pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **EMBASSY DARLINGTON LLC**
LEGAL ENTITY

To operate **LAKEVIEW PERSONAL CARE**
NAME OF FACILITY OR AGENCY

Located at **498 LISBON ROAD, DARLINGTON, PA 16115**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

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 **92** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

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

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

and shall remain in effect from **November 26, 2024** until **May 26, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **451611**

ISSUING OFFICER

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: NOVEMBER 26, 2024

[redacted], VP of Operations
Embassy Darlington LLC
[redacted]
[redacted]

RE: Lakeview Personal Care
498 Lisbon Road
Darlington, PA 16115
License/COC #: 45161

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on April 25, 2024, April 26, 2024, and July 9, 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), the Department hereby REVOKES your certificate of compliance (license number 45161) dated June 21, 2024 to June 21, 2025 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) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from November 26, 2024 to May 26, 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 FIRST 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 FIRST 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
[REDACTED]

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

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [REDACTED]

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

Facility Information

Name: *LAKEVIEW PERSONAL CARE* **License #**: *45161* **License Expiration**: *06/21/2023*

Address: *498 LISBON ROAD, DARLINGTON, PA 16115*

County: *BEAVER* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *EMBASSY DARLINGTON LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/23/1992* **Issued By**: *L&I*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/26/2024*

Inspection Dates and Department Representative

04/25/2024 - On-Site: [redacted]

04/26/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *92* **Residents Served**: *58*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *58*

Diagnosed with Mental Illness: *46* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *12* **Have Physical Disability**: *2*

Inspections / Reviews

04/25/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/25/2024*

05/30/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/21/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/03/2024*

06/12/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/21/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/21/2024*

10/01/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/21/2024*

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

17 - Record Confidentiality

1. Requirements

2600.

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

Description of Violation

On 4/25/24 and 4/26/24, at approximately 12:00 pm., name tags were placed at each resident's seat with the resident's name and prescribed diet, including resident #1's name and "mech" diet.

Plan of Correction ***Accept (- 06/12/2024)***

On 4/26/24 the Dining Services Director (removed all name cards with residents diets indicated.

On 4/27/24 the Administrator (and the Dietary Director (held a dietary inservice with all dietary staff about HIPPA and what information is not allowed to be visible to the public.

Beginning on 4/26/24 the Administrator (will perform a weekly inspection of the diningroom to ensure that no residents private information is placed for public viewing.

A Weekly log is being kept for four weeks.

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

Implemented (- 10/01/2024)

25a - Written Contract and Review

2. Requirements

2600.

25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #2, admitted , did not have a resident-home contract completed.

Plan of Correction ***Accept (- 06/12/2024)***

On 4/25/24 resident #2's completed contract was located and presented to the Inspector (said that would accept it.

Resident #2's contract was completed upon admission into Lakeview Persnal Care home on 1/8/2024 by the Administrator (

Beginning on 4/26/24 the Administrator (shall ensure that prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place.

25a - Written Contract and Review (continued)

Beginning on 4/26/24 the Administrator (shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Beginning on 4/26/24 the Administrator (is responsible for reviewing all contracts after they have been completed to ensure that all areas have been signed by the the resident, the responsible person and the designated person and dated appropriately.

A complete audit of all current resident contracts for content and timeliness was completed by the Administrator (on 5/9/2024.

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

Implemented (- 10/01/2024)

25b - Contract Signatures

3. 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 , was not signed by the resident. Resident #1's Power of Attorney signed the contract, however, there is no notation that resident #1 was given opportunity to sign the contract.

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

On 4/29/23 The Administrator (presented Resident #1's contract to to review and sign. Beginning 4/29/24 it will be the Administrators responsibility to ensure that all contracts are signed by all parties, i.e. Responsible Person, Guarantor, and Resident. If a resident is unable to sign or refuses to sign the contract the Administrator will make a notation with a date and reason for not signing the document. On 4/29/24 The Administrator reviewed all of the residents contracts to ensure that all signature lines were filled in with either a signature or a reason for not signing.

Licensee's Proposed Overall Completion Date: *05/17/2024*

Implemented (- 10/01/2024)

41e - Signed Statement

4. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1, #2, and #3's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedure.

41e - Signed Statement *(continued)*

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

On 4/29/24 the Administrator (presented all of the residents in the community a copy of the residents rights along with complaint procedures. The Administrator (presented Resident #1, #2, and #3 with a copy of the residents rights along with complaint procedures and asked them to sign the contract page that they had recieved them. Beginning 4/29/24 the Administrator will ensure that all admissions are presented with the residents rights and complaint procedures during the signing of the community contract and ensure that they sign the contract acknowledging reciept of the information. on 4/29/24 the Adminsitrator audited all resident contracts to ensure that all resident have the residents rights and complaint procedure documents and have signed acknowledging reciept of the informaiton. A tracking sheet for all new admissions will be kept by the Adminstrator for all new admissions for 4 weeks.

Licensee's Proposed Overall Completion Date: *05/17/2024*

Implemented (- 10/01/2024)

51 - Criminal Background Check

5. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A, hired has not had a Pennsylvania Criminal Background Check completed.

Repeat violation; 4/4/23 et al.; 9/12/23

Plan of Correction ***Directed (- 06/12/2024)***

On 4/30/24 Direct Care Staff A criminal background check was resubmitted by the Business Office Manager (

Beginning 4/30/24 Beginning on 4/26/24 the Administrator (administrator will review each new hire with the Business Office Manager (to ensure that the Criminal Background Checks are being completed appropriately and prior to each new staff member beginning employment at the community.

On 4/30/24 the Administrator (completed an audit of all staff at the community and all Background checks are complete for all staff.

Beginning 4/30/24 Monthly documentation of all new hires will be kept indefinitely by the Business Office Manager (

Proposed Overall Completion Date: 05/30/2024

Documentation of the background check audit shall be kept. 6/12/24

Directed Completion Date: *06/20/2024*

Implemented (- 10/01/2024)

54a - Direct Care Staff

6. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff persons A and B, do not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Directed (- 06/12/2024)***

Beginning 4/30/24 the Administrator (will review all new hires and ensure that all new employees have their high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

On 5/1/24 the Administrator (audited all staff files to ensure that all staff persons files include have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

On 5/1/24 staff persons A and B diplomas were located and are now available.

Proposed Overall Completion Date: 05/30/2024

DIRECTED PLAN:
By 6/20/24: The administrator or designee shall develop and implement a system for record retention to ensure required records, including criminal background checks are available for the Department's review. 6/12/24

Directed Completion Date: *06/20/2024*

NOT IMPLEMENTED 10/2/24

57d - Waking Hours

7. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 4/20/24, the home served 58 residents, 9 with mobility needs requiring a total of 67 hours of direct care services. However, only 47 hours, or 63 percent, were provided during waking hours.

Plan of Correction ***Directed (- 06/12/2024)***

Beginning 4/26/24 The staff schedule has one med tech and three direct care givers on each shift.

Beginning on 4/26/24 if there is a call off during a shift it will be the staff persons responsibility to find a replacement to cover their shift.

If a staff member is unable to find a replacement the staff member will contact the Wellness Director (or the Administrator (to come in and cover the shift until a replacement can be found or they will cover the shift.

On 4/26/24 the Wellness Director (or the Administrator (all direct care staff were reeducated on the staffing policy.

57d - Waking Hours (continued)

Proposed Overall Completion Date: 05/30/2024

DIRECTED PLAN:
By 6/20/24 and weekly thereafter: The administrator or designee shall check the schedule to ensure at least 75% of personal care service hours are available during waking hours.

Directed Completion Date: *06/20/2024*

NOT IMPLEMENTED 10/2/24

63a - First Aid/CPR Training

8. Requirements

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

Description of Violation

On 4/19/24 and 4/20/24, from 3:00 pm.- 7:00 am., 58 residents were present in the home. During this time no staff persons were present in the home who were certified in first aid and CPR.

On 4/20/24, from 11:00 pm.- 7:00 am., 58 residents were present in the home. During this time only 1 staff person was present in the home who was certified in first aid and CPR.

Plan of Correction ***Accept (- 06/12/2024)***

Beginning on 4/26/24 all shifts have been covered by at least two staff persons with CPR and First Aid certification.

Beginning 5/30/24 the Wellness Director (will perform a weekly audit of the schedule to ensure at least one staff person trained in CPR/First Aid is in the building for every 50 residents. A record shall be kept.

On 6/6/24 all staff persons from every department are being certified in CPR and First Aid by a trained professional.

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

Implemented (- 10/01/2024)

65a - FS Orientation 1st Day

9. 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.

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

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

Description of Violation

Staff person B, hired ████, did not receive any of the required orientation in general fire safety and emergency preparedness.

Repeat violation; 9/12/23; 4/4/23 et al.

Plan of Correction ***Accept (██ - 06/12/2024)***

On 4/30/24 staff person B received all required orientation in general fire safety and emergency preparedness for new hires.

On 4/30/24 the Maintenance Director conducted and orientation with staff person B of the required orientation in general fire safety and emergency preparedness.

Beginning on 4/26/24 the Business Office Manager (████ will ensure that all new hires complete the required orientation in general fire safety and emergency preparedness for the community prior to working on the floor.

Beginning on 4/26/24 the Administrator (████ will review all new hire paperwork to ensure that all required orientation and training is completed prior to the new staff person beginning work on the floor.

On 5/30/24 the Administrator (████ completed an audit of staff files to ensure that all staff members have completed the orientation training.

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

Implemented (██ - 10/01/2024)

65b - Rights/Abuse 40 Hours

10. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

On 4/26/24, staff person B completed ███ 40th scheduled work hour. However, this staff person did not complete any of the required orientation training, including resident rights and emergency medical plan.

Repeat violation; 9/12/23; 4/4/23 et al.

Plan of Correction ***Accept (██ - 06/12/2024)***

On 4/30/24 staff person B recieved ██ full training of the required orientation training, including resident rights

65b - Rights/Abuse 40 Hours (continued)

and emergency medical plan by the Administrator (

Beginning on 4/26/24 the Business Office Manager (will ensure that all new hires complete the required orientation training, including resident rights and emergency medical plan. for the community.

Beginning on 4/26/24 the Administrator (will review all new hire paperwork to ensure that all required orientation and training is completed prior to the new staff person beginning work on the floor.

On 5/30/24 the Administrator (completed an audit of staff files to ensure that all staff members have completed their orientation training prior to working directly with the residents.

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

Implemented (- 10/01/2024)

65d - Initial Direct Care Training

11. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person B, hired and direct care staff person C, hired , provide ADL services. However, staff persons B and C did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Directed (- 06/12/2024)***

Beginning on 4/26/24 the Business Office Manager (will ensure that all new hires complete the required completion and passing of the Department-approved direct care training course and passing of the competency test. No staff person will begin working on the floor with the residents until this has been completed.

Beginning on 4/26/24 the Administrator (will review all new hire paperwork to ensure that all required orientation and training is completed prior to the new staff person beginning work on the floor.

Staff person B completed their training on 5/30/24 and Staff person C completed their training on 5/31/24.

Proposed Overall Completion Date: 05/31/2024

DIRECTED PLAN:
By 6/20/24: The administrator or designee shall review direct care staff records to ensure each direct care staff person has successfully completed the Department-approved direct care training course and passed the competency test.

Directed Completion Date: *06/20/2024*

Implemented (- 10/01/2024)

65f - Training Topics

12. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A and C did not receive any training during training year 2023.

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

On 4/30/24 staff person A and C began thier training for their annual training to cover all training topics for the year 2023. This will be completed by 5/10/24. Beginnin 4/26/24 the Wellness Director (is responsible for presenting the monthly topics for all direct care staff persons which includes all of the required training topics as required in 2600.65.f.
Beginning 4/26/24 the Administrator (will perform a monthly audit of all trainings for each care staff member to ensure that every staff member has completed thier training for the month.

Licensee's Proposed Overall Completion Date: *05/25/2024*

Implemented (- 10/01/2024)

65g - Annual Training Content

13. 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

Staff persons A and C did not receive any training during training year 2023.

Staff person D did not receive in fire safety by a fire safety expert or by a staff person trained by a fire safety expert and falls and accident prevention during training year 2023.

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

On 4/30/24 staff person A and C began thier training for their annual training to cover all training topics for the year 2023. This will be completed by 5/10/24. Beginnin 4/26/24 the Wellness Director (is responsible

65g - Annual Training Content (continued)

for presenting the monthly topics for all direct care staff persons which includes all of the required training topics as required in 2600.65.g.
on 4/26/24 staff person D recieved [redacted] training in fire safety and falls and accident prevention.
Beginning 4/26/24 the Administrator ([redacted] will perform a monthly audit of all trainings for each care staff member to ensure that every staff member has completed thier training.

Licensee's Proposed Overall Completion Date: *05/25/2024*

Implemented ([redacted] - 10/01/2024)

89b - Hot Water Temperature

14. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 4/25/24, at 10:52 am., the hot water temperature at the sink in the bathroom in B hallway measured 142 degrees Fahrenheit

On 4/25/24, at 10:57 am., the hot water temperature at the whirlpool measured 139.1 degrees Fahrenheit.

On 4/25/24, at 11:11 am., the hot water temperature at the sink in the bathroom in A2 measured 124.4 degrees Fahrenheit.

On 4/25/24, at 11:20 am., the hot water temperature at the sink in the kitchen in A4 measured 141.7 degrees Fahrenheit.

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

On 4/25/24 The Maintenence Director ([redacted] lowered the water temperature on the hot water tank as requested by the state surveyor.

The water temperature at 5:00 was 120°F.

On 4/25/24 the Administrator ([redacted] had a training with the Maintenence Director ([redacted] about the state regulation that the water in the community cannot exceed 120°F.

Beginning 4/25/24 the Mintenence Director ([redacted] will perform a daily water temperature check at the closest point and the furthest point from the water heaters to ensure that the water temperature does not exceed 120°F. If the temperature does exceed 120°F [redacted] will adjust the water temperature accordingly and retest every half hour to ensure that it is at the proper temperature.

Beginning 4/26/24 a daily log shall be kept.

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

Implemented ([redacted] - 10/01/2024)

132c - Fire Drill Records

15. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on 2/21/24 does not include exits used or number of residents evacuated.

Plan of Correction ***Accept (- 06/12/2024)***

On 4/26/24 the Administrator met with the Maintenance Director to discuss the importance of utilizing alternate exits during fire drills.

Beginning 4/26/24 the Administrator will be present at all fire drills to ensure utilization of alternate exits are being utilized.

Beginning 4/26/24 this record will be kept by the Maintainence Director (identifying the time, date, number of staff and residents and exit utliized for the fire evacuation.

On 5/30/24 the Administraor (met with the Maintenence Director (and trained on the omissions on the fire drill record including exits used and number of residents evacuated.

Beginning 5/30/24 the Administrator (will be present for all fire drills and ensure that the fire drill record reflects all required documentation inluding exits used and number of residents evacuated. .

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

Implemented (- 10/01/2024)

132d - Evacuation

16. 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

On 4/12/23, the home had a safe evacuation time of 5 minutes, 48 seconds set by a fire safety expert. The fire drill log indicates the home exceeded this evacuation time on the following dates:

** 5/25/23, at 7:30 pm. - 6 minutes, 20 seconds*

** 6/14/23, at 4:30 am. - 8 minutes, 42 seconds*

** 8/19/23, at 12:00 am. - 8 minutes, 25 seconds*

** 1/31/24, at 10 pm. - 5 minutes, 55 seconds*

Repeat violation: 4/4/23, et al.

132d - Evacuation (continued)

Plan of Correction ***Accept (- 06/12/2024)***

On 4/26/24 the Maintenance Director (discussed the proper evacuation times with the Ohioville Volunteer Fire Department Fire Chief.

Beginning 4/26/24 the Administrator (along with the Maintenance Director (will train all staff what the expectation of the evacuation time is and train them on how to evacuate the community and what the expected evacuation time is.

The Maintenance Director (is setting up a meeting with the Ohioville Volunteer Fire Department Fire Chief for training with the department.

On 4/26/24 the Administrator met with the Maintenance Director to discuss the importance of utilizing alternate exits during fire drills.

Beginning 4/26/24 the Administrator (will be present at all fire drills to ensure utilization of alternate exits are being utilized.

On 4/26/24 the fire drill record was modified to reflect the alternative exits to be utilized for each fire drill by the Administrator (

On 6/4/24 a fire drill will be conducted with the Administrator (present to ensure that the community is evacuated within the evacuation time set by the Fire Chief.

Beginning 6/4/24 the Administrator (will ensure that alternative exits are being utilized by the residents during each drill.

On 6/5/24 all staff will be educated/inserviced on the fire drill evacuation procedure and safe evacuation time.

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

Implemented (- 10/01/2024)

132f - Alternate Exit Routes

17. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The downstairs dining room exit route is routinely used during the fire drills held from 6/14/23 to 8/19/23. Staff interviews indicate not all exit routes are randomly used during fire drills.

Repeat violation; 4/4/23, et al

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

On 4/26/24 the Administrator met with the Maintenance Director to discuss the

132f - Alternate Exit Routes (continued)

importance of utilizing alternate exits during fire drills.

Beginning 4/26/24 the Administrator [redacted] will be present at all fire drills to ensure utilization of alternate exits are being utilized.

Beginning 4/26/24 this record will be kept by the Maintainence Director ([redacted] identifying the time, date, number of staff and residents and exit utliized for the fire evacuation.

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

Implemented ([redacted] - 10/01/2024)

141a 1-10 Medical Evaluation Information

18. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

The medical evaluation for resident #2 did not include the date the resident was evaluated or the immunization history, these areas were blank.

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

On 4/26/24 the Wellness Director revised the medical evaluation for resident #2 and it now includes the date the resident was evaluated and the immunization history.

On 4/26/24 the Wellness Director contacted residents #2's physician and explained the importance of having all of the residents informaiton filled out on the DME.

Beginning on 4/26/24 the Wellness Director will review all residents DME's as they are returned to the community to ensure that the dphysician has filled in all fields on the residents DME.

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

Implemented ([redacted] - 10/01/2024)

161d - Dietary Needs

19. Requirements

2600.
161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

On 4/12/24, resident #1 was prescribed a mechanical soft diet. However, on 4/26/24, at approximately 12:00 pm., the resident was served pureed fish mixed with tartar sauce on a whole hamburger bun.

Plan of Correction ***Directed (- 06/12/2024)***

Beginning 4/26/24 resident #1 dietary needs will be addressed via a Dietary Alert Form.

On 4/26/24 the Administrator (met with the Wellness Director (and the Dietary Manager (to discuss resident meals and meeting a resident's dietary needs as prescribed by a physician, physician's assistant, CRNP or dietician.

On 4/26/24 the Dietary Manager (held and inservice with the dietary staff to ensure that are following the prescribed resident meals and meeting a resident's dietary needs as prescribed by a physician, physician's assistant, CRNP or dietician.

It is the Wellness Directors (responsibility to relay this informaiton to the Dietary Manager (via the Dietary Alert Form and ensure that the prescribed diet is being offered.

Proposed Overall Completion Date: 05/30/2024

DIRECTED PLAN:
By 6/20/24 and twice weekly thereafter: The administrator or designee shall observe the meals that are served to ensure resident's special dietary needs are being met.

Directed Completion Date: *06/20/2024*

Implemented (- 10/01/2024)

184a - Resident's Meds Labeled

20. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #3 is prescribed, Depakote Sprinkles, 125mg, 1 packet at 9:00 am. and 4:00 pm. However, the pharmacy label indicates, Divalproex DR, 125mg, 1 cap at 9:00 am. and 4:00 pm.

184a - Resident's Meds Labeled (continued)

Repeat violation: 4/4/23, et all

Plan of Correction ***Directed (- 06/12/2024)***

On 5/2/24 all Medication Technicians were re-trained by the Wellness Director (about the requirements for each resident medication record.

On 4/26/24 resident #3's MAR was revised by the Wellness Director (to reflect the prescribed medication.

On 5/1/24 the Wellness Director (contacted the communities pharmacy to ensure that all information is present on their MAR's when they are sent to the community. The Wellness Director will review each MAR when they are delivered to ensure that they reflect the required information for each medication.

Proposed Overall Completion Date: 06/03/2024

DIRECTED PLAN:
By 6/20/24: The administrator or designee shall obtain a pharmacy label that matches the current physician's order for Depakote Sprinkles 125 mg., or a staff person qualified to administer medications shall place a sticker on the incorrect label indicating to see the resident's MAR.

By 6/20/24: All staff persons qualified to administer medications shall be educated on regulation 2600.184a and the home's policy and procedure for identifying and correcting incorrect pharmacy labels. Documentation of the education shall be kept.

By 6/20/24 and monthly thereafter: A staff person qualified to administer medications shall audit resident pharmacy labels to ensure they in accordance with 2600.184a and match the current physician's orders. Documentation of the audits shall be kept.

Directed Completion Date: *06/20/2024*

Implemented (- 10/01/2024)

185a - Implement Storage Procedures

21. Requirements

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

Description of Violation

Resident #5 is prescribed, Novolog, 100 units/ML Flexpen, use per sliding scale and inject 3 times a day:
** 151-200 =1 unit*
** 201-250 = 2 units*
** 251-300 = 3 units*
** 301-350 = 4 units*
** 351-400 = 5 units*
** BS>400 = Call MD*

On 4/23/24, at 5:11pm., resident #5's glucometer indicated 94, however the April 2024 medication administration

185a - Implement Storage Procedures (continued)

record (MAR), indicates 64.

On 4/24/24, at 4:00pm., resident #5's glucometer indicated 98, however the April 2024 MAR, indicates 94.

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

On 4/26/24 The Wellness Director retrained all med techs about proper recording of a residents glucose levels.

Beginning on 4/26/24 The Wellness Director (is performing a daily audit of diabetic residents MAR's to ensure that the correcto glucose levels have been recorded.

On 5/30/24 all Med Techs are scheduled to have a full Diabetic Training.

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

Implemented (- 10/01/2024)

186a - Authorized Prescriber

22. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

The label for resident #4's QC Saline Nasal Spray, indicates 2 sprays each nostril 2 times per day as needed for nasal dryness. The pharmacy label indicates, Ayr Saline Nasal Spray, indicates 2 sprays each nostril for nasal dryness. The home does not have the prescriber's orders available.

The label for resident #4's Senna Plus, 8.6mg, 1 tab daily per day as needed for constipation. The pharmacy label indicates, Stool Softener, 1 tab daily for constipation. The home does not have the prescriber's orders available.

Plan of Correction ***Accept (- 06/12/2024)***

On 4/26/24 the Wellness Director (obtained the prescribers orders for resident #4's Ayr Saline Nasal Spray and the Senna Plus from the residents physician.

Beginning 4/26/24 the Wellness Director will review and ensure that all medication reflects the prescribers orders available in the residents record.

4/30/24 A Complete audit of all resident medications was completed by the Wellness Director (

186a - Authorized Prescriber (continued)

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

Implemented (- 10/01/2024)

187a - Medication Record

23. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #1 is prescribed Tamsulosin HCL, 0.4mg, and Escitalopram, 5mg. However, the resident's April 2024 MAR does not indicate the diagnosis or purpose for the medication.

Resident #4 is prescribed Cephalexin, 500mg. However, the resident's April 2024 MAR does not indicate the diagnosis or purpose for the medication.

Plan of Correction ***Accept (- 06/12/2024)***

On 5/2/24 all Medication Techs were re-trained about the requirements for each resident medication record by the Wellness Director (.

On 4/26/24 resident #1 MAR was revised by the Wellness Director (to reflect the diagnosis and purpose of their medication.

On 4/26/24 resident #4 MAR was revised by the Wellness Director (to reflect the diagnosis and purpose of their medication.

Beginning on 4/26/24 the Wellness Director (has begun auditing all residents MAR's to ensure that they reflect the diagnosis and purpose for each residents medication.

On 5/1/24 the Wellness Director (contacted the communities pharmacy to ensure that all information

187a - Medication Record (continued)

is present on their MAR's when they are sent to the community. The Wellness Director will review each MAR when they are delivered to ensure that they reflect the required information for each medication.

Licensee's Proposed Overall Completion Date: *06/03/2024*

Implemented (█ - 10/01/2024)

190a - Completion Medication Course

24. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person A has not successfully completed the required annual practicum in the medication administration course.

Staff person A administered medications to residents to include the following:

On 4/24/24, at 8:00 am. Escitalopram to resident #1

On 4/6/24, at 8:00 am., Lasix to resident #2

On 4/9/24, at 9:00 am., Depakote to resident #3

Plan of Correction ***Accept (█ - 05/30/2024)***

On 4/30/24 Staff person A has successfully completed the required annual practicum in the medication administration course. Beginning 4/26/24 the Wellness Director (█ will ensure that all Med-Tecks have successfully completed the required annual practicum in the medication administration course prior to being scheduled and working as a Med-Teck in the community. Beginning 4/26/24 the Administrator (█ will perform a monthly audit of all Med-Teck trainings to ensure that all staff have successfully completed the administration course. A record will be kept.

Annual practicum remediation for requalification shall follow the requirements on the ODP Medication Administration Course website at https://medadmin.myodp.org/. █ *5/30/24*

Proposed Overall Completion Date: 05/25/2024

Licensee's Proposed Overall Completion Date: *05/25/2024*

NOT IMPLEMENTED 10/2/24 █

190b - Insulin Injections

25. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On 4/13/24, at 8:00 am., staff person A, who has not completed the Department-approved Diabetes patient education program, administered insulin to resident #5.

190b - Insulin Injections (continued)

Repeat violation; 4/4/23, et all

Plan of Correction ***Accept (- 05/30/2024)***

On 4/30/24 Staff person A has successfully completed the Department-approved Diabetes patient education program. Beginning 4/26/24 the Wellness Director (will ensure that all Med-Tecks have successfully completed the Department approved Diabetes patient education program. A Diabetic training for all Med-Tecks has been scheduled for June 6th 2024. Beginning 4/26/24 the Administrator (will perform a monthly audit of all Med-Teck trainings to ensure that all staff have completed the Department approved Diabetes patient education program. A record will be kept.

Licensee's Proposed Overall Completion Date: *05/25/2024*

Implemented (- 10/01/2024)

191 - Resident Right to Refuse

26. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1, admitted resident #2, admitted , and resident #3, admitted have not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept (- 05/30/2024)***

On 4/29/24 the Administrator (presented all of the residents in the community a copy of the residents right to refuse medication.

The Administrator (presented Resident #1, #2, and #3 with a copy of the residents right to refuse medication and requested them to sign the contract page that they had recieved them.

Beginning 4/29/24 the Administrator will ensure that all admissions are presented with the residents right to refuse medication during the signing of the community contract and ensure that they sign the contract acknowledging reciept of the information.

On 4/29/24 the Adminsitrator audited all resident contracts to ensure that all resident have the residents right to refuse medication and have signed acknowledging reciept of the informaiton.

A tracking sheet for all new admissions will be kept by the Adminstrator for all new admissions for 4 weeks.

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

Implemented (- 10/01/2024)

225c - Additional Assessment

28. Requirements

2600.

225c - Additional Assessment *(continued)*

225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #2's assessment, dated [redacted], does not address the resident's level of need for ambulation. This area was blank.

Plan of Correction ***Directed ([redacted] - 06/12/2024)***

On 4/26/24, resident #2's assessment was revised by the Wellness Directors ([redacted] to reflect the resident's level of needing assistance with ambulation.

On 4/29/24 the Administrator ([redacted] re-educated the Wellness Director ([redacted] about proper assessments, when they should be be completed, and when they should be revised.

On 4/29/24 the Administrator ([redacted] and Wellness Director ([redacted] audited the tickler system and current assessments for each resident to ensure that all assessments are current and correct.

Beginning 4/29/24 the Administrator ([redacted] and Wellness Director ([redacted] will review the monthly tickler system to ascertain what assessments need to be amended and or completed. A log shall be kept.

Proposed Overall Completion Date: 06/03/2024

DIRECTED PLAN:
By 6/20/24: The administrator or designee shall complete an annual assessment for resident #5 (if still served by the home) and place the assessment in the resident's record.

Directed Completion Date: *06/20/2024*

Implemented ([redacted] - 10/01/2024)

227d - Support Plan Medical/Dental

29. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident #2, dated [redacted], indicates the resident has a need for an enabler bar. The resident's support plan, dated [redacted] does not address the specific need for device, intended use and risks associated with the use, resident's ability to use the device safely for the purpose it was intended, and the indication of the specific device to be used and whether a cover is required to meet FDA guidelines and how these needs will be met.

227d - Support Plan Medical/Dental (continued)

Plan of Correction ***Directed (- 06/12/2024)***

On 4/26/24 the assessment for resident #2, was revised by the Wellness Director (to reflect that the resident has a need for an enabler bar.

On 4/26/24 the resident's support plan, was revised by the Wellness Director (to reflect the specific needs for the handrail device, it's intended use and risks associated with the use, the resident's ability to use the device safely for the purpose it was intended, and the indication of the specific device to be used and whether a cover is required to meet FDA guidelines and how these needs will be met.

On 4/26/24, resident #6's support plan was revised the Wellness Directors (and now address the resident's mechanical soft diet. The dietary department has been alerted via Dietary Alert Form of the residents dietary needs for a mechanical soft diet.

Beginning 4/26/24 any residents dietary needs will be discussed during the managements morning meetings.

Beginning 4/26/24 any new residents dietary needs will be addressed upon admission via Dietary Alert Form. It will be the Wellness Directors (responsibility to relay this informaiton to the Dietary Manager (via the Dietary Alert Form.

Proposed Overall Completion Date: 06/03/2024

DIRECTED PLAN:
By 6/20/24: The administrator or designee shall audit all current support plans for accuracy and completion, including bedside mobility devices and special diets. Documentation of the audit shall be kept.

Directed Completion Date: *06/20/2024*

NOT IMPLEMENTED 10/2/24

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

Facility Information

Name: *LAKEVIEW PERSONAL CARE* **License #**: *45161* **License Expiration**: *06/21/2024*

Address: *498 LISBON ROAD, DARLINGTON, PA 16115*

County: *BEAVER* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *EMBASSY DARLINGTON LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/23/1992* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *61* **Waking Staff**: *46*

Inspection Information

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

Reason: *Interim* **Exit Conference Date**: *07/09/2024*

Inspection Dates and Department Representative

07/09/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *92* **Residents Served**: *54*

Secured Dementia Care Unit

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

Hospice

Current Residents: *8*

Number of Residents Who:

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

Diagnosed with Mental Illness: *7* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *7* **Have Physical Disability**: *2*

Inspections / Reviews

07/09/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/30/2024*

Inspections / Reviews *(continued)*

08/16/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *09/17/2024*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *08/20/2024*

08/28/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *09/17/2024*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *09/18/2024*

10/01/2024 - Document Submission

Submitted By: [redacted]
Date Submitted: *09/17/2024*
Reviewer: [redacted]
Follow-Up Type: *Exception*

Withdrawn AD 10/25/24

57d - Waking Hours

2. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 7/6/24, there were 53 residents in the home, including 6 residents with mobility needs, requiring a total minimum of 59 hours of direct care service and 44.25 hours of direct care service during waking hours. However, only 42 hours

57d - Waking Hours (continued)

were provided during waking hours.

Plan of Correction ***Accept (- 08/28/2024)***

Beginning 7/16/24 The staff schedule has one med tech and three direct care givers on each shift.

Beginning on 7/16/24 if there is a call off during a shift it will be the staff persons responsibility to find a replacement to cover their shift.

If a staff member is unable to find a replacement the staff member will contact the Regional Wellness Director and the Administrator (to come in and cover the shift until a replacement can be found.

On 7/16/24 the Regional Wellness Director and the Administrator (all direct care staff were
reeducated on the staffing policy.

Beginning on 7/16/24 the Administrator (shall review the weekly schedule to ensure at least 75% of personal care service hours are available during waking hours.

Beginning on 8/19/2024 The acting Wellness Director and the Administrator (will review the weekly staffing schedule daily to ensure there is least 75% of personal care service hours are available during waking hours and has proper coverage on each shift.

Licensee's Proposed Overall Completion Date: *08/21/2024* NOT IMPLEMENTED 10/2/24

132a - Monthly Fire Drill

3. Requirements

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

Description of Violation

An unannounced fire drill was not held during the months of April and May 2024.

Plan of Correction ***Accept (- 08/16/2024)***

On 7/15/24 the Administrator (met with the new Maintenance Director and trained on the fire system, corporate and State policies on the expected procedures of "Fire Drills" the "Evacuation Times" and utilizing different "Exits" for each drill. is a certified fire fighter and is a volunteer fire fighter.

Beginning 7/15/24 the Administrator (will be present at all fire drills to ensure utilization of alternate exits are being utilized.

Beginning 7/26/24 this record will be kept by the Maintenance Director identifying the time, date, number of staff and residents and exit utilized for the fire evacuation.

A Fire Drill was conducted by the new Maintenance Director and observed by the Administrator (on 7/25/24. The entire community was evacuated (First and Second Floors) and was well within the evacuation time set by the local Fire Chief of 8 Minutes and 30 seconds) (Actual evacuation time (6

132a - Monthly Fire Drill (continued)

minutes 48 Seconds).

On 7/26/24 The new Maintenance Director [redacted]) held an in-service for all staff concerning the fire system and fire panel, corporate and State policies on the expected procedures of "Fire Drills" the "Evacuation Times" and utilizing different "Exits" for each drill.

Licensee's Proposed Overall Completion Date: *07/30/2024*

NOT IMPLEMENTED 10/2/24