



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to ET 141 OPERATIONS LLC
LEGAL ENTITY

To operate ELIZABETHTOWN PERSONAL CARE
NAME OF FACILITY OR AGENCY

Located at 141 HEISEY AVENUE, ELIZABETHTOWN, PA 17022
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide Personal Care Homes
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed 39
(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 August 23, 2024 until February 23, 2025,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **338812**

Janette Biderup
ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.



CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: AUGUST 23, 2024

[REDACTED]

ET 141 Operations LLC

[REDACTED]

RE: Elizabethtown Personal Care
141 Heisey Avenue
Elizabethtown, Pennsylvania 17022
License #: 338812

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on April 2, 2024 and June 4, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND 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);(4) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed.


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:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
2600.51	III	26	\$3	\$78	15 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 SECOND 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. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, 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 17120
 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,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summaries

cc:



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

Facility Information

Name: *ELIZABETHTOWN PERSONAL CARE* License #: *33881* License Expiration: *06/28/2024*
Address: *141 HEISEY AVENUE, ELIZABETHTOWN, PA 17022*
County: *LANCASTER* Region: *CENTRAL*

Administrator

Name: [REDACTED]

Legal Entity

Name: *ET 141 OPERATIONS LLC*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *12/07/1992* Issued By: *Dept of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *28* Waking Staff: *21*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Provisional* Exit Conference Date: *04/02/2024*

Inspection Dates and Department Representative

04/02/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *39* Residents Served: *28*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *9* Are 60 Years of Age or Older: *27*
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *0* Have Physical Disability: *0*

Inspections / Reviews

04/02/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/26/2024*

Inspections / Reviews (*continued*)

04/29/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 04/26/2024
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 05/06/2024

07/03/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 05/06/2024
Reviewer: [REDACTED] Follow-Up Type: Bypass Document Submission

07/18/2024 - Bypass Document Submission

Submitted By: [REDACTED] Date Submitted: 07/03/2024
Reviewer: [REDACTED] Follow-Up Type: Enforcement

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 4/2/2024, the home's most current licensing summary issued by the Department, dated 11/15/2023 was not posted in a conspicuous and public place in the home.

Repeated Violation – 7/13/2023, et al

Plan of Correction

Accept (████ - 05/07/2024)

On 4/2/2024, the home's most current licensing summary issued by the Department, dated 11/15/2023 was posted to the bulletin board in main entrance area of home by front desk. All personal care home staff given verbal education on 4/15/2024 by Administrator that summary must remain on bulletin board.

Administrator will round weekly for 4 weeks then ongoing monthly thereafter, beginning 4/29/24 to ensure current summary remains posted on board.

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

Implemented (████ - 07/18/2024)

51 - Criminal Background Check

2. 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 Member A was hired █████/2023; however, a Pennsylvania State Police Criminal Background Check was not obtained for Staff Member A until 2/29/2024.

Repeated Violation – 7/13/2023, et al

Plan of Correction

Accept (████ - 05/07/2024)

Administrator provided verbal education to Human Resources Coordinator on 4/15/2024 regarding all background checks being completed prior to date of hire. Beginning 5/6/2024, Administrator will review all new hire onboarding checklists to ensure completion prior to first day of work. All employee files will be audited by 5/31/2024.

Administrator will audit all existing employee files and all new hire files as received and quarterly thereafter.

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

Not Implemented (████ - 07/18/2024)

63a - First Aid/CPR Training

3. Requirements

63a - First Aid/CPR Training (continued)

2600.

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

Description of Violation

During the night shifts (10:00PM-6:00AM) from 3/17/2024 through 3/23/2024, 28 residents were present in the home. During this time, 0 staff were present in the home who were certified in CPR/First Aid.

Plan of Correction

Accept [REDACTED] - 05/07/2024)

Human Resources Coordinator will audit all employee files to ensure current CPR card copies are in employee file on 4/29/2024.

Due to size of home, only CPR certified staff member is required to be scheduled each shift. Beginning 5/6/2024, Administrator will ensure at least 1 CPR certified staff member is scheduled.

Beginning 5/15/2024, Human Resources Coordinator will complete quarterly audits of employee CPR certifications to maintain compliance.

Staff in need of CPR recertification will attend scheduled CPR training on 5/10/24 and certification will be copied and placed in employee file upon completion.

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

Implemented [REDACTED] - 07/18/2024)

65a - FS Orientation 1st Day**4. 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 Member A, whose first day of work was [REDACTED] 2023, did not receive orientation on the following topics until 2/22/2024:

(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

Repeated Violation – 11/15/2023

Plan of Correction [REDACTED] - 05/07/2024)

On 4/11/2024, Administrator provided verbal education to human resources coordinator and maintenance director regarding completion of training prior to or on first day work.

Beginning 5/15/2024, Administrator will review all new hire files prior to first day of work and on first day of work to ensure completion of orientation requirements.

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

Implemented [REDACTED] - 07/18/2024)

65e - 12 Hours Annual Training

5. Requirements

- 2600.
- 65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
 1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
 2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Staff Member B, Med Tech hired [REDACTED] /2021, did not have at least 12 hours of annual training relating to [REDACTED] job duties in training year 2023.

Plan of Correction [REDACTED] - 05/07/2024)

Administrator/ Designee will provide monthly in-service trainings to all direct care staff to meet requirement of 12 hours of annual training related to job duties.

Beginning 5/15/2024, Administrator will complete audit of staff member's training records to ensure receipt of required annual trainings.

Administrator will be responsible for ensuring staff receive required monthly trainings. Administrator will review staff training schedule for 2024 by 5/31/2024.

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

Implemented [REDACTED] - 07/18/2024)

65f - Training Topics

6. 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.

65f - Training Topics (*continued*)

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

Staff Member B did not receive training in the following topics during training year 2023:

- (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.*

Plan of Correction

Accept (████ - 05/07/2024)

Administrator/ Designee will provide monthly staff in-service trainings to direct care staff to include required topics.

Administrator is responsible for ensuring training topics are completed timely for new hires. Administrator will provide Human Resources Coordinator verbal education on 5/6/2024 regarding required training topics.

Administrator will provide education to Staff member B on missing training topics by 5/31/2024.

Human Resources Coordinator will complete review of all staff records by 5/31/2024 to ensure receipt of training on required topics.

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

Implemented (████ - 07/03/2024)

65g - Annual Training Content

7. 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.

65g - Annual Training Content (continued)

Description of Violation

Staff Member B did not receive training in the following topics during training year 2023:

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.

Plan of Correction

Accept [REDACTED] - 05/07/2024)

Administrator/ Designee will provide annual in-service trainings to all required staff on required topics.
Administrator is responsible to ensure annual trainings are completed.

Administrator will provide education to Staff member B on missing training topics by 5/31/2024.

Human Resources Coordinator will complete review of all staff records by 5/31/2024 to ensure receipt of training on required topics.

By 5/31/2024, Administrator will review current training plan and if needed update topics to include required trainings.

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

Implemented [REDACTED] 07/03/2024)

85a - Sanitary Conditions

8. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 4/2/2024, Resident bedroom #6 smelled of a strong urine odor.

On 4/2/2024 at approximately 12:00PM, a puddle of urine was observed on the floor next to the toilet in the 2nd floor communal bathroom.

Plan of Correction

Accept [REDACTED] - 05/07/2024)

On 4/2/24, Resident bedroom #6 was deep cleaned and mattress replaced to eliminate urine odor. On 4/2/24, the 2nd floor communal bathroom was deep cleaned.

Beginning week of 4/29/24, housekeeping supervisor will round twice daily for 4 weeks to monitor resident rooms for any unpleasant odors.

Beginning week of 4/29/24, housekeeping supervisor will round twice daily for 4 weeks to ensure cleanliness of all bathrooms.

To ensure ongoing compliance, beginning 6/1/2024, housekeeping staff and personal care staff will complete

85a - Sanitary Conditions (continued)

bathroom check log with hourly checks throughout the day.

Licensee's Proposed Overall Completion Date: 06/30/2024

Implemented [redacted] - 07/03/2024)

101j7 - Lighting/Operable Lamp

9. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident rooms 26, 8D, and 1W do not have a source of light within reach that can be turned on/off at bedside.

Repeated Violation – 3/22/2023

Plan of Correction

Accept [redacted] 05/07/2024)

On 4/2/24, Maintenance Director moved source of light to bedside in rooms 26, 8D, and 1W. Administrator provided verbal education to residents on 4/16/2024, regarding requirement to have light source at bedside despite additional light sources in room.

Maintenance Director completed audit of all resident rooms on 4/8/2024. Beginning week of 4/29/24, Maintenance Director will audit 3 rooms weekly for 4 weeks to ensure light source is kept at bedside. To ensure ongoing compliance, Maintenance Director will complete monthly audits of all resident rooms beginning 6/1/2024.

Licensee's Proposed Overall Completion Date: 06/30/2024

Implemented [redacted] - 07/03/2024)

102h - Toilet Paper

10. Requirements

2600.

102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 4/2/2024 at approximately 12:00PM, toilet paper was not available in the 2nd floor communal bathroom.

Plan of Correction

Accept [redacted] - 05/07/2024)

On 4/2/24, additional toilet paper was placed in the 2nd floor communal bathroom. Administrator provided verbal education to residents on 4/16/2024, about asking staff for more toilet paper if they use all toilet paper.

Housekeeping Director will audit all bathrooms twice daily for 4 weeks to ensure toilet paper provided at every toilet. To ensure ongoing compliance, beginning 6/1/2024, housekeeping and personal care staff will check for toilet paper at time of cleanliness checks with routine daily bathroom logs.

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

Not Implemented [redacted] - 07/03/2024)

103i - Outdated Food

11. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 4/2/2024, two dented cans containing 4 oz. of mushroom bits and 15 oz. of kidney beans were observed in the dry food storage area.

Plan of Correction Accept [redacted] - 05/07/2024)

On 4/2/24, 2 dented cans containing mushroom bits and kidney beans were removed from dry storage area and disposed of. Dietary Manager checked all other cans in dry storage area to ensure no dented cans.

On 4/8/2024, Administrator provided verbal education to Dietary Manager on reviewing cans and removing if dented or damaged.

Beginning 4/29/24, Dietary Manager will audit all cans in dry storage weekly for 4 weeks and monthly thereafter beginning 6/1/2024 to monitor for any dented cans to ensure ongoing compliance.

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

Implemented [redacted] - 07/03/2024)

123b - Emergency Procedures Posted

12. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On 4/2/2024, the written emergency procedures for the home's municipality were not posted in a conspicuous and public place in the home.

Plan of Correction Accept [redacted] - 05/07/2024)

On 4/2/2024, the home's emergency procedures were placed at the front desk of the main lobby entrance area.

Beginning 4/29/24, Administrator will round daily for 4 weeks and monthly thereafter beginning 6/1/2024 to ensure emergency procedures binder is visible at front desk area.

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

Not Implemented [redacted] 07/03/2024)

132b - Safety Inspection/Fire Drill

13. Requirements

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection and fire drill conducted by a fire safety expert was conducted on 3/30/2022.

132b - Safety Inspection/Fire Drill (continued)

Plan of Correction

Accept [redacted] - 05/07/2024)

A fire safety inspection and fire drill conducted by a fire safety expert will be completed Wednesday 5/22/24 with documentation completed by Maintenance Director upon completion. Administrator will schedule annually thereafter.

For ongoing compliance, Maintenance Director or Administrator will plan to schedule and reserve fire safety expert at beginning of each year when finalizing annual training plan to ensure training scheduled and completed timely.

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

Implemented [redacted] 07/18/2024)

132c - Fire Drill Records

14. 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 home's monthly fire drill records for drills held 10/25/2023 through 3/30/2024 do not include 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, nor whether the fire alarm or smoke detector was operative.

Plan of Correction

Accept [redacted] - 05/07/2024)

On 4/2/24, the DPW fire drill record sheet was provided and reviewed with Maintenance Director. Facility will use this form with all required information moving forward.

Beginning May 2024, Administrator will check log after each monthly drill to ensure accuracy and completion.

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

Not Implemented [redacted] - 07/03/2024)

132d - Evacuation

15. Requirements

2600.

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

Description of Violation

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills:

On 10/25/2023 at 3:35 PM, the evacuation time was 5 minutes and 28 seconds

On 11/17/2023 at 2:25 PM, the evacuation time was 4 minutes and 44 seconds

On 12/31/2023 at 4:45 AM, the evacuation time was 4 minutes and 43 seconds

On 1/25/2024 at 5:10 PM, the evacuation time was 5 minutes and 48 seconds

On 2/27/2024 at 11:15 AM, the evacuation time was 5 minutes and 50 seconds

On 3/30/2024 at 4:59 AM, the evacuation time was 6 minutes 25 seconds

132d - Evacuation (continued)

Plan of Correction

Accept [REDACTED] 05/07/2024)

The home will have a maximum safe evacuation time specified in writing by a fire safety expert upon annual review on 5/22/24. Administrator will monitor evacuation times monthly beginning May 2024 after completion of fire drill.

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

Not Implemented [REDACTED] 07/03/2024)

144c1 - Smoking Area Guidelines

17. 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

On 4/2/2024, at approximately 10:30 AM, the designated smoking area was observed to have at least ten cigarette butts on the ground.

Plan of Correction

Accept [REDACTED] - 05/07/2024)

On 4/2/24, Maintenance Director removed cigarette butts and cleaned smoking area. Administrator will provide verbal education to staff and residents week of 5/6/2024 on keeping smoking area clean and placing butts in receptacles.

Beginning week of 4/29/24, Maintenance Director will round twice daily for 4 weeks and weekly thereafter beginning 6/1/2024, to ensure smoking receptacles are not full and smoking area is clean.

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

Implemented [REDACTED] 07/03/2024)

183b - Meds and Syringes Locked

18. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 4/2/2024, Resident #3's prescribed Nystatin powder was unlocked, unattended, and accessible in Resident #3's bedroom. Resident #3 cannot self-administer medications per the resident's Assessment and Support Plan, dated 6/2/2023.

On 4/2/2024, Resident #4's prescribed Calmoseptine ointment was unlocked, unattended, and accessible in Resident #4's bedroom. Resident #4 cannot self-administer medications per the resident's Assessment and Support Plan, dated 6/26/2023.

Repeated Violation – 7/13/2023, et al

183b - Meds and Syringes Locked (*continued*)**Plan of Correction**

Accept [REDACTED] - 05/07/2024)

On 4/2/24, Resident #3's prescribed Nystatin powder was removed from bedroom and placed back in medication cart. Resident #4's prescribed ointment was removed from bedroom and placed back in medication cart.

On 4/11/2024, verbal education was provided by Administrator to staff regarding medications not being left in room and keeping in locked area.

Administrator will complete initial audit of all resident rooms week of 5/6/2024. Beginning week of 5/13/24, Administrator will audit 3 resident rooms weekly for 4 weeks to ensure no medications or treatments are at bedside for resident's that cannot self-administer.

Licensee's Proposed Overall Completion Date: 06/14/2024

Not Implemented [REDACTED] - 07/03/2024)

183d - Prescription Current

19. 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

On 4/2/2024, Guainfenesin 100mg/5mL prescribed for Resident #4, was in the home's medication cart; however, the pharmacy label included an expiration date of 12/15/2023. Additionally, per Administrator, the order for this medication was previously discontinued.

Plan of Correction

Accept [REDACTED] - 05/07/2024)

On 4/2/24, Guainfenesin for Resident #4 was removed from medication cart and disposed of.

On 4/11/24, Administrator provided verbal education to staff on removing expired and discontinued medications from med carts.

Beginning week of 4/29/24, Administrator/Designee will audit medication carts weekly for 4 weeks to monitor for expired or discontinued medications. To ensure ongoing compliance, med tech staff will complete monthly audits of med carts beginning June 2024.

Licensee's Proposed Overall Completion Date: 06/30/2024

Implemented [REDACTED] - 07/03/2024)

185a - Implement Storage Procedures

20. 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 #3's glucometer was incorrectly calibrated. On 4/2/2024 at 4:49 PM, the glucometer read 6/3 2:01 AM.

Resident #3 is prescribed glucose checks three times daily before meals. The blood glucose checks on two glucometers

185a - Implement Storage Procedures (continued)

used for the resident did not match the numbers transcribed on the Administration History log including the following:

- Glucometer reading on 3/29/2024 at 6:50AM was 228 - the number documented in the MAR on 3/29/2024 at 7:28 AM reads blood glucose is 152.
- Glucometer reading on 3/27/2024 at 9:08AM was 227 - the number documented in the MAR on 3/27/2024 at 10:47AM reads blood glucose is 140.
- Glucometer reading on 3/24/2024 at 10:31AM was 237 - the number documented in the MAR on 3/24/2024 at 10:49AM reads blood glucose is 210.

Plan of Correction

Accept () - 05/07/2024)

On 4/2/24, Resident #3 was issued a new Glucometer.

Administrator provided education to staff on 4/11/2024 and 4/17/2024 on calibration and documentation of blood glucose levels.

Administrator will complete initial audit of all glucometers on 5/10/2024 to ensure proper calibration.

Beginning week of 4/29/24, Administrator/ Designee will audit weekly for 4 weeks all glucometer logs to ensure numbers match glucose readings. To ensure ongoing compliance, med techs will check glucometer calibration weekly beginning June 2024. Administrator will complete monthly audits of glucometers to resident record, beginning June 2024.

Licensee's Proposed Overall Completion Date: 06/30/2024

Not Implemented () - 07/03/2024)

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 #3 is prescribed Meclizine 25mg chews 1 tablet orally 3 times daily as needed for dizziness. On 04/2/2024, Resident #3's medication was not available in the home.

Repeated Violation – 7/13/2023, et al

Plan of Correction

Accept () - 05/07/2024)

On 4/2/24, the home received additional supply of Resident #3's Meclizine from pharmacy.

Administrator will provide education to med tech staff on reordering medication from pharmacy on 5/15/2024.

Week of 5/6/2024, Administrator will complete initial audit of orders and medications on hand. Beginning week of 5/13/24, Administrator/Designee will audit 3 resident's PRN medication orders weekly for 4 weeks to ensure PRN medications are available in the home. Beginning June 2024, med tech staff will complete ongoing monthly audits of medication carts.

Licensee's Proposed Overall Completion Date: 06/30/2024

Implemented () - 07/03/2024)

187d - Follow Prescriber's Orders

22. Requirements

2600.

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

Description of Violation

The pharmacy label provides instructions for Resident #3 to receive Ketoconazole 2% shampoo to scalp and rinse off three times weekly as directed; however, this medication is only being administered twice weekly per March 2024 Medication Administration Record which indicates "every day shift on Monday & Thursday."

Repeated Violation – 3/22/2023

Plan of Correction

Accept [REDACTED] - 05/07/2024)

On 4/2/24, Resident #3's order was revised by physician to read for resident to receive Ketoconazole shampoo to scalp and rinse off twice per week, every Monday and Thursday.

Administrator provided verbal education to staff on 4/11/24 on following prescriber's orders.

Beginning week of 4/29/24, Administrator/Designee to perform audit of physician's orders to resident MARs of 3 resident's orders weekly for 4 weeks.

Beginning month of June 2024, Administrator will choose sample of 3 residents' orders to review to residents' MARs monthly to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: 06/30/2024

Not Implemented ([REDACTED] - 07/03/2024)

190a - Completion Medication Course

23. 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 Member A, completed the Modified Department-approved medications administration course. However, Staff Member A did not complete the required Standard Department-approved Medication Administration course and administered medications to the following:

Resident #3 on 3/31/2024 at 4:00PM

Resident #3 on 3/27/2024 at 4:00PM

Resident #3 on 3/24/2024 at 4:00PM

Resident #3 on 3/23/2024 at 4:00PM

Resident #4 on 3/31/2024 at 5:00PM

Resident #4 on 3/31/2024 at 8:00PM

Resident #4 on 3/27/2024 at 5:00PM

Resident #4 on 3/27/2024 at 8:00PM

190a - Completion Medication Course (continued)

Staff Member B was certified in Medication Administration in 1/24/2022. An Annual Practicum was not completed in 2023 as evidenced by lack of staff signature, trainer signature, and only one Medication Administration observation was completed. Staff Member B administered medications to the following:

- Resident #3 on 4/2/2024 at 11:00AM
- Resident #3 on 4/1/2024 at 11:00AM
- Resident #3 on 3/26/2024 at 11:00AM
- Resident #3 on 3/25/2024 at 11:00AM
- Resident #1 on 3/26/2024 at 12:00PM
- Resident #2 on 3/26/2024 at 12:00PM
- Resident #2 on 3/25/2024 at 12:00PM

Repeated Violation - 11/15/2023

Plan of Correction

Accepted [REDACTED] - 05/07/2024)

Staff Member A completed full medication administration course and observations on 4/11/24. Staff Member B completed full medication administration course and observations on 4/16/24.

Administrator will audit all existing med tech files by 5/31/24 and schedule future required trainings and observations every 6 months to maintain compliance.

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

Not Implemented [REDACTED] - 07/03/2024)

191 - Resident Right to Refuse

24. 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 #2, admitted on [REDACTED], has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident #1 admitted on [REDACTED] has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Resident #4, admitted on [REDACTED], has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Repeated Violation - 11/15/2023, 7/13/2023 et al

Plan of Correction

Accepted [REDACTED] - 05/07/2024)

On 4/4/24, all residents were provided verbal education from Administrator regarding right to question or refuse medication. All residents signed updated resident rights form.

191 - Resident Right to Refuse (continued)

Administrator will audit all existing resident rights forms to ensure signature provided by 5/31/24. Administrator will review any new resident agreements to ensure explanation of right to refuse completed and signed within 48 hours of admission beginning 6/1/2024.

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

Implemented [redacted] - 07/03/2024)

227g -Support Plan Signatures

26. 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 participated in the development of the support plan on 6/11/2023. The resident did not sign the support plan, nor did the home make a notation regarding the resident's inability or refusal to sign.

Plan of Correction

Accept [redacted] - 05/07/2024)

On 4/2/24, Resident #2 signed the support plan.

By 5/31/24, Administrator will complete initial audit of all resident support plans to verify signature of plan or documented refusal noted. Beginning June 2024, Administrator will perform monthly audits of any annual or significant change RASPs to maintain compliance.

Administrator is only staff member responsible for completing/updating RASPs and obtaining signature at this time, no other staff to provide education to.

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

Not Implemented [redacted] - 07/03/2024)

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

Facility Information

Name: *ELIZABETHTOWN PERSONAL CARE* License #: *33881* License Expiration: *06/28/2024*
Address: *141 HEISEY AVENUE, ELIZABETHTOWN, PA 17022*
County: *LANCASTER* Region: *CENTRAL*

Administrator

Name: [REDACTED]

Legal Entity

Name: *ET 141 OPERATIONS LLC*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *12/07/1992* Issued By: *Dept of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *26* Waking Staff: *20*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Interim* Exit Conference Date: *06/04/2024*

Inspection Dates and Department Representative

06/04/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *39* Residents Served: *26*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *9* Are 60 Years of Age or Older: *26*
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *0* Have Physical Disability: *0*

Inspections / Reviews

06/04/2024 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *06/30/2024*

Inspections / Reviews *(continued)*

07/08/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/15/2024

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 07/15/2024

07/18/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/15/2024

Reviewer: [REDACTED]

Follow-Up Type: *Enforcement*

15a - Resident Abuse Report

1. Requirements

2600.

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

Description of Violation

On [REDACTED]/2024, Resident #2 grabbed Resident #1 on the breasts; this was reported to Staff Member A on the date of occurrence. As of 6/4/24, the Act 13 Mandatory Abuse form was not completed and submitted to AAA.

On [REDACTED]/2024, Staff Member A observed Resident #2 holding hands with Resident #4 and Resident #2 moved [REDACTED] hand to Resident #4's breasts. As of 6/4/24, the Act 13 Mandatory Abuse form was not completed and submitted to AAA.

On [REDACTED]/2024, Staff Member A observed Resident #2 sitting in dining room next to Resident #3, rubbing Resident #3's inner thigh. Resident #3 asked Resident #2 to stop and Resident #2 was moved by staff to another table. As of 6/4/24, the Act 13 Mandatory Abuse form was not completed and submitted to AAA.

Plan of Correction

Directed [REDACTED] - 07/03/2024)

Personal care staff were unaware of incident reporting. Personal Care staff were documenting incidents, calling family, POA's or guardians, and taking residents out of situations by moving them to other areas of the home.. On 6/6/2024 at 2pm PCHA educated the personal care staff on reporting incidents. What they should report, where they should report too, and who they should report too. PCHA will be notified immediately on any incidents that happen in the home, PCHA will direct staff on what to do until she gets to the facility. PCHA will check all reportable incidents to make sure they are complete and sent to the correct locations, DHS, OOA. and that they were completed in a timely manner. This will be ongoing with all incidents with no end date. The incident and act 13 for this incident will be submitted late. on July 2, 2024

(Directed)

- In addition to the above plan of correction, the incidents that occurred on 5/30/24, 4/24/24 and 4/21/24 will be documented on the Act 13 form and submitted to AAA no later than 7/15/24.

Directed Completion Date: 07/15/2024

Not Implemented [REDACTED] - 07/18/2024)

16c - Written Incident Report

2. Requirements

2600.

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

Description of Violation

On [REDACTED]/2024, Staff Member A observed Resident #2 holding hands with Resident #4 and Resident #2 moved [REDACTED] r

16c - Written Incident Report (continued)

hand to Resident #4's breasts. As of 6/4/24, this incident has not been reported to the Department.

On [REDACTED], Staff Member A observed Resident #2 sitting in dining room next to Resident #3, rubbing the resident's inner thigh. Resident #3 asked Resident #2 to stop and Resident #2 was moved by staff to another table. As of 6/4/24, this incident has not been reported to the Department.

Plan of Correction

Accept [REDACTED] - 07/03/2024)

On 6/6/2024 PCHA educated all personal care staff on reportable incidents, Personal care staff have been documenting and making sure residents are safe, but unaware that they needed to report to DHS and / or OOA. Staff were educated by the PCHA on 6/6/2024 on reporting incidents including where to report when to report and who to report too. all new staff members will be educated on reporting incidents within their first 40 hours of training by the PCHA. Resident 2 no longer resides at the home. Family and the facility agreed that this personal care home is not a good fit. [REDACTED] left the facility on 5/21/2024 . The incident and ACT 13 will be submitted on 7/2/2024. Going forward all incidents will be reported immediately.

Licensee's Proposed Overall Completion Date: 06/26/2024

Not Implemented [REDACTED] 07/18/2024)

42b - Abuse

3. 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 [REDACTED] 2024, Resident #2 was rubbing Resident #3's inner thigh in the dining room. Resident #3 asked Resident #2 to stop and Resident #2 was moved by staff to another table. On [REDACTED]/2024, Resident #2 was holding Resident #4's hand and then moved [REDACTED] hand to Resident #4's breasts. On [REDACTED]/2024, Resident #2 repeatedly grabbed Resident #1's breast area. The police were called as per Resident #1's request and a report was filed.

Plan of Correction

Directed [REDACTED] - 07/03/2024)

On 6/6/2024 PCHA educated all personal care staff on incident reporting. What to report, where to report , and who to report too. Staff will also call the PCHA immediately, for any direction they may need with filling out the incident report. Personal care staff are all aware of what to do in the event of another incident in the home. On [REDACTED]/2024 resident 2 left on [REDACTED]/2024 with [REDACTED], and family and the facility agreed that [REDACTED] would not come back to the home, Staff did document and called OOA but failed to fill out the proper forms, all staff are aware of what steps and paperwork to fill and and send for any future incidents that may occur.. PCHA will check all future incidents reports and make sure all steps were taken, this task will be ongoing with no end date. The incident on 5/30 was reported to DHS. OOA was called.

(Directed)

In addition to the above plan of correction:

- The Administrator or designee will provide education to all staff members in the home on Resident Rights as well as Abuse and Neglect by 7/15/24.

42b - Abuse (continued)

- Documentation of completed training will be kept by the home and available for review by the Department.

Directed Completion Date: 07/15/2024

Not Implemented [redacted] - 07/18/2024)

51 - Criminal Background Check

4. 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 Member B was hired [redacted] 2024; however, a Pennsylvania State Police Criminal Background Check was not obtained for Staff Member B as of 6/4/2024.

Repeated Violation – 7/13/2023, et al

Plan of Correction

Directed [redacted] - 07/02/2024)

On 6/5/2024 PCHA created a check off sheet for the HR director to use when hiring any new staff. On 6/7/2024 PCHA educated the HR director that all task on the created hire sheet must be complete and needed forms such as background check will be placed in the new hire folder immediately after completion. Once these task are complete the new hire can be placed on the schedule by the scheduler. PCHA will check each new hire file during the first day of hire to make sure task check off form is complete. This task by the HR director and PCHA will be ongoing with no end date.

(Directed)

In addition to the above POC:

- By 7/15/24, the HR director will begin utilizing the new check off sheet for new hires.
- Beginning no later than 7/15/24, the PCHA will check each new hire file and check sheet to ensure background check's have been obtained.
- An audit will be completed by the PCHA or designee on all current staff by 7/15/24 to ensure background checks have been obtained for each staff member, as applicable.
- Staff Member B's background check will be obtained no later than 7/15/24.

Directed Completion Date: 07/15/2024

Not Implemented [redacted] - 07/18/2024)

56 - Admin 20 Hours/Week

6. Requirements

2600.

56. Administrator Staffing - The administrator shall be present in the home an average of 20 hours or more per week, in each calendar month.

Description of Violation

During the calendar month of May 2024, an administrator was not present in the home an average of 20 hours or

56 - Admin 20 Hours/Week (continued)

more per week.

Plan of Correction

Directed (████) - 07/02/2024)

On 5/17/2024 the owner reached out to the now PCHA . PCHA agreed to work a 20 varied hour week. On 5/21/2024 the PCHA started the 20 hour position.

Proposed Overall Completion Date: 06/26/2024

(Directed)

By 7/15/24, the Administrator will obtain paystubs or other documentation to confirm the Administrator has been present in the home at least 20 hours per week. Documentation will be kept by the home and available for review by the Department.

Directed Completion Date: 07/15/2024

Implemented (████) - 07/18/2024)

60a - Staff/Support Plan

7. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident’s assessment and support plan.

Description of Violation

The home did not have staff trained in Medication Administration during overnight shifts on 5/6/2024 from 10:00PM to 6:00AM and 5/16/2024 from 10:00PM to 2:00AM. As a result, the home was unable to provide medication administration services during this time. There are no scheduled medications at the home during this time; however, the following residents had these medications scheduled pro re nata (PRN):

- Resident #5: Benzonatate 100MG capsule - take 1 capsule by mouth 3 times daily as needed, Ondansetron ODT 4MG tablet - dissolve 1 tablet orally every six hours as needed.
- Resident #2: Tobradex eye ointment - apply to affected eyes up to 8 times daily as needed.

Plan of Correction

Directed (████) - 07/03/2024)

On 5/22/2024 PCHA went through the staff files to determine what training was needed for each staff person. It was determined that staff members did start the medication administration with the previous PCHA. Staff members are trying to get the documents needed to make them compliant from the previous PCHA. On 6/23/2024 PCHA reached out to previous PCHA and she has agreed to send the needed documents. PCHA will train the remainder of the staff in the medication administration course. All staff should be complete by 7/30/2024. PCHA will manage and keep all med techs compliant , this will be an ongoing task with no end date.

Proposed Overall Completion Date: 06/26/2024

(Directed)

- In addition to the above plan of correction, education will be provided to applicable staff member(s) on scheduling each shift with at least one staff member who has completed the medication administration course requirements. Training to be completed by 7/15/24.
- On 6/23/2024 PCHA reached out to previous PCHA and she has agreed to send the needed documents.

60a - Staff/Support Plan (continued)

PCHA will train the remainder of the staff in the medication administration course. All staff should be complete by 7/15/24.

Directed Completion Date: 07/15/2024

Not Implemented (████) - 07/18/2024)

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 5/6/2024 from 10:00PM to 6:00AM and 5/16/2024 from 10:00PM to 2:00AM, 26 residents were present in the home. During this time, 0 staff persons were present in the home who are certified in CPR/First Aid.

Plan of Correction

Directed (████) 07/03/2024)

On 6/24/24 PCHA had the scheduler go through and put CPR beside everyone's name that is current with CPR/ First Aid. This will allow her to see that there is a CPR certified staff member on each shift. PCHA will create a sheet to show when staff members are due for recertification. The recertifications will be kept current. PCHA will have all new hires certified in CPR/ First Aid with in their first month of employment.

(Directed)

- On 6/24/24 PCHA had the scheduler go through and put CPR beside everyone's name that is current with CPR/ First Aid.
- Education will be provided to the scheduler by the Administrator or designee by 7/15/24 on regulation 2600.63(a).
- By 7/15/24, the Administrator or designee will create a sheet to show when staff members are due for CPR/FA recertification.
- Beginning 7/15/24, the staff list of CPR/FA will be audited quarterly by the Administrator or designee to ensure staff remain current with CPR/FA certification.

Directed Completion Date: 07/15/2024

Implemented (████) - 07/18/2024)

95 - Furniture and Equipment

10. Requirements

2600.

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

Description of Violation

On 6/4/2024, the standing urinal handle in the 1st floor pink common bathroom was broken and did not flush.

Plan of Correction

Directed (████) 07/03/2024)

The urinal on the first floor pink bathroom has been removed by the maintenance director on 6/25/2024, This urinal wasn't being used by the residents, there is a workable toilet in first floor pink bathroom. All holes on the floor from

95 - Furniture and Equipment (continued)

the urinal removal were prepared by the maintenance director immediately on 6/25 /24 after removal of the urinal.

(Directed)

In addition to the above plan of correction:

- Education will be provided by the Administrator or designee to maintenance and/or other applicable staff members on regulation 2600.95 no later than 7/15/24.
- Beginning no later than 7/15/24, the Administrator or designee will complete weekly audits of the home's furniture and equipment to ensure they are clean, in good repair and free of hazards.
- Documentation of training and weekly audits will be retained by the home for review by the Department; documentation must include any issues found.

Directed Completion Date: 07/15/2024

Not Implemented [REDACTED] /18/2024)

102h - Toilet Paper

11. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 6/4/2024 at 10:15 AM, there was no toilet paper for the toilets in the 1st floor pink common bathroom, 2nd floor white common bathroom, and 2nd floor pink common bathroom.

Plan of Correction

Directed [REDACTED] - 07/03/2024)

On 6/26/2024 housekeeping director ordered locking toilet paper holders for each bathroom on personal care. These will be put in place when they are delivered to the home.

On 6/3/2024 Housekeeping manager put in place that the house keepers will check the bathrooms twice a day once in the am and then before they leave for the day, Replacing any toilet papers that is needed. They will keep the closet in housekeeping stocked so that when they are off shift PCA/Med techs can keep the bathrooms stocked with toilet paper. Med Tech/ PCA's will check the bathrooms on 2nd and third shift after the housekeeper leaves.

PCHA made a sign off sheet on 6/3/24 for each staff member to sign off on when they check the bathrooms. This sign off sheet will be in place for 6 weeks.

(Directed)

In addition to the above plan of correction, education will be provided to all staff in the home on regulation 2600.102(h) by the Administrator or designee no later than 7/15/24. Documentation of training and audits will be kept by the the home and available for review by the Department.

Directed Completion Date: 07/15/2024

Not Implemented [REDACTED] - 07/18/2024)

123b - Emergency Procedures Posted

12. Requirements

2600.

123b - Emergency Procedures Posted (*continued*)

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On 6/4/2024, the written emergency procedures for the home's municipality were not posted in a conspicuous and public place in the home.

Plan of Correction

Directed [REDACTED] **07/03/2024)**

On 6/27/2024 PCHA made a copy of the emergency procedures that is located at the nurse station in personal care , and hung it on the bulletin board beside the license. This will be checked daily by the med tech on first shift, and document it in the 24 hour shift report. This check will continue for 6 weeks.

(Directed)

In addition to the above plan of correction:

- *Education will be provided by the Administrator or designee on regulation 2600.123(b) no later than 7/15/24.*
- *Beginning no later than 7/15/24, daily audits will be completed by the med tech's on first shift to ensure the emergency procedures remain posted on the bulletin board in the home.*
- *Documentation of education and completed audits will be kept by the home and available for review by the Department.*

Directed Completion Date: 07/15/2024

Not Implemented [REDACTED] **- 07/18/2024)**

132b - Safety Inspection/Fire Drill

13. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection and fire drill conducted by a fire safety expert was conducted on 3/30/2022.

Plan of Correction

Directed [REDACTED] **- 07/03/2024)**

On 6/3/2024 PCHA spoke with the maintenance director about the annual fire drill. Maintenance director immediately called the Rheem's fire company. He left a message , and later that day the fire chief did call and would call back with a date. On 6/18/2024 , Rheem's fire chief called back and set the fire training up for 6/19/2024 On 6/19/2024 The Rheem's fire did come to the facility and completed the annual fire drill . The maintenance director will have this on his calendar to complete annually in June. The annual fire drill will be in addition to his monthly fire drills.

(Directed)

In addition to the above plan of correction:

- *Education will be provided to the Maintenance Director and/or other applicable staff members on regulation 2600.132(b) by the Administrator or designee no later than 7/15/24. Documentation of completed training will be kept by the home and available for review by the Department.*

Directed Completion Date: 07/15/2024

132b - Safety Inspection/Fire Drill (continued)

Implemented [redacted] 07/18/2024)

132c - Fire Drill Records

14. 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 home's monthly fire drill records for drills held 4/27/2024 and 5/30/2024 do not include 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, nor whether the fire alarm or smoke detector was operative.

Plan of Correction

Directed [redacted] 07/03/2024)

On 6/27/2024. The PCHA verbally went over the fire drill logs, with the maintenance director and explained to [redacted] that all areas of the form need filled out completely. Maintenance director will check all exit doors to make sure they are labeled. The med tech on duty at the time of the fire drill will have a resident list to check off before residents return to the facility. and all staff members involved will sign off on the training paper after the fire drill is complete. Immediately after all staff have signed the maintenance director will check the paper to make sure all areas of the form are complete and initial it before placing it in the fire drill binder.

(Directed)

- On 6/27/2024. The PCHA verbally went over the fire drill logs, with the maintenance director and explained to him that all areas of the form need filled out completely.
- The Maintenance director will check all exit doors to make sure they are labeled by 7/15/24.
- Beginning no later than 7/15/24, the med tech on duty at the time of the fire drill will have a resident list to check off before residents return to the facility. All staff members involved will sign off on the training paper after the fire drill is complete.
- Beginning no later than 7/1/24, the maintenance director will audit each fire drill record after the completion of the drill to ensure all required documentation is present before filing it in the fire drill binder.
- Documentation of education and audits will be kept by the home and available for review by the Department.

Directed Completion Date: 07/15/2024

Not Implemented [redacted] 07/18/2024)

132d - Evacuation

15. Requirements

2600.

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

Description of Violation

The home does not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills:

132d - Evacuation (continued)

On 4/27/2024 at 11:00AM, the evacuation time was 4 minutes and 12 seconds

On 5/30/2024 at 6:20 PM, the evacuation time was 5 minutes and 35 seconds

Plan of Correction

Directed (redacted) - 07/03/2024

On 6\19\2024 the Rheem's fire chief came to the facility to complete an annual fire drill with the staff. This fire drill gave the facility a new time to evacuate of 5min and 30 seconds. The fire safe area of evacuation is outside the PC in the parking lot by the garage, where there will be a resident call to make sure all residents are safely out of the facility in the require 5 min 30 sec. Once the building is all clear the residents will return back inside. This fire drill will take place annually with the Rheem's fire company.

(Directed)

In addition to the above plan of correction:

- Education will be provided to staff and residents in the home by the Administrator or designee no later than 7/15/24 on the requirements to evacuate to a designated safe area within the period of time specified in writing by the fire safety expert.
- Starting 7/15/24, if a fire drill evacuation time exceeds the time specified by the fire safety expert, the home will review the fire drill within five days to discuss any obstacles that may have caused the delay in evacuation; documentation will be kept by the home and available for review by the Department.

Directed Completion Date: 07/15/2024

Not Implemented (redacted) 07/18/2024

183b - Meds and Syringes Locked

16. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 6/4/2024, Resident #2's Thera Tears dry eye therapy drops, SOLGAR brand Vitamin B 12 tablets, Immodium A-D caplets, Dollar General brand Anti-Diarrheal/Anti-Gas caplets, and prescribed Prednisolone 1% eye drops and Fluticasone Prop 50 mcg Nasal Spray were unlocked, unattended, and accessible in Resident #2's bedroom. Resident #2 cannot self-administer medications per the resident's Assessment and Support Plan, dated 4/23/2024.

On 6/4/2024, Resident #6's prescribed Nystatin powder was unlocked, unattended, and accessible in Resident #6's bedroom. Resident #6 cannot self-administer medications per the resident's Assessment and Support Plan, dated 6/26/2023.

Repeated Violation - 7/13/2023 et al

Plan of Correction

Directed (redacted) - 07/03/2024

Immediately the med tech on duty gathered all the medications in resident 2 and resident 6 rooms and placed them in the locked med cart. PCHA went over the with them the importance of not leaving medications in the rooms unattended. On 6/27/2024 PCHA at 230 PM educated the all staff on not leaving medications unattended in resident rooms that are not a self administer. Starting immediately all med techs will take the medications to the

183b - Meds and Syringes Locked (continued)

resident during the med pass, administer the medication and bring the medication back to the medication cart. If the resident states that they do not want to have the medication, the med tech will place the medication back in the cart and try again in 30 mins. the medication will not be taken into the room the 2nd time of asking unless the resident is ready to take the medication. Once the medication is taken /and or used it will be put back in the medication cart. Med tech on duty will check the cart after each med pass to make sure all medications are put away as directed.

(Directed)

In addition to the above plan of correction:

- Beginning 7/15/24, the Administrator or designee will complete weekly audits of all resident bedrooms to ensure medications are kept in an area or container that is locked per the resident's current DME and assessment and support plan.
- Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 07/15/2024

Not Implemented (████) - 07/18/2024)

184b - Labeling OTC/CAM**17. Requirements**

2600.

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 4/5/2024, Thera Tears dry eye therapy drops, SOLGAR brand Vitamin B 12 tablets, Immodium A-D caplets, and Dollar General brand Anti-Diarrheal/Anti-Gas caplets, belonging to Resident #2 were found on the resident's bedroom nightstand and were not labeled with the resident's name.

Plan of Correction

Directed (████) - 07/03/2024)

Immediately the unlabeled medications were taken by the med tech and labeled, On 6/27/2024, PCHA verbally spoke with the staff and made them aware that any meds that are found laying in resident rooms should be brought to the med room, The medications will be checked with the MAR to confirm that there is an order. If there is an order the container will be labeled and placed in the medication cart. If there is no order, med techs will immediately contact the PCP to get an order, and send order to the pharmacy so that it comes with a label. Med techs are aware that no medications can be without a label and it must be locked in the med cart unless they are a self administer and then medications should be locked in a locked box in their room.

(Directed)

In addition to the above plan of correction:

- Beginning 7/15/24, the Administrator or designee will audit all resident medications monthly to ensure medications are labeled with the resident's name.
- Documentation of education and completed audits will be kept by the home and available to the Department for review.

184b - Labeling OTC/CAM (continued)

Directed Completion Date: 07/15/2024

Not Implemented [REDACTED] - 07/18/2024)

185a - Implement Storage Procedures

18. 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

On 6/4/2024 at approximately 3:30 PM, Resident #5's glucometer was not calibrated to the correct time.

Resident #5 is prescribed glucose checks three times daily before meals. The blood glucose checks on glucometer used for the resident did not match the numbers transcribed on the Administration History log including the following:

- Glucometer reading on 6/2/2024 at 3:23AM was 140 – this reading was not documented on the MAR
- Glucometer reading on 6/1/2024 at 6:59AM was 270 - this reading was not documented on the MAR
- Glucometer reading on 5/29/2024 at 6:22AM was 331 - this reading was not documented on the MAR
- Glucometer reading on 5/28/2024 at 10:45PM was 182 - this reading was not documented on the MAR
- Glucometer reading on 5/28/2024 at 10:41PM was 130 - this reading was not documented on the MAR
- Glucometer reading on 5/28/2024 at 6:53AM was 242 - this reading was not documented on the MAR

Plan of Correction

Directed [REDACTED] - 07/03/2024)

Immediately the med techs went through all glucometers and calibrated them, On 6/7/24 PCHA, had a verbal training with all med techs that a cart audit will be complete every Weds , this audit will include the accu check machine, making sure they are calibrated and all numbers are matching from machine to MAR. All cart audit forms will be kept in the binder for the PCHA to check weekly on Thursdays, This will be an ongoing task with no end date.

(Directed)

In addition to the above plan of correction:

- Beginning no later than 7/15/24, a weekly cart audit will be completed by med tech's every Wednesday which will include making sure glucometers are calibrated and all numbers are matching from the glucometer to MAR. All cart audit forms will be kept in the binder for the PCHA to check weekly on Thursdays.
- Documentation of education and completed audits will be kept by the home and available for review by the Department.

Directed Completion Date: 07/15/2024

Not Implemented [REDACTED] - 07/18/2024)

187d - Follow Prescriber's Orders

19. Requirements

2600.

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

187d - Follow Prescriber's Orders (continued)

Description of Violation

The pharmacy label provides instructions for Resident #5 to receive Ketoconazole 2% shampoo to scalp and rinse off three times weekly as directed; however, this medication is only being administered twice weekly per May 2024 Medication Administration Record which indicates "every day shift on Monday & Thursday."

Plan of Correction

Directed [REDACTED] - 07/03/2024)

On 6/27/2024, staff member A spoke with resident # 5 and resident # 5 would prefer to have [REDACTED] head washed twice a week. PCP will be notified on his next visit to the home on 6/28/24 , to see if we can get the order changed to twice weekly. Going forward med techs will speak with the PCP to keep the orders consistent with how many times the particular resident gets a shower to keep the shampoo times in line with the shower times .

(Directed)

In addition to the above plan of correction:

- The Administrator or designee will complete an initial audit of all resident orders compared to the resident Medication Administration Record (MAR) by 7/15/24 to ensure medications and treatments are being administered as ordered.
- Education will be provided to all staff who administer medications on regulation 2600.187(d) by the Administrator or designee by 7/15/24.
- Beginning 7/15/24, the Administrator or designee will complete monthly audits of all resident MAR's to ensure medications are being administered as ordered.
- Documentation of completed audits and education will be kept by the home and available for review by the Department.

Directed Completion Date: 07/15/2024

Not Implemented [REDACTED] - 07/18/2024)

190a - Completion Medication Course

20. 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 Member E completed the Modified Department-approved medications administration course. However, Staff Member E did not complete the required Standard Department-approved Medication Administration course and administered medications to the following:

Resident #5 on 5/1/2024 at 8:00PM

Resident #5 on 5/5/2024 at 8:00PM

Resident #5 on 5/15/2024 at 8:00PM

Resident #5 on 5/22/2024 at 8:00PM

Resident #5 on 5/29/2024 at 8:00PM

190a - Completion Medication Course (continued)

Staff Member F completed the Modified Department-approved medications administration course. However, Staff Member F did not complete the required Standard Department-approved Medication Administration course and administered medications to the following:

- Resident #5 on 5/1/2024 at 8:00AM
- Resident #5 on 5/7/2024 at 8:00AM
- Resident #5 on 5/14/2024 at 8:00AM
- Resident #5 on 5/22/2024 at 8:00AM
- Resident #5 on 5/31/2024 at 8:00AM

Staff Member G attended a Standard Department-approved medications administration course. However, Staff Member G did not receive passing exam scores of 90% or higher and administered medications to the following:

- Resident #5 on 5/3/2024 at 4:00PM
- Resident #5 on 5/9/2024 at 4:00PM
- Resident #5 on 5/16/2024 at 4:00PM
- Resident #5 on 5/21/2024 at 4:00PM
- Resident #5 on 5/27/2024 at 4:00PM

Staff Member H did not complete the required Standard Department-approved Medication Administration course and administered medications to the following:

- Resident #5 on 5/5/2024 at 8:00AM

Staff Member C has a certificate of completion for the Standard Department-approved medication administration course dated 10/13/2021. However, there are no pass observation nor MAR review documentation available and staff administered medications to the following:

- Resident #5 on 5/17/2024 at 8:00AM
- Resident #5 on 5/20/2024 at 8:00AM
- Resident #5 on 5/25/2024 at 8:00AM
- Resident #5 on 5/28/2024 at 8:00AM

Repeated Violation - 11/15/2023

Plan of Correction

Directed [redacted] - 07/03/2024)

Staff member G does have [redacted] medication administration. Staff member E, F, and H started there medication administration with the previous PCHA , on 6/7/24 staff member F did reach out to the previous PCHA to get [redacted] certificate. On June 23 the PCHA reached out to the previous PCHA about the staff members certification, [redacted] stated that they will have to complete the last part of the course and she would bring the certifications over to the facility. Staff member E,F and H have all started to complete the coarse. Going forward Med Trainer will keep a tracking system to keep all med techs current with MAR Checks and Observations. This tracking system will be checked monthly by the med trainer.

(Directed)

- An initial audit will be completed on all current med tech's files to ensure staff have properly completed the medication administration course requirements including: completing the Department-approved standard medication administration course, passing scores for exams and other areas as applicable and fully completing all required observations and MAR reviews. Audit will be completed by 7/15/24.
- Beginning 7/15/24, a tracking system will be implemented and checked monthly to ensure med tech's

190a - Completion Medication Course (continued)

remain current with medication administration requirements.

Directed Completion Date: 07/15/2024

Not Implemented [REDACTED] 07/18/2024)

227g -Support Plan Signatures

22. 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 #7 participated in the development of the support plan on [REDACTED]/2024. The resident had not signed the support plan as of 6/4/2024 during the POC verification inspection nor did the home make a notation regarding the resident's inability or refusal to sign.

Plan of Correction

Accept [REDACTED] - 07/03/2024)

Immediately on 6/4/2024 resident #7 did sign the support plan.

On 5/22/2024 PCHA went through all residents charts updated DME, Med Evals and RASP. Updating all. 6/27/24 PCHA continues to go through charts to check for missing signatures and any changes that may need to be added and to continue with updating DME, Med Evals ,and RASP. On 6/4/24 PCHA created a form to place in the front of all charts to sign off on when each chart in complete with Signatures, updated DME's Med evals and RASP. The resident charts will be checked monthly by the PCHA, and the created form will be checked that the chart was checked and the date it was checked.by the PCHA. On 6/27/24 the PCHA educated all staff on the RASP and where to add any changes if needed such as PCP, behaviors , case managers , power of attorneys .

Proposed Overall Completion Date: 06/27/2024

Licensee's Proposed Overall Completion Date: 06/27/2024

Not Implemented [REDACTED] - 07/18/2024)