pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SUCCESS REHABILITATION, INC.**
LEGAL ENTITY

To operate **SUCCESS REHABILITATION AT ROCK RIDGE**
NAME OF FACILITY OR AGENCY

Located at **5666 CLYMER ROAD, QUAKERTOWN, PA 18951**
(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 **35**
(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 **September 20, 2024** until **March 20, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **127301**

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

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: SEPTEMBER 20, 2024

[redacted]
CEO/President
Success Rehabilitation, Inc.
5666 Clymer Road
Quakertown, Pennsylvania 18951

RE: Success Rehabilitation at Rock Ridge
License #: 127301

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection February 22 and 26, 2024, June 13, 2024, and July 8, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from September 20, 2024 to March 20, 2025.

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

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

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)
85d	III	23	$3	$69	15 calendar days from mailing date of this letter
132f	II	23	$5	$115	5 calendar days from mailing date of this letter

[redacted]

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 FIRST 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 FIRST 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

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: *SUCCESS REHABILITATION AT ROCK RIDGE* **License #:** *12730* **License Expiration:** *08/18/2024*

Address: *5666 CLYMER ROAD, QUAKERTOWN, PA 18951*

County: *BUCKS* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *SUCCESS REHABILITATION, INC.*

Address: *5666 CLYMER ROAD, QUAKERTOWN, PA, 18951*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *11/15/1995* **Issued By:** *Department of Labor & Industry*

Staffing Hours

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

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *02/26/2024*

Inspection Dates and Department Representative

02/22/2024 - On-Site: [redacted]

02/26/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *35* **Residents Served:** *21*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *15* **Are 60 Years of Age or Older:** *5*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *7* **Have Physical Disability:** *0*

Inspections / Reviews

02/22/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/29/2024*

04/17/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/01/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/19/2024*

05/01/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/01/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/01/2024*

07/18/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *07/01/2024*

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

42b - Abuse

1. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted] resident #1 and resident #2 were smoking outside in the smoke area. Resident #1 became agitated when resident #2 made a statement that cigarette butts should be extinguished or put out properly. Resident #1 became agitated by this statement and grabbed resident #2 by the neck with both hands stating "I'm going to kill you" repeatedly. The residents were unattended by staff during this altercation.

Resident #1's assessment and support plan (RASP), dated [redacted] indicates the resident will "lash out at staff or peers verbally or physically if told something that [redacted] doesn't like." The plan to address this need states "Staff will be educated with [resident #1's] ARAF to know how to address situations if they arise." The home maintains a separate document called the "ARAF" - Acute Risk Assessment Form. The resident was re-evaluated on [redacted] The home's "team", which consists of nursing staff, psychotherapists, case manager, psychiatrist, and the resident's parents, placed risk reduction measures to address resident #1's behaviors to include: "15 minute checks must be conducted by staff during shift to make sure [resident #1] is in program, in [redacted] room at home." and "Staff must keep eyes on [redacted] at all times and keep your self and [resident #1] peers safe." The ARAF also states "If [redacted] is agitated, please try and move [resident #1] away from the situation and away from the staff or peer that is upsetting [redacted] and "Please be careful with approaching [resident #1] when [redacted] is overly aggressive"

The home issued a 30 day notice to resident #1 on [redacted] which describes the resident's past violations, to include verbal abuse and threats toward staff, inflicting damage to a door that was locked in May of 2023, and on 7/19/23, threatening and intimidating a staff member, removing [redacted] access to communication outside of the home, and prevented the staff member from getting away. Though the letter states that the resident would be discharged effective [redacted], the resident remained in the home. The home's discharge criteria states that a client can be discharged without notice or at the end of a 30 day notice period for reasons which include "Excessive violence that endangers the safety of client or others and that cannot be successfully curtailed in this setting through behavior management practices or medication."

Plan of Correction ***Directed ([redacted] - 04/30/2024)***

Please see attached. Success Rehabilitation Inc's Discharge Criteria Policy was modified in January 2023 and states that clients are provided a 30-day notice period for reasons which include but not limited to "Excessive violence that endangers the safety of client or others that cannot be successfully curtailed in this setting through behavior management practices."
Resident #1 is assigned a 1:1 staff during wake hours from 7am-11pm as well as a staff stationed outside of [redacted] bedroom on 11-7am shift. Resident #1 is assigned 15-minute checks to ensure [redacted] safety and well being as well as the s
At Exit Interview, the PCH Administrator provided documentation to the licensing investigator highlighting contacts made since Resident #1's discharge notice became effective on [redacted] between SRI, Resident #1's family, and Resident #1's Service Coordinator to work together to attempt to find an appropriate and safe discharge disposition for Resident #1. Due to Resident #1's high incidents of verbally aggressive behavior, [redacted] has been denied admission to all other TBI facilities in the State of Pennsylvania. While Resident #1 remains in placement at SRI until an alternative placement is found, measures have been put in place to increase staff monitoring and oversight to ensure the well-being and safety of Resident #1, other residents in the program, and staff. These measures ensure that a

42b - Abuse (continued)

resident is not neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment, or mistreated in any way.
On [redacted] following the incident where Resident #1 made physical contact with Resident #2 on SRI's outside smoking deck, Resident #1 was assigned a 1:1 staff during wake hours from 7am-11pm as well as a staff assigned to remain outside of [redacted] apartment in the hallway on the 11-7am shift while Resident #1 sleeps. Staff are required to complete 15-minute checks throughout all 3 shifts to ensure Resident #1 is accounted for and safe, as well as ensuring the safety of the other residents that they are not in harm's way. 1:1 staffing with 15-minute checks will remain in place until a new residential placement can be found to discharge Resident #1 from SRI.
This plan is highlighted in our Risk Assessment Policy (1:1 assignment with 15-minute checks) and will be instituted immediately in the event there are any future incidents of another resident attempting to harm self or another resident. This process is instituted and monitored by On Call Personnel and the PCH Administrator to ensure plan is instituted immediately following an incident of this nature until further assessment by the treatment team if resident can remain safely in program or a 30-day discharge notice is warranted.

Proposed Overall Completion Date: 04/30/2024

Directed Plan of Correction 5/1/24 [redacted]

Immediately, the administrator shall develop and maintain a weekly schedule to ensure that staff are available to provide 24 hours of continuous supervision in a one staff to one resident ratio for resident #1.

Within 10 days of the receipt of the acceptable plan of correction, the administrator shall update resident #1's RASP to include the details of supervision needs required as described in the resident's Risk Assessment.

Within 10 days of the receipt of the acceptable plan of correction, the administrator shall educate all direct care staff on the requirements of meeting the needs of the resident as described in the resident assessment and support plan.

Directed Completion Date: *05/11/2024*

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

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted])

187c - Refusal of Medication

3. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 1/12/24, 1/23/24, and 1/25/24 at 3:30pm, resident #1 refused to take a scheduled dose of Clonazepam 1mg tablet. The home did not report these refusals to the resident's prescriber.

Plan of Correction ***Accept ([redacted] - 04/17/2024)***

Resident #1's refusal to take scheduled doses of Clonazepam 1mg tablet on 1/12/24, 1/23/24, and 1/25/24 were reported to the resident's prescriber on 2/26/24 and note updated in Resident #1's Chart to reflect this contact. The PCH Administrator attended the Med Staff Meeting on 2/28/24 to review/retrain all med admin trained staff on the requirements and action required to be taken if a resident refuses to take a prescribed medication as stated in 2600 187.c This requirement will also be reviewed with all staff during the completion of their mandatory med practicums throughout year/each year.

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

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

187d - Follow Prescriber's Orders

4. Requirements

2600.

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

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

Description of Violation

Resident #1 is prescribed Clonazepam 1mg at 8am. However, resident #1 was administered this medication late on the following occasions:

- *12/1/23, at 10:21am*
- *1/1/24, at 9:33am*
- *1/2/24, at 9:59am*
- *1/3/24, at 9:39am*
- *1/12/24, at 9:34am*
- *2/10/24, at 10:05am*
- *2/23/24, at 10:10am*
- *2/26/24, at 9:32am*
- *1/23/24, at 9:52am*
- *1/29/24, at 10:17am*
- *2/2/24, at 11:25am*

Plan of Correction ***Directed ([redacted] - 04/30/2024)***

Resident #1 continues to have difficulty getting up in the morning to have Clonazepam 1mg at 8am administered; prescriber of medication notified of continuing difficulty and recommended a change in time. Please see attached.
During monthly audits of resident EMARs and Medications completed by assigned med trained staff, audits will now include flagging any patterns such as a resident's inability to take a prescribed medication within the designated time frame in order to address concerns and issues in a timely manner.
This plan started on 4/1/24, completed monthly, and completed by a med tech assigned on shift and/or personal care home administrator on site.

Proposed Overall Completion Date: 04/30/2024

Directed Plan of Correction 5/1/24 [redacted]

Immediately, the administrator or designee shall obtain clear and definitive orders from resident #1's physician that defines the administration time and is in accordance with 186a-c.

Immediately, a designated staff person qualified to administer medications shall review all resident MARs at least daily to ensure all resident medications are administered as prescribed for four weeks, then weekly for two months.

Within 15 days of the receipt of the acceptable plan of correction, all staff persons administering medication will be reeducated on administering medication including following the orders of the prescriber by the administrator or a staff person qualified as a medication administration train-the-trainer.

Directed Completion Date: *04/30/2024*

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

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

Facility Information

Name: *SUCCESS REHABILITATION AT ROCK RIDGE* **License #:** *12730* **License Expiration:** *08/18/2024*

Address: *5666 CLYMER ROAD, QUAKERTOWN, PA 18951*

County: *BUCKS* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *SUCCESS REHABILITATION, INC.*

Address: *5666 CLYMER ROAD, QUAKERTOWN, PA, 18951*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *11/15/1995* **Issued By:** *Department of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *31* **Waking Staff:** *23*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *06/13/2024*

Inspection Dates and Department Representative

06/13/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *35* **Residents Served:** *23*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older:** *6*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *8* **Have Physical Disability:** *0*

Inspections / Reviews

06/13/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/10/2024*

07/18/2024 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/20/2024*

07/25/2024 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/05/2024*

08/07/2024 - Document Submission

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

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

183e - Storing Medications

2. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On June 13, 2024, Resident#2 was prescribed Felbatol 400mg tablets. A tablet was discovered in the medication cart with the foil of blister pack #20 broken and taped over. This is not in accordance with the manufacturer's guidelines for maintaining proper sanitation conditions.

Plan of Correction ***Accept ([redacted] - 07/25/2024)***

On June 20th, 2024, a mandatory all staff meeting was held by SRI's lead certified Med Admin Trainer and PCH Administrator to review the recent incident of a foil blister pack being broken and taped over and that it is not in accordance with the manufacturer's guidelines for maintaining proper sanitation conditions. In the event of a future occurrence, staff were instructed to dispose of the medication following proper medication disposal guidelines and a replacement medication to be reordered.
SRI's Med Admin Trainers were also instructed by lead certified Med Admin Trainer at SRI, Nurse Administrator, and PCH Administrator to emphasize this process in upcoming med admin certification classes and assess staff for competency and understanding during med practicums.
SRI med cart audits continue to remain in place and completed on a bi-weekly basis by Nurse Supervisor and this is an area that is monitored by PCH Administrator to ensure completion. This plan will remain in place with no end date.

Proposed Overall Completion Date: 07/10/2024
Proposed Overall Completion Date: 07/23/2024

Licensee's Proposed Overall Completion Date: *07/23/2024*

Not Implemented ([redacted] - 08/07/2024)

185a - Implement Storage Procedures

3. Requirements

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

Description of Violation

Resident #3 is prescribed to have their fasting glucose levels checked every other day. On June 4, 2024, the glucometer showed a reading of 127, while the MAR recorded a reading of 134.

Plan of Correction ***Accept ([redacted] - 07/25/2024)***

The med tech that entered the wrong information in the MAR was counseled by the nursing supervisor and directed to always double check entry prior to submitting into the MAR.
Resident#3 is currently the only resident at SRI's PCH that has a glucometer for fasting glucose levels. Glucometer checks for accuracy of input into the MARs will be added and included in the bi-weekly med cart audits to be proactive in identifying any errors to ensure that information is accurate and correct.

A mandatory all staff meeting was held on June 20th and this topic was reviewed as well as the double check entry

185a - Implement Storage Procedures (continued)

method prior to submitting into the MAR.

To ensure that education was effective for the med tech, the individual's entries will be checked during the bi-weekly med cart audits by SRI's nurse supervisor, as well as checks of all staff completing any of these entries. This topic will also be included in the agenda for our regularly scheduled monthly staff meetings facilitated by the PCH Administrator and lead Med Admin Trainer periodically over the course of this year and moving forward with no end date.

Proposed Overall Completion Date: 07/23/2024

Licensee's Proposed Overall Completion Date: *07/23/2024*

Not Implemented (- 08/07/2024)

[redacted]

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

Facility Information

Name: *SUCCESS REHABILITATION AT ROCK RIDGE* **License #:** *12730* **License Expiration:** *08/18/2024*

Address: *5666 CLYMER ROAD, QUAKERTOWN, PA 18951*

County: *BUCKS* **Region:** *SOUTHEAST*

Administrator

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

Legal Entity

Name: *SUCCESS REHABILITATION, INC.*

Address: *5666 CLYMER ROAD, QUAKERTOWN, PA, 18951*

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

Certificate(s) of Occupancy

Type: *Other* **Date:** *11/15/1995* **Issued By:** *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *31* **Waking Staff:** *23*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *07/08/2024*

Inspection Dates and Department Representative

07/08/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *35* **Residents Served:** *23*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older:** *5*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *8* **Have Physical Disability:** *0*

Inspections / Reviews

07/08/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/29/2024*

Inspections / Reviews *(continued)*

08/13/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/12/2024*

Reviewer: [redacted] *her* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/16/2024*

09/09/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/20/2024*

Reviewer: [redacted] **Follow-Up Type**: *Bypass Document Submission*

09/09/2024 - Bypass Document Submission

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

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

17 - Record Confidentiality

1. Requirements

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

Description of Violation

On 7/8/2024, at 9:05am, an open laptop with resident records in view on the screen was unlocked, unattended, and accessible at the end of the B wing hallway.

Plan of Correction ***Accept (- 08/13/2024)***

On 7/8/2024, the open laptop was immediately locked by the PCH Administrator and the staff member who was responsible for leaving the laptop unlocked and unattended was immediately counseled by direct supervisor on the importance of keeping resident records confidential. The PCH Administrator already had an all-staff monthly meeting scheduled on 7/11/24- maintaining resident record confidentiality was added to the agenda for review. The PCH Administrator will continue to keep this topic on the agenda for periodic review in upcoming all staff meetings. The PCH Administrator has completed random checks since this violation was noted of all laptops that are accessible by staff at the PCH and will also add this extra check for the PCH Administrator to the monthly safety unit checks for this PCH.

Licensee's Proposed Overall Completion Date: *07/29/2024*

Not Implemented (- 09/09/2024)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated for resident 1 was not signed by the resident.

Plan of Correction ***Accept (- 08/22/2024)***

The resident-home contract dated was re-reviewed with Resident #1 during case management meeting scheduled on 7/12/24. Resident #1 confirmed awareness and understanding of current care plan in place with Case Manager and signed/date this acknowledgment after review.
An initial audit of all resident records was completed on 8/14/24 to ensure compliance by the PCH Administrators. To ensure compliance in this area, the PCH Administrator will complete a double check for accuracy and proper completion of all RASPS due on a monthly basis. This plan started on 7/29/24.

Licensee's Proposed Overall Completion Date: *08/14/2024*

Not Implemented (- 09/09/2024)

41e - Signed Statement

3. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident 1's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept (- 08/22/2024)***

The statement forms were re-reviewed by Resident #1's case manager and signed by Resident #1 acknowledging understanding and awareness of the resident rights and complaint procedures during case management meeting scheduled on 7/12/24.
An initial audit of all resident records was completed on 8/14/24 to ensure compliance by the PCH Administrators.
To ensure compliance in this area, the PCH Administrator will complete a double check for accuracy and proper completion of all resident admissions to the PCH when applicable. This plan started on 7/29/24.

Licensee's Proposed Overall Completion Date: *08/14/2024*

Not Implemented (- 09/09/2024)

51 - Criminal Background Check

4. Requirements

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A hired did not have a background check completed until

Plan of Correction ***Accept (- 08/22/2024)***

Staff person A is an agency staff contracted to work Success Rehabilitation Inc. The agency is required to ensure that all required, mandatory criminal history checks and paperwork are completed and current at contract start with Success Rehabilitation Inc. The agency also requires all agency staff complete criminal history checks annually. Copies of the 2024 criminal history checks for Staff Person A were provided to the licensing representative for review to ensure that Staff Person A is cleared and in compliance.
An initial audit of agency staff employee files was completed on 8/14/24 to ensure compliance by the PCH Administrators. SRI's Human Resources Director and HR Team have reviewed all agency staff/current staff files currently contracted and/or employed by Success Rehabilitation Inc to ensure accuracy and availability of all required documentation including but not limited to Criminal History Checks. SRI's Human Resources Director will double check all consultant files at start of contract and annually to ensure compliance is maintained in this area. This plan started on 7/29/24.

Licensee's Proposed Overall Completion Date: *08/14/2024*

Not Implemented (- 09/09/2024)

65e - 12 Hours Annual Training

6. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person B received no hours of annual training in training year 2023.

Plan of Correction ***Accept (- 08/22/2024)***

Direct Staff Person B received 12 hours of annual training related to job for the training year of 2023. The form that is required to be completed by Success Rehabilitation Inc. to track the completion of annual training hours was signed by Direct Care Staff Person B but not dated for each category. Direct Care Staff Person B has reviewed individual training record and signed off that the information is correct, and training was received.
Supervisors of all staff teams were notified by the PCH Administrators that they are now required to review training records for the staff they supervise on a monthly basis to ensure compliance and follow through on verifying and documenting successful completion of trainings as scheduled and provided. A secondary review will be completed monthly by the PCH Administrators monthly to ensure compliance. This plan started on 8/14/24.

Licensee's Proposed Overall Completion Date: *08/14/2024*

Not Implemented (- 09/09/2024)

65f - Training Topics

7. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

65f - Training Topics *(continued)*

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person B did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, personal care service needs of the resident, safe management techniques , care for residents with mental illness or an intellectual disability, or both, if the population is served in the home during training year 2023.

Direct care staff person C did not receive training in medication self-administration training during training year 2023.

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

Direct Staff Person B received training in the key categories as highlighted in the description of this violation as related to [redacted] job for the training year of 2023. The form that is required to be completed by Success Rehabilitation Inc. to track the completion of these training hours was signed by Direct Care Staff Person B but not dated for each category. Direct Care Staff Person B has reviewed [redacted] individual training record and signed off that the information is correct, and training was received.

Supervisors of all staff teams were notified by the PCH Administrators that they are now required to review training records for the staff they supervise on a monthly basis to ensure compliance and follow through on verifying and documenting successful completion of trainings as scheduled and provided. A secondary review will be completed monthly by the PCH Administrators monthly to ensure compliance. This plan started on 8/14/24.

Licensee's Proposed Overall Completion Date: *08/14/2024*

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

65g - Annual Training Content

8. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

65g - Annual Training Content *(continued)*

Description of Violation

Staff person B did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, during training year 1/1/2023 to 12/31/2023.

Plan of Correction ***Accept (- 08/22/2024)***

Direct Staff Person B received training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crisis and emergency situations, resident rights, the Older Adult Protective Services Act as related to job for the training year of 2023. The form that is required to be completed by Success Rehabilitation Inc. to track the completion of these training hours was signed by Direct Care Staff Person B but not dated for each category. Direct Care Staff Person B has reviewed individual training record and signed off that the information is correct, and training was received. Supervisors of all staff teams were notified by the PCH Administrators that they are now required to review training records for the staff they supervise on a monthly basis to ensure compliance and follow through on verifying and documenting successful completion of trainings as scheduled and provided. A secondary review will be completed monthly by the PCH Administrators monthly to ensure compliance. This plan started on 8/14/24.

Licensee's Proposed Overall Completion Date: *08/14/2024*

Not Implemented (- 09/09/2024)

65i - Training Record

9. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff training for staff person C does not include the dates the trainings occurred.

Plan of Correction ***Accept (- 08/22/2024)***

Direct Staff Person C received trainings as related to job for the training year of 2024. The form that is required to be completed by Success Rehabilitation Inc. to track the completion of these training hours was signed by Direct Care Staff Person C but not dated for each category. Direct Care Staff Person C has reviewed individual training record and signed off that the information is correct, and training was received.
Supervisors of all staff teams were notified by the PCH Administrators that they are now required to review training records for the staff they supervise on a monthly basis to ensure compliance and follow through on verifying and documenting successful completion of trainings as scheduled and provided. A secondary review will be completed monthly by the PCH Administrators monthly to ensure compliance. This plan started on 8/14/24.

Licensee's Proposed Overall Completion Date: *08/14/2024*

Not Implemented (- 09/09/2024)

66b - Training Plan Content

10. Requirements

2600.

66b - Training Plan Content *(continued)*

66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

1. The name, position and duties of each direct care staff person.
2. The required training courses for each staff person.
3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home's staff training plan for 2024 does not include the dates and times of the scheduled training for each staff person for the upcoming year.

Plan of Correction ***Directed ([redacted] - 08/22/2024)***

Please see attached. Success Rehabilitation Inc has maintained the same format listing the home's staff training plan for 2024 as years' prior without issue. We list dates/times as open ended as we are a facility that operates 24-hour p/day 365 days p/year with staff assigned to multiple shifts across the day. Our training dates/times vary to accommodate changing staff schedules to ensure training is offered to all and completed. (i.e. annual training hours are completed at staff's annual review. Annual reviews vary each month with a different group of staff)
Please see attached update; implemented on 8/16/24.

Directed plan of correction: In addition to the above plan of correction, Within 14 calendar days of the receipt of this POC, the administrator or designee shall update the annual training plan to include all required information and training topics for each staff person as determined by 2600 regulations and by the homes additional training requirements. The training plan shall be reviewed quarterly by the administrator or designee to ensure that the plan is being followed and that employees are receiving the required trainings according to the plan. Documentation of the reviews shall be kept and made available for Department review upon request.

Directed Completion Date: *08/19/2024*

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

81b - Resident Personal Equipment

11. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 7/8/2024, resident 3's bedside standing mobility pole is not securely installed in the ceiling. It was able to be moved with enough force to cause the drop ceiling to loosen and descend from the ceiling.

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

Resident #3's bedside standing mobility pole was adjusted and securely installed in the ceiling by Success Rehabilitation Inc's Maintenance Person immediately after being found. Staff did report this issue on a Maintenance Report that was submitted in the evening of 7/7/2024. All safety related maintenance concerns are elevated and addressed within 24 hours of receiving a safety related maintenance report from staff.
Alongside Maintenance Reports that are completed as needed when concerns are identified. Administrators are assigned to complete monthly safety checks of the main building which includes all client bedrooms. One of the categories on the safety unit checks is to check all DME equipment (as applicable) in client bedrooms (i.e. trapeze, transfer poles, bed enabler, etc. This plan continues to remain in place.
An all-staff meeting is scheduled on 8/20/24 to be facilitated by the PCH Administrator. This topic will be reviewed and the importance of being mindful and aware to report any safety and/or maintenance concerns to the

81b - Resident Personal Equipment (continued)

maintenance department to address.
A secondary review will be completed monthly by the PCH Administrators monthly to ensure compliance. This plan started on 8/14/24.

Licensee's Proposed Overall Completion Date: *08/20/2024*

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

85a - Sanitary Conditions

12. Requirements

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

Description of Violation

On 7/8/2024 at 9:42am, the box spring in room E1 was dirty and stained..

On 7/8/2024 at 9:45am, the shared bathroom of rooms E3 and E5 was covered in dots of an unknown white substance on the toilet, walls, and floors that appeared to be toothpaste or soap.

On 7/8/2024 at 10:05am, the shared bathroom of rooms B5 and B5 had a used wash rag on the floor touching the toilet cleaning brush, and a used wash rag on the vertical grab bar next to the toilet.

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

The items listed in this violation were addressed immediately by new box spring placed in E1s bedroom and E3, E5, B5 bathrooms wiped down and towel discarded while licensing investigator was onsite. The residents in Success Rehabilitation Inc's program all have a primary diagnosis of traumatic brain injuries that are using their bathrooms daily and working on regaining independency with ADLS/IADLS (i.e. relearning to brush their teeth independently and/or washing their face with towels) Client bedrooms and bathrooms are checked and cleaned daily each shift (7-3pm and 3-11pm) by staff assigned on shift to that assigned area. Administrators are also assigned to complete a monthly safety and cleanliness check of all bedrooms and common areas. This plan continues to remain in place. An all-staff meeting is scheduled on 8/20/24 to be facilitated by the PCH Administrator. This topic will be reviewed and the importance of ensuring sanitary conditions are maintained and/or identified problem and elevated to the PCH Administrator to address,
A secondary review will be completed monthly by a member of the Maintenance Team monthly to ensure compliance. This plan started on 8/14/24.

Licensee's Proposed Overall Completion Date: *08/20/2024*

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

85d - Trash Receptacles

13. Requirements

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

Description of Violation

On 7/8/2024 at 9:45 am there was a full, uncovered, unattended trash can in the shared bathroom of rooms E3 and E5.

85d - Trash Receptacles (continued)

On 7/8/2024 at 10:15 am there was a full, uncovered, unattended trash can in the shared bathroom of the A wing.

Repeated violation: 7/20/23

Plan of Correction ***Accept (- 08/22/2024)***

Please see attached photos. On 7/9/24, all trash receptacles were replaced in shared bathrooms to ensure that the lids remain attached and unable to be detached by residents. Administrators' complete monthly safety inspections of the PCH/main building that includes checking and ensuring that trash receptables are kept covered in the kitchen and client bathrooms. This plan remains in place.

An all-staff meeting is scheduled on 8/20/24 to be facilitated by the PCH Administrator. This topic will be reviewed and the importance of ensuring trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents and/or identified problem and elevated to the PCH Administrator to address,

A secondary review will be completed monthly by a member of the Maintenance Team monthly to ensure compliance. This plan started on 8/14/24.

Licensee's Proposed Overall Completion Date: *08/20/2024*

Not Implemented (- 09/09/2024)

88a - Surfaces

14. 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

On 7/8/2024 at 10:00 am, The drop ceiling in room B3 had a bedside standing mobility pole running through it. The pole was not secured properly, causing the opening in the ceiling to become jagged and erode, and movement of the pole caused the ceiling tile to fall from the ceiling.

Plan of Correction ***Accept (- 08/22/2024)***

Resident # 's (Room B3) bedside standing mobility pole was adjusted and securely installed in the ceiling by Success Rehabilitation Inc's Maintenance Person immediately after being found. The ceiling tile was also replaced immediately with a protective sealer around pole. Staff did report this issue on a Maintenance Report that was submitted in the evening of 7/7/2024. All safety related maintenance concerns are elevated and addressed within 24 hours of receiving a safety related maintenance report from staff.

Alongside Maintenance Reports that are completed as needed when concerns are identified. Administrators are assigned to complete monthly safety checks of the main building which includes all client bedrooms. One of the categories on the safety unit checks is to check all DME equipment (as applicable) in client bedrooms (i.e. trapeze, transfer poles, bed enabler, etc. This plan continues to remain in place.

An all-staff meeting is scheduled on 8/20/24 to be facilitated by the PCH Administrator. This topic will be reviewed and the importance of ensuring floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards and/or identified problem and elevated to the PCH Administrator to address,

A secondary review will be completed monthly by a member of the Maintenance Team monthly to ensure compliance. This plan started on 8/14/24.

Licensee's Proposed Overall Completion Date: *08/20/2024*

Not Implemented (- 09/09/2024)

95 - Furniture and Equipment

15. Requirements

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

Description of Violation

On 7/8/24, multiple cigarette burn holes were observed on the chairs located on the side porch connected to wing A that is used as a designated smoking area.

Plan of Correction ***Accept ([redacted] - 08/13/2024)***

The chairs were replaced on 7/12/24 in wing A/designated smoking area. Administrators are assigned to complete monthly safety checks of all sections of the PCH main building of common areas and client bedrooms. This additional check has been added to A section monthly safety checks to start in the month of 8/2024.
On 7/11/24, PCH Administrator facilitated an all-staff meeting. The topic of: Furniture and equipment remaining in good repair, clean and free of hazards was reviewed and the importance of being mindful and aware to report any safety and/or maintenance concerns to the maintenance department to address. (i.e. cigarette burns in designated smoking area)

Licensee's Proposed Overall Completion Date: *07/29/2024*

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

101j1 - Mattress Fire Retardant

16. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire retardant mattress.

Description of Violation

On 7/8/24 ,the bed in room E1 was not on a solid foundation. The box spring sagged towards the ground on the bottom right side. When box spring was lifted, it was not properly positioned on the bed frame.

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

The item listed in this violation was addressed immediately by new box spring placed in E1s bedroom while licensing investigator was onsite. The box spring was lifted and repositioned to fit appropriately in the bed frame. Client bedrooms and bathrooms are checked and cleaned daily each shift (7-3pm and 3-11pm) by staff assigned on shift to that assigned area. Administrators are also assigned to complete a monthly safety and cleanliness check of all bedrooms and common areas. This plan continues to remain in place.
An all-staff meeting is scheduled on 8/20/24 to be facilitated by the PCH Administrator. This topic will be reviewed and the importance of ensuring each resident shall have the following in the bedroom: A bed with a solid foundation and fire-retardant mattress that is in good repair, clean and supports the resident. A legal entity with a personal care home license for the home as of October 24, 2005, shall be exempt from the requirement for a fire-retardant mattress and/or identified problem and elevated to the PCH Administrator to address,
A secondary review will be completed monthly by a member of the Maintenance Team monthly to ensure compliance. This plan started on 8/14/24.

Licensee's Proposed Overall Completion Date: *08/20/2024*

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

101j2 - Bedroom Chairs

17. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

Bedroom E5 is occupied by 1 resident; however, there is no chair in this room. Resident [redacted] stated [redacted] has never had a chair and would like one.

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

The item listed in this violation was addressed immediately by placing a chair in Resident [redacted] /Bedroom E5 bedroom. Resident [redacted] has a primary medical diagnosis of traumatic brain injury that often directly impacts [redacted] ability to have good short term memory recall and a cognitive impairment that impact [redacted] ability to retain information. Resident [redacted] did state "[redacted] never had a chair and would like one", then proceeded to ask the PCH Administrator right after this statement "Or did I just forget I did or take out of my bedroom into the living room?"
Client bedrooms and bathrooms are checked and cleaned daily each shift (7-3pm and 3-11pm) by staff assigned on shift to that assigned area. Administrators are also assigned to complete a monthly safety and cleanliness check of all bedrooms and common areas which includes ensuring that there is a chair in each client bedroom. This plan continues to remain in place.
An all-staff meeting is scheduled on 8/20/24 to be facilitated by the PCH Administrator. This topic will be reviewed and the importance of ensuring each resident shall have the following in the bedroom: A chair for each resident that meets the resident's needs and/or identified missing and elevated to the PCH Administrator to address,
A secondary review will be completed monthly by a member of the Maintenance Team monthly to ensure compliance. This plan started on 8/14/24.

Licensee's Proposed Overall Completion Date: *08/20/2024*

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

102i - Soap Dispenser

18. 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

On 7/8/24, there was a pile of unlabeled used bars of soap in the bathroom shared by bedrooms B3 and B5.

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

There was one used bar of soap that was owned by client residing in B3 while licensing investigator was onsite and witnessed by the PCH Administrator. The bar of soap was immediately removed and replaced with a new dispenser with same soap product. Client's family with client participating on the call was contacted on 7/9/24 to review this requirement. Client/family requested to shift to liquid dispenser format. Client bedrooms and bathrooms are checked and cleaned daily each shift (7-3pm and 3-11pm) by staff assigned on shift to that assigned area. Administrators are also assigned to complete a monthly safety and cleanliness check of all bedrooms and common areas which includes the use and labeling and proper storage of bar soap vs liquid soap dispensers. This plan continues to remain in place.
An all-staff meeting is scheduled on 8/20/24 to be facilitated by the PCH Administrator. This topic will be reviewed and the importance of ensuring 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 and/or identified problem and elevated to the PCH Administrator to address and educate.

102i - Soap Dispenser (continued)

A secondary review will be completed monthly by a member of the Maintenance Team monthly to ensure compliance. This plan started on 8/14/24.

Licensee's Proposed Overall Completion Date: *08/20/2024*

Not Implemented (- 09/09/2024)

[redacted]

103i - Outdated Food

20. Requirements

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

Description of Violation

On 7/8/24, there was an undated opened squeeze bottle of grape jelly that's label reads "Refrigerate after opening" in the cabinet in the kitchen serving area.

Plan of Correction ***Accept (- 08/22/2024)***

On 7/8/24, the undated opened squeeze bottle of grape jelly was removed immediately from the kitchen cabinet and staff was counseled by the PCH Administrator after admitting fault with not dating and placing the item in the refrigerator following Safe Serve guidelines.
On 7/11/24, an all-staff meeting was held and 2600.103.i. -Outdated or spoiled food or dented cans may not be

103i - Outdated Food (continued)

used was reviewed.
The kitchen area is checked and cleaned daily each shift (7-3pm and 3-11pm) by staff assigned on shift to that assigned area. Administrators are also assigned to complete a monthly safety check of all bedrooms and common areas which includes the kitchen area. This plan continues to remain in place.
A secondary review will be completed monthly by the PCH Administrators monthly to ensure compliance. This plan started on 8/14/24.

Licensee's Proposed Overall Completion Date: *08/20/2024*

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

131f - Fire Extinguisher Inspection

21. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the Chevy Traverse vehicle has not been inspected by a fire safety expert.

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

Please see attached. Contract signed on 8/13/24 where a fire safety expert will inspect and tag all vehicle fire extinguishers by 8/26/24. Then moving forward the same fire safety expert company will complete inspection and tags of both the main building and vehicles annually. Bi-weekly vehicle inspections are completed by SRI's Transportation Coordinator to monitor and staff are trained on the expectations/procedure to ensure compliance and safety is maintained. Please see attached.

Licensee's Proposed Overall Completion Date: *08/20/2024*

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

132f - Alternate Exit Routes

22. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

Exits "A,B,C, E front" were used during fire drills held from 1/25/2024-6/21/2024. Resident's are directed to go through the nearest exit instead of using alternate exits.

Repeat Violation date 7/20/2023

Plan of Correction ***Accept ([redacted] - 08/13/2024)***

Success Rehabilitation's PCH Administrator assigned to oversee fire drills at the PCH reviewed the fire drills with the licensing investigator as the drills were conducted based on the location of the "fire" and the residents at that time drill was taking place, so the nearest exit was used based on their location at that time which was also the alternate exit. The licensing inspector reviewed better practices and examples with this PCH Administrator to conduct these fire drills moving forward to meet the requirement of 2600.132.f. Alternate exit routes shall be used during fire drills. This plan is now in place and will be applied by the PCH Administrator during the next fire drill in August 2024.

132f - Alternate Exit Routes (continued)

On 7/11/24, an all-staff meeting was held and the topic of 2600.132.f. Alternate exit routes shall be used during fire drills. On 7/11/24, this topic was also reviewed with the residents of the PCH during day program groups to review and ensure competency in following this plan during fire drills. This will be reviewed periodically with staff throughout the year in staff meetings as well as the clients in day program groups.

Licensee's Proposed Overall Completion Date: *07/29/2024*

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

141b1 - Annual Medical Evaluation

23. Requirements

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

Description of Violation

Resident 2's most recent medical evaluation was completed on 4/28/2024. The resident's previous medical evaluation was completed on 3/31/2023.

Resident 3's most recent medical evaluation was completed on 5/15/2024. The resident's previous medical evaluation was completed on 4/14/2023.

Plan of Correction ***Accept ([redacted] - 08/13/2024)***

Success Rehabilitation Inc's PCH Administrator met with the CRNP scheduled to complete DMEs for the PCH clients to review 2600.141.b.1. A resident shall have a medical evaluation: At least annually and cannot be completed past the 15-day grace period. SRI assigned a clinical administrative assistant to track and manage the medical calendar monthly to flag and notify CRNP when clients annual DMEs are due to ensure that clients moving forward complete their individual DME in a timely manner and within the annual time frames. This plan will be monitored by the PCH Administrator during monthly checks. This plan in effect beginning 7/12/24.

Licensee's Proposed Overall Completion Date: *07/29/2024*

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

183b - Meds and Syringes Locked

24. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 7/8/2024 at 9:45am, Mupirocin 2% ointment and Clotrimazole 1% cream belonging to resident 2 was unlocked, unattended, and accessible in shared bathroom of rooms E3 and E5.

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

Resident 2 was prescribed and cleared to self-administer OTC Medications, Mupirocin 2% ointment and Clotrimazole 1% cream short term to address a condition by CRNP who completed [redacted] evaluation and DME update. Resident 2 was counseled and showed competency in keeping [redacted] creams locked and accessible to only him to use in the privacy of [redacted] bedroom then proceed to lock creams up for safe keeping until next use. The CRNP prescribing these creams which are now finished and have addressed Resident 2's condition with no further medical treatment required was

183b - Meds and Syringes Locked (continued)

notified of the incident on 7/8/24. Resident 2 met with the CRNP to review the criteria to be approved to self-medicate again in the future and that this would be re-evaluated if the need should present itself again.
Currently, there are no residents at the PCH that are approved to self- medicate routine or OTC medications. In the event that a client requests to be evaluated to self-medicate in the future, a check procedure is now in place where the staff on shift each shift in the client's assigned area would check client bedroom to ensure the client is maintaining self-medication protocols that includes the safe- guarding of medications. This plan remains in place.
An all-staff meeting is scheduled on 8/20/24 to be facilitated by the PCH Administrator which will include an in-service training to ensure understanding and competency in the importance of maintaining ongoing compliance in ensuring that meds remain locked and in safekeeping at all times and/or if identified problem of unlocked meds found that this concern is immediately elevated to the PCH Administrator on site to address and educate.
This in -service training will continue bi-annually and facilitated by the PCH Administrators.

Licensee's Proposed Overall Completion Date: *08/20/2024*

Not Implemented (- 09/09/2024)

191 - Resident Right to Refuse

25. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident 1, admitted 10/18/2022, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Accept (- 08/22/2024)***

Resident 1's Home Contract was re-reviewed with Resident #1 during case management meeting scheduled on 7/12/24. Resident #1 confirmed awareness and understanding of right to refuse medication if he believes that there may be a medication error.
The Resident Rights which include the right to refuse medication if a resident believes that there may be a medication error is included in the Participant Handbook which is reviewed annually with each resident. Resident 1 signed off on this review and understanding of all guidelines highlighted in this Participant Handbook and was provided a copy to keep current in bedroom for reference as needed at admission on 10/18/2022, then annually in 2023 and 2024. Signature form confirming review and receipt is kept in Resident 1's Case Record for proof and verification.
To ensure compliance in this area, the PCH Administrator will complete a double check for accuracy and proper completion of all new admissions' paperwork which includes the Resident Home Contract on a monthly basis. This plan started on 7/29/24.
An initial audit of all resident records was completed on 8/14/24 to ensure compliance by the PCH Administrators.

Licensee's Proposed Overall Completion Date: *08/20/2024*

Not Implemented (- 09/09/2024)

252 - Record Content

26. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:

252 - Record Content *(continued)*

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident 3's record does not include a photograph of the resident that is no more than 2 years old.

Resident 4's record does not include a photograph of the resident that is no more than 2 years old.

Plan of Correction ***Accept ([redacted] - 08/22/2024)***

On 7/8/24, Resident #3 and Resident #4's photographs were taken and their individual face sheets updated in their perspective case records.
Resident photos are taken annually and updated in the individual's face sheet and resident records by the clinical administrative assistants at the start of each new year. To avoid this clerical error from occurring in the future, a double check of face sheets will be completed annually in the first quarter by the Director of Operations prior to filing face sheets in individual Client Case Records to ensure compliance is maintained in this area.
An initial audit of all resident records was completed on 8/14/24 to ensure compliance by the PCH Administrators.

Licensee's Proposed Overall Completion Date: *08/20/2024*

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