



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: [REDACTED]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: AUGUST 20, 2024

[REDACTED]
450 East Philadelphia Avenue Operations LLC
450 East Philadelphia Avenue
Shillington, Pennsylvania 19607

RE: Mifflin Court
License: 222061

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on March 26, 2024, March 28, 2024, and May 31, 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 222060) dated April 2, 2024, to April 2, 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. The license dated April 2, 2024 to April 2, 2025 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from August 20, 2024 to February 20, 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.


Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 or 2800 Section:	Class of Violation	Census at Inspection X	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
184a	II	49	\$5	\$245	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

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:


 Pennsylvania Department of Human Services Bureau of Human
 Services Licensing
 Room 631, Health and Welfare Building 625 Forster Street
 Harrisburg, Pennsylvania 1712
 PH: 717-265-8942

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,

A handwritten signature in black ink that reads "Juliet Marsala". The signature is written in a cursive, flowing style.

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:



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

Facility Information

Name: *MIFFLIN COURT* License #: *22206* License Expiration: *04/02/2025*
Address: *450 EAST PHILADELPHIA AVENUE, SHILLINGTON, PA 19607*
County: *BERKS* Region: *NORTHEAST*

Administrator

██████████ Phone: ██████████

Legal Entity

Name: *450 EAST PHILADELPHIA AVENUE OPERATIONS LLC*
Address: *450 EAST PHILADELPHIA AVENUE, SHILLINGTON, PA, 19607*
Phone: ██████████

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *10/30/1987* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *66* Waking Staff: *50*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Interim* Exit Conference Date: *05/31/2024*

Inspection Dates and Department Representative

05/31/2024 - On-Site: ██████████

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *67* Residents Served: *49*

Secured Dementia Care Unit

In Home: *Yes* Area: *n/a* Capacity: *14* Residents Served: *14*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *49*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *17* Have Physical Disability: *0*

Inspections / Reviews

05/31/2024 - Partial

Lead Inspector: ██████████ Follow-Up Type: *Bypass Document Submission*

08/02/2024 - Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/17/2024

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

100a - Exterior - Free of Hazards

1. 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

The grounds surrounding the concrete patio areas of the memory care courtyard were overgrown with grass and weeds approximately one foot tall.

Plan of Correction

Directed [REDACTED] 07/01/2024)

Directed Plan of Correction:

The home will be responsible for maintaining the grass and weeds in the home's memory care courtyard weekly. The home's administrator will conduct weekly checks of memory care courtyard. The home's administrator will be responsible for maintaining compliance.

Directed Completion Date: 07/16/2024

Not Implemented [REDACTED] - 07/17/2024)

132h - Designated Meeting Place

2. Requirements

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

The home conducted a fire drill on 5/20/24 at 9pm. Resident #1 was not evacuated during the fire drill.

Plan of Correction

Directed [REDACTED] 07/02/2024)

Directed Plan of Correction:

The home's administrator will educate resident #1 on mandatory evacuation requirements during a fire drill. The home's administrator will be responsible for all residents evacuating to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Directed Completion Date: 07/16/2024

Not Implemented [REDACTED] - 07/17/2024)

183d - Prescription Current

3. Requirements

2600.

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

Description of Violation

During the medication cart audit the medication Divalproex Sodium 125mg was found in the cart for resident #4. Resident #4 does not have a current order for this medication.

183d - Prescription Current (continued)

Plan of Correction

Directed [REDACTED] 07/02/2024)

Directed Plan of Correction:

The home's administrator will get a medication order from resident #4's Physican or have the medication DC. The administrator will be responsible for all medications techs being retrained in this regulation. The home will conduct monthly audits of the home's medication carts. The home's administrator will be responsible for maintaining compliance.

Directed Completion Date: 08/01/2024

Not Implemented [REDACTED] - 08/02/2024)

183e - Storing Medications

4. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

The Novolin insulin pen belonging to resident #2 was not dated and initialed when the pen was opened for use. The Novolog insulin pen for resident #3 was also not dated and initialed when it was opened for use.

Plan of Correction

Directed [REDACTED] - 07/02/2024)

Directed Plan of Correction:

The home's administrator will have resident #2 and #3's insulin dated when opened. The administrator will be responsible for all medications techs being retrained in this regulation. The home will conduct monthly audits of the home's medication carts. The home's administrator will be responsible for maintaining compliance.

Directed Completion Date: 08/01/2024

Not Implemented [REDACTED] - 08/02/2024)

184a - Resident's Meds Labeled

5. Requirements

2600.

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

- 4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #2 has an order for Novolin insulin, 20 units twice daily. The pharmacy label for the medication states the order for Novolin insulin is 12 units in the morning and 14 units in the afternoon.

Also, resident #5 has an order for Lantus insulin, 14 units every morning. The pharmacy label for the medication states the order for Lantus is 15 units every morning.

Repeated Violation 5-24-23 et al.

184a - Resident's Meds Labeled (continued)

Plan of Correction

Directed [REDACTED] - 07/02/2024)

Directed Plan of Correction:

The home's administrator will get resident #2 and #3's pharmacy labels updated to match the resident's MARs. The administrator will be responsible for all medications techs being retrained in this regulation. The home will conduct weekly audits of the resident's insulin orders matching the resident's MARs. The home's administrator will be responsible for maintaining compliance.

Directed Completion Date: 08/01/2024

Not Implemented [REDACTED] - 08/02/2024)

187a - Medication Record

6. Requirements

2600.

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

- 12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #3's Medication administration record (MAR) did not list diagnoses or purposes for the medications Magnesium Oxide and Ferrous Sulfate.

Plan of Correction

Directed [REDACTED] - 07/02/2024)

Directed Plan of Correction:

The home's administrator will be responsible for listing the diagnoses or purpose for resident #3's Magnesium Oxide and Ferrous Sulfate. The home's administrator will be responsible to audit and update all resident's MARs for diagnoses or purpose for all resident's medications on a monthly basis. The administrator will be responsible for all medications techs being retrained in this regulation. The home's administrator will be responsible for maintaining compliance.

Directed Completion Date: 08/01/2024

Not Implemented [REDACTED] - 08/02/2024)

187c - Refusal of Medication

7. Requirements

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 5/24/24 and 5/25/24 resident #4 did not receive the medication Metoprol Tartrate at 9am. It was determined through staff interview that the resident refused the medication on those dates but the refusal was not documented on the MAR.

187c - Refusal of Medication (continued)

Plan of Correction

Directed [REDACTED] - 07/02/2024)

Directed Plan of Correction:

The home's administrator will notify resident's #4's physician that resident #4 refused their Metoprol Tartrate and retain documentation from the resident's physician. The administrator will be responsible for all medications techs being retrained in this regulation. The home will conduct weekly audits of all resident's refusals and will notify the resident's physician. The home's administrator will be responsible for maintaining compliance.

Directed Completion Date: 08/01/2024

Not Implemented [REDACTED] - 08/02/2024)

187d - Follow Prescriber's Orders

8. Requirements

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

Description of Violation

Resident #2 has an order for Novolin insulin, 20 units twice daily, hold for blood sugar less than 120. On 5/3/24 the resident's blood sugar was 116 in the morning and the insulin was administered.
On 5/4/24 the resident's blood sugar was 117 in the morning and the insulin was administered.
Resident #3 has an order for Glargine insulin, 38 units once daily. The insulin was not administered on 5/18/24, 5/19/24, and 5/28/24.
Resident #4 has an order for Metoprolol Tartrate 25mg, twice daily, hold for systolic blood pressure (SBP) less than 110 or heart rate less than 60. On the following dates and times the medication was not held as per the physician's orders:
5/10/24 at 9pm the heart rate was 52.
5/14/24 at 9pm the heart rate was 59
5/18/24 at 9pm the heart rate was 57 and the SBP was 107
5/19/24 at 9pm the SBP was 108
5/29/24 at 9am the heart rate was 57.
Also, on the following dates and times resident #4 did not receive these medications:
5/7/24—Loratadine 10mg at 9am; 5/19/24—Atorvastatin Calcium at 9pm.

Plan of Correction

Directed [REDACTED] - 07/02/2024)

Directed Plan of Correction:

The home's administrator will ensure all med techs are following prescriber's orders. The administrator will be responsible for all medications techs being retrained in this regulation. The home will conduct weekly audits of the home's MARs to ensure that the home is following prescriber's orders. The home's administrator will be responsible for maintaining compliance.

Directed Completion Date: 08/01/2024

Not Implemented [REDACTED] - 08/02/2024)

227d - Support Plan Medical/Dental

9. Requirements

227d - Support Plan Medical/Dental (continued)

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

Residents #6, #7, and #8 all have enabler bars attached to their beds. The support plans for those residents do not include the type of enabler bar attached to their beds and do not indicate if the enabler bars need to be covered to meet FDA guidelines:

Resident #6—Support plan addendum dated 2/27/24;

Resident #7 —Support plan addendum dated 2/27/24

Resident #8—Support plan addendum dated 2/27/24.

Plan of Correction

Directed [redacted] - 07/02/2024)

Directed Plan of Correction:

The home's administrator will immediately update resident #6, #7, and 8's RASPs to indicate the resident's use of an enabler bar attached to the resident's beds. The administrator will be responsible for all staff being retrained in this regulation. The home will conduct an audit of residents RASPs who is using an enabler bar. The home's administrator will be responsible for maintaining compliance.

Directed Completion Date: 07/16/2024

Not Implemented [redacted] - 07/17/2024)

233c - Key-Locking Devices

10. Requirements

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The gate located in the memory care courtyard was equipped with a magnetic lock; the code to operate the gate’s keypad was not posted at or near the gate.

Plan of Correction

Directed [redacted] - 07/02/2024)

Directed Plan of Correction:

The required directions will be posted near the identified doors. The home will conduct weekly audits of all magnetic lock for codes to operate the magnetic locks are posted. The home's administrator will be responsible for maintaining compliance.

Directed Completion Date: 07/16/2024

Not Implemented [redacted] - 07/17/2024)

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

Facility Information

Name: *MIFFLIN COURT* License #: *22206* License Expiration: *04/02/2024*
Address: *450 EAST PHILADELPHIA AVENUE, SHILLINGTON, PA 19607*
County: *BERKS* Region: *NORTHEAST*

Administrator

Name: [REDACTED]

Legal Entity

Name: *450 EAST PHILADELPHIA AVENUE OPERATIONS LLC*
Address: *450 EAST PHILADELPHIA AVENUE, SHILLINGTON, PA, 19607*
Phone: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *10/30/1987* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *58* Waking Staff: *44*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Complaint* Exit Conference Date: *03/28/2024*

Inspection Dates and Department Representative

03/26/2024 - On-Site: [REDACTED]
03/28/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *67* Residents Served: *42*

Secured Dementia Care Unit

In Home: *Yes* Area: *n/a* Capacity: *14* Residents Served: *12*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *42*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *16* Have Physical Disability: *0*

Inspections / Reviews

03/26/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/18/2024*

04/23/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/22/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 04/17/2024

07/10/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/26/2024

Reviewer: [REDACTED]

Follow-Up Type: Bypass Document
Submission

07/17/2024 - Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/10/2024

Reviewer: [REDACTED]

Follow-Up Type: Enforcement

25c2 - Fee Schedule

1. Requirements

2600.

25.c. At a minimum, the contract must specify the following:

- 2. A fee schedule that lists the specify the following: actual amount of allowable resident charges for each of the home's available services.

Description of Violation

The contract dated [REDACTED]/23 for resident #1 did not include the monthly fee charged for the home's fall monitoring service "Safely You".

Plan of Correction

Accept [REDACTED] 04/29/2024)

An addendum is in place for any changes to fees for our residents on 4/2/2024. Our business office manager will be responsible for ensuring compliance for this matter. All addendums have been addressed and signed by our current residents. This process has begun immediately

Licensee's Proposed Overall Completion Date: 04/25/2024

Not Implemented [REDACTED] - 07/16/2024)

65a - FS Orientation 1st Day

2. 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

Staff person A was hired [REDACTED]/23. The training sheet for the topics required under this regulation was not signed by the staff person to verify that the staff person received the trainings.

Staff person B was hired [REDACTED] 23. Staff person B's training sheet was also not signed by the staff person to verify the person received the trainings.

Plan of Correction

Accept [REDACTED] - 04/29/2024)

Our new business office manager was in-serviced on the proper training required by DHS and who needs to acknowledge receipt and where on 4/2/2024. Annual Training for the staff will begin May 22nd. The BOM will be responsible for maintaining compliance and the ED will be responsible for overseeing that compliance is maintained effective immediately. Staff members A and B were re-educated on 4/8/2024. The BOM and the ED did an audit on the employee files to confirm compliance on 4/4/2024.

Licensee's Proposed Overall Completion Date: 04/25/2024

Implemented [REDACTED] - 07/10/2024)

65b - Rights/Abuse 40 Hours

3. 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 person A was hired [REDACTED] 23. The training sheet for the topics required under this regulation was not signed by the staff person to verify that the staff person received the trainings.

Staff person B was hired [REDACTED] 23. Staff person B's training sheet was also not signed by the staff person to verify the person received the trainings.

Plan of Correction

Accepted [REDACTED] - 04/29/2024)

Both employees in question were trained and their papers were signed off on 4/1/2024. The BOM will be responsible for maintaining compliance of the mandatory day 1 training and all required signatures. This is effective immediately. An audit was done for all employee files and completed by 4/5/2024 with all of the trainings completed.

Licensee's Proposed Overall Completion Date: 04/26/2024

Implemented [REDACTED] - 07/10/2024)

65f - Training Topics

4. 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.

Description of Violation

Staff person C did not receive training in the following required annual topics during the 2023 training year: Medication self administration and Meeting the needs of the residents using the medical evaluation, support plan, and pre screen forms.

Plan of Correction

Accepted [REDACTED] - 04/29/2024)

HR is responsible for scheduling the annual training effective Immediately. The ED will trust but verify every quarter to ensure there is headway made towards completion of the annual training. Inservicing begins in May. Staff member C was trained on 4/4/2024 and a complete audit of all staff was completed on 4/10/2024

Licensee's Proposed Overall Completion Date: 04/26/2024

Implemented [REDACTED] - 07/10/2024)

65g - Annual Training Content

5. Requirements

65g - Annual Training Content (continued)

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.
- 4. The Older Adult Protective Services Act (35 P.S. § 10225.101—10225.5102).
- 5. Falls and accident prevention.

Description of Violation

Staff persons C and D did not receive training in the following required annual topics during the 2023 training year: Fire safety conducted by a fire safety expert, Older adult protective services Act, and Falls and accident prevention.

Plan of Correction

Accept () - 04/29/2024)

All staff are scheduled for their annual training, effective May 2024. This will be monitored by HR with ED oversight. Training will happen every other month to ensure compliance by all staff is completed by December of every year. Staff C & D made up their missing inservices on 4/1/2024 and 4/4/2024. The BOM, (), is responsible for ensuring these inservices are completed and will do an audit after every new hire to ensure that are signed off on and completed correctly beginning 4/1/2024. The BOM and ED will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: 04/26/2024

Implemented () - 07/10/2024)

82c - Locking Poisonous Materials

6. Requirements

2600.

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

Description of Violation

During the initial walk through the memory care kitchenette area was unattended by staff and the gate leading into the kitchenette area was unlocked, allowing residents who were seated in the adjacent dining area to have access to the area. Lysol, Virex, and Dawn dish liquid were stored in a cupboard under the sink in the kitchenette.

Plan of Correction

Accept () - 04/23/2024)

Inservice was provided to staff on 4/15/2024 and a child lock was placed on the cabinet containing chemicals on our memory support unit. All chemicals were also removed from the unit and placed in a closet outside of the unit. Our memory support director will be in charge of maintaining compliance as of 4/11/2024

Licensee's Proposed Overall Completion Date: 04/11/2024

Implemented () - 07/10/2024)

121a - Unobstructed Egress

7. 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 keypad installed next to the gate used to exit the memory care courtyard was not functioning when it was tested

121a - Unobstructed Egress (continued)

during the initial walk through.

Plan of Correction

Accept [REDACTED] - 04/23/2024)

The Keypad was fixed the next business day and our maintenance director will be responsible for doing weekly walk-throughs to ensure we have operating keypads at all times.

Licensee's Proposed Overall Completion Date: 04/11/2024

Implemented [REDACTED] - 07/10/2024)

125a - Combustible Storage

8. Requirements

2600.

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

Description of Violation

During the initial walk through, 3 white cotton blankets were found stacked on a chair located in the home's designated smoking area.

Plan of Correction

Accept [REDACTED] - 04/29/2024)

All staff were reeducated on fire safety and requirements for our smoking area for the residents on 4/15/2024. The Ed and Maintenance will be responsible for ensuring compliance. It will be added to the ED's daily rounds. The blankets that were found were removed immediately from the area.

Licensee's Proposed Overall Completion Date: 04/26/2024

Implemented [REDACTED] 07/10/2024)

132h - Designated Meeting Place

9. Requirements

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

The home's fire drill logs indicate that during the fire drill conducted 8/19/23 at 1:56am only 40 of the 46 residents present in the home at the time of the drill were evacuated. The drill log indicates six residents on hospice did not participate in the drill.

Plan of Correction

Accept [REDACTED] 04/22/2024)

Staff was in-serviced on fire drill responsibilities on 4/15/2024 and re- educated on when it is appropriate to allow a resident to remain in their room during a routine fire drill. We have maintained compliance since the date in question. The DHW will be responsible for maintaining compliance and education in the community.

Licensee's Proposed Overall Completion Date: 04/11/2024

Not Implemented [REDACTED] - 07/10/2024)

141a - Medical Evaluation

10. 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.

Description of Violation

Resident #2 was admitted to the home on [REDACTED]/23. The resident’s documentation of medical evaluation (DME) form indicates the resident was evaluated 6/1/23, more than 60 days prior to admission.

Plan of Correction

Accept [REDACTED] - 04/29/2024)

This was fixed immediately and we have had no incidents occur since this specific DME. Our DHW will be responsible for ensuring that the DME and the admission date meet the mandatory deadline. The DHW will be also be responsible for maintaining compliance moving forward. The DME was corrected on 3/28/2024. A complete audit was done on 4/2/2024 of all charts.

Licensee's Proposed Overall Completion Date: 04/26/2024

Implemented [REDACTED] - 07/10/2024)

182b - Prescription Medication

11. Requirements

2600.

182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

- 4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person A passes medications. The home did not have documentation that staff person A completed the required medication administration course. Staff person E also passes medications; staff person E's most current annual practicum indicates only 1 medication administration record (MAR) review and 1 medication administration observation completed by 7/25/23

Plan of Correction

Accept [REDACTED] 04/29/2024)

Both staff members have retaken the Pennsylvania Med Admin class and passed. This was completed on 4/1/24. The DHW will be responsible for ensuring the med techs are assessed every 6 months and maintain appropriate documentation to maintain compliance. The community did a full audit of all Med Techs certifications on 4/3/2024

Licensee's Proposed Overall Completion Date: 04/26/2024

Implemented [REDACTED] - 07/10/2024)

183d - Prescription Current

12. Requirements

2600.

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

Description of Violation

The Wixela Hub Fluticasone inhaler belonging to resident #3 was labeled to indicate it was removed from the package for use on 1/11/24. According to manufacturer’s instructions the inhaler is to be disposed of one month after removal from the package for use.

183d - Prescription Current (*continued*)

Plan of Correction

Accept [REDACTED] - 04/22/2024)

A list of inhalers, and when they expire has been posted in our med room for reference as of 4/12/24. The DHW will be responsible for maintaining ongoing compliance.

Licensee's Proposed Overall Completion Date: 04/12/2024

Not Implemented [REDACTED] - 07/10/2024)

184a - Resident's Meds Labeled

13. 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.

Description of Violation

Resident #4's Novolog insulin pen was stored in a box with no pharmacy label.

Resident #4's Levemir insulin pen pharmacy label indicates the daily dose is 60 units. The MAR indicates the daily dose is actually 32 units. Repeated Violation 5-24-23 et al.

Plan of Correction

Accept [REDACTED] - 04/23/2024)

All insulin pens are stored with the appropriate label attached. The DHW is responsible for maintaining compliance. The DHW will do monthly checks to ensure we are maintaining the standard. This process will begin on 4/15/2024

Licensee's Proposed Overall Completion Date: 04/15/2024

Not Implemented [REDACTED] - 07/10/2024)

185a - Implement Storage Procedures

14. 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 #4 has an order for blood glucose monitoring three times daily with meals. On the following dates the resident's 7:30am blood glucose readings were documented incorrectly on the MAR:

- 3/13/24—the blood glucose reading was 253 but documented as 256*
- 3/18/24—the blood glucose reading was 253 but documented as 256*
- 3/24/24—the blood glucose reading was 246 but documented as 248*

Plan of Correction

Accept [REDACTED] - 04/29/2024)

Staff was in-serviced on documenting glucose readings immediately after testing on 4/15/2024. The DHW will be doing monthly audits on the glucometers to ensure proper usage and documentation are occurring. 5/1/2024. A full audit of glucometers was done on 3/30/2024

185a - Implement Storage Procedures (continued)

Licensee's Proposed Overall Completion Date: 04/26/2024

Implemented [redacted] - 07/10/2024)

187a - Medication Record

15. Requirements

2600.

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

12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #4's MAR did not indicate a diagnosis or purpose for the medications Furosemide and Magnesium Oxide.

Plan of Correction

Accept [redacted] - 04/23/2024)

DHW made proper adjustments to the MAR. An in-service was provided to nursing staff on proper change-over techniques to ensure this does not get missed in the future on 4/16/24. 3rd shift nurse will review the MARS upon changeover. The DHW will be responsible for checking the work and the ED will be responsible for maintaining compliance

Licensee's Proposed Overall Completion Date: 05/01/2024

Not Implemented [redacted] - 07/10/2024)

187d - Follow Prescriber's Orders

16. Requirements

2600.

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

Description of Violation

Resident #4 has an order for blood glucose readings 3 times daily with meals and insulin administered on a sliding scale. On 3/17/24 at 7:30am the blood glucose reading was 238 requiring 4 units of sliding scale insulin; 6 units of insulin were administered.

Resident #4 has an order for Tamsulosin, 2 caps once daily; on 3/3/24 the medication was not administered.

Resident #5 has an order for Olopatadine HCL drops, one drop into each eye daily; the medication was not administered from 3/20/24 through 3/28/24 and was not found in the medication cart to be administered.

Resident #6 has an order for Losartan 50mg tablets, to be held for heart rate less than 55 and systolic blood pressure (SBP) less than 110. On 3/17/24 the medication was initialed as administered but the pulse and blood pressure were not documented.

Also, resident #6's 9pm order for Memantine 5mg tablet was not administered on 3/13/24.

Resident #7 has an order for Docusate Sodium, one capsule two times daily; the medication was not administered from 3/25/24 through 3/28/24 due to not being available in the medication cart.

Plan of Correction

Accept [redacted] - 04/29/2024)

All staff were spoken to and in-serviced on the proper distribution of medications, Vitals signs, the need for diagnosis for each med and following prescriber's orders to the T on 4/9/2024, 4/10/2024, and 4/11/2024. Any missed

187d - Follow Prescriber's Orders (continued)

medication MUST notify the PCP and document. The DHW will be responsible for ongoing compliance and weekly checks to the MARS. An audit was conducted on 4/5/2024 of all MARS.

Licensee's Proposed Overall Completion Date: 04/26/2024

Not Implemented [redacted] - 07/10/2024)

224a - Preadmission Screen Form

17. Requirements

2600.

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 dated [redacted]/23 for resident #1 did not indicate the resident's level of supervision needed.

Plan of Correction

Accept [redacted] - 04/29/2024)

The new DHW was made aware of this regulation and will be responsible for maintaining the compliance of the prescreen moving forward. The ED and Admissions Director will review the prescreen form to help oversee the process. The preadmission screening was corrected on 3/28/2024, The admissions director will review each prescreen as it is completed for accuracy and then given to the RCD for any changes. An audit of all pre admission screenings was done on 4/9/2024.

Licensee's Proposed Overall Completion Date: 04/26/2024

Implemented [redacted] - 07/10/2024)

227d - Support Plan Medical/Dental

18. 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

Resident #1 has an enabler bar attached to their bed. The support plan dated [redacted]/23 does not specify the need for the device, any risks associated with the device, the resident's ability to use the device safely for the intended purpose, identification of the specific device to be used and if a cover is required to meet FDA guidelines.

Also, resident #1 was admitted to hospice services on [redacted] 3. The resident's support plan dated 4/22/23 was not updated to reflect this.

Residents #1, #2, and #6 have the home's fall monitoring system "Safely You" activated in their rooms to monitor falls. The home did not document this on resident #1's support plan dated 4/22/23, on resident #2's support plan dated 10/2/23, or on resident #6's support plan dated 10/22/23.

Plan of Correction

Accept [redacted] - 04/23/2024)

DHW was educated on the information needed for a RASP. The correct verbiage has been added to all residents

227d - Support Plan Medical/Dental (continued)

who use an Enabler bar. After speaking with DHS it was discovered that our Safely You system would need to be added to the RASP as well. All resident documents have been updated appropriately as of 4/5/24 and the DHW will be responsible for maintaining compliance

Licensee's Proposed Overall Completion Date: 04/12/2024

Not Implemented [REDACTED] - 07/10/2024)

227g -Support Plan Signatures

19. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #2 was admitted to the home on [REDACTED]/23. The support plan completed on 10/2/23 was not signed by the resident.

Plan of Correction

Accept [REDACTED] 04/23/2024)

The support plan of this resident has been updated to reflect the necessary signatures as of 4/5/2024. The DHW will be held responsible for ensuring that all required signatures are obtained during the review of the plan. The ED will be responsible for double-checking the RASPS to ensure compliance every month.

Licensee's Proposed Overall Completion Date: 05/01/2024

Not Implemented [REDACTED] - 07/16/2024)