pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail [redacted]
Sent via e-mail [redacted]
February 12, 2025

[redacted]
Senior Vice President
Salisbury Behavioral Health, LLC
[redacted]
[redacted]

RE: Salisbury Behavioral Health, LLC
626 Easton Road
Glenside, Pennsylvania 19038
License #: 12832

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) review on July 18, 2024 and September 13, 2024 of the above facility, we have determined that your submitted plan of correction for the May 22, 2024 inspection is not fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

[redacted]

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *SALISBURY BEHAVIORAL HEALTH LLC* **License #:** *12832* **License Expiration:** *03/25/2025*

Address: *626 EASTON ROAD, GLENSIDE, PA 19038*

County: *MONTGOMERY* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *SALISBURY BEHAVIORAL HEALTH LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff:** *10* **Waking Staff:** *8*

Inspection Information

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

Reason: *Incident* **Exit Conference Date:** *05/22/2024*

Inspection Dates and Department Representative

05/22/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *9* **Residents Served:** *9*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older:** *8*

Diagnosed with Mental Illness: *9* **Diagnosed with Intellectual Disability:** *1*

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

Inspections / Reviews

05/22/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/01/2024*

Inspections / Reviews *(continued)*

07/02/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/05/2024*

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

07/26/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/05/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/02/2024*

09/13/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/05/2024*

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

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 5/22/24 at 9:28 A.M. , resident records and resident medication administration records were unlocked, unattended, and accessible in the third floor staff office.

Plan of Correction ***Directed ([redacted] - 07/18/2024)***

Immediately on 5/22/24 after the exit call and findings of violation 17. The administrator spoke to the staff in the office working that day of the importance of locking the office door. On 6/21/24 a staff meeting was held with all employees where the administrator reviewed the 2600 17 regulation regarding record confidentiality. Moving forward a sign has been posted to prompt and remind staff to shut and lock the office door at all times. Please see attached sign in sheet from staff meeting. On 7-2-24 the admin implemented a door monitoring checklist please see attached.

Proposed Overall Completion Date: 07/05/2024
Proposed Overall Completion Date: 07/26/2024

Directed Plan of Correction:

Starting within 5 days of the receipt of the acceptable plan of correction, the administrator or designee shall monitor the staff office door and complete the door monitoring checklist daily for two weeks, then monthly thereafter.

Directed Completion Date: *07/26/2024*

Not Implemented ([redacted] - 09/13/2024)

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 5/17/24 at approximately 11:00 A.M. Staff Member A was repairing the sink in the bathroom on the first floor. Staff Member A looked to the side and saw a Glock handgun barrel pointing at them. The handgun was located between the toilet base and the wall, with a toilet brush and a plunger placed in front of the handgun in an attempt to conceal it. Staff Member A, after seeing the handgun, secured it to ensure resident safety. Staff Member A then locked the bathroom, called 911, and informed the Administrator. An officer responded and secured the gun, and determined the handgun was not registered. The handgun was modified to be automatic, not equipped with an external safety, and was equipped with an extended magazine. While the police were onsite conducting their investigation, Staff Member B was pacing and trying to see what was going on in the bathroom, while texting and talking on a cell phone. Staff Member B was terminated [redacted] due to them returning to the home late after an extended period of time when running an errand. Resident # 1 used the restroom while the handgun was present and unsecured, but was unaware of its presence.

42b - Abuse (continued)

Plan of Correction ***Accept (- 07/02/2024)***

Immediately on 5/17/24 when staff found the gun proper protocol was performed to ensure the safety of the residents. Still currently this is an on going investigation with the Abington police department. Detective is in communication regarding any updates with this investigation. A staff meeting was held on 6/21/24 where the administrator reviewed regulation 42.b abuse and our RHA gun policy. Moving forward the administrator and maintenance department will conduct monthly checks of the site and report any findings. These checks began on 5/22/24 and will continue for a year .Please see attached checks.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented (- 09/13/2024)

42c - Treatment of Residents

3. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

At approximately 1:30P Resident # 2 was sitting in a chair in the living room that had a disposable underpad present. This is a product used to protect furniture from incontinence.

Plan of Correction ***Accept (- 07/02/2024)***

Immediately on 5/22/2024 the disposable under pad for incontinence use was removed from the chair. It was replaced with rubber backing washable pads for the chair. A staff meeting was held to discuss how to keep the chair from getting wet, so all residents would have a dry chair to sit in . Also during that meeting the administrator reviewed the violation 42c treatment of residents. Moving forward the administrator will complete monthly checks of the chair to ensure staff is no longer using disposable under pads. Please see attached admin checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 09/13/2024)

42q - Compensation

4. Requirements

2600.
42.q. A resident shall be compensated in accordance with State and Federal labor laws for labor performed on behalf of the home. Residents may voluntarily and without coercion perform tasks related directly to the resident's personal space or common areas of the home.

Description of Violation

Resident # 3 was seen on 5/22/24 at approximately 1:30 P.M. taking pizza boxes from lunch and putting them in the dumpster for the home.

Resident # 4 reported that the home expects residents to do their own laundry and assigns each resident a day to complete their laundry. Resident # 4 reported the home also expects the residents to vacuum the home. One resident is assigned to vacuum the second floor and another is assigned to vacuum the third floor.

42q - Compensation *(continued)*

Plan of Correction ***Accept (- 07/02/2024)***

On 6/26/24 the administrator and direct support supervisor attended the residents community meeting. During this meeting the administrator reviewed 2600. 42.q. A resident shall be compensated in accordance with State and Federal labor laws for labor performed on behalf of the home. Residents may voluntarily and without coercion perform tasks related directly to the resident's personal space or common areas of the home. The residents understand and acknowledged that they are not responsible to complete any task around the site. That is the responsibility of the direct care staff. A staff meeting was held on 6/21/24 where the administrator reviewed the regulation 42q. Compensation. The administrator will conduct monthly checks of speaking to the residents to ensure no one is being assigned work task. Please see attached admin checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented (- 09/13/2024)

57d - Waking Hours

5. 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 5/12/24, 5/17/24, and 5/18/24, a total of 20 hours of direct care was required. However, only 18.5 hours total were provided. On 5/12/24, 5/17/24, and 5/18/24 15 hours of direct care were required to be provided during the waking hours. The home only provided 13 hours during the waking hours.

Plan of Correction ***Accept (- 07/02/2024)***

Immediately on 5/23/22 the administrator contacted the staffing agency that was assigned to work one on one with resident #2. Due to them not showing up for scheduled shift the administrator had to conduct direct care hours for the resident instead of administrative hours. The agency under stands the importance of having that direct care one on one person arriving to the scheduled shift and must find replacement staff for call outs. Moving forward the administrator has allowed staff to work overlapping hours to prevent any instances of being under the personal care service hours specified. A staff meeting was held on 6/21/24 where the administrator reviewed regulation 57d waking hours. The administrator will also conduct monthly waking hours checks with the staff and scheduled worker. Please see attached admin checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented (- 09/13/2024)

65a - FS Orientation 1st Day

6. 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.

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

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.

Description of Violation

Staff Member B, whose first day of work was [redacted] did not receive orientation.

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

Staff member B did receive [redacted] orientation however there was a documented error with the date. Moving forward the Administrator who does the scheduling will coordinate with the direct care supervisor to ensure that all direct care staff persons; including temp agency staff receive an orientation prior to there first day of work. The administrator will conduct monthly chart checks of the direct care staff charts to ensure all direct care received the required orientation. These checks began on 5/23/24 and will continue for a year. Please see attached admin checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented ([redacted] - 09/13/2024)

65b - Rights/Abuse 40 Hours

7. 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

Staff Member B completed [redacted] 40th scheduled work hour on [redacted]. However, this staff person did not complete training.

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

Resident B was terminated so [redacted] can not complete the required trainings. However moving forward the administrator will conduct monthly chart checks of the direct care staff charts including temp staff to ensure all direct care complete all required training. These checks began on 5/23/24 and will continue for a year. A staff meeting was held on 6/21/24 where the administrator reviewed regulation 65b rights/ abuse 40 hours. Please see attached admin checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented ([redacted] - 09/13/2024)

65d - Initial Direct Care Training

8. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.

65d - Initial Direct Care Training *(continued)*

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   i. Safe management techniques.
   ii. ADLs and IADLs
   iii. Personal hygiene.
   iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   vi. Implementation of the initial assessment, annual assessment and support plan.
   vii. Nutrition, food handling and sanitation.
   viii. Recreation, socialization, community resources, social services and activities in the community.
   ix. Gerontology.
   x. Staff person supervision, if applicable.
   xi. Care and needs of residents with special emphasis on the residents being served in the home.
   xii. Safety management and hazard prevention.
   xiii. Universal precautions.
   xiv. The requirements of this chapter.
   xv. Infection control.
   xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care Staff Member B hired on [redacted] began providing unsupervised ADL services on [redacted] However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test. Staff Member B was discharged for an unrelated incident on [redacted]

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

Resident B was terminated so [redacted] can not complete the required trainings. However The administrator will conduct monthly chart checks of the direct care staff charts to ensure all direct care staff complete and pass the department-approved direct care training course. These checks began on 5/23/24 and will continue for a year .A staff meeting was held on 6/21/24 where the administrator reviewed regulation 65d initial direct care training. Please see attached admin checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented ([redacted] - 09/13/2024)

85a - Sanitary Conditions

9. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

There was fecal matter in the shared toilet in the 1st floor bathroom across from resident bedroom 2.

There was no means of hand-drying in the two bathrooms on the first floor.

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

Immediately on 5-22-2024 staff replaced all tissues from the bathroom with paper towels and cleaned the toilet. A staff meeting was held on 6/21/24 where the administrator reviewed violation 85a sanitary conditions with staff.

85a - Sanitary Conditions (continued)

Moving forward staff will conduct daily bathroom checks during each shift to ensure that paper towels are always kept in the bathroom and bathrooms are kept clean. This check list will be in effect for 90 days. The administrator will be responsible for reviewing and ensuring the checklist is completed daily. Please see attached bathroom inspection chart and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented ([redacted] - 09/13/2024)

85d - Trash Receptacles

10. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 5/22/24 at 9:00A.M. there was a dumpster full, uncovered, unattended in the back of the home.

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

Immediately on 5/22/2024 the receptacle lid on the dumpster was covered and closed and secured. A staff meeting was held on 6/21/24 where the administrator reviewed violation 85d trash receptacles. Moving the administrator will conduct a monthly checklist to ensure that the dumpster lid is closed as well as all trash cans, this will be for one year. Please see attached admin checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 09/13/2024)

95 - Furniture and Equipment

11. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The third floor bathroom the right side cabinet where the sink bowl meets is peeling and exposing the underboard. This disrepair can cut someone and will absorb moisture which can lead to mold growth.

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

Immediately on 5/22/24 the administrator contacted maintenance and the right side of the cabinet was repaired on 5-23-24. A staff meeting was held on 6/21/2024 where the administrator reviewed Reg.95, Regarding furniture and equipment. All staff are now aware that all furniture and equipment must be in good repair, clean, and free of hazards. Moving forward staff will report to the administrator any findings of things not in good repair. The administrator will relay that information to maintenance to conduct the repairs. The maintenance department will also conduct monthly safety checks inside and around the home. All findings will be dealt with immediately. Please see attached maintenance safety checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented ([redacted] - 09/13/2024)

100a - Exterior - Free of Hazards

12. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

There is an uncovered drain in the concrete slab outside of the basement emergency exit. There is a raised open grate on the landing outside the kitchen emergency exit. Both of these provide a tripping hazard when using these exits.

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

Immediate the administrator contacted maintenance to report both of these trip hazards. Maintenance came out and repaired the uncovered drain and the raised grate. A staff meeting was held on 6/21/24 where the administrator reviewed regulation 100a. free of hazards. Moving forward the maintenance department will conduct monthly safety checks inside and around the home. All findings will be dealt with immediately. Please see attached maintenance safety checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented ([redacted] - 09/13/2024)

103f - Refrigerator/Freezer Temps

13. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 5/22/24 at 10:02 A.M. the temperature in the freezer was 10 degrees Fahrenheit and at 10:16 A.M. it was 4 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

Immediately on 5/22/2024 our maintenance adjusted the temperature set on the freezer to reflect below 0 degrees Fahrenheit. A staff meeting was held on 6/21/24 where the administrator reviewed violation 103F. refrigerator/freezer temps. Moving forward staff will conduct daily freezer shift checks and document using the refrigerator log on going. Please see attached refrigerator/freezer log and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented ([redacted] - 09/13/2024)

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

On 5/22/24 at the kitchen door was locked and blocked egress from the home's kitchen emergency exit. The administrator stated the home's kitchen door is always locked.

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

Immediately on 5/22/24 the kitchen door was unlocked and will continue to be unlocked. To ensure this is carried out the doorknob was changed to an unlockable knob. A staff meeting was held on 6/21/24 where the administrator educated staff on regulation 123a. and how important it is to keep all stairways, hallways, doorways, passageways

121a - Unobstructed Egress (continued)

and egress routes from rooms and from the building unlocked and unobstructed. The administrator will conduct monthly site checks to ensure unobstructed egress. These checks began on 5/23/24 and will continue for a year. Please see attached admin checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 09/13/2024)

125a - Combustible Storage

15. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

On 5/22/24 at 10:47 A.M. two box springs, covered in plastic, were stored within three feet of the heater. The home could not provide documentation that the plastic coverings were non-flammable.

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

Immediately on 5/22/2024 maintenance removed two box springs that were covered with plastic that were located near the heat source. Moving forward, the maintenance department will not store any box spring in the maintenance supply room. The maintenance department will also conduct monthly safety checks inside and around the home. All findings will be dealt with immediately. Please see attached maintenance safety checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 09/13/2024)

133.1 - Exit Signs

16. Requirements

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits.

Description of Violation

There is no exit sign over the kitchen doorway. An emergency exit is located at the far end of the kitchen. The home currently serves 9 residents.

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

Immediately on 5/22/2024 our maintenance installed an exit sign over the kitchen doorway that leads to the emergency exit that is located at the far end of the kitchen. The maintenance department will also conduct monthly safety checks inside and around the home. All findings will be dealt with immediately. A staff meeting was held on 6/21/24 where the administrator reviewed violation 133.1 exit signs. Please see attached maintenance safety checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 09/13/2024)

141a 1-10 Medical Evaluation Information

17. Requirements

141a 1-10 Medical Evaluation Information *(continued)*

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

Resident #2's medical evaluation states that the resident [redacted]. However, the resident requires [redacted]

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

On 5/22/2024 Resident #2 PCP was notified, and an appointment was scheduled to review, evaluate, and update Resident #2 medical Evaluation form. The Care coordinator took Resident #2 to the doctor's office for an evaluation on [redacted] and [redacted] PCP updated [redacted] medical evaluation form. A staff meeting was held on 6/21/24 where the administrator reviewed violation 141a annual medial evaluation. Moving forward the care coordinator will review all Medical Evaluation Information on the resident's form before they leave the doctor's office. The administrator will review the residents' forms and all chart paperwork monthly, for 1 year end date 5/23/2025. Please see attached administrator house checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 09/13/2024)

141b1 - Annual Medical Evaluation

18. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's most recent medical evaluation was completed on [redacted] The resident's previous medical evaluations were completed on [redacted].

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

On 6/13/24 a new, updated annual medial evaluation was completed by resident #2 doctor. A staff meeting was on 6/21/24 where the administrator reviewed regulation 141b1 annual medical evaluation. Moving forward the administrator will conduct monthly resident chart checks to ensure all resident receive a medical evaluation at least annually. These checks began on 5/23/24 and will continue for a year. Please see attached admin checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 09/13/2024)

144c1 - Smoking Area Guidelines

19. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home's designated smoking area is the gazebo off the back parking lot. There was a paper cup filled with water and cigarette ashes found shoved behind the down spout on the third floor landing off the emergency exit located across from the staff office.

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

Immediately on 5/22/24, the paper cup that was filled with water and cigarette ashes was removed off the emergency exit landing located across from the office. A non Smoking sign was placed on the outside exit door as well as inside exit door. A staff meeting was held to discuss the home designated smoking area and review of violation144c1 smoking area guidelines. All staff understand the importance of smoking in the designated smoke area and where that area is located. Moving forward the administrator will conduct monthly house checks for one year, to ensure all staff are complying to the rules and safety policy of the home. This will start on 5/23/2024 and end on 5/23/2025. Please see attached administrator house checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 09/13/2024)

162c - Menus Posted

20. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menu for the week of 5/19/24 was posted. However, the week of 5/26/24 was not posted.

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

Immediately on 5/23/24 two weeks of menus were posted in the home so that all residents and staff will be aware of what food will be severed in advance. A staff meeting was held on 6/21/2024 where the administrator reviewed violation 162c. menus posted. The direct support supervisor will conduct weekly checks of the menus to ensure that they are posted a minimum of 1 week in advance. The administrator will conduct monthly house checks to ensure the menus are posted in advance. These checks began on 5/23/24 and Please see attached administrator house checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 09/13/2024)

183f - Discontinued Medications

21. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

The following medications, belonging to resident 4 were found in a supply closet on 5/22/24. This is not an approved method of destroying medications according to the Department of Environmental Protection and Federal and State regulation:

- [redacted] *discontinued on 3/5/24*
- [redacted] *, discontinued on 5/6/24*

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

Immediately on 5/22/24 the two discontinued medications were placed in the pill destroyer. A staff meeting was held on 6/21/24 where the administrator reviewed the regulation 183f discontinued medications. Moving forward the administrator will conduct monthly site discontinued med checks audits. This will ensure that staff are properly disposing any discontinued medications. These checks began on 5/23/24 and will continue for a year. Please see attached admin checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 09/13/2024)

225c - Additional Assessment

23. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #2's assessment, dated [redacted], does not reflect the resident's current needs of [redacted]

Plan of Correction ***Accept ([redacted] - 07/02/2024)***

Immediately on 5/22/24 The Direct support supervisor staff updated resident #2 assessment as a significant change, due to [redacted] A staff meeting was held on 6/21/24 where the administrator reviewed violation 225.C addition assessments. Moving forward the direct care supervisor and care coordinator will review all residents' Assessment forms before they are filed. The administrator will review the residents' forms and all chart paperwork monthly, for 1 year end date 5/23/2025. Please see attached administrator house checklist and staff meeting/ review of violations held on 6/21/24.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Not Implemented ([redacted] - 09/13/2024)