pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **VICTORIA MANOR LIVING LLC**
LEGAL ENTITY

To operate **VICTORIA MANOR LIVING**
NAME OF FACILITY OR AGENCY

Located at **100 ROSE COURT, OAKDALE, PA 15071**
(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 **38**
(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 **July 31, 2024** until **January 31, 2025**, unless sooner revoked for non-compliance with applicable laws and regulations.

No: **455981**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

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

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: July 26, 2024

[redacted]
Victoria Manor Living LLC
100 Rose Court
Oakdale, Pennsylvania 15071

RE: Victoria Manor Living
License #: 455981

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on June 21, 2024, of the above facility, we have found that your facility is in substantial compliance with the regulations, set forth in 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), that can be adequately assessed at this time. The licensing inspector was unable to complete a full inspection because this is a new legal entity operating the home.

In accordance with 55 Pa.Code § 2600.11(b) (relating to procedural requirements for licensure or approval of personal care homes) a re-inspection of your newly licensed facility will be conducted within 3 months of the effective date of this license. Complete compliance with all applicable regulations is required in order to maintain your license.

During the inspection, citations on the enclosed Licensing Inspection Summary were found. All citations specified on the Licensing Inspection Summary must be corrected by the dates specified on the Licensing Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Your PROVISIONAL license is enclosed, based on substantial but not complete compliance with 55 Pa.Code Ch. 2600.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

Facility Information

Name: *Victoria Manor Living* **License #:** *45598* **License Expiration:**

Address: *100 Rose Ct, Oakdale, PA 15071*

County: *ALLEGHENY* **Region:**

Administrator

Name: [redacted]

Legal Entity

Name: *Victoria Manor Living LLC*

Address:

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *09/17/1997* **Issued By:** *PA Dept L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *43* **Waking Staff:** *32*

Inspection Information

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

Reason: *Change Legal Entity* **Exit Conference Date:** *06/21/2024*

Inspection Dates and Department Representative

06/21/2024 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: **Residents Served:** *36*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *4*

Are 60 Years of Age or Older: *34*

Diagnosed with Mental Illness: *7*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *7*

Have Physical Disability: *3*

Inspections / Reviews

06/21/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/18/2024*

07/17/2024 - POC Submission

Submitte [redacted] **Date Submitted:** *07/18/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/24/2024*

Inspections / Reviews *(continued)*

07/18/2024 - POC Submission

Submitted [redacted] **Date Submitted:** *07/18/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/28/2024*

07/19/2024 - Document Submission

Submitted [redacted] **Date Submitted:** *07/18/2024*

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

According to the Clean indoor Air Act (CIAA), Act 27 of 2008, Section 4 indicates that the CIAA requires that "smoking" or "no smoking" signs or the international "no smoking" symbol which consists of a pictorial representation of a burning cigarette in a circle with a bar across it must be prominently posted and properly maintained where smoking is not permitted. However, the only sign present indicating that the building is smoke-free was a small sign approximately 10" long X 2" high adhered to the back rest of a bench to the right of the main entrance to the home. When there is an individual sitting on the bench, the sign is obscured.

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

A non-smoking sign was attached to the bench stating No Smoking. Upon building inspection, inspector suggested to post a "no smoking" sign freestanding but not attached to the bench. On July 8th, 2024, the supervisor purchased a sign and placed it in the ground next to the bench. Supervisor educated staff, families and residents that the bench area is not a smoking area. Staff will observe the area to assure that no one smokes in this area on a daily basis. On July 10th 2024, the operations manager reviewed this regulation with the supervisor. On July 8th documentation of the education of staff will be kept on site in a binder with all of the staff training. This regulation will be added to our Quality Management quarterly meeting. see Attach "Extra" and #1

Proposed Overall Completion Date: 07/18/2024

DIRECTED
Within one Calander day of receipt of the accepted plan of correction: The administrator shall implement all aspects of the plan of correction including the daily observations of the staff. 7/18/24 [redacted]

Proposed Overall Completion Date: 07/19/2024

Not Implemented - [redacted] 7/22/24

Directed Completion Date: *07/19/2024*
Licensee's Proposed Date for POC Implementation

85a - Sanitary Conditions

2. Requirements

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

Description of Violation

At 11:00 a.m., there was a strong smell of urine in the last room ("Annex B") on the left at the end of the hall to the right when facing the front of the home.

At 11:00 a.m., there was an accumulation of dirt and debris in the window track of room "Annex B."

At 11:04 a.m., there were no paper towels or means of drying hands in the common half-bathroom near the television room.

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

During the building inspection, the inspector noticed a strong smell of odor in annex B. Immediately, the staff

85a - Sanitary Conditions (continued)

removed the bedside commode and sanitized it. Supervisor will put in place for all staff to make certain that the bedside commodes and any other device will be sanitized on a 2-hour check. Inspector also noticed the window tracks in resident rooms had dirt and debris in them. Immediately, the housekeeper cleaned the window tracks for all windows throughout the facility. On July 1st, the supervisor educated the staff to be aware of any dirt or debris in the resident's window and to immediately clean and notify the housekeeper to properly clean the window as soon as possible. Finally, the day of the inspection the facility did not have any paper towels in the public restrooms. Immediately the supervisor placed paper towels in the main public restrooms. July 1st staff education was given by the administrator, documentation will be kept on site in a binder at the facility to show training was completed.. On July 10th, 2024 the operations manager reviewed this regulation with the supervisor. Supervisor will be responsible to check the main restrooms twice daily and stock the bathrooms with the proper amount of paper products. see Attach "Extra" and #2

Proposed Overall Completion Date: 07/18/2024

DIRECTED
Within one Calander day of receipt of the accepted plan of correction: The administrator shall implement all aspects of the plan of correction including the supervisor checks. 7/18/24 [redacted]

Directed Completion Date: *07/19/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented – [redacted] 7/22/24

91 - Telephone Numbers

3. Requirements

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

Description of Violation

The list of emergency telephone numbers posted throughout the home, including in each resident's room, did not include the telephone number for the Department's personal care home complaint hotline.

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

Inspector noticed the emergency numbers listed in resident's rooms was missing information. Immediately the day of the inspection the supervisor updated the emergency numbers to include nearest hospital, nearest police department, nearest fire department, nearest ambulance and the Department's personal care home compliant hotline. On June 21st the Supervisor had staff place the emergency numbers within a reasonable area for each outside phone line in the resident's rooms. This list was updated on June 21, 2024. July 1st the supervisor educated staff on this regulation to be vigilant of the list and ensure that all of the required information is included on the emergency number list. Staff was instructed to report any list or any part of the list that could be missing to notify the supervisor for replacement. On July 10th, 2024 the operations manager reviewed this violation with the supervisor reflecting the importance of having the information readily available and updated. See Attach "Extra" and #16

Proposed Overall Completion Date: 07/18/2024

DIRECTED
Within one Calander day of receipt of the accepted plan of correction: The administrator or designee shall audit all of the telephones with an outside line monthly to ensure compliance with Regulation 2600.91, 7/18/24 [redacted]

91 - Telephone Numbers *(continued)*

Directed Completion Date: *07/19/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented - JK 7/22/24

92 - Windows

4. Requirements

2600.
92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

At 10:50 a.m., the exit door that leads from the dining room to the back patio was propped open with a rock. The door did not have a screen.

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

The day of the inspection a resident went outside the dining area to the patio and used an object to prop open the door to reenter. Inspector asked Supervisor to remove the object immediately and to alert the resident that when he wanted to return inside the facility to knock on door. On July 1st the supervisor educated the staff and residents that we are not to have any exit door propped open. On July 1st staff was educated that no exit door is to be propped open and for staff to remove any object from the door and notifying anyone outside the exit to return to the building. On July 10th, 2024 operations manager reviewed this violation with the supervisor requesting all exit doors shall be monitored daily for the next 3 months. The administrator or designee will walk through facility to take note ensuring this regulation is met. If any exit door is difficult or not working properly it shall be reported to the maintenance consultant and the owner immediately to schedule immediate repair. See Attach "Extra" and #3

Proposed Overall Completion Date: 07/18/2024

DIRECTED
Within one Calander day of receipt of the accepted plan of correction: The administrator shall implement all aspects of the plan of correction including the administrator/designee walk throughs. 7/18/24 [redacted]

Directed Completion Date: *07/19/2024*
Licensee's Proposed Date for POC Implementation

Not Im[redacted]ented - [redacted]7/22/24

95 - Furniture and Equipment

5. Requirements

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

Description of Violation

At approximately 10:40 a.m., the toilet paper holder in the bathroom in resident room #20 was not operational. There was no spindle on which the toilet paper could be placed.

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

Inspector sited a toilet paper holder that was broken. Supervisor called the building manager who came in on July 1st to replace the broken toilet paper holder. Supervisor asked the building manager to walk through all resident rooms including the public restrooms to assure no other toilet paper holders needed tightened or replaced. On July 1st supervisor educated staff of this regulation and the importance of having equipment in good working condition. Operations manager reviewed this regulation with the supervisor on July 10th, 2024. Supervisor will be responsible to perform walkthroughs daily for 3 months to stay compliant. Documentation of the walkthrough will be signed off daily and kept in a binder on-site. See Attach "Extra" and #5

95 - Furniture and Equipment (continued)

Proposed Overall Completion Date: 07/18/2024

DIRECTED
Within one Calander day of receipt of the accepted plan of correction: The administrator shall implement all aspects of the plan of correction including the supervisor walk throughs. 7/18/24[redacted]

Directed Completion Date: *07/19/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented - [redacted] 7/22/24

102i - Soap Dispenser

6. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

At approximately 9:50 a.m., there was an unlabeled bar of gold Dial soap in a shell shaped soap dish in the shared bathroom of resident room #8.

Plan of Correction ***Accept [redacted] 07/18/2024)***

Day of inspection a resident in a shared room was using a bar of soap. The soap was not in an identified soap dish with a lid. Supervisor purchased plastic soap dishes with lids through Amazon. On July 11th, 2024 the soap dishes arrived and was distributed to those residents who share rooms and use bar soap. Supervisor placed with a permanent marker the residents name on the soap dishes placing them in the shared rooms. July 1st, the Supervisor educated the staff on the importance of proper placement of the bar of soap and why it protects anyone in a shared room. July 1st the supervisor explained that the soap was to be placed at all times in the soap dish and the lid to be closed to prevent the spread of any infection's diseases. On July 10, 2024 the operations manager reviewed this regulation with the supervisor and scheduled this topic to be review in detail at the next quarterly management meeting and the next infection control meeting. Effective July 1st the administrator or the designee will monitor this regulation daily documenting that the rooms have been inspected for soap dishes not properly being utilized to meet this regulation. This documentation shall be kept in a binder on-site for future record of completeness. See Attach "Extra" and #4

Licensee's Proposed Overall Completion Date: *07/18/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented - [redacted]/22/24

102k - No Common Towel

7. Requirements

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

At approximately 10:00 a.m., the shared bathroom of resident room #10 shared by resident #1 and resident #2 had a towel bar identified with only resident #2's name. There was no towel bar or ring identified as resident #1's.

Plan of Correction ***Accept [redacted] 07/18/2024)***

Upon the building inspection it was discovered that resident towel racks did not have resident names on the rack to identify who the towels belonged to. Supervisor purchased luggage tags and immediately placed each resident name on each towel rack. This task was completed on July 3rd. Supervisor reviewed this regulation with the staff to make them aware of the process of identifying each towel to each resident to help control infections and to maintain

102k - No Common Towel (continued)

sanitary conditions. Staff was educated on proper placement of towels in the proper location of all towel racks with luggage tags attached identifying each residents name. On July 10th, 2024 the operations manager reviewed this regulation with the supervisor and scheduled this topic to be review in detail at the next infection control meeting and the next quarterly management meeting. Effective July 3rd the administrator or the designee will monitor this regulation daily documenting that the rooms have been inspected for identification of resident's proper placement of towels to ensure full compliance of this regulation. This documentation shall be kept in a binder on-site for future record of completeness See Attach "Extra" and #5

Licensee's Proposed Overall Completion Date: *07/18/2024* Not Implemented - [redacted] 7/22/24
Licensee's Proposed Date for POC Implementation

107c - Food/Water 3 Day Supply

8. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

At 1:10 p.m., the home served 36 residents requiring 108 gallons of emergency water to be on site. However, there were only 60 gallons of emergency water on site. The home does not have a contract with a company that will provide water on an emergency basis.

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

Facility did not meet the proper 3-day water supply needed to meet this regulation. Previous owner has a large outstanding invoice that has not been paid in full. Supervisor discussed the situation immediately with new owner and arranged to have bottled water purchased immediately by the supervisor. Operations manager will be setting up an account with a food vendor who will include an emergency water procedure on letterhead including the regulatory guidance of this regulation for any emergency situation. Operations manager educated the supervisor on maintaining the allotted gallons needed to meet this regulation. On July 8th the complete allotment of water was purchased and stored on-site. Effective July 8th the supervisor or designee will monitor the emergency water ensuring that this regulation is being met. This audit will occur daily for 3 months, documentation of the audit will be kept in a binder and on-site. See Attach "Extra" and #6

Licensee's Proposed Overall Completion Date: *07/18/2024* Not Implemented - [redacted] 7/22/24
Licensee's Proposed Date for POC Implementation

107d - Procedure Emergency Management Agency Submission

9. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's emergency preparedness plan was not reviewed and submitted to the local emergency management agency in the past year.

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

The inspector reviewed the current emergency management plan posted at the current facility. The approved management plan was approved at the Harrisburg office by Jill and not posted due to the sale of the building not final. To satisfy this violation, we have included the approved plan as an attachment for your review. Immediately the supervisor will deliver the emergency management procedure by USPS by certified mail requiring a receipt of the document delivery accepted by the local fire department. Upon completion of the sale, current ownership will

107d - Procedure Emergency Management Agency Submission (continued)

immediately post the emergency plan in the main lobby of the facility. see Attach "Extra" and #7

Proposed Overall Completion Date: 07/18/2024

DIRECTED
Within one Calander day of receipt of the accepted plan of correction: The administrator shall audit the annual submission of the emergency procedures to the local emergency management office through the quality management review process. 7/18/24 [redacted]

Directed Completion Date: *07/19/2024* Not Implemented - [redacted] 22/24
Licensee's Proposed Date for POC Implementation

126a - Furnace Inspection

10. Requirements

2600.
126.a. A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

Description of Violation

The home did not have verification that a furnace inspection was completed within the past year. The only documentation provided was a partially illegible invoice from a heating/cooling company that could not confirm that a furnace inspection was conducted at the home.

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

It was discovered the day of inspection that the previous owner did not arrange a yearly furnace inspection. Operations manager arranged the furnace inspection for July 24th, 2024 and will set up appointment for the following year's annual inspection once the inspection is completed for this year. Effective July 24th the administrator and or the designee will schedule the annual furnace inspection allowing a grace period to stay within compliance if for any reason a reschedule is needed. Owner will monitor the scheduling of the inspection annually, documentation will be kept on-site in a binder. Attach "Extra".

Proposed Overall Completion Date: 07/18/2024

Within one Calander day of receipt of the accepted plan of correction: The administrator shall audit the annual furnace inspection through the quality management review process. 7/18/24 [redacted]

Directed Completion Date: *07/19/2024* Not Implemented [redacted] 7/22/24
Licensee's Proposed Date for POC Implementation

132a - Monthly Fire Drill

11. Requirements

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

Description of Violation

An unannounced fire drill was not conducted in March 2024.

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

On July 12, 2024 the supervisor completed an unannounced fire drill. Effective July 17th the administrator will monitor each fire drill by an audit of the documentation of the unannounced drill within 2 days of the drill to ensure the documentation is completed in full. This regulation will be reviewed in detail at the next quality management

132a - Monthly Fire Drill (continued)

meeting to further ensure compliance is within the regulation. Owner will review with the administrator this regulation over the next 3 months to confirm that this regulation is being followed according to the outlined regulation. Documentation will be completed over the 3-month time frame and kept on-site in a binder. See Attach "Extra" and #12

Proposed Overall Completion Date: 07/18/2024

DIRECTED
Within one Calander day of receipt of the accepted plan of correction: The administrator shall implement all aspects of the plan of correction including the review of the home's fire drill record to ensure an unannounced fire drill was held at least once a month. 7/18/24 J[redacted]

Directed Completion Date: *07/19/2024* Not Implemented - [redacted]22/24
Licensee's Proposed Date for POC Implementation

132b - Safety Inspection/Fire Drill

12. 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 most recent fire safety inspection and supervised fire drill conducted by a fire safety expert took place on 3/17/23.

Plan of Correction ***Accept*** [redacted] ***07/17/2024)***

On July 10th, 2024 the operations manager verbally reached out to schedule a fire safety expert. Fire expert is to be in facility on July 17th at 1:30p to perform training. Staff was notified that this is a mandatory meeting. Operations manager educated the supervisor to leave a grace period when scheduling next year's annual fire expert training in case of unforeseen cancelation on either party. This would allow facility to reschedule and stay in compliance of this regulation. This shall be added to the quarterly management meeting. See Attach "Extra" and #12

Licensee's Proposed Overall Completion Date: *07/16/2024* Not Implemented - [redacted] 7/22/24
Licensee's Proposed Date for POC Implementation

132c - Fire Drill Records

13. Requirements

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

Description of Violation

The fire drill record for the fire drill completed 6/14/24 does not indicate if the fire drill was conducted at 4:10 a.m. or 4:10 p.m.

Plan of Correction ***Accept*** [redacted] ***07/18/2024)***

On the day of the inspection, the operations manager reviewed with the supervisor educating on how to completed the paperwork correctly. Effective July 17th, supervisor will audit monthly to ensure documentation is accurate and completed in full to meet this regulation. Supervisor has been made aware of this process and understands this regulation, the importance of completing accurately with details. Owner has reviewed this with the administrator and will follow up monthly with supervisor to ensure the regulation is being followed over a 3-month period.

132c - Fire Drill Records (continued)

Documentation of this monitoring will be kept in a binder and on-site. See Attach "Extra"

Licensee's Proposed Overall Completion Date: *07/18/2024* Not Implemented - [redacted]/22/24
Licensee's Proposed Date for POC Implementation

132d - Evacuation

14. 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

Because a fire safety inspection was not conducted since 3/17/23, the home's safe evacuation time reverted to the default time of 2 minutes and 30 seconds on 3/17/24. The following drills exceeded 2 minutes and 30 seconds as follows:
4/4/24 at 1:00 p.m. – 4 minutes, 54 seconds
4/16/24 at 3:45 p.m. – 4 minutes, 27 seconds
5/1/24 at 10:30 a.m. – 4 minutes, 32 seconds
5/9/24 at 2:45 a.m. – 4 minutes, 51 seconds
6/7/24 at 7:01 a.m. – 4 minutes, 3 seconds
6/14/24 at 4:10 – 4 minutes, 18 seconds

Plan of Correction ***Directed [redacted]7/18/2024)***

On the day of the inspection the supervisor reached out to the local volunteer fire department to schedule the past due annual inspection. On 6/28/24 the supervisor scheduled the fire department to perform and complete the training, DHS required paperwork and walk through of the facility. On July 10th, the operation manager educated the supervisor on how to completed the paperwork properly. Operations manager will follow up monthly for 3 months with new management team on the completeness of this regulation. This regulation will be added to the quarterly management meeting and discussed in full. The administrator shall complete the fire safe evacuation within 4 minutes and 48 seconds outlined by the fire department expert. Administrator and fire department expert will provide resident and staff education on the evacuation policies and procedures and documentation of this regulation will be kept on-site. Administrator will conduct the fire drills according to the regulation. Administrator will follow the emergency medical plan as well as the emergency plan for any relocations needed. Documentation will be kept in a binder on-site at the facility. See Attach "Extra" and #9

Proposed Overall Completion Date: 07/18/2024

DIRECTED
Within one calendar day of receipt of the accepted plan of correction: If the home is unable to meet the safe evacuation established by the home's fire safety expert, the administrator shall complete the following steps to reduce the safe evacuation:
• Provide additional resident and staff education on evacuation policies and procedures. Documentation will be kept.
• Conduct additional monthly fire drills.
• Relocate residents who require special assistance with evacuation closer to exits or fire-safe areas.
• Add additional staff (at all times) to meet the safe evacuation time specified by the fire safety expert within the past year.

132d - Evacuation (continued)

7/18/24 JK

Directed Completion Date: *07/19/2024* Not Implemented - [redacted] 7/22/24
Licensee's Proposed Date for POC Implementation

183b - Meds and Syringes Locked

15. 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

At approximately 10:30 a.m., there was a 4oz tube of Calmoseptine ointment with pharmacy label for resident #3 setting unlocked and accessible on the water tank of the toilet in the bathroom in room #12.

Plan of Correction ***Accept [redacted]07/17/2024)***

On the day of inspection, a hospice aide left a crème behind in a resident's room. Inspector found it and passed it off to me. Immediately I had it locked up in the med cart. On July 8th, 2024 the supervisor developed a sign off sheet to educate all home health and hospice personnel to return all medications, including OTC to the med tech in charge and to not leave it in the resident's room. On July 8th the supervisor immediately re-educated our staff that if they see any medication's or OTC's left in any resident room to take it to the med tech or supervisor. On July 10th, 2024 the operations manager reviewed this policy in full to the supervisor and suggested weekly walkthroughs to continue checking rooms. This regulation shall be added to the quarterly management meetings. See Attach "Extra" and #15

Licensee's Proposed Overall Completion Date: *07/16/2024* Not Implemented - [redacted] 7/22/24
Licensee's Proposed Date for POC Implementation