pennsylvania
DEPARTMENT OF HUMAN SERVICES

# CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **GRACEFUL CARE LIVING, LLC**
LEGAL ENTITY

To operate **GRACEFUL CARE LIVING**
NAME OF FACILITY OR AGENCY

Located at **211 GARNIER STREET, SHARPSBURG, PA 15215**
(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 **52**
(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 **January 10, 2025** until **July 10, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **454672**

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.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JANUARY 10, 2025

[redacted] Executive Director
Graceful Care Living LLC
[redacted]

RE: Graceful Care Living
211 Garnier Street
Sharpsburg, Pennsylvania 15215
License/COC #: 454672

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on July 1, 2024, July 2, 2024, October 16, 2024, and November 20, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), failure to submit an acceptable plan to correct noncompliance items and failure to comply with the acceptable plan to correct noncompliance items, 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); (3); (4) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from January 10, 2025 to July 10, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

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

| 55 Pa. Code Chapter 2600 Section: | Class of Violation | Census at Inspection | Fine Per resident X Per day | Calculated Fine = Per day | Mandated Correction Date (to avoid Fine) |
|---|---|---|---|---|---|
| 100(a) | II | 31 | $5 | $155 | 5 calendar days from mailing date of this letter |
| 185(a) | II | 31 | $5 | $155 | 5 calendar days from mailing date of this letter |

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

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

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[redacted]

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

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

Department of Human Services
Bureau of Human Service Licensing

# LICENSING INSPECTION SUMMARY - PUBLIC

## Facility Information

**Name:** *GRACEFUL CARE LIVING* **License #:** *45467* **License Expiration:** *10/09/2024*

**Address:** *211 GARNIER STREET, SHARPSBURG, PA 15215*

**County:** *ALLEGHENY* **Region:** *WESTERN*

## Administrator

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

## Legal Entity

**Name:** *GRACEFUL CARE LIVING, LLC*

**Address:** [redacted]

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

## Certificate(s) of Occupancy

**Type:** *C-2 LP* **Date:** *03/08/1996* **Issued By:** *PA Dept L&I*

## Staffing Hours

**Resident Support Staff:** *0* **Total Daily Staff:** *38* **Waking Staff:** *29*

## Inspection Information

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

**Reason:** *Renewal, Complaint* **Exit Conference Date:** *07/02/2024*

## Inspection Dates and Department Representative

*07/01/2024 - On-Site:* [redacted]

*07/02/2024 - On-Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity:** *52* **Residents Served:** *32*

### Secured Dementia Care Unit

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

### Hospice

**Current Residents:** *12*

### Number of Residents Who:

**Receive Supplemental Security Income:** *3* **Are 60 Years of Age or Older:** *29*

**Diagnosed with Mental Illness:** *13* **Diagnosed with Intellectual Disability:** *2*

**Have Mobility Need:** *6* **Have Physical Disability:** *8*

# Inspections / Reviews

## 07/01/2024 - Full

**Lead Inspector** [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *08/24/2024*

**08/26/2024 - POC Submission**

**Submitted By**: [redacted] **Date Submitted**: *09/17/2024*

**Reviewer**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/02/2024*

**09/11/2024 - POC Submission**

**Submitted By**: [redacted] **Date Submitted**: *09/17/2024*

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

**11/25/2024 - Document Submission**

**Submitted By**: [redacted] **Date Submitted**: *09/17/2024*

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

## 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 Care Facility Carbon Monoxide Alarms Standards Act, Section 3(b)(3), The battery shall be labeled with the date of installation and replaced at least once annually or at such time as the unit signals a drained or failing battery, whichever is sooner. However, on 7/1/24, the batteries in the home's carbon monoxide detectors on the wall in the kitchen and in the basement boiler room were not dated when installed.*

**Plan of Correction** ***Accept [redacted] 08/26/2024)***

*On 7/3/24, administrator replaced the batteries and labeled the five carbon monoxide monitors within the facility in accordance with Care Facility Carbon Monoxide Alarms Standards Act, Section 3(b)(3), The battery shall be labeled with the date of installation and replaced at least once annually or at such time as the unit signals a drained or failing battery, whichever is sooner. Administrator shall implement documented weekly tests on the carbon monoxide monitors to ensure that they are working properly and will replace the batteries per need. Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *08/23/2024* Implemented ([redacted] - 12/4/24)
Licensee's Proposed Date for POC Implementation

## 65a - FS Orientation 1st Day

**3. 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**

*Direct care staff person A, hired [redacted] did not receive training on the following topics until [redacted]*

*(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 firesafe 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.*

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

**Plan of Correction** ***Accept [redacted] - 09/11/2024)***

*This violation was an oversight by administrator. The staff member noted in the violation was trained on the requirements under 2600.65.a. during the initial training and orientation. Moving forward, administrator will continue to ensure that all newly hired employees are to be oriented and educated on the topics listed under 2600.65.a, on their first day of training. Administrator reviewed all current employee charts to ensure that they all are in compliance with this regulation. Moving forward, administrator will continue to utilize and complete the already implemented DIRECT CARE STAFF INITIAL TRAINING AND ORIENTATION form on the first day of new staff member's employment (please see attached supporting documentation). Administrator will monitor and document all staff member training within the Staff Training Plan binder on a monthly basis to ensure that all training is completed within the department guidelines under 2600.65 and is on file and available to department inspectors per request to verify.*

**Licensee's Proposed Overall Completion Date:** *09/04/2024* Implemented ([redacted] - 12/4/24)
Licensee's Proposed Date for POC Implementation

## 85a - Sanitary Conditions

**4. Requirements**

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

**Description of Violation**

*On 7/1/24 at approximately 10:35 a.m., there were two large piles of feces on the exterior fire escape landing between the 4th and the 5th floors.*

*On 7/1/24 at approximately 10:44 a.m., there was a significant amount of what appeared to be fecal matter on the sink in the bathroom near the exit door to the courtyard/smoking area.*

*On 7/1/24 at approximately 11:15 a.m., there was an approximately two-inch smeared chunk of what appeared to be feces on the lid of the trash can in the bathroom between resident rooms #401 and #402.*

**Plan of Correction** ***Accept [redacted] 09/11/2024)***

*All areas in this violation were immediately rectified under 2600.85.a. On 7/3/24, the facility housekeeper [redacted] removed and disposed of the appeared to be fecal matter on the exterior fire escape landing between the 4th and the 5th floors. Also on 7/3/24, the facility housekeeper [redacted] cleaned and disinfected what appeared to be fecal matter on the sink in the bathroom near the exit door to the courtyard/smoking area and the lid of the trash can in the bathroom between resident rooms #401 and #402. Administrator shall re-implement documented weekly checks ,on7/6/2024, which include all facility bathrooms and the fire escape landings located between the 4th and 5th floors. Administrator re-educated all staff during the staff meeting on 8/30/2024 that sanitary conditions shall be maintained. All documentation is kept in accordance with Regulation 2600.65(i). Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *09/04/2024* Implemented ([redacted] - 12/4/24)
Licensee's Proposed Date for POC Implementation

## 88a - Surfaces

**5. Requirements**

## 88a - Surfaces *(continued)*

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

**Description of Violation**

*On 7/2/24, there was an 11 inch section of carpet lifting along the seam at the entrance to 4th floor from the ramp near the stairs to chapel which poses a tripping hazard.*

**Plan of Correction** ***Accept [redacted] - 09/11/2024)***

*The 11 inch section of carpet lifting along the seam at the entrance to 4th floor from the ramp near the stairs to chapel which poses a tripping hazard has been repaired by the facility housekeeper on 7/2/2024 by adhering industrial tape to the torn seams of the frayed carpet. Administrator implemented documented weekly checks on 7/6/2024 which will include facility floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards. A maintenance log located in both the med room and pantry are implemented and staff were re-educated on how to report any needed repairs to administration/owners to be immediately rectified on 8/30/24 at the staff meeting by the administrator. Documentation of education will be kept in accordance with Regulation 2600.65(i). Please see attached documentation/staff meeting agenda.*

**Licensee's Proposed Overall Completion Date:** *09/04/2024* Not Implemented ([redacted] - 12/4/24)
Licensee's Proposed Date for POC Implementation

## 93a - Handrails

**6. Requirements**

2600.
93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

**Description of Violation**

*On 7/1/24 at 10:38 a.m., the handrail on the exterior fire escape leading from the 4th floor to the courtyard is not secure and swayed approximately 1 ½".*

**Plan of Correction** ***Accept [redacted] - 09/11/2024)***

*The handrail in this violation has been repaired by the facility housekeeper on 7/3/2024 by utilizing new wood hardware and is now well-secured. Administrator shall implement documented weekly checks which will include all ramps, interior stairways and outside steps must have a well-secured handrail. Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *09/04/2024* Implemented ([redacted] - 12/4/24)
Licensee's Proposed Date for POC Implementation ***Implemented (JK - 11/25/2024)***

## 94b - Non-Skid Surface

**7. Requirements**

2600.
94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

**Description of Violation**

*On 7/1/24, the stairs of the exterior fire escape between the 4th and the 5th floors did not have a non-skid surface.*

**Plan of Correction** ***Accept [redacted] 09/11/2024)***

*The stairs of the exterior fire escape between the 4th and the 5th floors had new non-skid strips installed by the facility housekeeper on 7/3/2024. Administrator implemented on 7/6/24 documented weekly checks (which will include all interior stairs, exterior steps and ramps) to ensure that nonskid surfaces are adequately in place in*

## 94b - Non-Skid Surface (continued)

*accordance with 2600.94.b. and is kept on file at the facility. Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *09/04/2024* Not Implemented ([redacted] - 12/4/24)
Licensee's Proposed Date for POC Implementation

## 100a - Exterior - Free of Hazards

**8. Requirements**

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

**Description of Violation**

*The home received a letter dated 6/1/23 from the Borough of Sharpsburg code enforcement regarding the home's 2nd and 3rd floor fire escape indicating "do not use the deck unless an extreme emergency use only." The deck and fire escape has not yet been repaired.*

*Repeat Violation 8/30/23 et al.*

**Plan of Correction** ***Accept ([redacted] - 09/11/2024)***

*On August 19, 2024, the managing partners of Graceful Care Living, LLC received approval to proceed on construction of the home's fire escape named in this violation. The deck and fire escape has not yet been repaired due to the numerous protocols that must be followed by various outside governing agencies. This violation is a work in process and is not a repeat violation as previously both discussed and submitted documentation in full explanation with the department supervisors [redacted] and [redacted] The managing partners of Graceful Care Living, LLC has done and will continue to do full due diligence in rectifying this violation in the most timely manner (with Sharpsburg Borough Code Enforcement Officer, BUI of Allegheny County, the structural engineer and the contracted fabricators). Please see attached documentation. The managing partners of Graceful Care Living, LLC are currently accepting bids from contractors for the job. Until which time a bid is accepted, the 3rd floor of the facility will remain unoccupied. The third floor was completely evacuted on 01 September, 2023 following the warning from the Sharpsburg Borough Code Inspector and DHS. Upon the acceptance of a bid, the managing partners of Graceful Care Living, LLC will notify DHS with an updated timeline and Date of Completion. Update can be expected no later than 01 November, 2024.*

**Licensee's Proposed Overall Completion Date:** *09/04/2024* Not Implemented ([redacted] - 12/4/24)
Licensee's Proposed Date for POC Implementation

## 103f - Refrigerator/Freezer Temps

**9. Requirements**

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

**Description of Violation**

*On 7/1/24 at approximately 11:00 a.m., the temperature of the white chest freezer in the basement measured 9 degrees Fahrenheit.*

**Plan of Correction** ***Accept ([redacted] 09/11/2024)***

*The thermometer in the white chest freezer was rechecked by the department inspectors on 7/2/2024 and verified that the freezer measured at 0° F. Facility staff performs daily temperature checks on all refrigerator/freezer appliances within the home and are documented. Kitchen/staff members have been educated at the 8/30/24 staff meeting by the administrator regarding immediately reporting any maintenance concerns regarding the facility refrigerator/freezer appliances so that Food requiring refrigeration shall be stored at or below 40°F. Frozen food*

## 103f - Refrigerator/Freezer Temps (continued)

*shall be kept at or below 0°F. Thermometers that are required in refrigerators and freezers are in place. Memo posted in areas of all refrigerators/freezers for staff to reference correct temperatures and management reporting. Administrator shall implement documented weekly checks on all refrigerator/freezer appliances within the home and ensure if any adjustments/repairs that are needed are immediately completed. Documentation of education will be kept in accordance with Regulation 2600.65(i). Please see attached documentation/staff meeting agenda. Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *09/04/2024* Implemented ([redacted] - 12/4/24)

Licensee's Proposed Date for POC Implementation

## 183d - Prescription Current

**11. 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 7/2/24 at 11:27 a.m., the medication cart contained a clear zip-top bag with pharmacy label for resident #1 that indicates - Salonpas Lidocaine 4% pat – Apply topically to affected area every day. However, this medication was discontinued on 6/28/24.*

*On 7/2/24 at 11:35 a.m., the medication cart contained a box of Murine Ear Wax Removal with pharmacy label for resident #2 that indicates – Instill 4 drops into both ears every night as directed for 3 days. Start drops on Tuesday 6/25 for ear lavage on 6/28.*

**Plan of Correction** ***Accept [redacted] - 09/11/2024)***

*The medications in this violation were immediately removed from the med cart by the med tech supervisor [redacted] on 7/2/24 for on-site inspectors to verify. Administrator has implemented and still performs documented weekly med cart/mar audits which aid to ensure that any discontinued medications are removed from the cart. This violation was a complete oversight per administrator. Med tech supervisors were re-educated on 7/3/24 in regard to remove all medications from the cart post medication discontinuation per the home's policy and procedures. All med staff was re-educated on 8/30/24 by the administrator and documentation of education will be kept in accordance with Regulation 2600.65(i). Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *09/04/2024* Implemented ([redacted] - 12/4/24)

Licensee's Proposed Date for POC Implementation

## 185a - Implement Storage Procedures

**12. 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 #2 is prescribed ondansetron 4mg tablet – Take 1 tablet (4 mg total) by mouth every 8 (eight) hours as needed for nausea or vomiting. However, on 7/2/24 at 11:40 a.m., the medication was not available in home.*

*Resident #2 is ordered blood glucose checks three times daily before meals. The following readings were incorrectly*

## 185a - Implement Storage Procedures (continued)

*entered onto the resident's June 2024 medication administration record (MAR) as follows:*

| *Glucometer* | *MAR entry* |
|---|---|
| *06-24 4:33pm 138* | *6/24/24 5:00 p.m. 135* |
| *06-23 12:20pm 115* | *6/23/24 12:00 p.m. 105* |

*Repeat Violation 8/30/23 et al.*

**Plan of Correction** ***Accept [redacted] 09/11/2024)***

*The medication was immediately ordered by med tech supervisor [redacted] on 7/2/24 and was delivered from Health Direct Pharmacy to the facility that same evening. Administrator has implemented and still performs documented weekly med cart/mar and glucometer audits which aid to ensure that all ordered medications are available in the facility and that documentation is entered in the MAR correctly. All med tech staff was addressed on these violations upon receiving and is to be re-educated formally on 8/30/24 at an all staff meeting presented by the administrator. Documentation of education will be kept in accordance with Regulation 2600.65(i).Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *09/04/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented ([redacted] - 12/4/24)

## 252 - Record Content

**13. Requirements**

2600.
252. Content of Resident Records - Each resident's record must include the following information:
3. A photograph of the resident that is no more than 2 years old.

**Description of Violation**

*The most recent photograph for resident #3, admitted [redacted] was dated [redacted]*

**Plan of Correction** ***Accept [redacted] 09/11/2024)***

*This violation was an oversight by the administrator. The resident's photograph in this violation has been updated by the administrator on 7/2/24 in the Tabula Pro system. Moving forward, administrator will continue to ensure that all residents' photographs are updated no later than every two years to maintain compliance. All resident photographs are accurately dated by the Tabula Pro software system in place and gives users (administrator) a notification of when each resident photograph are about to expire. Administrator will perform documented monthly audits in Tabula Pro starting 9/1/24 to ensure that all resident pictures are taken and updated within every 2 years. Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *09/04/2024*
Licensee's Proposed Date for POC Implementation

Implemented ([redacted] - 12/4/24)

Department of Human Services
Bureau of Human Service Licensing

# LICENSING INSPECTION SUMMARY - PUBLIC

## Facility Information

**Name:** *GRACEFUL CARE LIVING* **License #:** *45467* **License Expiration:** *10/09/2024*

**Address:** *211 GARNIER STREET, SHARPSBURG, PA 15215*

**County:** *ALLEGHENY* **Region:** *WESTERN*

## Administrator

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

## Legal Entity

**Name:** *GRACEFUL CARE LIVING, LLC*

**Address:** [redacted]

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

## Certificate(s) of Occupancy

## Staffing Hours

**Resident Support Staff:** *0* **Total Daily Staff:** *41* **Waking Staff:** *31*

## Inspection Information

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

**Reason:** *Complaint, Interim* **Exit Conference Date:** *10/16/2024*

## Inspection Dates and Department Representative

*10/16/2024 - On-Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity:** *52* **Residents Served:** *36*

### Secured Dementia Care Unit

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

### Hospice

**Current Residents:** *9*

### Number of Residents Who:

**Receive Supplemental Security Income:** *6* **Are 60 Years of Age or Older:** *31*

**Diagnosed with Mental Illness:** *11* **Diagnosed with Intellectual Disability:** *3*

**Have Mobility Need:** *5* **Have Physical Disability:** *0*

# Inspections / Reviews

## 10/16/2024 - Partial

**Lead Inspector:** [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/08/2024*

## Inspections / Reviews *(continued)*

**11/12/2024 - POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *11/25/2024*

**Reviewer:** [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/19/2024*

**11/25/2024 - POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *11/25/2024*

**Reviewer:** [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/30/2024*

**12/04/2024 - Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *11/25/2024*

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

## 17 - Record Confidentiality

**1. Requirements**

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

**Description of Violation**

*At 9:05 a.m., the medication room across from the dining room was unlocked, unattended and resident #1 was sitting in a chair in the medication room. The laptop on the medication cart on the left was opened and the screen displayed resident photos, names and "DNR" status to include residents #2 and #3. Staff person A returned to the medication room after approximately three minutes.*

*The administrator's office by the home's entrance was unlocked and unattended with the resident's information accessible.*

**Plan of Correction** ***Accept [redacted] 11/21/2024)***

*Correction that was made that the door was immediately secured by med tech [redacted] Administrator [redacted] re-educated all med staff including the DCS med tech that is included in this violation on 10/22/2024 regarding 2600.17 and documentation will be kept in accordance with Regulation 2600.65(i).*
*Administrator to also insure that the administrator's office is secured as well at all times by installing a secondary lock to the administrator office door on 11/15/2024 by DCS [redacted] Administrator is to perform documented weekly checks beginning 10/30/2024 for 6 months to ensure that any office/med room that contains resident records, medications and any other confidential information is secure. The med room is already equipped with a keypad lock that administrator reiterated to all med staff on 10/22/2024 to ensure it is closed while vacant by staff. Please see attached documentation*

**Licensee's Proposed Overall Completion Date:** *11/19/2024*
Licensee's Proposed Date for POC Implementation ***Implemented [redacted] 12/04/2024)***

## 85d - Trash Receptacles

**2. Requirements**

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

**Description of Violation**

*The trash can in the home's kitchen coffee area did not have a lid. The trash can was approximately one-third full.*

**Plan of Correction** ***Directed [redacted] - 11/21/2024)***

*Administrator placed the kitchen trash lids on the respectable cans immediately for department to verify.*
*Administrator re-educated all med staff on 10/22/2024 regarding 2600.85.d. and documentation will be kept in accordance with Regulation 2600.65(i).*
*Administrator is to perform weekly checks beginning 10/30/2024 for 6 months to ensure that any trash receptacles requiring lids are in place. Please see attached documentation*

*Proposed Overall Completion Date: 11/12/2024*

## 85d - Trash Receptacles (continued)

*DIRECTED*

*Within one calendar day of receipt of the acceptable plan of correction: The administrator shall document the weekly checks indicate in the home's plan of correction.*

**Directed Completion Date:** *11/22/2024*

Licensee's Proposed Date for POC Implementation *Implemented [redacted] 12/04/2024)*

[redacted]

Violation withdrawn[redacted]. 12/24/2024

[redacted]

## 91 - Telephone Numbers

**4. 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 telephone in the dining area did not have any of the required telephone numbers posted on or by the telephone.*

**Plan of Correction** *Accept [redacted] 11/21/2024)*

*Administrator performed an initial audit on 10/17/2024 of all of the cordless phones and their bases to ensure that emergency phone numbers were in place. Per department supervisor's recommendation, administrator placed all required emergency phone numbers on the cordless phones to ensure that the needed phone numbers are accessible to all residents at all times. Administrator re-educated all med staff on 10/22/2024 regarding 2600.91. and documentation will be kept in accordance with Regulation 2600.65(i).*

*Administrator is to perform weekly checks beginning 10/30/2024 for 6 months to ensure that all facility phones are equipped with the required phone numbers. Please see attached documentation*

**Licensee's Proposed Overall Completion Date:** *11/12/2024*

Licensee's Proposed Date for POC Implementation *Implemented [redacted] 12/04/2024)*

## 94b - Non-Skid Surface

**5. Requirements**

2600.
94.b. Interior stairs, exterior steps and ramps must have nonskid surfaces.

**Description of Violation**

*The ramp outside of the dining area did not have a non-skid surface.*

**Plan of Correction** ***Accept [redacted] - 11/21/2024)***

*On 10/18/2024 during the initial audit of the interior stairs, exterior steps and ramps to ensure that nonskid surfaces are in place by Admin [redacted] and kitchen supervisor [redacted] Kitchen supervisor [redacted] installed non slip tracking strips on the ramp in the courtyard during the initial audit per 2600.94.b. Administrator re-educated all med staff on 10/22/2024 regarding 2600.94.b. and documentation will be kept in accordance with Regulation 2600.65(i).*
*Administrator is to perform weekly checks beginning 10/30/2024 for 6 months to ensure that all non slip strips are in good repair and in place to ensure safety. Please see attached documentation*

**Licensee's Proposed Overall Completion Date:** *11/12/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented ([redacted] - 12/4/24)

## 95 - Furniture and Equipment

**6. Requirements**

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

**Description of Violation**

*There were four chairs in the dining room that had at least 4" tears on the upholstered seats.*

*The lamp setting on the table in the fifth-floor day room did not have a lamp shade with and exposed light bulb was hot to the touch. The light socket was loose causing the lamp to flicker on and off.*

**Plan of Correction** ***Accept [redacted] 11/21/2024)***

*On 10/17/2024 the four chairs in disrepair and the lamp on the 5th floor were thrown away by DCS [redacted] and the administrator [redacted] Also, [redacted] and kitchen supervisor [redacted] performed an initial audit on 10/17/2024 of the entire facility to ensure furniture and equipment are in good repair, clean and free of hazards and disposed of any furniture that was damaged or in disrepair. Administrator re-educated all med staff on 10/22/2024 regarding 2600.95. and documentation will be kept in accordance with Regulation 2600.65(i).*
*Administrator is to perform weekly checks beginning 10/30/2024 for 6 months to ensure that all furniture and equipment must be in good repair, clean and free of hazards. Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *11/19/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented ([redacted] - 12/4/24)

## 102i - Soap Dispenser

**7. 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 2:45 p.m., there was an unlabeled, used, white bar of soap setting on the sink in the common resident restroom on the fifth floor across from room #505.*

## 102i - Soap Dispenser *(continued)*

**Plan of Correction** ***Accept [redacted] - 11/21/2024)***

*The bar soap was immediately discarded by the administrator for on site inspectors to verify. Administrator completed an initial audit of the home's restrooms, common and resident rooms, on 10/21/2024 to ensure compliance with 2600.101(i). Administrator re-educated all med staff on 10/22/2024 regarding 2600.102.i. and documentation will be kept in accordance with Regulation 2600.65(i).*
*Administrator is to perform weekly checks beginning 10/30/2024 for 6 months to ensure that all disposable soap dispensers are in place and no bar soap is left in the bathrooms. Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *11/19/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented ([redacted] - 12/4/24)

## 105g - Lint Removal and Duct Cleaning

**8. Requirements**

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

**Description of Violation**

*Both dryer lint vents had excessive lint approximately ¼" thick inside the vents and an excessive amount of lint covering the outside steps measuring approximately three foot area.*

**Plan of Correction** ***Accept [redacted] 11/21/2024)***

*On 10/18/2024, DCS [redacted] removed the lint from the outer vent and stairs. Administrator re-educated all med staff on 10/22/2024 regarding 2600.105.g. and documentation will be kept in accordance with Regulation 2600.65(i). Administrator is to perform weekly checks beginning 10/30/2024 for 6 months to ensure that the appliance traps, outer vents and steps are free from lint residue. Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *11/12/2024*
Licensee's Proposed Date for POC Implementation

***Implemented [redacted] - 12/04/2024)***

## 121a - Unobstructed Egress

**9. Requirements**

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

**Description of Violation**

*The emergency fire exit route (door) by room #406 was blocked by two wheelchairs.*

**Plan of Correction** ***Accept [redacted] - 11/21/2024)***

*Administrator immediately removed the two wheelchairs that were blocking the emergency fire exit door for onsite inspectors to verify. Administrator re-educated all med staff on 10/22/2024 regarding 2600.121.a. and documentation will be kept in accordance with Regulation 2600.65(i).*
*Administrator is to perform weekly checks beginning 10/30/2024 for 6 months to ensure that all egresses including stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed. Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *11/12/2024*
Licensee's Proposed Date for POC Implementation

***Implemented [redacted] - 12/04/2024)***

## 133.1 - Exit Signs

**10. Requirements**

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

**Description of Violation**

*The exit door leading from the hallway near the kitchen and medication room does not have an exit sign. The home currently serves 36 residents.*

**Plan of Correction** ***Accept [redacted] - 11/21/2024)***

*On 10/21/2024, Administrator [redacted] and DCS [redacted] installed a new exit sign on the door listed in this violation. [redacted] and [redacted] also completed a full audit (10/21/2024) on every exit door within the facility to ensure that all exit signs were in place and if lit, were operable Administrator re-educated all med staff on 10/22/2024 regarding 2600.133.1. and documentation will be kept in accordance with Regulation 2600.65(i). DCS [redacted] and/or Administrator [redacted] will complete monthly audits beginning 10/30/2024, the audits will be done on or around the 20th of each month and documentation will be kept. Please see attached documentation*

**Licensee's Proposed Overall Completion Date:** *11/19/2024*
Licensee's Proposed Date for POC Implementation ***Implemented [redacted] - 12/04/2024)***

## 133.3 - Exit Signs Letter Size

**11. Requirements**

2600.
133.3. Exit Signs - The following requirements apply for a home serving nine or more residents: Exit sign letters must be at least 6 inches in height with the principal strokes of letters at least 3/4 inch wide.

**Description of Violation**

*The exit door by the chapel leading to the courtyard has an exit sign with letters which were only 3 inches high. The home currently serves 36 residents.*

**Plan of Correction** ***Accept [redacted] - 11/25/2024)***

*Administrator and DCS [redacted] installed a new exit sign on the door listed in this violation on 10/18/2024. Administrator re-educated all med staff on 10/22/2024 regarding 2600.133.3. and documentation will be kept in accordance with Regulation 2600.65(i). Administrator [redacted] completed an initial audit on 10/21/2024. DCS [redacted] and Administrator [redacted] will complete monthly audits the audits will be done on or around the 20th of each month beginning on 10/30/2024, to ensure that all current regulated exit signs are in place and operable (if applicable) documentation of audits will be kept on file in the administrative office.*

*Please see attached documentation*

**Licensee's Proposed Overall Completion Date:** *11/19/2024*
Licensee's Proposed Date for POC Implementation ***Implemented [redacted] - 12/04/2024)***

## 141a - Medical Evaluation

**12. Requirements**

2600.

## 141a - Medical Evaluation *(continued)*

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

**Description of Violation**

*Resident #4 was admitted to the home on [redacted] However, a medical evaluation has not been completed.*

**Plan of Correction** ***Accept [redacted] - 11/25/2024)***

*Administrator did have a completed medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. Administrator is aware and maintains compliance with this regulation. Moving forward, the administrator will only give copies of the medical evaluation to the designated party when a relocation is involved. Administrator completed an initial audit on 10/23/2024 of all current resident charts and verified that all residents' medical evaluations were completed within the department required timeframe. This violation was an oversight by the administrator and the resident in the violation has since moved out of the facility on [redacted] Administrator [redacted] to educate staff responsible for maintaining compliance with the regulations and the home's policies and procedures, DCS [redacted] and DCS [redacted] on 11/18/2024, that upon completion of an initial, annual or status/significant change of a medical evaluation, that either [redacted] or [redacted] will verify and initial the bottom of the first page of the medical evaluation for accuracy and timeframe compliance prior to the provider approval of the medical evaluation. Documentation of the education will be kept in accordance with regulation 2600.65(i). Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *11/19/2024* Not Implemented ([redacted] - 12/4/24)

Licensee's Proposed Date for POC Implementation

## 183b - Meds and Syringes Locked

**13. 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 9:05 a.m., the medication room across from the dining room was unlocked, unattended and resident #1 was sitting in a chair in the medication room. Both medication carts were unlocked and there were numerous pre-poured medications in plastic cups with resident names to include resident #5, resident #6, resident #7 and resident #8. Staff person A did not return to the medication room for approximately three minutes.*

**Plan of Correction** ***Accept [redacted] 11/25/2024)***

*Administrator re-educated all med staff including the DCS med tech that is included in this violation [redacted] on 10/22/2024 regarding 2600.183.b. and documentation will be kept in accordance with Regulation 2600.65(i). This re-education of staff included that the med room door, medication carts (secured with key entry), the lap top computer (passcode protected), closet (secured by key entry) containing resident charts are to be secured at all times.*

*Administrator will reinforce facility policies and procedures regarding the med room door. On 11/18/2024 DCS supervisor [redacted] posted a sign on the med room door (that is already equipped with a keypad to ensure confidentiality), reminding staff members to close the door when all staff members leave the room and it is unoccupied so that unauthorized persons are not able to access confidential information. Administrator is to perform weekly checks beginning 10/30/2024 for 6 months to ensure that the med room that contains prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. Please see attached documentation*

## 183b - Meds and Syringes Locked *(continued)*

**Licensee's Proposed Overall Completion Date:** *11/19/2024*
Licensee's Proposed Date for POC Implementation

***Implemented [redacted] - 12/04/2024)***

## 184a - Resident's Meds Labeled

**15. Requirements**

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

**Description of Violation**

*At 1:15 p.m., there was a Lantus Solostar 3 mL pen in a clear zip top bag identified as belonging to resident #9 in the medication cart, but there was no pharmacy label on the bag. There were only handwritten directions on the bag. There was no pharmacy label for this medication in the home.*

*Resident #10 is ordered Ozempic 0.25-0.5mg dose pen – inject 0.25mg sub-q once a week on Friday times 4 weeks. However, the pharmacy label indicates Ozempic – inject 0.25mg sub-Q once a week on Saturday times 4 weeks.*

**Plan of Correction** ***Accept [redacted] 11/25/2024)***

*Administrator re-educated all med staff on 10/22/2024 regarding 2600.184.a. including all medications that are prescription only be labeled with a pharmacy label. Administrator completed an initial audit of all resident medications to ensure compliance with regulation 2600.184a on 10/18/2024. Administrator also addressed when 'change of direction' auxiliary labels are to be utilized. and documentation will be kept in accordance with Regulation 2600.65(i).*
*Administrator is to perform weekly checks beginning 10/30/2024 for 6 months to ensure that original container for prescription medications shall be labeled with a pharmacy label that includes the following: the resident's name, the name of the medication, the date the prescription was issued, the prescribed dosage and instructions for administration and the name and title of the prescriber.* [redacted] *Drug Store sent a new label to the facility on 10/16/2024 to ensure that the medication was accurately labeled. The original order for Ozempic does not specify "on Friday". Per the pharmacist at Health Direct Pharmacy* [redacted] *since this particular drug is only given weekly, a day of the week must be specified on the MAR so that the resident can administer this medication with compliance per MD order. A 'Change of Direction, refer to chart' was adhered to the medication even though the resident self-administers this medication, also per CRNP order on DME. This resident's Initial DME states this in the medication addendum section and was updated on 10/16/2024 for self administration clarification purposes. Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *11/19/2024*
Licensee's Proposed Date for POC Implementation

***Implemented [redacted] - 12/04/2024)***

## 185a - Implement Storage Procedures

**16. Requirements**

## 185a - Implement Storage Procedures *(continued)*

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

**Description of Violation**

*Resident #4 is ordered glucometer readings daily. On 10/2/25 at 7:05 a.m., the blood glucose measurement on the resident's glucometer was 67. However, 64 was entered on the resident's October 2024 medication administration record (MAR) for this reading.*

*Resident #10 is ordered Baclofen 10mg tablet – take one tablet by mouth two times a day as needed for spasms. However, at 1:48 p.m., this medication was not available in the home.*

*Resident #10 is ordered sumatriptan succ 100mg tablet – take 1 tablet by mouth at onset of headache and at least 2 hours between doses as needed if no relief **nte 2 doses in 24 hours for migraine headaches. At 1:50 p.m., this medication was not available in the home.* Repeat Violation 8/30/23 et al.

**Plan of Correction** ***Accept [redacted] - 11/25/2024)***

*Administrator [redacted] re-educated all med staff on 10/22/2024 regarding 2600.185.a. specifying that all blood glucose readings must be accurately entered into the MAR and documentation will be kept in accordance with Regulation 2600.65(i).*
*Administrator [redacted] completed an initial audit, on 10/18/2024, of all current resident medications to ensure compliance with 2600.185(a). Administrator [redacted] is to perform weekly audits beginning 10/30/2024 for 6 months to ensure that all glucometer readings accurately match all entered blood glucose readings documented in the MAR. This weekly audit also ensures that all medications ordered including PRNs are readily available in the home for all residents. Due to resident #10 is deemed able to take medications on outings to [redacted] house per CRNP on DME, the medications do not have to be available in the home when the resident is on an outing, which was the case. The resident returned to the facility on same day [redacted] with both medications on person. Med tech [redacted] re-ordered the baclofen and sumatriptan to ensure that both medications were readily available for the resident per need. The baclofen and sumatriptan were delivered on 10/18/2024. Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *11/19/2024* Not Implemented ([redacted] - 12/4/24)
Licensee's Proposed Date for POC Implementation

## 187d - Follow Prescriber's Orders

**17. Requirements**

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

**Description of Violation**

*Resident #10 is ordered insulin aspart 100 unit/ml pen – inject sub-q 3 times a day per scale: max daily dose 120 <70-90=0; 91-120=12u; 121-150=30u; 151-200=33u; 201-250=36u; 251-300=39u; 301-350=42u; 351-400=45u; >400=48u & call md. However, the resident's Dexcom 7 sensor has not been applied due to the home not having a reader available to read the resident's blood glucose levels. Therefore, the resident's blood glucose readings have not been taken and subsequent sliding scale insulin has not been administered three times daily from 10/1/24 – 10/16/24.*

**Plan of Correction** ***Accept [redacted] - 11/25/2024)***

*Administrator re-educated all med staff on 10/22/2024 regarding 2600.187.d on all residents that are ordered blood glucose checks must have all devices and supplies in the home, working properly and are readily available per MD order. Documentation will be kept in accordance with Regulation 2600.65(i).*
*Though the sliding scale order in this violation was discontinued per MD and CRNP on 10/23/2024 along with the*

## 187d - Follow Prescriber's Orders (continued)

*Dexcom 7 sensor and reader system, a One Touch Ultra Glucometer, test strips and related supplies were ordered to ensure that any ordered blood glucose testing can be performed. Administrator is to perform weekly checks beginning 10/30/2024 for 6 months to ensure that all supplies in the med cart are readily available in the home. the administrator will also ensure that all MARs will be reviewed, to ensure compliance with regulation 2600.187(d). Please see attached documentation*

**Licensee's Proposed Overall Completion Date:** *11/19/2024*
Licensee's Proposed Date for POC Implementation

***Implemented [redacted] - 12/04/2024)***

## 225a - Assessment 15 Days

**18. Requirements**

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

**Description of Violation**

*Resident #4 was admitted to the home on [redacted] However, an initial assessment has not been completed for the resident.*

**Plan of Correction** ***Accept [redacted] - 11/25/2024)***

*Administrator did have a completed written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator completed this assessment during the emergency closure of the resident's previous PCH. Administrator is aware and maintains compliance with this regulation. Moving forward, the administrator will only give copies of the initial assessment to the designated party when a relocation is involved. Administrator completed an audit on 10/23/2024 of all current resident charts and verified that all initial assessments were completed within the department required timeframe. This violation was an oversight by the administrator and the resident in the violation has since moved out of the facility on 10/17/2024. Administrator [redacted] to educate staff responsible for maintaining compliance with the regulations and the home's policies and procedures, DCS [redacted] and DCS [redacted] on 11/18/2024, that upon completion of an initial assessment, that either [redacted] or [redacted] will verify and initial the bottom of the first page of the initial assessment for accuracy and timeframe compliance. Documentation of the education will be kept in accordance with regulation 2600.65(i). Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *11/19/2024*
Licensee's Proposed Date for POC Implementation

Not Implemented ([redacted] - 12/4/24)

## 227a - Support Plan 30 Days

**19. Requirements**

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

**Description of Violation**

*Resident #4 was admitted to the home on [redacted] However, an initial support plan has not been completed for the resident.*

**Plan of Correction** ***Accept [redacted] - 11/25/2024)***

*Administrator did have a completed Support Plan documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. Administrator is aware and maintains compliance with*

227a - Support Plan 30 Days (continued)

*this regulation. Moving forward, the administrator will only give copies of the support plan to the designated party when a relocation is involved. Administrator completed an initial audit on 10/23/2024 of all current resident charts and verified that all residents' support plans were completed within the department required timeframe. This violation was an oversight by the administrator and the resident in the violation has since moved out of the facility on [redacted] Administrator [redacted] to educate staff responsible for maintaining compliance with the regulations and the home's policies and procedures, DCS [redacted] and DCS [redacted] on 11/18/2024, that upon completion of an initial, annual or status/significant change of a support plan, that either [redacted] or [redacted] will verify and initial the bottom of the first page of the support plan for accuracy and timeframe compliance. Documentation of the education will be kept in accordance with regulation 2600.65(i). Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *11/19/2024*

Licensee's Proposed Date for POC Implementation

Not Implemented ([redacted] - 12/4/24)

Department of Human Services
Bureau of Human Service Licensing

# LICENSING INSPECTION SUMMARY - PUBLIC

## Facility Information

**Name:** *GRACEFUL CARE LIVING* **License #:** *45467* **License Expiration:** *10/09/2024*

**Address:** *211 GARNIER STREET, SHARPSBURG, PA 15215*

**County:** *ALLEGHENY* **Region:** *WESTERN*

## Administrator

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

## Legal Entity

**Name:** *GRACEFUL CARE LIVING, LLC*

**Address:** [redacted]

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

## Certificate(s) of Occupancy

**Type:** *C-2 LP* **Date:** *03/08/1996* **Issued By:** *PA Dept L&I*

## Staffing Hours

**Resident Support Staff:** *0* **Total Daily Staff:** *35* **Waking Staff:** *26*

## Inspection Information

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

**Reason:** *Complaint* **Exit Conference Date:** *11/20/2024*

## Inspection Dates and Department Representative

*11/20/2024 - On-Site:* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity:** *52* **Residents Served:** *31*

### Secured Dementia Care Unit

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

### Hospice

**Current Residents:** *9*

### Number of Residents Who:

**Receive Supplemental Security Income:** *6* **Are 60 Years of Age or Older:** *26*

**Diagnosed with Mental Illness:** *12* **Diagnosed with Intellectual Disability:** *3*

**Have Mobility Need:** *4* **Have Physical Disability:** *2*

# Inspections / Reviews

## 11/20/2024 - Partial

**Lead Inspector:** [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/05/2024*

## Inspections / Reviews *(continued)*

**12/04/2024 - POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *12/05/2024*

**Reviewer:** [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/09/2024*

**12/09/2024 - Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *12/05/2024*

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

## 88a - Surfaces

**1. Requirements**

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

**Description of Violation**

*At approximately 9:55 a.m., the common full bathroom on the fifth-floor was missing the third floor-tile from the right-side wall at the threshold for the shower stall basin and exposed an approximate twelve-inch-by-twelve-inch opening to the sub-floor. The floor-tile immediately to the left was also cracked, loose, and completely separated from the the sub-floor. Debris from the broken tile that measured approximately one-inch by one-half-inch had sharp edges and presented a risk for injury to any resident using the bathroom without foot protection. At approximately 9:38 a.m. resident #1 was observed entering and leaving the fifth-floor bathroom barefoot. Additionally, a section of floor-tile was missing from the tile directly in front of the bathroom waste basket that measured approximately twelve-inches across, approximately three-quarters-of-an-inch at the narrowest point, and approximately three-and-three-quarters-of-an-inch at the widest point and also exposed the sub-floor beneath.*

**Plan of Correction** ***Accept[redacted] - 12/04/2024)***

*On 11/21/2024, administrator[redacted] completed an initial audit of all facility restrooms floors, walls/ceilings, baseboards for any disrepair. Administrator[redacted] and DCS[redacted] replaced the noted floor tiles (on 11/21/2024) listed in this violation so that they are now in good repair. Administrator will perform documented weekly checks of the facility restrooms beginning 11/25/2024 for 6 months, then resume monthly checks thereafter to ensure that all facility floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards in accordance with 2600.88.a. Staff was educated by administrator[redacted] on 8/30/2024 and re-educated by administrator [redacted] on 11/29/2024 regarding the maintenance reporting either via the maintenance reporting logs located within the kitchen pantry as well as the staff communication electronic portal of any floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards. Documentation of the education will be kept on file in accordance with regulation 2600.65.i. Please see attached documentation.*

**Licensee's Proposed Overall Completion Date:** *11/28/2024*

***Not Implemented [redacted] - 12/09/2024)***