #1 has an order for blood glucose readings to be completed daily at 7:00am. On 4/8/24, Resident's Medication Administration Record (MAR) documented a reading of 155, however there was no corresponding reading on the Resident's glucometer.

Repeat violation - 9/26/23, et al.

Plan of Correction ***Do Not Accept [redacted] 05/14/2024)***

Unable to fix at time of inspection. Moving forward, Med tech Supervisors, [redacted] are responsible for completing bi-weekly audits of all blood sugar machines and to notify Administration of any and all non-compliant issues.

Licensee's Proposed Overall Completion Date: *05/10/2024*

[redacted] [redacted]

Update: *05/14/2024*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date).
When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.
What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept ([redacted] - 05/29/2024)***

Unable to fix at time of inspection on 4/11/2024. Med Tech Responsible for administering the blood sugar for Resident #1 on 4/8/2024 received re-education on Regulation 2600.185a Implement Storage Procedures on 5/17/2024 by [redacted] All Med Techs and potential Med Techs received re-education on Regulation 2600.185a with emphasis on blood glucose supporting proof of documentation of glucometer readings and proper documentation of blood glucose results on 5/21/2024 by Assistant Administrator and Medication Administration Train the Trainer, [redacted]. Starting 5/20/2024, Med Tech Supervisors, [redacted] will perform audits of blood glucose machines bi-weekly x 4 and weekly thereafter to assure compliance with this Regulation. The Administrator, [redacted], will review these audits and address any findings.

Licensee's Proposed Overall Completion Date: *05/23/2024*

Update: *05/29/2024*

Reviewed audits and trainig

Evidence of Completion ***Implemented [redacted] - 07/01/2024)***

"Evidence of Completion"-See attached documentation. [redacted] Administrator.

Update: *07/01/2024*

Reviewed documentation 7/1/24[redacted]

[redacted]

[redacted]

187a - [redacted]

[redacted]

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident #1 has an order for blood glucose readings to be completed daily at 7:00am. On 4/8/24, the resident did not receive a blood sugar reading as ordered.

Resident #3 is receiving Hospice Services and the Hospice Agency ordered the Resident to have fall mats when resident is in bed. The Resident fell out of bed on [redacted]30/24 and the mats were not available. The mats were also not available when Licensing representatives were on site. The mats were not in the Resident's room.

Repeat Violation: 2/14/24

Plan of Correction ***Do Not Accept [redacted] 05/14/2024)***

All med techs are responsible to follow the orders as prescribed by the Physician. All glucometers will be monitored bi-weekly by Med Tech Supervisors, [redacted] to maintain ongoing compliance. Resident # 3 received fall mats on [redacted]/11/2024 and will be monitored for correct usage by all direct care staff caring for resident #3 to maintain ongoing compliance.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Update: *05/14/2024*

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date). When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.
What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.

187d - Follow Prescriber's Orders (continued)

The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] - 05/29/2024)***

Med Tech responsible for Resident #1's blood glucose monitoring on 4/8/2024 at 7am received re-education in Regulation 2600.187d on 5/17/2024 by Administrator, [redacted]. All Med Techs and potential Med Techs received re-education in Regulation 187d Following Prescribers Orders with emphasis on following prescribed orders for glucose monitoring and documenting results, and for implementing physician orders including dme equipment related to violation for Resident # 3. Starting 5/20/2024, Med Tech Supervisors,[redacted] will perform audits of blood glucose machines bi-weekly x 4 and weekly thereafter to assure compliance with this Regulation. The Administrator, [redacted], will review these audits and address any findings. Resident # 3 received Fall mats and a sign as placed in the room on appropriate use on 4/11/2024. Starting 5/20/2024, all Med Techs assigned Medication Carts will audit their respective carts bi-weekly x 4, and weekly thereafter to ensure compliance with DHS Regulations. The Administrator, [redacted], will review these audits and address any findings to maintain compliance with DHS Regulations.

Licensee's Proposed Overall Completion Date: *05/24/2024*

Update: *05/29/2024*

Reviewed fall mat sign in Resident 3's room, training with staff

Evidence of Completion ***Implemented [redacted] - 06/07/2024)***

"Evidence of Completion"-See attached documentation. [redacted], Administrator.

Update: *06/07/2024*

Onsite POC 6/6/24 [redacted]

225a - Assessment 15 Days

13. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #8 was admitted to the facility on [redacted]24. Resident #8 did not have an initial assessment completed by date of inspection on 4/11/24.

Repeat violation - 9/26/23, et al.

Plan of Correction ***Do Not Accept [redacted] - 05/14/2024)***

Resident # 9 was admitted to the facility on [redacted]/2024. [redacted] initial RASP was completed on 4/12/2024. Moving Forward, Assistant Administrator, [redacted] is responsible for the completion all RASP's. Every Thursday, Administrator and Assistant Administrator will meet to conduct weekly audits of all Rasp's due to maintain

[redacted]

ongoing compliance.

Licensee's Proposed Overall Completion Date: *05/10/2024*

Update: *05/14/2024*

The above noted Resident should be Resident #9 from the privacy coding document not #8 as noted in the violation.

Please include in plan of correction:
Who is responsible for fixing the problem (title) and what did they do to fix the immediate violation (include date).
When you write your immediate solution, it should address who is responsible for fixing the problem and monitoring compliance, what action that person will take, and when that action will happen (include date). The solution needs to be realistic, sustainable, and specific.
What action that person will take to ensure the violation will not occur again, and when that action will happen - (must have date).
I.e.- Audit all staff records for compliance, include by whom and date completed.
The goal of the POC is not only to fix the violation, but make sure there is a sustainable plan in place to keep it from happening again.
These long-term solutions should greatly reduce or eliminate the chances of the violation happening again and do it in a manner that is sustainable over time. The POC should detail specific, realistic, actionable steps that keep the violation from happening again.
Who (title) will monitor ongoing compliance?
All POC's at a minimum must include the above information.

Plan of Correction ***Accept [redacted] - 05/29/2024)***

Resident # 8 was not admitted to facility on [redacted]/2024-please see attached documentation. Citation should note Resident # 9 was admitted to the facility on [redacted]/2024. The initial RASP was completed on 4/12/2024 by Assistant Administrator, [redacted]. The Assistant Administrator, [redacted], responsible for completion of all RASP forms, was re-educated in Regulation 2600.225a on 5/15/2024 by Administrator, [redacted]. An audit was performed by Administrator, [redacted] on 5/15/2024 to ensure all RASP completion dates met DHS Regulations. Every Thursday, Administrator and Assistant Administrator will meet to conduct weekly audits of all Rasp's due to maintain ongoing compliance with DHS Regulations.

Licensee's Proposed Overall Completion Date: *05/24/2024*

Update: *05/29/2024*

Reviewed Resident #9's RASP, training, audits tracking sheet.

Evidence of Completion ***Implemented [redacted] 06/07/2024)***

"Evidence of Completion"-See attached documentation-[redacted], Administrator.

Update: *06/07/2024*

Onsite POC 6/6/24 [redacted]

225c - [redacted]

[redacted]

[redacted]

[redacted]

15. Requirements

[redacted]