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

July 29, 2024

[REDACTED], ADMINISTRATOR
THE VILLAGES OF MAPLE HEIGHTS, LLC

RE: THE VILLAGES OF MAPLE HEIGHTS
429 MANOR DRIVE
EBENSBURG, PA, 15931
LICENSE/COC#: 33865

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/16/2024, 04/17/2024, 04/18/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE VILLAGES OF MAPLE HEIGHTS* **License #**: *33865* **License Expiration**: *07/01/2024*

Address: *429 MANOR DRIVE, EBENSBURG, PA 15931*

County: *CAMBRIA* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *THE VILLAGES OF MAPLE HEIGHTS, LLC*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *11/20/2013* **Issued By**: *D L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *108* **Waking Staff**: *81*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *04/18/2024*

Inspection Dates and Department Representative

04/16/2024 - On-Site: [redacted]
04/17/2024 - On-Site: [redacted]
04/18/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *76* **Residents Served**: *68*

Special Care Unit

In Home: *Yes* **Area**: *5th floor* **Capacity**: *38* **Residents Served**: *34*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *67*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *2*
Have Mobility Need: *40* **Have Physical Disability**: *5*

Inspections / Reviews

04/16/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/09/2024*

Inspections / Reviews *(continued)*

05/28/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/10/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/04/2024*

06/03/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/10/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/10/2024*

07/29/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *06/10/2024*

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

16c Incident reporting

1. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On 2/8/24 at approximately 5:30pm, staff witnessed a staff to resident incident of abuse. The residence did not report this incident to the Department until 2/14/24 at 4:30pm.

On 3/12/24 at approximately 6:15pm, staff witnessed a staff to resident incident of abuse. The residence did not report this incident to the Department until 3/14/24 at 2:00pm

Repeated Violation - 8/8/23, et al

Plan of Correction ***Accept (█ - 06/03/2024)***

The allegation of abuse that was reported to the residence late was unsubstantiated.
All staff will be given education by the Administrator/designee, regarding Reportable Incidents and Abuse and the time frames. Education will be completed by 5/24/2024. A validation quiz will be completed by each staff member showing understanding and comprehension of abuse guidelines.
Reportable incidents will be reviewed monthly at the Quality Management meeting. Staff will receive education monthly at staff meetings regarding Reportable Incidents and Abuse.
Administrator or designee will audit Reportable Incidents monthly at the Quality Management meetings to ensure reports are sent within 24 hours. Audit will be completed monthly starting in May and will continue through December. Will be completed 12/27/2024
Incident reported to administrator on 2/14/24. Was reported to DHS by administrator on 2/14/24 at 4:30pm.
Incident that was reported on 3/14/24 to administrator was reported on 3/14/24 to DHS by administrator at 2:00pm.
Incidents that are reported to administrator or Clinical coordinator will be reported by administrator/clinical coordinator within 24 hours.

Licensee's Proposed Overall Completion Date: *12/27/2024*

Implemented (█ - 07/29/2024)

63a First Aid/CPR 1:35

2. Requirements

2800.
63.a. For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

Description of Violation

On 3/31/24 and 4/5/24 from 11:00pm to 7:00am, 68 residents were present in the residence. During this time, there were no staff present in the residence who were trained in first aid and certified in obstructed airway techniques and CPR.

On 4/1, 4/4, 4/6 - 4/9, 4/11 and 4/13/24 from 11:00pm to 7:00am, 68 residents were present in the residence. During this time, there was only 1 staff present in the residence who was trained in first aid and certified in obstructed airway

63a First Aid/CPR 1:35 (continued)

techniques and CPR.

Plan of Correction ***Accept (- 06/03/2024)***

The facility completed a baseline review and staff needing CPR or recertified were notified of training on April 15th. Training completed.
Another training was held May 8th.
Beginning 5/8/24, once schedule is completed, a second check will be conducted by the Administrator/designee to ensure that at least one staff person is trained in first aid and certified in obstructed airway techniques for every 35 residents.
Beginning 5/8/24, the Administrator will keep a binder with copies of CPR training for staff. A list with expiration dates will be kept in the binder and checked monthly by the Administrator for upcoming expirations and staff will be scheduled for training accordingly.
Education for staff regarding 2800.63.a will be completed for all staff by the Administrator/designee by 5/24/2024.
Audit will be completed by Administrator/Designee bi-weekly when the schedule comes out to ensure that there is at least one staff person trained in CPR/First aid for every 35 residents and that staff needing CPR or recertified are scheduled for training. Audit will begin 5/8/2024 and will be done bi-weekly. Audit will be completed 11/8/2024

Proposed Overall Completion Date: 11/08/2024

Licensee's Proposed Overall Completion Date: *11/08/2024*

Implemented (- 07/29/2024)

65a Fire Safety-1st day

3. Requirements

2800.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

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

Description of Violation

Staff Person A, whose first day of work was did not receive orientation on the following topics:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.

65a Fire Safety-1st day (continued)

6. *Smoke detectors and fire alarms.*
7. *Telephone use and notification of emergency services.*

Plan of Correction ***Accept (- 06/03/2024)***

All ancillary staff persons will have an orientation given by Administrator/Designee in general fire safety and preparedness, 2800.65.a by May 24, 2024. Staff person A completed orientation on 5/2/2024.
Beginning 5/22/24, orientation and training will be reviewed by Administrator/Designee at the Quality Management Meeting Monthly.
Administrator or designee will audit new hire ancillary records for 3 months to ensure training is complete. Audit will begin in May and be completed July 26, 2024

Proposed Overall Completion Date: 07/26/2024

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (- 07/29/2024)

65e Rights/Abuse 40 Hours

4. Requirements

2800.
65.e. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

2. Emergency medical plan.
4. Reporting of reportable incidents and conditions.
5. Safe management techniques.

Description of Violation

Staff Person A, hired on , has completed 40th scheduled work hour. However, this staff person did not complete training in the following topics:
- Emergency medical plan.
- Reporting of reportable incidents and conditions.
- Safe management techniques.

Plan of Correction ***Accept (- 06/03/2024)***

Staff person A completed orientation given by Administrator on 5/2/2024. All ancillary staff persons will have an orientation given by Administrator/Designee and be completed by May 24, 2024.
Beginning 5/22/24, Orientation and training will be reviewed at Quality Management Meetings monthly by Administrator/Designee.
Administrator or designee will audit new hire ancillary records for 3 months to ensure training is complete. Audit will begin in May and be completed July 26, 2024.

Proposed Overall Completion Date: 07/26/2024

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (- 07/29/2024)

82c Locked poisons

5. Requirements

82c Locked poisons *(continued)*

2800.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

Description of Violation

On 4/18/24, denture cleanser with a manufacture's label indicating, "IF SWALLOWED: Call a Poison Control Center or doctor," was unlocked, unattended and accessible in the cabinet in Resident #2's bathroom. Resident #2 resides on the 5th floor memory care unit and has been assessed as not being capable of recognizing and using poisons safely.

On 4/18/24, the door to a storage closet on the 5fth floor memory care unit was found to be unlocked. None of the residents of the residence on the memory care unit, including Resident #3, #4, #5, and #6, have been assessed capable of recognizing and using poisons safely. The following items were observed to be unlocked, unattended, and accessible to residents:
- hydrogen peroxide 3%, with a manufacture's label indicating, "If swallowed, get medical help or contact a Poison Control Center right away."
- saline enema, with a manufacture's label indicating, "If swallowed, get medical help or contact a Poison Control Center right away."
- denture cleanser tabs, with a manufacture's label indicating "Do not put tablets or solution into the mouth and do not use as a gargle or rinse. In case of accidental ingestion, seek professional assistance or contact the poison control center immediately at 1-800-222-1222."
- A&D+E ointment, with a manufacture's label indicating, "If swallowed, get medical help or contact a Poison Control Center right away."
- peri-area skin protectant ointment, with a manufacture's label indicating, "In case of accidental ingestion, contact a physician or Poison Control Center right away."
- moisture barrier cream, with a manufacture's label indicating, "In case of ingestion, contact a physician or poison control center immediately."

Repeated Violation - 8/8/23, et al

Plan of Correction ***Accept (- 06/03/2024)***

The door to the clean utility room was fixed upon discovery, 4/18/2024. Maintenance staff, was the person responsible for fixing the utility door on 4/18/24. Daily checks by housekeeping and staff began 4/19/2024 and will continue indefinitely.
All staff will be re-educated by Administrator/Designee on regulation 2800.82.c." Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials" beginning 5/6/2024 and completed 5/24/2024.
Administrator or designee will audit 5 rooms per day for 2 weeks, then 5 rooms per week for 2 weeks then 5 rooms monthly for 2 months to ensure that there are no poisonous materials accessible to residents who have been assessed as not being capable of recognizing and using poisons safely. Audit will be begin on 5/6/2024 and completed on 7/26/2024

Proposed Overall Completion Date: 07/26/2024

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (- 07/29/2024)

93a Handrail

6. Requirements

2800.
93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

The entrance handrail to the right of the 5th floor exterior main entrance was observed to be unsecure, loose, and wobbly.

Plan of Correction ***Accept (- 05/09/2024)***

Maintenance department was notified on 3/26/2024 regarding the handrail being loose. Maintenance director has ordered the clamp and is to be delivered.
Handrail will be repaired no later than May 31, 2024
Audit will be completed daily by Administrator/Designee daily starting 5/8/2024 for 2 weeks, weekly for 2 weeks and monthly for 2 months to ensure that handrail is secure. Audit will begin 5/8/2024 and completed 7/26/2024.
All staff will be educated by Administrator/Designee regarding 2800.93.a "Each ramp, interior stairway and outside steps must have a well-secured handrail" beginning 5/8/2024 and will be completed 5/24/2024

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (- 07/29/2024)

101b3 Telephone jack/thermostats

7. Requirements

2800.
101.b. The following conditions apply to a residence:
3. Each living unit must have a telephone jack and individually controlled thermostats for heating and cooling.

Description of Violation

Resident # living unit in room #521 and Resident # living unit in room #513 do not have a thermostat.

The remaining 28 rooms in the memory care unit on the 5th floor have thermostats. However, the thermostats are covered with lockboxes and are unable to be adjusted.

None of the 30 rooms on the 5th floor have telephone jacks.

Plan of Correction ***Accept (- 06/03/2024)***

A waiver will be completed and sent to DHS no later than May 24, 2024 for the telephone jacks and for rooms 513 and 521 not having a thermostat.
The lock boxes will be removed from all thermostats no later than May 24, 2024.
Cordless phones are available for resident use and can be used privately in their rooms.
All staff will be educated by Administrator/Designee regarding 2800.101b.3 "Each living unit must have a telephone jack and individually controlled thermostats for heating and cooling" beginning 5/8/2024 and will be completed 5/24/2024.

Administrator and Clinical Coordinator removed the lock boxes from all the thermostats on 5/24/24. The residents

101b3 Telephone jack/thermostats (continued)

who resided in units 521 and 513 were moved on 5/30/24 to rooms that have thermostats. Those rooms will not be used as living units until thermostats are installed.
Saber IT department will be sending a quote to the administrator and maintenance director for the cabling to install phone jacks in all the living units on the 5th floor. Work will be completed by 12/31/24

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

Implemented (█ - 07/29/2024)

101b4 Accessible for wheelchairs

8. Requirements

2800.
101.b. The following conditions apply to a residence:
4. The doors in living units, including entrance doors, must be accessible or adaptable for wheelchair use.

Description of Violation

On 4/17/23 and 4/18/23, residents in wheelchairs were observed attempting to open the exterior entrance door to the home. When the push plate used to open the door was pushed, the exterior door would not open, and the residents could not enter the home from the outside.

Plan of Correction ***Accept (█ - 06/03/2024)***

Maintenance director aware of Handicap push plate not always working and repair company was notified to come for repair.
Repair will be completed no later than May 31, 2024.
Residents that require assist with going in and out will be assisted by staff.
Audit for Handicap Push Plate will be completed by Administrator/Designee daily for 2 weeks, weekly for 2 weeks and monthly for 2 months. Audit will begin 5/8/2024 and be completed on 7/26/2024
All staff will be educated by Administrator/Designee regarding 2800.101.b.4 "The following conditions apply to a residence: The doors in living units, including entrance doors, must be accessible or adaptable for wheelchair use" beginning 5/8/2024 and will be completed 5/24/2024

Repair was made on 5/14/24

Proposed Overall Completion Date: 07/26/2024

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (█ - 07/29/2024)

102c Tub/shower

9. Requirements

2800.
102.c. There must be at least one bathtub or shower in the bathroom of the living unit.

Description of Violation

The bathrooms in the 30 living units on the 5th floor do not have a bathtub or shower.

102c Tub/shower *(continued)*

Plan of Correction ***Directed (- 06/03/2024)***

A waiver was sent to , DHS on 3/21/2024.
All staff will be educated by Administrator/Designee on regulation 2800.102.c "There must be at least one bathtub or shower in the bathroom of the living unit" beginning 5/8/2024 and completed 5/24/2024

Saber Corporate personnel is in conversation with DHS regarding this violation. A feasibility assessment, quotes etc will be completed by 12/31/24

Proposed Overall Completion Date: 12/31/2024

[Directed]
- Saber Corporate personnel and administrator or designee will have a feasibility assessment completed by 5/28/25, regarding having bathtubs and/or showers installed in all living units on the 5th floor. In the event that a waiver is approved, the provisions of the waiver must be followed and will supersede this POC.

Directed Completion Date: *05/28/2025*

Implemented (- 07/29/2024)

102j Towels/washcloths access

10. Requirements

2800.
102.j. Towels and washcloths shall be in the possession of the resident in the resident's living unit unless the resident has access to the residence's linen supply.

Description of Violation

According to observation of Resident #3's bathroom on the memory care unit and interview with staff on 4/18/24, Resident #3 does not have towels accessible in bathroom. There is no towel bar, and towels are kept high up on the bathroom's locked cabinet in the bathroom. This resident is in a wheelchair and unable to reach that high. Residents on the memory care unit do not have access to the residence's linen supply on the memory care unit.

Plan of Correction ***Accept (- 06/03/2024)***

All staff will be educated by Administrator/Designee on regulation 2800.102.j "Towels and washcloths shall be in the possession of the resident in the resident's living unit unless the resident has access to the residence's linen supply" beginning 5/6/2024 and completed 5/24/2024.
Administrator or designee will audit 5 rooms per day for 2 weeks, then 5 rooms per week for 2 weeks then 5 rooms monthly for 2 months to ensure there are towels and washcloths available in the resident's living area. Audit will be begin on 5/6/2024 and completed on 7/26/2024

Towels and washclothes were put in resident #3's room on 4/18/24 by administrator, and is within reach and accessible.

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (- 07/29/2024)

102l Shelves/hooks

11. Requirements

2800.
102.l. Shelves or hooks for the resident's towel and clothing shall be provided.

Description of Violation

There are no shelves or hooks available for the resident's clothes or towel in the bathroom of living unit # 517.

Plan of Correction ***Accept (█ - 06/03/2024)***

Maintenance Dept notified of missing towel bar in resident's room and was promptly replaced.
All staff will be educated by Administrator or Designee on regulation 2800.102.l "Shelves or hooks for the resident's towel and clothing shall be provided" beginning 5/6/2024 and completed 5/24/2024.
Administrator or designee will audit 5 rooms per day for 2 weeks, then 5 rooms per week for 2 weeks then 5 rooms monthly for 2 months to ensure that there are bowel bars for each resident in their room. Audit will be begin on 5/6/2024 and completed on 7/26/2024

Towel bar was replaced on 4/19/24 by maintenance staff.

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (█ - 07/29/2024)

103e Leftovers

12. Requirements

2800.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 4/16/24, an unlabeled, undated salad was observed in the refrigerator in the resident lounge area on the 6th floor.

On 4/17/24, 2 unlabeled salads and 2 bowls of dessert were observed in the refrigerator in the dining area on the 5th floor.

Plan of Correction ***Accept (█ - 06/03/2024)***

All staff will be educated by the Administrator/designee on regulation 2800.103.e "Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated" Beginning 5/6/2024 and completed 5/24/2024.
Administrator or designee will audit the refrigerators daily for 2 weeks, then weekly for 2 weeks and monthly for 2 months to ensure that food is labeled and dated. Audit will begin on 5/6/2024 and completed on 7/26/24.

On 4/16/24 the undated salad in refrigerator on the 6th floor was thrown away by the administrator.
On 4/17/24 the unlabeled salads and 2 bowls of desserts were thrown away by the administrator.

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (█ - 07/29/2024)

132a Monthly fire drill

13. Requirements

2800.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The fire drills held on 3/28/23 at 1:30am and 6/14/23 at 4:30am were announced. Per staff and the maintenance director, staff were not alerted of the fire drills by strobes and sirens but by the maintenance director calling the units to notify staff that there would be a fire drill.

Plan of Correction ***Accept (█ - 06/03/2024)***

Staff and maintenance director educated by Administrator/Designee on regulation 2800.132.a "an unannounced fire drill shall be held at least once a month" beginning on 5/13/2024 and completed 5/24/2024.
Administrator will audit fire drills and meet with maintenance director monthly to ensure that fire drills are being completed per regulations for 6 months and will be completed 11/22/2024.

Audit began and met with Maintenance director on 5/13/24.

Licensee's Proposed Overall Completion Date: *11/22/2024*

Implemented (█ - 07/29/2024)

132i Testing fire alarm

14. Requirements

2800.
132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

During the fire drill on 3/28/23 at 1:30am and 6/14/23 at 4:30am, the fire alarm was not sounded. In its place, staff was notified by phone that a fire drill was taking place.

Plan of Correction ***Accept (█ - 06/03/2024)***

Staff and maintenance director educated by Administrator on regulation 2800.132.i "a fire alarm or smoke detector shall be set off during each fire drill" beginning on 5/6/2024 and completed 5/24/2024.
Administrator will audit fire drills and meet with maintenance director monthly to ensure that fire drills are being completed per regulations for 6 months and will be completed 11/22/2024.

Audit began and met with Maintenance Director on 5/13/24.

Licensee's Proposed Overall Completion Date: *11/22/2024*

Implemented (█ - 07/29/2024)

141b1 Annual medical evaluation

15. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

Resident #8 does not have a current medical evaluation completed. The most recent medical evaluation was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 05/09/2024)***

A medical evaluation was completed by Clinical Coordinator on 4/24/2024 for resident. Audit was completed by clinical coordinator on 4/22/24 for all residents to ensure that each have a completed ADME. A list is kept of all residents and date when ADME is due.
Administrator or designee will audit the list weekly X4 beginning 5/6/2024 and then monthly x 6 to ensure Medical Evaluations are completed on time. Weekly audit will be completed 5/31/2024 and audit will completed 11/30/2024
Staff will be educated by Administrator regarding 2800.141.b.a.1 "A resident shall have a medical evaluation: 1. At least annually" beginning 5/13/2024 and completed 5/24/2024.

Licensee's Proposed Overall Completion Date: *11/30/2024*

Implemented ([redacted] - 07/29/2024)

144c2 Smoking area distance

16. Requirements

2800.
144.c. A residence that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
2. 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

On 4/16/24 at 9:00am, a resident was observed smoking at the front entrance of the home. The residence's designated smoking area is to the far right of the entrance. Signs on the door indicate no smoking.

Repeated Violation - 8/8/23, et al

Plan of Correction ***Accept ([redacted] - 06/03/2024)***

All residents who currently reside at the facility, and wish to smoke:
1. Smoking Assessment completed by May 17, 2024
2. Review and sign a Safe Smoking Agreement.
3. Facility Smoking Policy will be reviewed with all residents who wish to smoke and a copy will be given to them.
4. Review Behavior contract regarding smoking violations.
All staff will be educated by the Administrator/designee, on regulation 2800.144.c, "A residence that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: 2. 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" beginning on 5/6/2024 and will be completed 5/24/2024
Audit will be completed by Administrator/Designee beginning 5/8/2024 daily for 2 weeks, weekly for 2 weeks and monthly for 2 months to monitor that residents are smoking in the designated smoking area. Audit will be

144c2 Smoking area distance (continued)

completed August 9th.

On May 17, 2024, Administrator completed: "All residents who currently reside at the facility, and wish to smoke:
1. Smoking Assessment completed by May 17, 2024
2. Review and sign a Safe Smoking Agreement.
3. Facility Smoking Policy will be reviewed with all residents who wish to smoke and a copy will be given to them.
4. Review Behavior contract regarding smoking violations."

Licensee's Proposed Overall Completion Date: *08/09/2024*

Implemented (█ - 07/29/2024)

183d Current medications

17. Requirements

2800.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence.

Description of Violation

On 4/18/24 at approximately 10:40am, the Ipratropium-albuterol solution for Resident #9's nebulizer was located in the 5th floor medication cart. This medication was ordered on 11/1/23 and was to end on 11/5/23. The directions state to inhale 3mL via nebulizer four times a day while awake x 5 days.

Repeated Violation - 8/8/23, et al

Plan of Correction ***Accept (█ - 06/03/2024)***

The Ipratropium-albuterol solution was immediately removed from the med cart. Clinical Coordinator completed a med cart audit on 4/19/2024 to ensure that all medication in the med cart had a physician order.
All staff will be educated by Administrator or Designee on regulation 2800.183.d “Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the residence” beginning on 5/6/2024 and will be completed 5/24/2024.
Administrator or designee will audit new physician orders and med carts daily for 2 weeks, then weekly for 2 weeks and monthly for 2 months to ensure that all medication in the med cart has an order. Audit will begin on 5/8/2024 and completed on 7/26/24.

The clinical coordinator removed the Ipratropium-albuterol solution

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (█ - 07/29/2024)

183e Storing Medications

18. Requirements

2800.
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

On 4/18/24 at approximately 9:55am, a small oval blue pill was observed loose in the medication cart on the 5th floor.

183e Storing Medications *(continued)*

Plan of Correction ***Accept (- 06/03/2024)***

All staff will be educated by Administrator/designee on regulation 2800.183.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." Beginning on 5/6/2024 and will be completed 5/24/2024.
Administrator or designee will audit med carts daily for 2 weeks, then weekly for 2 weeks and monthly for 2 months to ensure medication is stored properly. Audit will begin on 5/6/2024 and completed on 7/26/24.

The Med Tech on the cart is responsible for disposing of the loose pill. had put in the red sharps container that is on the med cart on 4/18/24 at 9:55am

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (- 07/29/2024)

183f Discontinued medications

19. Requirements

2800.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the residence shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the residence, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the residence.

Description of Violation

On 4/18/24 at approximately 10:00am, a small oval blue pill was observed to be loose in the medication cart. Staff Person D disposed the medication by dropping it into the sharp's container. Per the home, staff are to dispose of medications by placing them into a drug buster bottle.

Plan of Correction ***Accept (- 06/03/2024)***

All staff will be educated by the Administrator/Designee on regulation 2800.183.f "Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the residence shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the residence, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the residence," beginning on 5/6/2024 and will be completed 5/24/2024.
All staff will be educated by the Administrator/Designee on the facility policy for medication disposal beginning on 5/6/2024 and will be completed 5/24/2024.
Administrator or designee will audit med carts daily for 2 weeks, then weekly for 2 weeks and monthly for 2 months to ensure medication is stored properly. Audit will begin on 5/6/2024 and completed on 7/26/24.

The med tech on the cart put the loose pill in the sharps container on the med cart. Drug Buster bottles were placed in the medication rooms on 5/24/24 and any loose pills, discontinued medications will be put in the drug buster bottles by the med tech.

Licensee's Proposed Overall Completion Date: *07/26/2024*

Implemented (- 07/29/2024)

187d Follow prescriber's orders

20. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #8 is ordered accu checks before meals at 6:00am. However, Resident #8's accu checks were completed over an hour early as follows:
- On 4/4/24, the accu check was completed at 4:35am.
- On 4/5/24, the accu check was completed at 4:30am.
- On 4/6/24, the accu check was completed at 4:36am.
- On 4/9/24, the accu check was completed at 4:40am.
- On 4/12/24, the accu check was completed at 4:36am.
- On 4/13/24, the accu check was completed at 4:35am.
- On 4/14/24, the accu check was completed at 4:38am.
- On 4/15/24, the accu check was completed at 4:39am.

Resident #8 is ordered insulin at 7:00am. However, the resident was administered insulin over an hour early as follows:
- On 4/11/24, the insulin was administered at 5:46am.
- On 4/14/24, the insulin was administered at 5:58am.

Repeated Violation - 8/8/23, et al

Plan of Correction ***Accept (- 05/09/2024)***

All staff will be educated by the Administrator/designee, on regulation 2800.187.d, "The home shall follow the directions of the prescriber", beginning 5/13/2024 and will be completed 5/24/2024.
All medication aides will be re- educated by Administrator/Clinical Coordinator regarding medication administration and appropriate administration timing and sliding scale insulin administration beginning 5/13/2024 and completed 5/24/2024.
Administrator or designee will audit MAR for appropriate times for sliding scale insulin accu checks and Insulin given, daily for 2 weeks, then weekly for 2 weeks and monthly for 2 months to ensure medication is administered properly. Audit will begin on 5/13/2024 and completed on 8/9/24.

Licensee's Proposed Overall Completion Date: *08/09/2024*

Implemented (- 07/29/2024)

236a Staff training

21. Requirements

2800.
236.a. Each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to dementia care and services, in addition to the 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

Description of Violation

Direct care staff person B, date of hire and direct care staff person C, date of hire , both work in the

236a Staff training (continued)

special care unit but did not complete any initial training related to dementia care within the first 30 days of the date of hire.

Repeated Violation - 11/15/23 and 8/8/23, et al

Plan of Correction ***Accept (- 06/03/2024)***

Administrator/Designee will complete audit to ensure that newly hired employees have completed Relias Training/Packets during their first week of orientation that include 8 hours of Alzheimer's disease or dementia training for all new employees for 6 months beginning 5/13/2024 and will be completed 11/15/2024.
All staff is assigned extra Dementia training through Relias and will be completed by 5/31/2024. Audit will be completed by Administrator to ensure all staff has completed.
Staff person C completed their Dementia Training. Staff person B has since resigned their position.

Staff person C completed their dementia training on 3/12/24.
Clinical Coordinator along with Administrator is responsible for creating the new hire checklist with includes dementia training. It was utilized starting on 4/29/24.

Licensee's Proposed Overall Completion Date: *11/15/2024*

Implemented (- 07/29/2024)