pennsylvania
DEPARTMENT OF HUMAN SERVICES

# CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **THE GATHERING PLACE PERSONAL CARE LLC**
LEGAL ENTITY

To operate **THE GATHERING PLACE PERSONAL CARE**
NAME OF FACILITY OR AGENCY

Located at **390 MOUNTAIN ROAD, UNIONTOWN, PA 15401**
(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 **16**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.
(MAXIMUM CAPACITY)

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 **September 3, 2024** until **March 3, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454171**

ISSUING OFFICER

Juliet Marsala
ACTING 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 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: SEPTEMBER 3, 2024

[redacted], Owner
The Gathering Place Personal Care LLC
[redacted]

RE: The Gathering Place Personal Care
390 Mountain Road
Uniontown Pennsylvania 15401
License/COC #: 454171

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on April 16, 2024, and June 5, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), mistreatment or abuse of a resident being cared for in the facility, failure to submit an acceptable plan to correct noncompliance items and failure to comply with the acceptable plan to correct noncompliance items, the Department hereby REVOKES your certificate of compliance (license number 454170) dated December 13, 2023 – December 13, 2024, and 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); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from September 3, 2024 to March 3, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

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. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
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,

[redacted]
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: Gene Cuccarese, Office of General Counsel
Theresa Hartman, Bureau Director
Sheila Page, Director of Operations
Brent Sutherland, Regional Director

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

## Facility Information

**Name:** *THE GATHERING PLACE PERSONAL CARE* **License #:** *45417* **License Expiration:** *12/13/2024*

**Address:** *390 MOUNTAIN ROAD, UNIONTOWN, PA 15401*

**County:** *FAYETTE* **Region:** *WESTERN*

## Administrator

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

## Legal Entity

**Name:** *THE GATHERING PLACE PERSONAL CARE LLC*

**Address:** [redacted]

**Phone** [redacted]

## Certificate(s) of Occupancy

**Type:** *C-2 LP* **Date:** *02/06/1993* **Issued By:** *Dept L&I*

**Type:** *Other* **Date:** *08/12/1992* **Issued By:** *Dept L&I*

## Staffing Hours

**Resident Support Staff:** **Total Daily Staff:** *16* **Waking Staff:** *12*

## Inspection Information

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

**Reason:** *Complaint* **Exit Conference Date:** *04/16/2024*

## Inspection Dates and Department Representative

*04/16/2024 - On-Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity:** *16* **Residents Served:** *13*

### Secured Dementia Care Unit

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

### Hospice

**Current Residents:** *6*

### Number of Residents Who:

**Receive Supplemental Security Income:** *0* **Are 60 Years of Age or Older:** *12*

**Diagnosed with Mental Illness:** *4* **Diagnosed with Intellectual Disability:** *0*

**Have Mobility Need:** *3* **Have Physical Disability:** *0*

# Inspections / Reviews

## 04/16/2024 - Partial

**Lead Inspector** [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/03/2024*

**05/06/2024 - POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *05/20/2024*

**Reviewer:** [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/13/2024*

**05/15/2024 - POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *05/20/2024*

**Reviewer:** [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/30/2024*

**07/25/2024 - Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *05/20/2024*

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

## 15a - Resident Abuse Report

**1. Requirements**

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

**Description of Violation**

*On 4/5/24, volunteer staff person A accompanied resident #1 and [redacted] wife to the resident's doctor appointment. Resident #1 did not want to put on [redacted] coat when leaving the doctor's office. Volunteer A grabbed him by [redacted] neck, yelled at [redacted] and put [redacted] against the wall, leaving a bruise on [redacted] neck. This was observed by the resident's wife and the doctor's office staff. The following day, volunteer A bragged about the incident to staff person B and staff person C, who reported it to staff person D, the home's administrator, and to staff person E. However, this allegation of abuse was not reported to the local Area Agency on Aging.*

**Plan of Correction** ***Directed [redacted]05/15/2024)***

*On 4/10/24, Area Agency on Aging was notified by Amedisys Hospice of the alleged abuse for a resident by a volunteer. After the Administrator was notified of the abuse that was seen, the Owner called the facility and terminated the employee/volunteer on the spot and was told to leave the premises immediately. The Agency later called the home and spoke with an employee. They did not come to the facility because they were aware that the employee was terminated immediately. The plan of correction will be to educate all staff members and volunteers on Regulation 2600.15.a, Older Adult Protective Services Act, and expectations according to the Home's Policies and Procedures. This training will include a course offered by Pennsylvania Department of Aging covering the Mandatory Abuse Reporting Module with certificate to show completion as well as The Administrator training on the Home's Policies and Procedures. All staff and volunteers will be trained. A training sheet will be signed off on by all employees and volunteers in attendance and certificates will be gathered and placed in each employee/volunteer file. Any future allegations or rumors will be reported to DHS immediately. The allegation will be fully investigated by interviewing the resident and employee involved, as well as any other residents that may have been present during the time of the alleged abuse. The Administrator or the designated administrative assistant will monitor the resident for signs of abuse, outbursts, fears, etc. and all will tracked in the residents charts. This monitoring will continue daily for the first week, and then weekly for the next month and the monitoring will begin the day the abuse has been alleged. The employee or volunteer will be removed from the facility until the investigation is complete. If the allegations are founded, the employee will be terminated and the proper authorities will be notified immediately.*

*Proposed Overall Completion Date: 06/30/2024*

*DIRECTED*
*Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall ensure all staff and volunteers have received education on reporting suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and the home's policy and procedures related to alleged abuse. Documentation of education shall be kept in accordance with Regulation 2600.65(i). 5/15/24 JK*

*Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit any allegations of abuse to ensure any allegation of abuse is reported in accordance with Regulation 2600.15(a). 5/15/24 JK*

*Within 5 calendar days of the accepted plan of correction: The administrator shall ensure all aspects of the plan of*

## 15a - Resident Abuse Report (continued)

*correction have been implemented. 5/15/24 JK*

**Directed Completion Date:** *05/20/2024*
**Licensee's Proposed Date for POC Implementation** *Implemented [redacted]- 08/02/2024)*

## 15b - Supervisor Plan

**2. Requirements**

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

**Description of Violation**

*On [redacted], volunteer staff person A accompanied resident #1 and [redacted] wife to the resident's doctor appointment. Resident #1 did not want to put on [redacted] coat when leaving the doctor's office. Volunteer A grabbed [redacted] by [redacted] neck, yelled at [redacted], and put [redacted] against the wall, leaving a bruise on [redacted] neck. This was observed by the resident's [redacted] and the doctor's office staff. The following day, volunteer A bragged about the incident to staff person B and staff person C, who reported it to staff person D, the home's administrator, and to staff person E. However, volunteer A continued to work in the home on multiple shifts until [redacted] at approximately [redacted]*

**Plan of Correction** *Directed [redacted]- 05/15/2024)*

*On [redacted] Area Agency on Aging was notified by Amedisys Hospice of the alleged abuse for a resident by a volunteer. After the Administrator was notified of the abuse that was seen, the Owner called the facility and terminated the employee/volunteer on the spot and was told to leave the premises immediately. The Agency later called the home and spoke with an employee. They did not come to the facility because they were aware that the employee was terminated immediately. The plan of correction will be to educate all staff members and volunteers on Regulation 2600.15.b, Older Adult Protective Services Act, and expectations according to the Home's Policies and Procedures. This training will include a course offered by Pennsylvania Department of Aging covering the Mandatory Abuse Reporting Module with certificate to show completion as well as The Administrator training on the Home's Policies and Procedures. All staff and volunteers will be trained. A training sheet will be signed off on by all employees and volunteers in attendance and certificates will be gathered and placed in each employee/volunteer file. Any future allegations or rumors will be reported to DHS immediately. The allegation will be fully investigated by interviewing the resident and employee involved, as well as any other residents that may have been present during the time of the alleged abuse. The Administrator or the designated administrative assistant will monitor the resident for signs of abuse, outbursts, fears, etc. and all will tracked in the residents charts. This monitoring will continue daily for the first week, and then weekly for the next month and the monitoring will begin the day the abuse has been alleged The allegation will be fully investigated and the employee or volunteer will be removed from the facility until the investigation is complete. If the allegations are founded, the employee will be terminated and the proper authorities will be notified immediately.*

*Proposed Overall Completion Date: 06/30/2024*

*DIRECTED*
*Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall ensure all staff and volunteers have received education on Regulation 2600.15(b) including the immediate development and implementation of a written plan of supervision preapproved by the Department and the Area Agency on Aging or the immediate suspension of the staff person involved in the alleged abuse, and the home's policy and procedures related to alleged abuse. Documentation of education shall be kept in accordance with Regulation 2600.65(i).*

## 15b - Supervisor Plan (continued)

*5/15/24*

*Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit any allegations of abuse to ensure a written plan of supervision preapproved by the Department and the Area Agency on Aging is in place or the immediate suspension of the staff person involved in the alleged abuse. 5/15/24*

*Within 5 calendar days of the accepted plan of correction: The administrator shall ensure all aspects of the plan of correction have been implemented. 5/15/24*

**Directed Completion Date:** *05/20/2024*
**Licensee's Proposed Date for POC Implementation** ***Implemented - 08/02/2024)***

## 16c - Written Incident Report

**3. Requirements**

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

**Description of Violation**

*On volunteer staff person A accompanied resident #1 and wife to the resident's doctor appointment. Resident #1 did not want to put on coat when leaving the doctor's office. Volunteer A grabbed by neck, yelled at and put against the wall, leaving a bruise on neck. This was observed by the resident's wife and the doctor's office staff. The following day, volunteer A bragged about the incident to staff person B and staff person C, who reported it to staff person D, , and to staff person E. However, the home did not report this incident to the department.*

*On at approximately a social worker went to resident #1's bedroom to retrieve an item had forgotten. walked past the resident to enter room, grabbed the item, and then saw resident #1 blocking the doorway, preventing from leaving. Volunteer staff person A approached the door carrying a breakfast tray and yelling in a stern voice – Come on resident #1, move. lowered shoulder and pushed with it started pushing back, so yelled - You're not gonna treat me that way. threw the tray onto the bed, put hands on each of biceps, and pushed across the room approximately 12 feet until was trapped against the wall. Volunteer staff person A was described as extremely angry and caused resident #1 to growl. Later in the day, staff person C observed the resident pointing at the wall where the incident occurred, crying and saying-I'm sorry. I didn't do anything. However, the home did not report this incident to the department.*

**Plan of Correction** ***Directed - 05/15/2024)***

*On , a volunteer abused a resident. It was reported by Amedisys Hospice after being witnessed by their social worker visiting the home at the time. The plan of correction will be first and foremost to submit an incident report to DHS, to educate all staff members and volunteers on Regulation 2600.16.c, Older Adult Protective Services Act, and expectations according to the Home's Policies and Procedures. This training will include a course offered by Pennsylvania Department of Aging covering the Mandatory Abuse Reporting Module with certificate to show completion as well as The Administrator training on the Home's Policies and Procedures. All staff and volunteers will be trained. A training sheet will be signed off on by all employees and volunteers in attendance and certificates will be gathered and placed in each employee/volunteer file. Any future allegations or rumors will be reported to DHS*

## 16c - Written Incident Report (continued)

*immediately. The allegation will be fully investigated by interviewing the resident and employee involved, as well as any other residents that may have been present during the time of the alleged abuse. The Administrator or the designated administrative assistant will monitor the resident for signs of abuse, outbursts, fears, etc. and all will tracked in the residents charts. This monitoring will continue daily for the first week, and then weekly for the next month and the monitoring will begin the day the abuse has been alleged The allegation will be fully investigated and the employee or volunteer will be removed from the facility until the investigation is complete. If the allegations are founded, the employee will be terminated and the proper authorities will be notified immediately.*

*Proposed Overall Completion Date: 06/30/2024*

*DIRECTED*
*Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall ensure all staff and volunteers have received education on Regulation 2600.16(c) and the home's policy and procedures for reporting reportable incidents and conditions. Documentation of education shall be kept in accordance with Regulation 2600.65(i). 5/15/24[redacted]*

*Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit any reportable incidents and conditions to ensure any reportable incident or condition are reported in accordance with Regulation 2600.16(c). 5/15/24[redacted]*

*Within 5 calendar days of the accepted plan of correction: The administrator shall ensure all aspects of the plan of correction have been implemented. 5/15/24[redacted]*

**Directed Completion Date:** *05/20/2024*
**Licensee's Proposed Date for POC Implementation**

***Implemented [redacted] - 08/02/2024)***

## 25b - Contract Signatures

**4. Requirements**

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

**Description of Violation**

*Resident #1's resident-home contract, dated[redacted] is not signed by the resident.*

*REPEAT VIOLATION: 3/8/2023*

**Plan of Correction** ***Directed [redacted] - 05/15/2024)***

*On[redacted] was found that resident-home contract wasn't signed by the resident. The resident has severe [redacted] and isn't able to sign. The resident-home contract was immediately updated to notate on the Resident Signature line that[redacted] was unable to sign and it was dated by the Administrator for the date of the violation, 4/16/24. The plan to correct this moving forward will be to notate on the Resident Signature line why the resident is unable to sign for themselves and witnessed by someone. The Administrator will audit all current resident files to ensure that the proper signatures are obtained, and if they are not, there is a reason on the line with a witness signature. This will be completed by 5/31/24 and an audit sheet will be completed and filed in the resident's folders. A line will not just be left blank moving forward. The Administrator will monitor all newly completed and future contracts before they are filed with the current residents. This will ensure compliance of Regulation 2600.25.b.*

## 25b - Contract Signatures (continued)

*Proposed Overall Completion Date: 06/30/2024*

*DIRECTED*
*Within 5 calendar days of the accepted plan of correction: The administrator shall ensure all aspects of the plan of correction have been implemented. 5/15/24*

**Directed Completion Date:** *05/20/2024*
**Licensee's Proposed Date for POC Implementation**

***Implemented - 08/02/2024)***

## 42b - Abuse

**5. 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 volunteer staff person A accompanied resident #1 and wife to the resident's doctor appointment. Resident #1 did not want to put on coat when leaving the doctor's office. Volunteer A grabbed him by neck, yelled at and put against the wall, leaving a bruise on neck. This was observed by the resident's wife and the doctor's office staff. The following day, volunteer A bragged about the incident to staff person B and staff person C, who reported it to staff person D, the home's administrator, and to staff person E. However, volunteer A continued to work in the home on multiple shifts until at approximately*

*On at approximately a social worker went to resident #1's bedroom to retrieve an item she had forgotten. She walked past the resident to enter her room, grabbed the item, and then saw resident #1 blocking the doorway, preventing her from leaving. Volunteer staff person A approached the door carrying a breakfast tray and yelling in a stern voice – Come on resident #1, move! She lowered her shoulder and pushed her with it. She started pushing back, so she yelled - You're not gonna treat me that way. She threw the tray onto the bed, put her hands on each of his biceps, and pushed him across the room approximately 12 feet until he was trapped against the wall. Volunteer staff person A was described as extremely angry and caused resident #1 to growl. Later in the day, staff person C observed the resident pointing at the wall where the incident occurred, crying and saying-I'm sorry. I didn't do anything.*

**Plan of Correction** ***Accept - 05/06/2024)***

*On , Area Agency on Aging was notified by Amedisys Hospice of the alleged abuse for a resident by a volunteer. The social worker called the Owner and Administrator were notified at . The employee/volunteer was terminated and was told to leave the premises immediately. The Agency (AAA) later called the home and spoke with an employee. They did not come to the facility because they were aware that the employee was terminated immediately. The plan of correction will be to educate all staff members and volunteers on Regulation 2600.15.a, Older Adult Protective Services Act, and expectations according to the Home's Policies and Procedures. This training will include a course offered by Pennsylvania Department of Aging covering the Mandatory Abuse Reporting Module with certificate to show completion as well as The Administrator training on the Home's Policies and Procedures. All staff and volunteers will be trained. A training sheet will be signed off on by all employees and volunteers in attendance and certificates will be gathered and placed in each employee/volunteer file. Any future allegations or rumors will be reported to DHS immediately. The allegation will be fully investigated and the employee or*

## 42b - Abuse (continued)

*volunteer will be removed from the facility until the investigation is complete. If the allegations are founded, the employee will be terminated and the proper authorities will be notified immediately. Also, in accordance with Regulation 2600.42.6, the Owner will privately interview 2 residents a week for 2 weeks and then one resident a week for another month. This interview will be in an informal, private setting. Questions that will be asked to these residents will be geared to the resident's feeling safe, free from abuse, etc. This will be on sheet of paper with the questions that were asked and the residents answers will be noted and filed in their files. Residents with dementia and other disabilities will also be interviewed to see their response, because they can have lucid moments and give legitimate answers.*

**Licensee's Proposed Overall Completion Date:** *06/30/2024* Not Implemented [redacted]/02/24)
Licensee's Proposed Date for POC Implementation

## 42s - Privacy

**6. Requirements**

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

**Description of Violation**

*Resident #1's bed extends past the frame of the doorway to the room he shares with resident #2, preventing the door from closing and causing a lack of privacy for both residents in the bedroom.*

**Plan of Correction** ***Directed [redacted]05/15/2024)***

*On 4/16/24, it was discovered that Resident 1's bed extended beyond the door frame, preventing the door from closing. Prior to this discovery, privacy screens were purchased by the home to place outside of the bedroom door and between beds in the rooms where this situation occurs. The reason the beds are so long is because the residents are on Hospice care. Hospice patients get their DME from a specific company in our local area. I called to see if there was a shorter bed available and there is not. The plan of correction will be to move the resident to a different room where the bed will fit and not extend beyond the door. The Owner reassigned Resident #1 to a different room to ensure that the door would close completely. This room change happened immediately, on 4/17/2024. The designated Administrative assistant will walk the floor monthly to be sure that all doors are functional and able to close completely in compliance with Regulation 2600.42.s.*

*Proposed Overall Completion Date: 05/31/2024*

*DIRECTED*
*Within 5 calendar days of the accepted plan of correction: The administrator shall ensure all aspects of the plan of correction have been implemented. 5/15/24* [redacted]

**Directed Completion Date:** *05/20/2024* Not Implemented ([redacted] - 08/02/24)
Licensee's Proposed Date for POC Implementation

## 54c - Volunteer

**7. Requirements**

2600.
54.c. A volunteer who performs ADLs shall meet the staff person qualifications and training requirements specified in this chapter.

**Description of Violation**

*Volunteer staff person A assisted residents with activities of daily living including eating, transferring, and personal hygiene; however, the home did not have documentation that volunteer staff person Ahad a high school diploma,*

## 54c - Volunteer (continued)

*GED or active registry status on the Pennsylvania nurse aide registry.*

**Plan of Correction** ***Directed [redacted] - 05/15/2024)***

*On 4/16/24, it was discovered that staff person A, who was a volunteer, didn't meet the staff person qualifications in compliance with Regulation 2600.54.c. That staff person/volunteer was terminated on the date of abuse incident, 4/10/24, and removed from the facility. The Administrator will audit all volunteer files moving forward to ensure that their files mirror a paid employee folder. This will include the diploma/GED, criminal background check, and will meet all qualifications required of a paid employee. This will include all new hire training that is required during the first day and first 40 hours of employment and continuous training. Volunteers will attend all required annual training and will sign on the attendance pages. An audit sheet will be created before submission of documents needed for this inspection and will be included in all current and future employees or volunteer files.*

*Proposed Overall Completion Date: 06/30/2024*

*DIRECTED*
*Within 5 calendar days of the accepted plan of correction: The administrator shall ensure all aspects of the plan of correction have been implemented. 5/15/24[redacted]*

**Directed Completion Date:** *05/20/2024*
**Licensee's Proposed Date for POC Implementation**

***Implemented [redacted] - 08/02/2024)***

## 65a - FS Orientation 1st Day

**8. Requirements**

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

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

**Description of Violation**

*Volunteer staff person A, whose first day of work was[redacted], did not receive orientation on any of the topics required under 2600.65a.*

**Plan of Correction** ***Directed [redacted] - 05/15/2024)***

*On 4/16/24, it was discovered that staff person A, who was a volunteer, didn't meet the staff person qualifications in compliance with Regulation 2600.65.a. That staff person/volunteer was terminated on the date of abuse incident, 4/10/24, and removed from the facility. The Administrator will audit all current paid employee and volunteer files to ensure that all training has been received and documented. The designated administrative assistant will audit the paid employee and volunteer files moving forward to ensure that their files mirror a paid employee folder. This will include the diploma/GED, criminal background check, and will meet all qualifications required of a paid employee. This will include all new hire training that is required during the first day and first 40 hours of employment and*

## 65a - FS Orientation 1st Day (continued)

*continuous training. Volunteers will attend all required annual training and will sign on the attendance pages. An audit sheet will be created before submission of documents needed for this inspection and will be included in all current and future employees or volunteer files.*

*Proposed Overall Completion Date: 06/30/2024*

*DIRECTED*
*Within 5 calendar days of the accepted plan of correction: The administrator shall ensure all aspects of the plan of correction have been implemented. 5/15/24*[redacted]

**Directed Completion Date:** *05/20/2024*
**Licensee's Proposed Date for POC Implementation** ***Implemented*** [redacted] ***- 08/02/2024)***

## 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**

*Volunteer staff person F assists residents with activities of daily living including eating and personal hygiene; however, the volunteer did not have at least 12 hours of annual training during training year 2023.*

**Plan of Correction** ***Directed*** [redacted] ***- 05/15/2024)***

*On 4/16/24, it was discovered that staff person A, who was a volunteer, didn't meet the annual training in compliance with Regulation 2600.65.e. That volunteer was terminated and removed from the facility. On 4/16/24. Volunteer F was removed from the schedule until they can attend all of the annual training that is required. They are scheduled to happen within the next month. The Administrator will audit Volunteer F's file to ensure that their file mirrors a paid employee folder. This will include the diploma/GED, criminal background check, and will meet all qualifications required of a paid employee. This will include all new hire training that is required during the first day and first 40 hours of employment and continuous training. Volunteers will attend all required annual training and will sign on the attendance pages. The designated administrative assistant will also audit all current employees/volunteers files have the required training. An audit will be done quarterly to ensure that all files have the proper annual training if there are new hires or new volunteers. New Hire folders will be reviewed before filing to ensure that all training has been completed. An audit sheet will be created before submission of documents needed for this inspection and will be included in all current and future employees or volunteer files.*

*Proposed Overall Completion Date: 05/30/2024*

*DIRECTED*
*Within 5 calendar days of the accepted plan of correction: The administrator shall ensure all aspects of the plan of correction have been implemented. 5/15/24*[redacted]

**Directed Completion Date:** *05/20/2024*
Licensee's Proposed Date for POC Implementation *Not Implemented* [redacted] *- 08/02/24)*

## 65f - Training Topics

**10. Requirements**

2600.

## 65f - Training Topics *(continued)*

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

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.
6. Safe management techniques.

**Description of Violation**

*Volunteer staff person F assists residents with activities of daily living including eating and personal hygiene; however, the volunteer did not received training under the topics covered under 2600.65(f) including care for residents with dementia and cognitive impairments, personal care service needs of the resident, and safe management techniques.*

**Plan of Correction** ***Directed ([redacted] 05/15/2024)***

*The immediate correction was to have an in-service with Volunteer F to cover the materials regarding Dementia Care. This information was covered by the Administrator. [redacted] has signed an attendance sheet for the training. This in-service was held on 4/18/24, [redacted] next shift to be in the facility. The plan of correction will be to educate all staff members and volunteers on Regulation 2600.65.f. This will include online training covering Caregiving Skills for Residents with Dementia as well as expectations according to the Home's Policies and Procedures. This will be a certificate course to show completion as well as The Administrator training on the Home's Policies and Procedures. All staff and volunteers will be trained. A training sheet will be signed off on by all employees and volunteers in attendance and certificates will be gathered and placed in each employee/volunteer file. This will be completed by 5/31/24. Future employee/volunteer files will be audited to ensure that they have been trained and certificates are in their folders.*

*Proposed Overall Completion Date: 06/30/2024*

*DIRECTED*
*Within 5 calendar days of the accepted plan of correction: The administrator shall ensure all aspects of the plan of correction have been implemented. 5/15/24[redacted]*

**Directed Completion Date:** *05/20/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented [redacted] - 08/02/24)

## 65g - Annual Training Content

**11. Requirements**

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

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

**Description of Violation**

*Volunteer staff person F, hired 8/30/22, did not receive training in any of the topics under 2600.65(g) during training year 2023.*

**Plan of Correction** ***Directed (JK - 05/15/2024)***

*The plan of correction will be to ensure all staff members and volunteers have the required training according to*

## 65g - Annual Training Content (continued)

*Regulation 2600.65.g. This will include all of the annual training that is mandatory. On 4/16/24. Volunteer F was removed from the schedule until they can attend all of the annual training that is required. They are scheduled to happen within the next month. Volunteers will be in attendance of this training as scheduled and will sign on all documents that they have received the proper training. All staff and volunteers will be trained. A training sheet will be signed off on by all employees and volunteers in attendance and certificates, if applicable, will be gathered and placed in each employee/volunteer file. Training is scheduled throughout the year and will be documented on the date of occurrence. Future employee/volunteer files will be audited to ensure that they have been trained and certificates are in their folders.*

*Proposed Overall Completion Date: 06/30/2024*

*Proposed Overall Completion Date: 05/31/2024*

*DIRECTED*
*Within 5 calendar days of the accepted plan of correction: The administrator shall ensure all aspects of the plan of correction have been implemented. 5/15/24*[redacted]

**Directed Completion Date:** *05/20/2024*
Licensee's Proposed Date for POC Implementation

*Not Implemented ([redacted] - 08/02/24)*

## 91 - Telephone Numbers

**12. Requirements**

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

**Description of Violation**

*There were no emergency telephone numbers to include the nearest hospital and fire department on or by the portable telephone in the hallway near bedroom #6.*

**Plan of Correction** ***Accept [redacted] - 05/06/2024)***

*on 4/16/24, it was determined that there were no emergency phone numbers by the phone in the hallway. This phone was just placed there the day before by the Administrator. This phone was placed in the hallway to make it more accessible to staff members in the back of the house to be able to answer the phone. The emergency phone numbers were printed, but needed to be laminated, which is why it wasn't present at the time of the walkthrough. The emergency phone numbers were placed next to the phone on 4/17/24, after laminating it. The Administrator will ensure monthly that phone numbers are present by every telephone with an outside line in accordance with Regulation 2600.91.*

**Licensee's Proposed Overall Completion Date:** *05/31/2024*
**Licensee's Proposed Date for POC Implementation**

***Implemented [redacted] - 08/02/2024)***

## 102i - Soap Dispenser

**13. 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.

## 102i - Soap Dispenser *(continued)*

**Description of Violation**

*At 1:02 p.m., the soap dispenser in the kitchen bathroom was empty, and there was no other means to follow sanitary hand washing practices.*

**Plan of Correction** ***Directed ( - 05/15/2024)***

*On 4/16/24, it was discovered that the kitchen bathroom was without hand soap. After the inspection was over, on the same day, hand soap was brought into the home by the Owner and placed on the sink. The following day, hand soap was brought in from the owner's own residence and placed in the storage area for backup measures to prevent running out in the future. This training will happen during the staff meeting on 5/10/24. All employees and volunteers will sign the roster sheet that they are in attendance of the meeting and understand Regulation 2600.102.i. Employees will be trained by the Owner, who does, the shopping, to communicate the needs of soaps, paper towels, etc. The monitoring of this started after the staff meeting on 5/10/24 and will be monitored nightly by the midnight staff person on schedule and will notify owner or Administrator immediately if there is no soap in any of the restrooms. This training will happen during the staff meeting on 5/10/24. All employees and volunteers will sign the roster sheet that they are in attendance of the meeting and understand Regulation 2600.102.i.*

*Proposed Overall Completion Date: 05/31/2024*

*DIRECTED*
*Within 5 calendar days of the accepted plan of correction: The administrator shall ensure all aspects of the plan of correction have been implemented. 5/15/24*

**Directed Completion Date:** *05/20/2024*
Licensee's Proposed Date for POC Implementation ***Implemented - 07/25/2024)***

## 121a - Unobstructed Egress

**14. Requirements**

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

**Description of Violation**

*The doorway in resident #1's and resident #2's bedroom is partially blocked by resident #1's bed.*

**Plan of Correction** ***Directed ( - 05/15/2024)***

*On 4/16/24, it was discovered that Resident 1's bed extended beyond the door frame, preventing the door from closing. This violated Regulation 2600.121.3 wherein doorways and egress routes from rooms must be unlocked and unobstructed. Prior to this discovery, privacy screens were purchased by the home to place outside of the bedroom door and between beds in the rooms where this situation occurs. The reason the beds are so long is because the residents are on Hospice care. Hospice patients get their DME from a specific company in our local area. I called to see if there was a shorter bed available and there is not. The plan of correction will be to move the resident to a different room where the bed will fit and not extend beyond the door. Resident #1 and Resident #2 share a room. Resident #1 was on the door side. This room change happened immediately, The afternoon shift staff person will ensure daily that all doors are functional and able to close completely in compliance with Regulation 2600.121.a. This will happen starting on 5/13/24 when they put the residents to bed for the evening and will happen every evening. If there are any issues, that person will alert the Administrator and actions will be taken to rectify the situation. Also, because the is Hospice DME equipment, Hospice residents will be placed on the window side of the*

## 121a - Unobstructed Egress (continued)

*room to ensure that the escape routes are cleared from any furniture or debris.*

*Proposed Overall Completion Date: 05/31/2024*

*DIRECTED*
*Within 5 calendar days of the accepted plan of correction: The administrator shall ensure all aspects of the plan of correction have been implemented. 5/15/24*[redacted]

**Directed Completion Date:** *05/20/2024*
**Licensee's Proposed Date for POC Implementation** ***Implemented*** [redacted] ***- 08/02/024)***

## 225a - Assessment 15 Days

**15. 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 #1 was admitted to the home on* [redacted]*; however, an initial assessment was not completed.*

*REPEAT VIOLATION: 6/29/2023; 3/8/2023*

**Plan of Correction** ***Directed*** [redacted] ***- 05/15/2024)***

*On* [redacted]*, it was discovered that the initial assessment wasn't completed on Resident #1. This form was not in the resident's folders, however it was in Tabula Pro. I didn't realize that it was completed in Tabula Pro until after the inspection. To ensure that all resident's folders are complete with the assessment in their folder, the Administrator will print out the assessment upon completion and place in the resident folders. This will ensure that it is present when an employee or state representative needs to access their information. The Administrator will audit all current residents to ensure that the assessment is present. This audit will occur by 5/31/24 and all new resident folders will be audited before filing to ensure that the assessment is present before filing.*

*Proposed Overall Completion Date: 06/15/2024*

*DIRECTED*
*Within 5 calendar days of the accepted plan of correction: The administrator shall ensure all aspects of the plan of correction have been implemented. 5/15/24*[redacted]

**Directed Completion Date:** *05/20/2024*
**Licensee's Proposed Date for POC Implementation** ***Implemented*** [redacted] ***- 08/02/2024)***

Department of Human Services
Bureau of Human Service Licensing

# LICENSING INSPECTION SUMMARY - PUBLIC

## Facility Information

**Name:** *THE GATHERING PLACE PERSONAL CARE* **License #:** *45417* **License Expiration:** *12/13/2024*

**Address:** *390 MOUNTAIN ROAD, UNIONTOWN, PA 15401*

**County:** *FAYETTE* **Region:** *WESTERN*

## Administrator

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

## Legal Entity

**Name:** *THE GATHERING PLACE PERSONAL CARE LLC*

**Address:** [redacted]

**Phone:** [redacted]

## Certificate(s) of Occupancy

**Type:** *C-2 LP* **Date:** *02/06/1993* **Issued By:** *Dept of L&I*

**Type:** *Other* **Date:** *08/12/1992* **Issued By:** *Dept of L&I*

## Staffing Hours

**Resident Support Staff:** *0* **Total Daily Staff:** *14* **Waking Staff:** *11*

## Inspection Information

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

**Reason:** *Complaint, Incident, Monitoring* **Exit Conference Date:** *06/24/2024*

## Inspection Dates and Department Representative

*06/05/2024 - On-Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity:** *16* **Residents Served:** *12*

### Secured Dementia Care Unit

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

### Hospice

**Current Residents:** *4*

### Number of Residents Who:

**Receive Supplemental Security Income:** *0* **Are 60 Years of Age or Older:** *12*

**Diagnosed with Mental Illness:** *1* **Diagnosed with Intellectual Disability:** *0*

**Have Mobility Need:** *2* **Have Physical Disability:** *1*

# Inspections / Reviews

## 06/05/2024 - Partial

**Lead Inspector:** *Scott Klein* **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/04/2024*

**07/15/2024 - POC Submission**

**Submitted By** [redacted] **Date Submitted:** *07/24/2024*

**Reviewer:** [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/22/2024*

**07/19/2024 - POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *07/24/2024*

**Reviewer:** [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/25/2024*

**07/25/2024 - Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *07/24/2024*

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

## 5a1 - DHS Access

**1. 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 [redacted] resident #2's DNR was requested by agents of the Department and the documentation was not provided to the Department until [redacted]*

**Plan of Correction** ***Accept ([redacted] - 07/19/2024)***

*2600.42.b Resident #2 DNR was given the following day because the Hospice Dr. needed to sign the document. This was provided by the Hospice agency upon request. To prevent this from happening in the future, the Administrator trained staff members on 7/17/24 on where to find the resident folders in the event that it is requested by Agents of the Department or EMS employees. This document of education will be kept in accordance with Regulation 2600.65(i). An audit was completed on 7/17/24 to ensure that all resident records are complete, accurate, and available upon request. An audit will be performed within the first week of admission to the home or Hospice program to ensure that the resident folder is complete. A monthly audit will also be done by the Administrator's designated person to ensure that the resident file is complete. This audit documentation will be kept in the resident folder. A wrist band will also be placed on the resident's wrist or ankle to prevent delay in treatment or stop employees from performing CPR.*

**Licensee's Proposed Overall Completion Date:** *07/17/2024* Not Implemented [redacted] - 08/02/24)
Licensee's Proposed Date for POC Implementation

## 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 resident #1's date of death at approximately [redacted] direct care staff person A entered resident #1's room to check the resident for incontinence care needs. Direct care staff person A stated that resident #1 was lying in bed and having trouble breathing on entry to the room indicating the resident was breathing in a "Death Rattle". Direct care staff person A proceeded to change the resident's adult brief and not notify emergency medical services. After direct care staff person A completed the resident's adult brief change, [redacted] noticed the resident was no longer breathing.*

*Upon emergency medical services being dispatched at [redacted] it was advised that cardiopulmonary resuscitation (CPR) was being performed. However, at approximately [redacted] on arrival of emergency medical services, CPR was not being performed and at [redacted] the resident was found pulseless and apneic alone in bed and there were no signs of attempts to perform CPR according to the emergency medical services providers. Staff person A was unable to provide information related to the resident's resuscitation status to include a Pennsylvania Orders for Life-Sustaining Treatment (POLST) form, an out of hospital do not resuscitate order, or any document accepted by the home's local emergency medical services responders. Resuscitation efforts by emergency medical services began at [redacted] and continued until [redacted] after there was no response to the effort.*

**Plan of Correction** ***Accept [redacted] - 07/19/2024)***

*2600.42.b Resident #1 was an emergency transfer from a PCH that sent all of their residents to the emergency room and then closed the facility while they were gone. The resident had no where else to go. Because she was brought*

## 42b - Abuse (continued)

*in on an emergency situation, her file was not yet in the computer. The paper file was on the Administrators desk and easily accessible to the employee working at the time.*

*The Administrator trained staff members on 7/17/24 on where to find the resident folders in the event that it is requested by Agents of the Department or EMS employees. This document of education will be kept in accordance with Regulation 2600.65(i). Staff Member A no longer works for the facility in order to receive training.*

*On 7/17/24, all staff members were also trained on how to identify and recognize changes in a resident's condition and what to do if a change happens. They were all trained on where to find the phone numbers and contacts of who to notify of all changes and who will be responsible for providing this information to the Agents or EMS in accordance with the Older Adult Protective Services Act, as well as the home's policies and procedures related to conveying information to Agents or EMS. All current staff were CPR trained and certificates were obtained. They were also trained on the new armband policy to know if and when to start CPR. This documentation of training will be kept in accordance with Regulation 200.65(i).*

*An audit was completed on 7/17/24 to ensure that all resident records are complete, accurate, and available upon request. An audit will be performed within the first week of admission to the home or Hospice program to ensure that the resident folder is complete. A monthly audit will also be done by the Administrator's designated person to ensure that the resident file is complete. This audit documentation will be kept in the resident folder.*

*The POLST will also be found on the outside sleeve of all residents. POLSTs will also become part of the admission paperwork so that, moving forward, all residents have them within access. All CPR certificates that were needed will be attached when request for documentation is sent.*

*A questionnaire was created to interview residents privately. The Administrator will interview at least three residents a week for three months and then three residents a monthly to ensure that residents are receiving timely and appropriate medical care. This questionnaire will also include overall satisfaction questions so that things can be brought to the attention of staff of any issues that might need addressed. These questionnaires will be kept in separate folder and available upon request by the Agent.*

**Licensee's Proposed Overall Completion Date:** *07/27/2024* Not Implemented [redacted] - 08/02/24)
Licensee's Proposed Date for POC Implementation

## 42s - Privacy

**3. Requirements**

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

**Description of Violation**

*The home has six cameras that have the capability to audio and video record. Direct care staff person B, the home's administrator, indicated the applications for the cameras are currently set to audio and video record and the administrator has access to use the camera applications.*

**Plan of Correction** ***Accept [redacted] 07/19/2024)***

*2600.42.s. states that a resident has the right to privacy of self and possessions. Cameras are only in the common areas of the home such as hallways, entrances, laundry, medication cart, etc. On 6/5/24, it was discussed that cameras cannot record audio or video. At that time, the Administrator changed the settings to only be accessible in*

## 42s - Privacy (continued)

*real time. There is no recording on the cameras effective 6/5/24. All cameras are set to live with no audio or recording capabilities. All residents and family members are aware of the cameras. Bathrooms and bedrooms have no view of the cameras. 07/7/17/24, all staff were retrained by the owner and Administrator on audio or video recording devices being prohibited from being used in any resident area. Documentation of training will be kept in accordance with Regulation 2600.42(s). The Owner or Administrator will walk through the facility during all shifts to ensure that cell phones are not being used by employees. This will begin on 7/20/24 and will continue on a weekly basis.*

**Licensee's Proposed Overall Completion Date:** *07/20/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented ([redacted]- 08/02/24)
***Implemented (JK - 07/25/2024)***

## 57a - Designee Present/Age

**4. Requirements**

2600.
57.a. At all times one or more residents are present in the home a direct care staff person who is 21 years of age or older and who serves as the designee, shall be present in the home. The direct care staff person may be the administrator if the administrator provides direct care services.

**Description of Violation**

*Volunteer staff person C and volunteer staff person D are not employees of the home. There was no direct care staff employee present in the home during the dates and times as follows:*

- *On [redacted] Only volunteer staff person C was present.*
- *On [redacted] Only volunteer staff person D was present.*
- *On [redacted] n. Only volunteer staff person D was present.*
- *On [redacted] n. Only volunteer staff person D was present.*
- *On [redacted] m. Only volunteer staff person C was present.*
- *On [redacted] Only volunteer staff person C was present.*
- *On [redacted] n. Only volunteer staff person D was present.*
- *On [redacted] n. Only volunteer staff person D was present.*
- *On [redacted] m. Only volunteer staff person C was present.*
- *On [redacted] Only volunteer staff person C was present.*
- *On [redacted] m. Only volunteer staff person C was present.*
- *On [redacted] Only volunteer staff person C was present.*
- *On [redacted] n. Only volunteer staff person D was present.*
- *On [redacted] n. Only volunteer staff person D was present.*
- *On [redacted] Only volunteer staff person D was present.*
- *On [redacted] Only volunteer staff person C was present.*
- *On [redacted] Only volunteer staff person C was present.*
- *On [redacted] Only volunteer staff person D was present.*
- *On [redacted] Only volunteer staff person C was present.*
- *On [redacted] Only volunteer staff person C was present.*
- *On [redacted] Only volunteer staff person D was present.*
- *On [redacted] Only volunteer staff person D was present.*
- *On [redacted] Only volunteer staff person D was present.*
- *On [redacted] Only volunteer staff person C was present.*
- *On [redacted] Only volunteer staff person D was present.*

## 57a - Designee Present/Age (continued)

- On [redacted] m. Only volunteer staff person C was present.
- On [redacted] n. Only volunteer staff person D was present.
- On [redacted] n. Only volunteer staff person C was present.
- On [redacted] Only volunteer staff person C was present.
- On [redacted] n. Only volunteer staff person C was present.
- On [redacted] Only volunteer staff person C was present.
- On [redacted] Only volunteer staff person D was present.
- On [redacted] Only volunteer staff person D was present.
- On [redacted] Only volunteer staff person C was present.
- On [redacted] Only volunteer staff person C was present.

**Plan of Correction** ***Accept [redacted] 07/19/2024)***

*Beginning the week of 7/21/24, the Owner will write the schedule to include a paid staff member to be present during the times that a volunteer is on the schedule. This will ensure that a staff member is able to act as the designee should any information be requested by the Agency or EMS. The Administrator will review the weekly schedules before they are posted to ensure that there are no volunteers in the home without a paid staff member. This is in compliance with Regulation 2600 63(a)*

**Licensee's Proposed Overall Completion Date:** *07/21/2024* Not Implemented [redacted] - 08/02/24)
Licensee's Proposed Date for POC Implementation

## 63a - First Aid/CPR Training

**5. Requirements**

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

**Description of Violation**

*During the dates and times indicated direct care staff person A was the only staff person present in the home. Direct care staff person A is not trained in first aid and certified in obstructed airway techniques and CPR.*

- [redacted] there were 11 residents present in the home.
- here were 11 residents present in the home.
- there were 11 residents present in the home.
- here were 11 residents present in the home.
- there were 11 residents present in the home.
- here were 11 residents present in the home.
- there were 11 residents present in the home.
- there were 12 residents present in the home.
- here were 12 residents present in the home.
- there were 12 residents present in the home.
- here were 12 residents present in the home.
- there were 13 residents present in the home.
- here were 13 residents present in the home.
- there were 13 residents present in the home.
- here were 13 residents present in the home.
- there were 13 residents present in the home.
- here were 13 residents present in the home.
- there were 14 residents present in the home.

63a - First Aid/CPR Training (continued)

[redacted]

During the dates and times indicated direct care staff person C was the only staff person present in the home. Direct care staff person C is not trained in first aid and certified in obstructed airway techniques and CPR.

[redacted]

**Plan of Correction** ***Accept ([redacted] 07/19/2024)***

*On 6/5/24, it was determined at the time of the inspection that there were a couple of employees who had an expired CPR certification. Since the inspection, all employees who needed the certification has been through the class and certificates were obtained. Certificates will be provided during documentation submission.*

*Beginning the week of 7/21/24, the Owner will write the schedule to include a CPR certified staff member to be present at all times in the facility. The Administrator will review the weekly schedules before they are posted to ensure that there is a CPR certified employee in the home at all times in order to be compliant with Regulation 2600.63(a)*

*The CPR expirations of all employees will be logged in the planner to ensure that they are renewed before their*

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

*expiration dates.*

**Licensee's Proposed Overall Completion Date:** *07/21/2024* Not Implemented [redacted] 08/02/24)
Licensee's Proposed Date for POC Implementation

## 63d - Certified CPR Staff

**6. Requirements**

2600.
63.d. A staff person who is trained in first aid or certified in obstructed airway techniques or CPR shall provide those services in accordance with his training, unless the resident has a do not resuscitate order.

**Description of Violation**

*On resident #1's date of death at approximately [redacted] direct care staff person A entered resident #1's resident room to check the resident for incontinence care needs. Direct care staff person A stated that resident #1 was lying in bed and experiencing difficulty breathing on entry to the room, and began to provide incontinence care. Direct care staff person A stated the resident let out a sound like a "death rattle" gasp, however, direct care staff person A continued to change the resident's brief and did not call for emergency medical services until the resident had ceased to breathe. Upon emergency medical services being dispatched at [redacted] was advised that cardiopulmonary resuscitation (CPR) was being performed. However, at approximate [redacted] on arrival of emergency medical services, CPR was not being performed and at [redacted] the resident was found pulseless and apneic alone in bed and there were no signs of attempts to perform CPR. The home was unable to provide information related to the resident's resuscitation to include a Pennsylvania Orders for Life-Sustaining Treatment (POLST) form, an out of hospital do not resuscitate order, or any document accepted by the home's local emergency medical services responders.*

*On resident #2's date of death, emergency medical services responded to the home, and the home was unable to provide information related to resident #2's resuscitation to include a Pennsylvania Orders for Life-Sustaining Treatment (POLST) form, an out of hospital do not resuscitate order (DNR), or any document accepted by the home's local emergency medical services responders. On [redacted] resident #2's DNR was requested by agents of the Department and the documentation was not provided to the Department until [redacted]*

**Plan of Correction** ***Directed ([redacted] - 07/19/2024)***

*Resident #1 was a emergency transfer from a PCH that sent all of their residents to the emergency room and then closed the facility while they were gone. The resident had no where else to go. Because she was brought in on an emergency situation, her file was not yet in the computer. The paper file was on my desk and easily accessible to the employee working at the time. Staff Member A is no longer employed at the facility. Staff Member B is the Administrator.*
*On 6/10/24, all staff members were trained in CPR and all have received their cards. Certificates will be provided during documentation submission.*
*Beginning the week of 7/21/24, the Owner will write the schedule to include a CPR certified staff member to be present at all times in the facility. The Administrator will review the weekly schedules before they are posted to ensure that there is a CPR certified employee in the home at all times in order to be compliant with Regulation 2600.63(a)*
*The CPR expirations of all employees will be logged in the planner to ensure that they are renewed before their expiration dates. This is in compliance of Regulation 2600.63(d)*

## 63d - Certified CPR Staff (continued)

*Proposed Overall Completion Date: 07/21/2024*

*DIRECTED*
*Within five calendar days or receipt of the accepted plan of correction: The administrator shall educate all staff persons regarding Regulation 2600.63(d) and the home's policy and procedures. Documentation of education will be kept in accordance with Regulation 2600.65(i). 7/19/24 JK*

*Within one day of receipt of the accepted plan of correction: The administrator shall audit any events where a resident passes in the home to determine if the appropriate measures were taken in accordance with Regulation 2600.63(d). 7/19/24* [redacted]

**Directed Completion Date:** *07/24/2024* Not Implemented [redacted] - 08/02/24)
Licensee's Proposed Date for POC Implementation

## 109b - Rabies Vaccination

**7. 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**

*The current certificate of rabies vaccination for the home's female pet cat named "Caroline" indicated the rabies vaccination was due on 3/17/24.*

*The current certificate of rabies vaccination for the home's male pet cat named "Blam" indicated the rabies vaccination was due on 3/22/24.*

**Plan of Correction** ***Accept*** [redacted] ***07/19/2024)***

*2600.109.b. The cats were to go to the walk-in clinic the morning of the inspection. Because of the inspection, we could not take them to the vet. They were taken to the next open walk in clinic on 6/10/2024 and vaccinated. Vaccination reports will be provided at time of submission.*
*The vaccination dates will be written in the daily planner on the first day of the month that vaccinations are due to ensure that they are taken to the vet in time before the deadline. This will be monitored by the Administrator, as she is the one who schedules appointments and references the planner on a daily basis.*

**Licensee's Proposed Overall Completion Date:** *07/17/2024* Implemented [redacted] - 08/02/24)
Licensee's Proposed Date for POC Implementation ***Implemented (JK - 07/25/2024)***

## 132a - Monthly Fire Drill

**8. Requirements**

2600.
132.a. An unannounced fire drill shall be held at least once a month.

**Description of Violation**

*The home did not conduct an unannounced fire drill during the month of May 2024.*

*REPEAT VIOLATION 3/8/23*

**Plan of Correction** ***Directed*** [redacted] ***07/19/2024)***

*AGAIN, I DON'T HAVE A CORRECTIVE ACTION BECAUSE THIS ISN'T A REPEAT VIOLATION. THE DATES WERE*

## 132a - Monthly Fire Drill (continued)

*NOT NOT REQUESTED SO THEY WERE NOT PROVIDED. A DRILL WAS DONE. I AM NOT SURE WHAT YOU ARE WANTING ME TO PUT HERE. PLEASE ADVISE!!!*

*2600 132.a. When speaking with [redacted] requested fire drill records from [redacted] didn't ask for [redacted] A fire drill was, in fact, completed on [redacted] This is not a repeat violation. This was not part of the request. I will attach a copy of the fire drill upon acceptance and request for documentation.*

*Proposed Overall Completion Date: 07/17/2024*

*DIRECTED*
*Within five calendar days or receipt of the accepted plan of correction: The administrator shall educate all staff persons on the requirements of Regulation 2600.132(a) and the home's policy and procedures for maintaining compliance with the regulation. Documentation shall be kept in accordance with Regulation 2600.65(i). 7/19/24 JK*

*Within one calendar day or receipt of the accepted plan of correction:*
*The administrator shall audit the home's fire drill record monthly to ensure an unannounced fire drill shall be held at least once a month. 7/19/24 JK*

**Directed Completion Date:** *07/24/2024*
Licensee's Proposed Date for POC Implementation

Implemented [redacted] - 08/02/24)
***Implemented (JK - 07/25/2024)***

## 132b - Safety Inspection/Fire Drill

**9. 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 home's most recent fire safety inspection and supervised fire drill conducted by a fire safety expert was held on 12/3/22.*

**Plan of Correction** ***Directed [redacted] 07/19/2024)***

*Upon the inspection on 6/5/24, it was discovered that the fire safety inspection was not completed. Upon this discovery, the local Fire Department was called and an inspection was completed. That inspection was completed by Lieutenant Levi Fox from the Fairchance Fire Department on 6/12/24. A fire drill was completed at this time and a revised time from the original Fire Evacuation Time. The time to evacuate was 2:27, exceeding the allotted time of 2:45.*
*To ensure that an annual fire drill by the local fire department is done, a 3 year planner was purchased and these renewal dates were placed in the planner for the month of May all three years to ensure that the inspections are done in a timely fashion. The Administrator schedules appointments are will have access to the planner on a daily basis. A copy of the certification will be provided at time of submission.*

*Proposed Overall Completion Date: 07/17/2024*

*DIRECTED*
*Within five calendar days of the accepted plan of correction: The administrator shall have a fire drill conducted by a fire safety expert. Documentation of the fire drill shall be documented in accordance with Regulation 2600.132c.*

## 132b - Safety Inspection/Fire Drill (continued)

7/19/24 JK

Within one calendar day of the accepted plan of correction: The administrator shall audit the scheduling and completion of the requirements of Regulation 2600.132(b) through the quality management review process. Documentation shall be kept in the quality management review documents. 7/19/24 JK

**Directed Completion Date:** 07/24/2024
Licensee's Proposed Date for POC Implementation

Implemented [redacted] - 08/02/24)
***Implemented (JK - 07/25/2024)***

## 132d - Evacuation

**10. Requirements**

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

**Description of Violation**

*The home does not have a fire safe evacuation time designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. Therefore, the home must meet a s minute and 30 second safe evacuation time. On the following dates and times the home exceeded the 2 minute and 30 second safe evacuation time:*

- *On [redacted] with an evacuation time of 2 minutes and 37 seconds.*
- *On [redacted] with an evacuation time of 2 minutes and 46 seconds.*
- *On [redacted] with an evacuation time of 3 minutes and 25 seconds.*
- *On [redacted] with an evacuation time of 3 minutes and 47 seconds.*
- *On [redacted] with an evacuation time of 3 minutes and 56 seconds*
- *On [redacted] with an evacuation time of 3 minutes and 59 seconds*
- *On [redacted] with an evacuation time of 3 minutes and 22 seconds.*
- *On [redacted] with an evacuation time of 3 minutes and 18 seconds.*
- *On [redacted] with an evacuation time of 3 minutes and 7 seconds.*
- *On [redacted] with an evacuation time of 3 minutes and 16 seconds.*
- *On [redacted] with an evacuation time of 3 minutes and 34 seconds.*
- *On [redacted] with an evacuation time of 3 minutes and 28 seconds*
- *On [redacted] with an evacuation time of 3 minutes and 8 seconds*

**Plan of Correction** ***Directed [redacted] - 07/19/2024)***

*Upon the inspection on 6/5/24, it was discovered that the fire safety inspection was not completed. Upon this discovery, the local Fire Department was called and an inspection was completed in order to have a target time. That inspection was completed by Lieutenant [redacted] from the Fairchance Fire Department on 6/12/24. A copy of the certification will be provided at time of submission.*

*A fire drill was completed at this time and a revised time from the original Fire Evacuation Time was given. The time to evacuate was 2:27, not exceeding the allotted time of 2:45 that was given during the inspection.*

*On 7/17/24, during the training day, staff members were trained by [redacted] Owner, and the Administrator on more efficient ways to ensure the safety of all residents and employees in the event of an actual fire. Each*

## 132d - Evacuation (continued)

*resident was educated on our evacuation procedure in order to ensure their safety in the event of an actual emergency. Documentation will be kept in accordance with Regulation 2600.65(i). We will conduct additional fire drills until the 2:45 time limit can be met. All attempts will be made to relocate residents with mobility needs closer to an exit in order to evacuate easier. Additional staff may be added to the schedule if the overnight shift with one person cannot meet the required evacuation time.*

*To ensure that an annual fire drill by the local fire department is done, a 3 year planner was purchased and these renewal dates were placed in the planner for the month of May all three years to ensure that the inspections are done in a timely fashion. The Administrator schedules appointments are will have access to the planner on a daily basis.*

*Proposed Overall Completion Date: 08/30/2024*

*DIRECTED*
*Within one calendar day of receipt of the accepted plan of correction the administrator shall audit the home's fire drill record monthly to ensure compliance with Regulation 2600.132(d). 7/19/24* [redacted]

*Within five calendar days of the accepted plan of correction: The administrator shall initiate all steps in the accepted plan of correction. 7/19/24* [redacted]

**Directed Completion Date:** *07/24/2024* Not Implemented [redacted] - 08/02/24)
Licensee's Proposed Date for POC Implementation

## 132g – Fire Drills Days/Times

**11. Requirements**

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

**Description of Violation**

*The homes most recent sleeping hours fire drills were held as follows:*

- [redacted]

*The home's schedule only demonstrates one staff person during sleeping hours from 11:00 p.m. to 7:00 a.m., however, the home's most recent sleeping hours fire drills held on 5/22/23, 10/14/23, and 3/16/24 all indicated two staff persons participated in the fire drill.*

*The home's schedule only demonstrates one staff person on 4/21/23 from 3:00 p.m. to 11:00 p.m., however, the fire drill record from 4/21/23 at 5:30 p.m. indicated two staff persons participated in the fire drill.*

*The home's schedule only demonstrates one staff person on 7/12/23 from 3:00 p.m. to 11:00 p.m., however, the fire drill record from 7/12/23 at 4:00 p.m. indicated two staff persons participated in the fire drill.*

*The home's schedule only demonstrates one staff person on 2/20/24 from 3:00 p.m. to 11:00 p.m., however, the fire*

## 132g - Fire Drills Days/Times (continued)

*drill record from 2/20/24 at 8:30 p.m. indicated two staff persons participated in the fire drill.*

**Plan of Correction** ***Directed [redacted] - 07/19/2024)***

*Regulation 2600.132g states that fire drills need to not be routinely held. It was found that the overnight fire drills were held too close in the 11pm time frame. Moving forward, a fire drill will be held between the hours of midnight and 6am. The person conducting the fire drill will not participate in the evacuation because on any normal overnight shift, that second person isn't present. The times will be documented with how long it takes that one person on the overnight to evacuate the building. If it is determined that the 2:45 time frame cannot be met with one person, administration will look into moving rooms around in order to get the less mobile residents closer to an exit. Additional fire drills will be held by the designated employee representative in order to practice the evacuation process. If needed, an additional staff member may be added in order to streamline the process.*

*Proposed Overall Completion Date: 07/31/2024*

*DIRECTED*
*Within five calendar days of receipt of the accepted plan of correction: The administrator shall conduct a sleeping hour fire drill at an alternate time using only the regular scheduled staff. Documentation shall be kept in accordance with Regulation 2600.132(c), 7/19/2[redacted]*

*Within five calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the requirements of Regulation 2600.132(g) and the home's policy and procedures to maintain compliance with the regulation. Documentation of education shall be kept in compliance with Regulation 2600.65(i). 7/19/24 JK*

*Within five calendar days of the accepted plan of correction: The administrator shall initiate all steps in the accepted plan of correction. 7/19/24 [redacted]*

**Directed Completion Date:** *07/24/2024* Not Implemented [redacted] - 08/02/24)

Licensee's Proposed Date for POC Implementation

## 142a - Secure Medical Care

**12. Requirements**

2600.
142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

**Description of Violation**

*On date of death #1 at approximately [redacted] direct care staff person A found resident #1 in bed having difficulty breathing and expressing a "death rattle" gasp. However, direct care staff person A continued to change the resident's brief and did not call for emergency medical services until the resident had ceased to breathe.*

**Plan of Correction** ***Directed [redacted] 07/19/2024)***

*At the time of Resident #1's death, the staff person continued to change the resident instead of calling for emergency medical services. The employee has been retrained by the Administrator and the owner as to protocol when encountering a resident near end of life and how to prioritize the situation.*

*On 7/17/24, all staff members were also trained by [redacted] LPN and owner, on how to identify and recognize changes in a resident's condition and what to do if a change happens. They were all trained on where to*

## 142a - Secure Medical Care (continued)

*find the phone numbers and contacts of who to notify of all changes and who will be responsible for providing this information to the Agents or EMS in accordance with the Older Adult Protective Services Act, as well as the home's policies and procedures related to conveying information to Agents or EMS.*

*A questionnaire will be generated to interview residents on their thoughts as to the services offered at the facility. This includes their feelings on the standard of care, timeliness of response to concerns, etc. The Administrator will interview 3 residents a week for three months and three residents per month thereafter to ensure that concerns are being met. These interviews will begin on 8/1/24 and will be performed by the Administrator. Results of the questionnaires will be discussed with staff to ensure that everyone is cared for appropriately. Resident interviews will be kept in a binder.*

*On 7/17/24, staff members were also trained on the new armband policy to know if and when to start CPR. This documentation of training will be kept in accordance with Regulation 200.65(i).*

*Proposed Overall Completion Date: 08/31/2024*

*DIRECTED*
*Within five calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the requirements of Regulation 2600.142(a) and the home's policy and procedures to maintain compliance with the regulation. Documentation of education shall be kept in compliance with Regulation 2600.65(i).*
*7/19/24* [redacted]

**Directed Completion Date:** *07/24/2024* Not Implemented ([redacted] - 08/02/24)
Licensee's Proposed Date for POC Implementation

## 143b - Residents Medical Information

**13. Requirements**

2600.
143.b. The following current emergency medical and health information shall be available at all times for each resident and shall accompany the resident when the resident needs emergency medical attention:

1. The resident's name and birth date.
2. The resident's Social Security number.
3. The resident's medical diagnosis.
4. The resident's physician's name and telephone number.
5. Current medication, including the dosage and frequency.
6. A list of allergies.
7. Other relevant medical conditions.
8. Insurance or third party payer and identification number.
9. The power of attorney for health care or health care proxy, if applicable.
10. The resident's designated person with current address and telephone number.
11. Personal information and related instructions regarding advance directives, do not resuscitate orders or organ donation, if applicable.

**Description of Violation**

*On resident #1's date of death at approximately* [redacted] *direct care staff person A entered resident #1's room to check the resident for incontinence care needs. Direct care staff person A stated that resident #1 was lying in bed and having trouble breathing on entry to the room indicating the resident was breathing in a "Death Rattle". Direct care staff person A proceeded to change the resident's adult brief and not notify emergency medical services. After direct care staff person A completed the resident's adult brief change, he noticed the resident was no longer breathing, then*

## 143b - Residents Medical Information (continued)

*called emergency medical services.*

*Upon emergency medical services being dispatched at [redacted] it was advised that cardiopulmonary resuscitation (CPR) was being performed. However, at approximate[redacted] on arrival of emergency medical services, CPR was not being performed and at [redacted] the resident was found pulseless and apneic alone in bed and there were no signs of attempts to perform CPR according to the emergency medical services providers. Staff person A was unable to provide information related to the resident's resuscitation status to include a Pennsylvania Orders for Life-Sustaining Treatment (POLST) form, an out of hospital do not resuscitate order, or any document accepted by the home's local emergency medical services responders. Resuscitation efforts by emergency medical services began at [redacted] and continued until [redacted] after there was no response to the effort.*

*On resident #2's date of death, emergency medical services responded to the home, and the home was unable to provide information related to resident #2's resuscitation to include a Pennsylvania Orders for Life-Sustaining Treatment (POLST) form, an out of hospital do not resuscitate order (DNR), or any document accepted by the home's local emergency medical services responders*

**Plan of Correction** ***Directed ([redacted] - 07/19/2024)***

*On [redacted] it was determined that pertinent information was not readily available to EMS and/or DHS upon request. The DNR information for Resident #1 was on the Administrators desk in a folder. The employee working only had to look in her folder for the DNR. Resident #2 didn't have one in the house because the Hospice doctor needed to sign his. The immediate corrective action was to have the DNR sent from Hospice and placed in [redacted] file. This was completed by the Administrator. Education was provided by the Administrator on 7/17/24 during the training sessions that were scheduled as to educate staff on where the information will be kept in order to have information readily available to Agents or EMS, upon request. In order to prevent the use of CPR or the delay of treatment, the home has adopted the use of red and green wrist/ankle bands. These will be placed on the resident's wrist or ankle once the POLST is signed by both resident and doctor. The POLST will be stored in the back outside sleeve of the resident file for everyone to have access to. This will include the resident, resident's designated person, staff member, EMS, etc. This will be added to the New Resident Checklist to ensure that all information is available and the checklist will be filled out with each new resident. The resident folder will not be filed until all information is received. The checklist will be done by the Administrator and the Administrator's designated person will go through the file to ensure that everything is present.*

*Proposed Overall Completion Date: 07/19/2024*

*DIRECTED*
*Within five calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the requirements of Regulation 2600.143(b) and the home's policy and procedures to maintain compliance with the regulation. Documentation of education shall be kept in compliance with Regulation 2600.65(i). 7/19/24 JK*

**Directed Completion Date:** *07/24/2024* Not Implemented (JK - 08/02/24)
Licensee's Proposed Date for POC Implementation

## 224a - Preadmission Screen Form

**14. Requirements**

2600.

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

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

**Description of Violation**

*The preadmission screening form for resident #1, dated [redacted] did not indicate that the home could meet the resident's needs.*

*REPEAT VIOLATION 3/8/23, 6/29/23*

**Plan of Correction** ***Directed [redacted] - 07/19/2024)***

*This completed form was in the Tabula Pro program. An audit was performed on 6/20/24 by the designated Administrative assistant of all resident files to ensure that the Tabula Pro copy of the pre-screen form was completed fully, ensuring that all of the questions were answered, and was printed and placed in the residents file, replacing the original, hand-written one. Resident #1 no longer resides in the facility, but one was printed and put in [redacted] file for future reference, if needed. To prevent this in the future, the New Resident Checklist will have two different people confirming that all folders are complete and accurate before filing with current residents.*

*Proposed Overall Completion Date: 07/19/2024*

*DIRECTED*
*Within one calendar days of receipt of the accepted plan of correction: The administrator shall audit all newly completed preadmission screening forms for accuracy and completeness. 7/19/24 [redacted]*

**Directed Completion Date:** *07/20/2024* Not Implemented [redacted] - 08/02/24)
Licensee's Proposed Date for POC Implementation

## 251b - Record Entries Legible

**15. Requirements**

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

**Description of Violation**

*Resident #3's contract, dated [redacted] had corrective tape used in the area of the contract to document the date signed by the resident, and the date [redacted] was written over the corrective tape.*

**Plan of Correction** ***Directed [redacted] 07/19/2024)***

*Regulation 2600.251b requires all entries be permanent. There was a misunderstanding when speaking with Jon K. from DHS regarding that specific residents file. Moving forward, there will be no more corrective tape used on any forms in the resident's file. An audit was performed on 6/20/24 by the Administrator to ensure that there was no correction tape on any resident paperwork. To ensure that no corrective tape will be used in the future, as the New Resident Checklists are being filled out and verified by the Administrator and the designated employee, all paperwork will be double checked before filing with resident folders.*

*Proposed Overall Completion Date: 07/19/2024*

*DIRECTED*
*Within one calendar day of receipt of the accepted plan of correction: The administrator or designee shall audit all*

## 251b - Record Entries Legible (continued)

*newly completed resident documents to ensure all documentation permanent, legible, dated and signed by the staff person making the entry.*

**Directed Completion Date:** *07/20/2024*

Not Implemented [redacted] 08/02/24)

Licensee's Proposed Date for POC Implementation